THE STATE OF WORLD POPULATION 2000

Lives Together, Worlds Apart

Shezad Noorani/Still Pictures

Men and Women in a Time of Change

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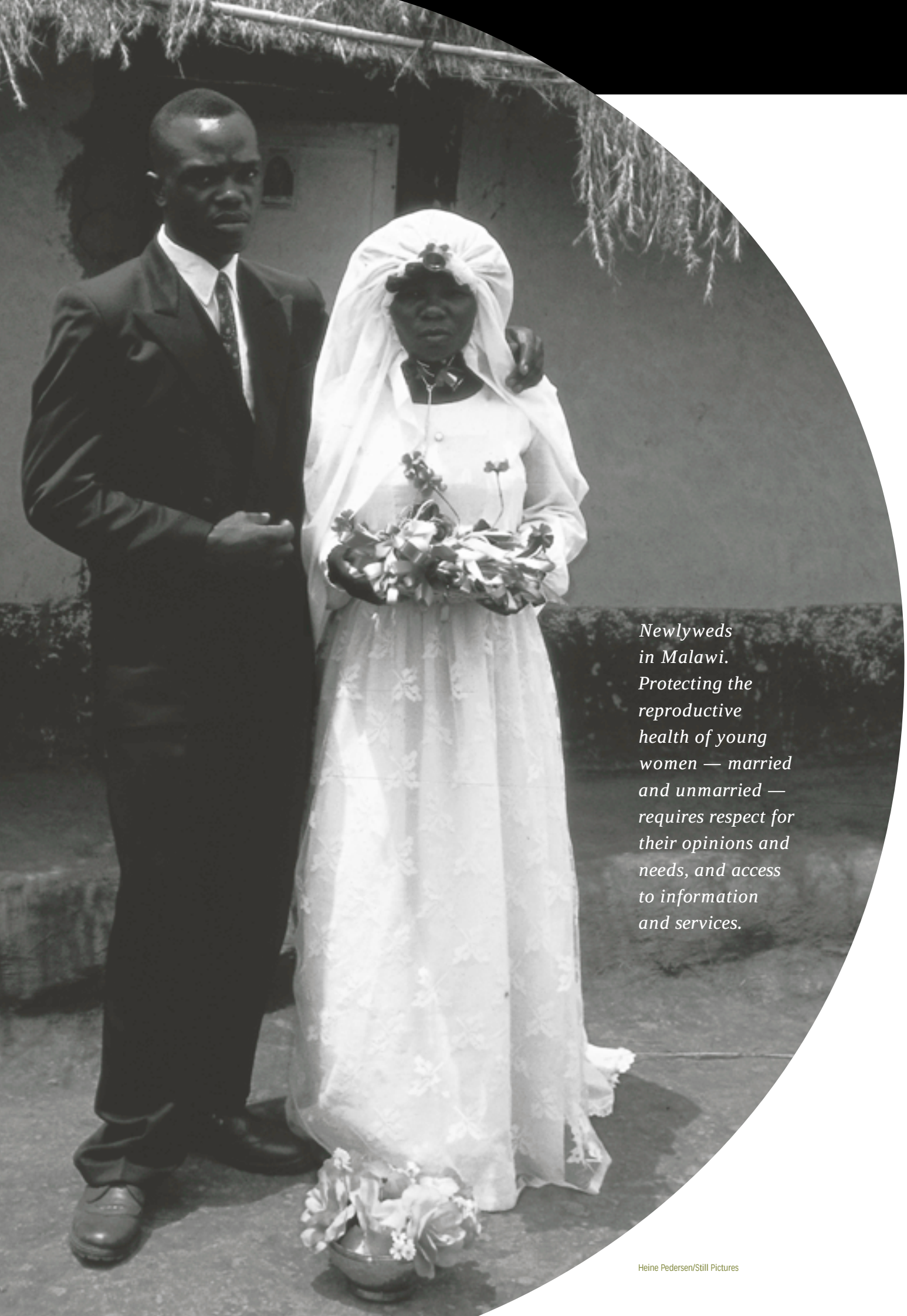

Newlyweds in Malawi. Protecting the reproductive health of young women — married and unmarried — requires respect for their opinions and needs, and access to information and services.

Heine Pedersen/Still Pictures

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Overview

Introduction

Gender inequality holds back the growth of individuals, the development of countries and the evolution of societies, to the disadvantage of both women and men.

The facts of gender inequality — the restrictions placed on women's choices, opportunities and participation — have direct and often malign consequences for women's health and education, and for their social and economic participation. Yet until recent years, these restrictions have been considered either unimportant or non-existent, either accepted or ignored. The reality of women's lives has been invisible to men. This invisibility persists at all levels, from the family to the nation. Though they share the same space, women and men live in different worlds.

The first steps have been taken to end this invisibility. In 1979, by adopting the Convention on the Elimination of All Forms of Discrimination against Women, the global community agreed to eliminate gender discrimination. The Convention, which has the force of international law, has now been ratified by 165 of the 188 member states of the United Nations.

Health care and education for girls and women have been the subject of international agreements, notably those reached at a series of world conferences on women beginning in 1975, the World Conference on Education for All in 1990 and the International Conference on Population and Development (ICPD) in 1994.

A rapidly growing number of countries have adopted population and development policies that include measures to meet the health care and education needs of girls and women, including their reproductive health needs. Education and health, including reproductive health, are human rights. Meeting education and health needs and working towards gender equality will also contribute to balanced population growth and economic development.

Most countries have some measures in place to protect women's personal security and their rights in marriage, property, inheritance, political representation and the workplace. Those measures are being expanded and increasingly enforced.

The impact of women's empowerment on the rights and roles of men is being considered. Efforts to bring women into the mainstream of development now emphasize partnership between women and men.

"Gender issues" are not the same as "women's issues": understanding gender means under-

PHOTO: Indian girl at work. Lack of support for girls' education limits their future choices.

UNICEF/0667/Vilas

standing opportunities, constraints and the impact of change as they affect both women and men. It is increasingly understood that partnership between women and men is the basis for strong families and viable societies in a rapidly changing world.

Equal partnership is also the aim of women's organizations, which are rapidly growing in number and strength in many countries of Asia, Africa and Latin America. The advantages of partnerships between official organizations and women's groups are increasingly recognized.

Yet gender inequality remains pervasive. It is a public concern, but it also relates to private behaviour, and therefore has not yet been fully discussed, especially where male dominance is the basis of family life. Elsewhere, though unequal restrictions on women may be outlawed or condemned, they persist in forms that have been rendered more socially acceptable.

This year's *State of World Population* report makes the case for bringing gender inequality fully into the light and treating it as a matter of urgency affecting both human rights and development priorities. Gender discrimination will not end until all eyes are opened to its inherent contradictions, and countries, communities and families take action to end it.

BOX 1

Discrimination and Poverty Go Hand in Hand

Gender inequality undermines development and prospects for reducing poverty, while economic growth and rising incomes reduce inequality, the World Bank reports. Studies show that societies where discrimination is greatest have more poverty, slower economic growth and a lower quality of life than societies with less discrimination. The effects are strongest in the poorest countries.

Ensuring that women and men enjoy the same rights and have equal access to education, jobs, property and credit, and fostering women's participation in public life reduces child mortality, improves public health, slows population growth and strengthens overall economic growth. This is true in all countries, but particularly in the poorest.

The ratio of girls' school attendance to that of boys is highest where both incomes and gender equality are relatively high. Countries where either incomes or equality are relatively low have lower girls' enrolment. Educating girls is one of the most effective ways to promote development.

As incomes rise, previously poor families increase their spending on children's education, health care and nutrition; girls generally benefit more than boys. Similarly, development that creates new job opportunities often benefits women more than men.

Gender inequality is also reduced by economic development that improves the infrastructure for water, energy and transportation. This cuts the time women have to spend fetching water, gathering cooking fuel and producing food for family consumption, giving them more time to earn additional income and participate in community affairs.

Economic growth by itself will not eliminate inequalities. Societies that promote women's rights and gender equality along with growth are more effective in reducing gender disparities than societies that focus on growth alone.

Summary

More equal power relations between men and women, combined with increased access to good reproductive health care, would save the lives of hundreds of thousands of women, including many of those who die from pregnancy-related causes. If women had the power to make decisions about sexual activity and its consequences, they could avoid many of the 80 million unwanted pregnancies each year, 20 million unsafe abortions, some 500,000 maternal deaths (including 78,000 as a result of unsafe abortion), and many times that number of infections and injuries. They could also avoid many of the 333 million new sexually transmitted infections contracted each year. Adolescent girls are particularly vulnerable (Chapter 2).

Violence against women also takes a steep toll on women's health, well-being and social participation (Chapter 3). Men must involve themselves in protecting women's reproductive health as a matter of self-interest and to protect their families, as well as for its own sake (Chapter 4).

The equality of women and men is integral to development (Chapter 5). It is also a human right (Chapter 6). Governments must take the fundamental decisions. Donor countries have agreed to support these priorities, but donors in the 1990s have not met even half of the agreed resource targets in the area of population and reproductive health (Chapter 7).

Gender and Health (Chapter 2)

Quality reproductive health services enable women to balance safe childbearing with other aspects of their lives. The International Conference on Population and Development and the United Nations' "ICPD+5" five-year review recognized the important relationship between gender and reproductive health. Gender-sensitive programmes listen to clients and involve them in programme and service design.

Components of reproductive health

About one third of pregnancies — about 80 million a year — are believed to be unwanted or mistimed. The number of users of **family planning** services in developing countries — assuming services can be provided — is expected to increase by more than 40 per cent by 2015: 742 million compared with 525 million in 2000.

Just over half of the increase will be due to rising numbers of women of reproductive age (15-49) in these countries. This group will grow by more than one fifth in the next 15 years, to 1.55 billion. The rest of the increase in users will result from increased demand as the proportion of people using contraception rises.

Good family planning programmes share several characteristics:[1]

- Government support is strong;
- Providers are well trained, sensitive to cultural conditions, listen to clients' needs, and are friendly and sympathetic;
- Services are affordable and a choice of contraceptive methods is available;
- Counselling ensures informed consent;
- Privacy and confidentiality are ensured;
- Facilities are comfortable and clean;
- Service is prompt.

Universal access to sexual and reproductive health care is a central objective of the ICPD Programme of Action. Since the ICPD, many countries have expanded services beyond family planning to care for women's and men's broader reproductive health needs.

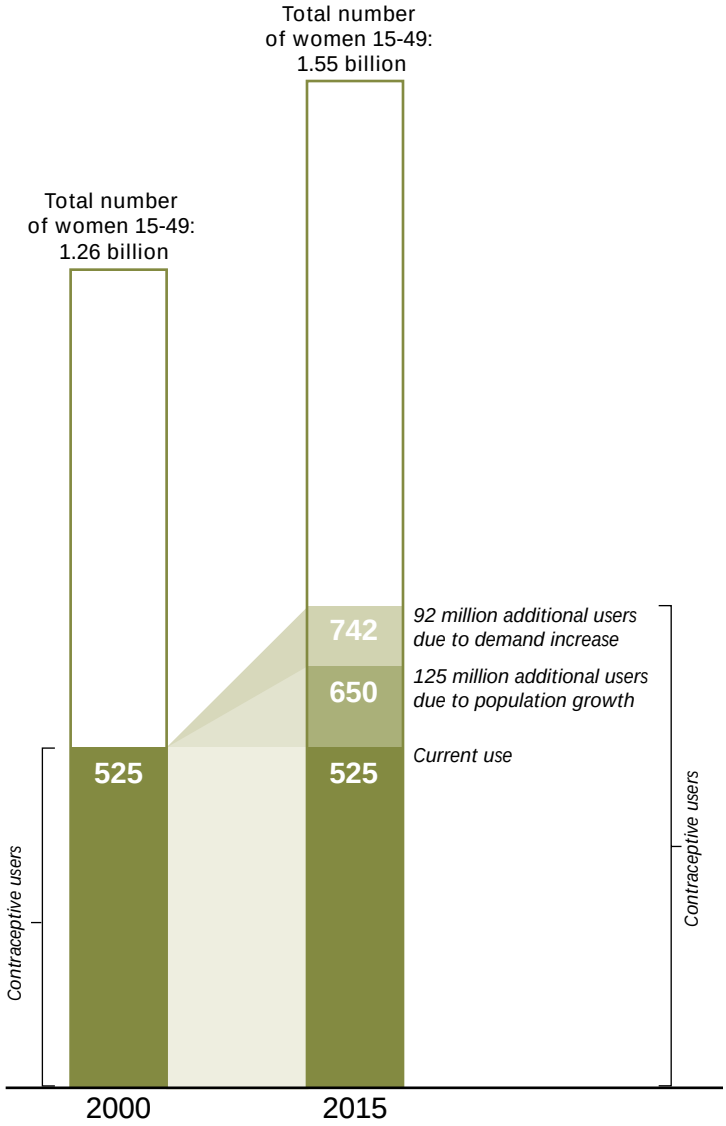
One woman a minute dies of **pregnancy-related causes**. Maternal mortality is preventable by:

- Helping women avoid unwanted pregnancy;
- Ensuring the presence of trained attendants at every birth;
- Providing emergency obstetric care;
- Providing post-natal care — 61 per cent of maternal deaths occur after delivery;
- Providing effective post-abortion care — 78,000 maternal deaths are due to unsafe abortions, 95 per cent of which take place in developing countries.

Some 20 million of the estimated 50 million **abortions** each year are unsafe; 78,000 women die and millions suffer injuries and illness as a result. Expanded access to family planning would prevent many unwanted pregnancies and many unsafe abortions. In many low-income countries effective post-abortion care would reduce maternal mortality by as much as one fifth.

Figure 1: Family Planning Needs Will Grow as Both Population and Demand Increase

Projected Increase in Contraceptive Users, 2000-2015
(Millions of women aged 15-49, developing countries)



Sources: United Nations Population Division, *World Population Prospects: The 1998 Revision;* and UNFPA draft report.

Sexually transmitted diseases (STDs) afflict five times more women than men. There are an estimated 333 million new cases every year. These diseases cause infertility, pregnancy-related complications, post-partum illness and cervical cancer.

Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is now the leading cause of death in Africa and the fourth most common cause of death worldwide. At the end of 1999, 34.3 million men, women and children were living with HIV or AIDS, 5.4 million were newly infected that year,

BOX 2

Most Maternal Deaths Could be Prevented

Complications of pregnancy and childbirth are the leading cause of death and disability for women aged 15 to 49 in most developing countries.

Of all the health statistics monitored by the World Health Organization (WHO), maternal mortality shows the largest discrepancy between developed and developing countries: women in developing countries are about 30 times more likely to die from pregnancy-related causes than those in developed countries.

Every day almost 1,400 women — one every minute — die from complications of pregnancy and childbirth, with more than 99 per cent of those deaths in low- and middle-income countries. Each year more than 50 million pregnancy-related complications lead to long-term illness or disability.

Only 53 per cent of deliveries in developing countries take place with a skilled birth attendant — doctor, nurse or midwife. Better care at childbirth and more access to care, costing about $3 per person a year, would substantially reduce maternal mortality. In Oran, Algeria, after public hospital fees were abolished in the 1970s, the maternal mortality rate fell 42 per cent and the number of home deliveries dropped sharply.

Adequate health care is crucial to safe motherhood. One study found that among members of a religious group in the United States that rejected all medical care, the maternal mortality ratio was 870 per 100,000 live births, as high as the ratios in the poorest countries, although members of the group had incomes comparable to their neighbours.

Chronic diseases and malnutrition leave many women unable to meet the physical demands of pregnancy. Anaemia, often the result of poor nutrition, affects 40-60 per cent of pregnant women in developing countries, excluding China, more than twice the percentage in developed countries. A woman's age and the number of previous births affect her chances of dying in childbirth as well.

Avoiding unwanted pregnancy saves lives. During a study in Bangladesh from 1977 to 1985, intensive family planning services, including home visits, were provided in some villages, and the percentage of women using contraception rose from 8 to 40 per cent. As a result, maternal mortality fell to less than half of that in other villages in the same district — even though there was no change in the risk of dying from any one pregnancy.

and 18.8 million had already died from the disease. More than 95 per cent of all HIV-infected people live in the developing world.

Women are more vulnerable to infection than men and are becoming infected at a faster rate. In Africa, HIV-positive women outnumber infected men by 2 million. The ICPD+5 review agreed that women need information, education, skills, services and social support to reduce their vulnerability. There should be wider access to male and female condoms, and retroviral drugs where possible. Information and counselling are needed on sexuality, gender roles and power imbalances, gender-based violence and other issues. Family planning and services for STDs and HIV/AIDS should be integrated within reproductive health services.

Women tend to become infected far younger than men. In several African populations, girls aged 15-19 are five or six times more likely to be HIV-positive than boys their own age. Clearly, older males are infecting teenage girls. Good-quality sex education helps adolescents delay sexual intercourse and increase safe sexual practices.

Worldwide, some 130 million girls and young women have undergone **female genital mutilation** (FGM). Genital mutilation is extremely painful and may result in severe infection, shock or even death. Survivors experience painful sexual intercourse and may be at greater risk during and after childbirth. FGM can lead to repeated infections and sterility.

Gender biases can also lead to a variety of **restrictions on care** — for example, restricting certain procedures to doctors, or providing public clinics only for maternal and child health, so men and childless or unmarried women feel uncomfortable going to them for reproductive health services.

Reproductive health services are increasingly recognizing that reproductive health is a matter for men as well as women, including the effect of women's reproductive health on men and men's support for their partners' reproductive health.

Young people's reproductive health

Young men and women face different social pressures and expectations which may work against responsible sexual behaviour. Training young people as peer educators encourages discussion and responsible behaviour. Sometimes, simply calling attention to double standards can lead to improvements.

Many girls and boys, however, are forced into early and unsafe intercourse by sexual abuse, child marriage or poverty. Adults also prevent young people from acting responsibly by limiting their access to information and health services. Parents can learn to be sources of information and counselling to their children. Many other adults in and out of the family can also play a part, especially political and religious leaders, who have a great deal of influence on changing social attitudes.

Men's reproductive health needs

Men are subject to sexually transmitted infections and have other reproductive health problems such as impotence and infertility. Men also want to space their children — and in some developing countries between one quarter and two thirds of men say they want no more children, but neither they nor their wives are using contraception.

Reproductive health services for men have concentrated on treatment and control of STDs.

The proportion of contraception attributable to men has fallen in recent years. Information on avoiding pregnancy and preventing infection is still limited among unmarried men. Good programmes can increase men's interest in and their use of contraception.

Migrants and refugees

Migrants and refugees have special reproductive health needs. UNFPA has provided timely emergency assistance in a number of developing countries.

Partnerships for reproductive health

Non-governmental organizations (NGOs) have helped to bring about major shifts in population and development programmes, and have brought gender concerns to the centre of these programmes. NGOs are working for gender equality and engaging in advocacy and policy formulation covering such sensitive topics as unwanted pregnancy, STDs and HIV/AIDS, and adolescent reproductive health, among others.

NGOs' work on violence against women is one of the most important contributions to ending gender-based abuse. National NGOs are promoting reproductive health and women's well-being, providing health care and social services, and participating actively in health reforms.

One of the great strengths of NGOs is their ability to form partnerships and alliances among themselves and with governments. International networks validate and strengthen national groups and raise the NGO profile in international discussion.

Civil society/government partnerships can be highly productive. In Bangladesh, for example, 25 per cent of reproductive health activities are carried out by NGOs. Effective partnerships are especially important where public-sector investments are most limited.

Violence against Women (Chapter 3)

Girls and women worldwide, across lines of income, class and culture, are subjected to physical, sexual and psychological abuse. Violence against women includes rape, genital mutilation and sexual assault; forced pregnancy, sterilization or abortion; forced use or non-use of contraceptives; "honour" crimes; sexual trafficking; and dowry-related violence.

Around the world, at least one in every three women has been beaten, coerced into sex, or abused in some other way — most often by someone she knows, including her husband or another male family member. One woman in four has been abused during pregnancy.

Each year rape and domestic violence cost women worldwide the equivalent of millions of lost years of healthy life. Physical violence is nearly always accompanied by psychological abuse, which can be just as demeaning and degrading.

Many cultures condone or at least tolerate a certain amount of violence against women. Even women often view a certain amount of physical abuse as justified under certain conditions. As many as 5,000 women and girls are killed annually in so-called "honour" killings, many of them for the "dishonour" of having been raped.

The reproductive health consequences of violence include unwanted pregnancies, complications of pregnancy, unsafe abortion and sexually transmitted infections.

An estimated 4 million women and girls are bought and sold worldwide each year, either into marriage, prostitution or slavery. Although the greatest volume of trafficking occurs in Asia, Eastern European women are increasingly vulnerable.

Recognizing the growing use of violence against women as a weapon of war, a conference of the International Criminal Court in 1998 added to its definition of war crimes a statute on gender justice stating that rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence are "grave breaches" of the Geneva Conventions against war crimes.[2]

Many cultures condone or at least tolerate a certain amount of violence against women.

Men, Reproductive Rights and Gender Equality (Chapter 4)

Gender considerations involve men as well as women, so understanding gender means understanding opportunities and constraints as they affect both women and men. Definitions of gender roles are often rigidly stereotypical, and increasingly fail to correspond to external change. These anomalous expectations are at the root of continuing gender inequality.

Men develop an interest in women's reproductive health when they learn more about how they can help ensure safe pregnancy and delivery. Shared beliefs about marriage and proper behaviour improve the reproductive health of both partners.

The Cost of Inequality (Chapter 5)

Empowerment and equality for women are important human rights aims in themselves, but they are also integral to development. It is more than a matter of economics: in the words of UNFPA's Executive Director, Dr. Nafis Sadik, "Better health and education, and freedom to plan their families' future, will widen women's

economic choices, but it will also liberate their minds and spirits."

Much of women's work, paid and unpaid, has an economic impact, though their contribution is rarely noticed or fully quantified. If it were recognized for what it is and supported accordingly, its value would be even greater. Giving women farmers in Kenya the same support as men, for example, would increase their yields by more than 20 per cent; raising Latin American women's wages to men's levels would increase national output by 5 per cent.

One of the keys to sustainable development will be recognizing the costs of gender discrimination and the advantages of equality, making them visible to policy makers and families, and agreeing on action.

Health care and education

The absence of health care has economic as well as personal costs. As much as 30 per cent of economic growth may be attributed to better health and nutrition. On the other hand, life expectancy is shorter in poor nations and among poor people. Cuts in health services such as those imposed after the Asian financial crisis affect the poor most acutely, and poor women in particular, as the heaviest users of public services. Where funding cuts led to fees being imposed, more recovery time was needed after illness, and labour force participation dropped. Poor women were among those most seriously affected.

Limited access to health care among the poor has a greater relative impact on women than on men. In particular, poor women are more likely to die as a result of pregnancy. A mother's death represents more than a personal tragedy: the economic and social costs include the impact on children's health and education, and on the father's ability to hold the family together.

Like maternal death and disability, HIV/AIDS has a heavy economic and social cost, in part because deaths are concentrated in the early to mid-adult years, when family responsibilities are greatest and earning power highest. Partly as a result of gender inequality, women are now more likely than men to contract HIV infection. Economic costs may amount to a loss of 0.5 percentage points in annual gross domestic product (GDP) growth, a considerable burden where growth is already slow.

Gender violence also imposes costs, from the cost of caring for the injured to the cost of family dissolution; indirect costs include missed opportunities for women and their children. Inequality also has psychological costs, notably from reduced self-esteem and depression among women, and frustration among men due to unrealistic expectations.

Studies repeatedly show that educating girls and women raises every index of development. Denying education to women has slowed social and economic development. An estimated two thirds of the 300 million children without access to education are girls, and two thirds of the some 880 million illiterate adults are women.

Economic returns on investment in women's education, on the other hand, exceed those for men. Differences in fertility levels between regions are strongly related to differences in levels of health and women's education. A recent study attributed one third of the increase in male and female life expectancy between 1960 and 1990 to gains in the educational attainment of women.

Demographic trends

Family planning and reproductive health programmes in general improve women's health. They tend to result in lower total fertility and slower population growth. The ageing of populations will also have social and economic consequences; old age poses different challenges for

BOX 3

Beyond 6 Billion

World population at mid-2000 was 6.06 billion and growing by 75 million people a year. More than 95 per cent of the growth is taking place in developing countries.

The future size and rate of growth of the global population depends on action taken to end gender discrimination. Experience in developing countries over 30 years has shown that when women are offered a full range of choices, they have smaller but healthier and better-educated families than their mothers did. If there were universal access to family planning, and women could have only the number of children they wanted, the total fertility rate in many countries would fall by one third.

Desired rates of growth are a matter for public discussion and policy; effective rates depend on private decisions. Since 1968, countries have agreed that couples and individuals have the right to choose the size and spacing of their families, and to the means and information to do so. The ICPD reaffirmed this and stressed that population policy, including incentives and disincentives to childbearing, must respect this basic human right.

Many countries are nearing or below replacement level fertility, the level where parents have only the number of children needed to replace themselves in the population. High fertility, however, challenges many of the poorest countries, in which gender inequalities also tend to be sharpest. Working towards gender equality, with close attention to health and education needs — including family planning as part of reproductive health — will both promote human rights and liberate women's potential to contribute to development. Women in control of their own destiny help to shape their nations' future.

BOX 4

ICPD+5 Review and Gender

The 1994 International Conference on Population and Development made gender equality and women's empowerment central goals of a 20-year Programme of Action aimed at meeting individual needs and helping countries achieve sustainable development.

Last year, a United Nations review of progress in the five years since the conference (ICPD+5) assessed progress towards the agreed goals, identified obstacles and set new benchmarks.

Among key gender-related actions recommended by the ICPD+5 review were:

- Establishing mechanisms to promote women's equal representation at all levels of the political process and public life;
- Promoting the rights of adolescents, including married girls, to reproductive health education, information and care;
- Ensuring universal access to appropriate, affordable and quality health care for women throughout their life cycle;
- Meeting men's reproductive and sexual health needs without prejudicing reproductive and sexual health services for women;
- Removing gender inequalities in the labour market, and instituting and enforcing laws ensuring equal pay for equal work or for work of equal value;
- Monitoring the different impact on women and men of economic globalization and privatization of basic social services, particularly reproductive health services;
- Fostering zero tolerance for harmful attitudes like son preference, which can result in prenatal sex selection, discrimination and violence against girls, and for all forms of violence against women, including female genital mutilation, rape, incest, trafficking, sexual violence and exploitation;
- Promoting girls' access to health, nutrition, education and life opportunities;
- Supporting parents' role in strengthening girls' self-image, self-esteem and status;
- Promoting positive male role models so boys will become adults who respect women's reproductive health and rights.

women and men. Gender factors strongly influence these trends and demand fresh attention from policy makers.

Economic benefits from declining fertility include a one-time "demographic bonus" as the workforce increases relative to the dependent population. Improving education for girls and meeting their special health needs will help make the most of the demographic bonus.

Measuring gender bias

Several composite measures are used to assess gender bias. Variation is considerable, and for many countries, the indicators differ on what areas need most attention; but all agree to a large extent on the relative standing of countries and localities.

Working to End Gender Inequality (Chapter 6)

Equality is a human right

The equality of women and men has been accepted as a fundamental principle of human rights since the adoption of the United Nations Charter in 1945. Several international treaty agreements, such as the Convention on the Elimination of All Forms of Discrimination against Women, oblige signatory states to take action against discriminatory practices.

As expressions of the world's conscience, the consensus decisions of international conferences are powerful instruments for promoting the right to equality. The 1994 ICPD and the Fourth World Conference on Women in 1995 and their respective five-year reviews agreed on specific goals towards achieving it.

Action Taken, Action Needed (Chapter 7)

Governments must take the fundamental decisions to move ahead on gender equality. Legal changes are a matter for sovereign decision; also, in many developing countries civil society is relatively small and powerless. Governments are also major employers, and their rules and practices have a powerful influence on social change. Governments are the major suppliers of services such as health and education, and public policy in these areas will determine the pace of change.

Parliamentarians are the interface between people and governments, though non-governmental organizations are playing a growing part in defining and promoting gender equality and equity. Parliamentarians are often the channel

BOX 5

"Beijing+5" Review Reaffirms Commitment to 1995 Platform for Action

At the 23rd special session of the United Nations General Assembly, "Women 2000: Gender Equality, Development and Peace for the 21st Century" (informally, "Beijing+5"), held in New York from 5 to 10 June, governments reaffirmed their commitment to the goals of the Fourth World Conference on Women in 1995.

Delegates found that there has been significant progress in carrying out the 1995 accord but major obstacles remain. They adopted a Political Declaration and an agreement on "Further actions and initiatives to implement the Beijing Declaration and Platform for Action".

Although the gender dimensions of poverty are increasingly recognized, the special session found that economic inequality between men and women is widening. While globalization has brought some women greater economic opportunities and autonomy, it has further marginalized others.

Among other key findings and recommendations:

- Action is needed to increase women's participation in economic policy decision-making, development activities, and conflict prevention and resolution; and to encourage women's entry into politics;
- Adult literacy should be increased by 50 per cent by 2015, and free compulsory primary education provided for both girls and boys; curricula should address gender stereotyping as a cause of segregation in working life;
- Stronger legislation is needed against all forms of domestic violence, including marital rape and sexual abuse; violence against women and girls is a human rights violation;
- Laws, policies and educational programmes are needed to eradicate harmful traditional practices, including female genital mutilation, early and forced marriage and "honour" crimes; and to eliminate commercial sexual exploitation, trafficking in women and children, female infanticide, racially motivated crimes and dowry-related violence;
- Recent years have seen "increased attention to sexual and reproductive health and reproductive rights of women"; governments should implement the agreement reached at the 1999 "ICPD+5" special session, including its benchmarks (Box 7);
- Reducing maternal morbidity and mortality is a priority — women should have ready access to essential obstetric, post-partum and maternal care, as well as effective referral and transport to higher levels of care when necessary;
- Among other health priorities are preventing unwanted pregnancies, and preventing, detecting and treating breast, cervical and ovarian cancer, osteoporosis and sexually transmitted diseases, including HIV/AIDS;
- The Platform for Action's recommendations that governments deal with the health impact of unsafe abortion as a major public health concern and reduce the recourse to abortion through expanded and improved family planning services "have not been fully implemented";
- "Adolescents continue to lack the education and service needed to enable them to deal in a positive and responsible way with their sexuality," and should be provided with "education, information and appropriate, specific, user-friendly and accessible services without discrimination to address effectively their reproductive and sexual health needs";
- Programmes are needed "to encourage and enable men to adopt safe and responsible sexual and reproductive behaviour, and to effectively use methods to prevent unwanted pregnancies and sexually transmitted infections, including HIV/AIDS";
- Women and men should have universal and equal access throughout their lives to social services related to health care, including education, clean water and safe sanitation, nutrition, food security and health education programmes.

through which responses to policy, and news of changing needs and practices, reach governments.

Social change cannot be brought about merely through legislation; it must be encouraged by leadership and example. It can also be encouraged by international action to put into effect the agreements reached in legally binding instruments such as the Convention on the Elimination of All Forms of Discrimination against Women and the morally binding consensus of international discussions such as the ICPD. Major initiatives such as the global campaign for girls' education have been launched to re-energize the discussion and mobilize the promised support.

Donor countries are called upon to support these priorities, and have agreed to do so. But donors in the 1990s have not met even half of the agreed resource targets in the area of population and reproductive health; international assistance for education and women's empowerment is also woefully inadequate. The shortage of funding to help countries advance gender equality harms the interests of women and men, their countries and the global future.

CHAPTER 2

Gender and Health

PHOTO: Cuban teacher shows how to use a condom. Young people need access to reproductive health information and services.

Mark Edwards/Still Pictures

Gender inequality and discrimination harm girls' and women's health directly and indirectly, throughout the life cycle; and neglect of their health needs prevents many women from taking a full part in society. Unequal power relations between men and women often limit women's control over sexual activity and their ability to protect themselves against unwanted pregnancy and sexually transmitted diseases including HIV/AIDS; adolescent girls are particularly vulnerable.

Inadequate reproductive health care for women results in high rates of unwanted pregnancy, unsafe abortion, and preventable death and injury as a result of pregnancy and childbirth. Violence against women, including harmful traditional practices like female genital mutilation, takes a steep toll on women's health, well-being and social participation. Violence in various forms also reinforces inequality and prevents women from realizing their reproductive goals (see also Chapter 3).

Men also have reproductive health needs, and the involvement of men is an essential part of protecting women's reproductive health.

Reproductive Health Services Help Empower Women

Providing quality reproductive health services enables women to balance safe childbearing with other aspects of their lives. It also helps protect them from health risks, facilitates their social participation, including employment, and allows girls to continue and complete their schooling.

The ICPD Programme of Action recognizes the important relationship between gender and reproductive health, and the 1999 ICPD+5 review underscored this connection. The agreement on key future actions stressed, "A gender perspective should be adopted in all processes of policy formulation and implementation and in the delivery of services, especially in sexual and reproductive health, including family planning."[1]

Reproductive health does not affect women alone; it is a family health and social issue as well. Gender-sensitive programmes can address the dynamics of knowledge, power and decision-making in sexual relationships, between service providers and clients, and between community leaders and citizens.[2]

BOX 6

Discrimination against Girls: A Matter of Life and Death

Female infanticide, inadequate food and medical care, physical abuse, genital mutilation, forced sex and early childbirth take many girls' lives.

In some Asian countries, there are 105 adult men for every 100 women because of discrimination against girls. Although many countries have banned prenatal gender tests, illegal tests are available and females are aborted more often than males.

Girls are more likely to die than boys are in parts of the world, especially South Asia, South-western Asia and North Africa. In some countries where girls are most severely disadvantaged, boys receive more medicine and more medical treatment than girls.

In one study at a diarrhoea treatment centre in Bangladesh, boys were seen 66 per cent more frequently than girls. In Latin America and India, girls are often immunized later than boys or not at all. In some places, boys get more and better food than girls. Breastfeeding and weaning practices also seem to favour boys in some countries.

BOX 7

Benchmark Indicators Adopted at the ICPD+5 Review

The ICPD Programme of Action recommended a set of interdependent quantitative goals and objectives. These included universal access to primary education, with special attention to closing the gender gap in primary and secondary school education; universal access to primary health care; universal access to a full range of comprehensive reproductive health care services, including family planning; reductions in infant, child and maternal morbidity and mortality; and increased life expectancy.

After reviewing progress in these areas, the 1999 General Assembly special session agreed on a new set of benchmarks:

- The 1990 illiteracy rate for women and girls should be halved by 2005; and by 2010, the net primary school enrolment ratio for children of both sexes should be at least 90 per cent;
- By 2005, 60 per cent of primary health care and family planning facilities should offer the widest achievable range of safe and effective family planning methods, essential obstetric care, prevention and management of reproductive tract infections, including sexually transmitted diseases, and barrier methods to prevent infection; 80 per cent of facilities should offer such services by 2010; and all should do so by 2015;
- At least 40 per cent of all births should be assisted by skilled attendants where the maternal mortality rate is very high, and 80 per cent globally, by 2005; these figures should be 50 and 85 per cent, respectively, by 2010; and 60 and 90 per cent by 2015;
- The gap between the proportion of individuals using contraceptives and the proportion expressing a desire to space or limit their families should be reduced by half by 2005, by 75 per cent by 2010, and by 100 per cent by 2015; recruitment targets or quotas should not be used in attempting to reach this goal;
- To reduce vulnerability to HIV/AIDS infection, at least 90 per cent of young men and women aged 15-24 should have access by 2005 to preventive methods — such as female and male condoms, voluntary testing, counselling and follow-up — and at least 95 per cent by 2010; HIV infection rates in persons aged 15-24 should be reduced by 25 per cent in the most affected countries by 2005 and by 25 per cent globally by 2010.

A gender perspective implies also that institutions and communities adopt more equitable and inclusive practices. Clients must be listened to and involved in the design of programmes and services. As the primary users of reproductive health services, women have to be involved at all levels of policy-making and programme implementation. Policy makers need to consider the impacts of their decisions on men and women and how gender roles aid or inhibit programmes and progress towards gender equality.

Universal access to sexual and reproductive health care was a central objective of the ICPD. The ICPD+5 review agreed that progress towards this goal should be measured by monitoring the provision of services.

Components of Reproductive Health Care

Family Planning

At ICPD+5, governments agreed to redouble efforts to find the resources needed to implement the ICPD Programme of Action. They recognized the importance of providing the widest possible range of contraceptive methods, including offering new contraceptive options and promoting underutilized methods.

The new benchmarks on closing the gap between the proportion of individuals using contraception and those expressing a desire to space or limit their families represent a significant challenge. About one third of all pregnancies — 80 million a year — are believed to be unwanted or mistimed.[3] Over the next 15 years the number of contraceptive users in developing countries is projected to increase by more than 40 per cent, from 525 million to 742 million, as population continues to grow, programmes expand and an increasing proportion of couples want to practise contraception.[4]

Social and cultural factors, including gender norms, condition women's reproductive intentions — that is, the number of children they want and how they want their births spaced. If women could have only the number of children they wanted, the total fertility rate in many countries would fall by nearly one child per woman. The fewer children women want, the more time they spend in need of contraception, and the more services are required.

Women do not always get the support they need to fulfil their reproductive intentions. In some settings, fearing reprisal from disapproving husbands or others, many resort to clandestine use of contraception.[5] Women interviewed in a five-year Women's Studies Project, carried out in eight countries by Family Health International, said that to attain their family planning objectives, they needed supportive partners, adequate information, unobtrusive methods and respectful services.[6]

Most modern contraceptives rely on women to initiate and control their use: oral contraceptives, intra-uterine devices (IUDs), diaphragms, cervical caps and injectables have no counterpart methods for men. Among the 58 per cent of married couples practising contraception worldwide, less than one third rely on a method requiring male participation (condom and vasectomy) or cooperation (rhythm and withdrawal). In less developed regions, nearly two thirds of contraceptive users rely on female sterilization or IUDs.[7]

The female condom is proving popular in many places where it has been introduced in recent years. However, in many countries, even where HIV/AIDS prevalence is high, condom use remains relatively low.

Periodic abstinence and withdrawal, to be used effectively, place demands on users which many find difficult, and there is widespread misinformation about proper use.[8] Even committed and informed users experience higher levels of unwanted pregnancies than those using other methods.

By 2015, contraceptive needs in developing countries will grow by more than 40 per cent.

Good family planning programmes share several characteristics:[9]

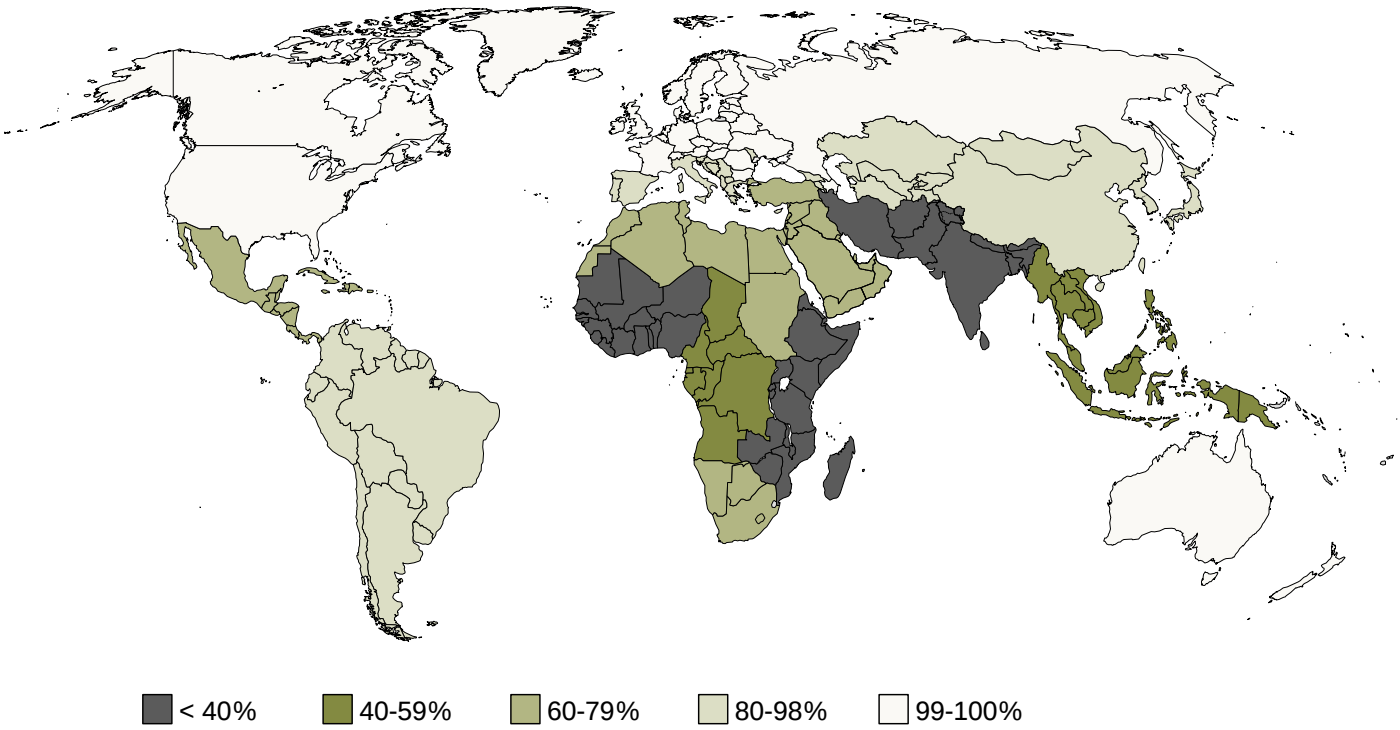
- Government support is strong;
- Providers are well trained, sensitive to cultural conditions, listen to clients' needs, and are friendly and sympathetic;
- Services are affordable and a choice of contraceptive methods is available (a full range of modern methods includes oral contraceptives, IUDs, injectables, implants, male and female condoms, emergency contraception and voluntary sterilization);
- Counselling ensures informed consent in contraceptive choice;
- Privacy and confidentiality are ensured;
- Facilities are comfortable and clean;
- Service is prompt.

Since the ICPD, many countries — among them Bangladesh, Brazil, Burkina Faso, Côte d'Ivoire, Egypt, Ghana, India, Indonesia, Jamaica, Jordan, Mexico, Morocco, Nepal, Pakistan, Peru, the Philippines, Senegal, South Africa, Sri Lanka, Uganda, the United Republic of Tanzania and Zambia — have acted to expand services beyond family planning to care for women's and men's broader reproductive health needs.[10]

Safe Motherhood

Ninety-nine per cent of the approximately 500,000 maternal deaths each year are in developing countries, where complications of pregnancy and childbirth take the life of about

Figure 2: Percentage of Births with Skilled Attendants, by Subregion



Source: World Health Organization

BOX 8

Honduras Reduces Maternal Mortality

Maternal deaths in Honduras fell dramatically between 1990 and 1997, after the Government increased its commitment to women's health.

Following a 1990 study on the subject, the Honduran Government made maternal mortality reduction a public health priority. Increased resources enabled the Ministry of Health to make emergency obstetric care available in more rural and urban health centres and district hospitals. Health personnel were increased in remote areas, and birthing centres were established in areas of difficult access. Utilization of prenatal care in health centres increased. Traditional birth attendants were trained and integrated into the health system, resulting in greater community acceptance and more emergency referrals to hospitals. Transportation, roads and communication were also improved.

As a result, the maternal mortality ratio, deaths per 100,000 live births, declined from 182 to 108. The maternal mortality rate, deaths per 1,000 women of reproductive age, declined by half, from 0.26 to 0.13.

1 out of every 48 women. It is not uncommon for women in Africa, when about to give birth, to bid their older children farewell. In the United Republic of Tanzania, mothers have a saying: "I am going to the sea to fetch a new baby, but the journey is long and dangerous and I may not return."[11] In some settings, as many as 40 per cent of women suffer from serious illness following a birth.[12]

Infants and children also suffer as a result of poor maternal health. The same factors that cause maternal mortality and morbidity, including complications and the associated poor management of pregnancy and childbirth, contribute to an estimated 8 million stillbirths and newborn deaths each year. Tragically, when a mother dies, her children are also more likely to die. A study in Bangladesh found that if a woman dies after delivery, her newborn infant is almost certain to die. Another study in Bangladesh found that children up to age 10 whose mothers die are 3 to 10 times more likely to die within two years than are children with living parents.[13] In the United Republic of Tanzania, children whose mothers died were likely to have to leave school to take on household tasks.[14]

Avoiding unwanted pregnancy through family planning reduces maternal mortality. So does antenatal care: only 70 per cent of births

in the developing world are preceded by even a single antenatal visit. Each year, 38 million women receive no antenatal care. Only about half of all pregnant women receive tetanus injections; tetanus currently kills more than 300,000 children under age 5 each year.

It is also important to ensure that someone with midwifery training is present at every delivery. In the developing countries, only 53 per cent of all births are professionally attended.[15] This translates into the neglect of 52.4 million women each year.

The primary means of preventing maternal deaths, however, is to provide access to emergency obstetric care, including treatment of haemorrhage, infection, hypertension and obstructed labour. Life-saving interventions, such as referral to medical centres, antibiotics and surgery, are unavailable to many women in the developing world, especially in rural areas. Four common problems greatly increase women's risk in childbirth: delays in recognizing a developing problem, delays in deciding to act, delays in arranging transport and delays in reaching services. A community-based system for ensuring rapid transport to an equipped medical facility is crucial to save mothers' lives.

Post-partum care is especially important. Of women who die of pregnancy-related causes, 24 per cent die during pregnancy; 16 per cent during delivery; and 61 per cent after delivery, from post-partum haemorrhage, hypertensive disorders and sepsis.[16] Community health workers can be trained to detect and treat post-partum problems, as well as to counsel on breastfeeding, infant care, hygiene, immunizations, family planning, and maintaining good health.

Communities are organizing to prevent mothers from dying in childbirth. Education efforts stress the importance of prompt reporting to health centres when complications arise. The Prevention of Maternal Mortality Network has introduced measures to improve safe motherhood services in parts of Africa. Improved quality in other aspects of health care has led to increased use of facilities for high-risk deliveries.

In Juaben, Ghana, a blood bank and an operating theatre were established at a community health centre. Midwives were trained in life-saving skills and given a central role in the delivery of services. The number of women coming in for care almost tripled, while the proportion referred to higher levels in the health system declined.[17]

Some communities in Africa offer self-financing transportation schemes for safe motherhood.[18] Indonesia is experimenting with social insurance programmes to cover the cost of emergency obstetric care.[19]

Safe motherhood experts contend that more emergency obstetric care could be provided without large amounts of additional resources, by improving services already covered in hospitals and some health centres.[20]

Abortion and Post-abortion Care

Each year, women undergo an estimated 50 million abortions, 20 million of which are unsafe; some 78,000 women die and millions suffer injuries and illness as a result. At least one fourth of all unsafe abortions are to girls aged 15-19.[21]

The ICPD recognized abortion as an important public health issue, and called on governments to reduce unwanted pregnancies and prevent abortion by increasing access to family planning services. "In circumstances where abortion is not against the law," the Programme of Action states, "such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion."[22]

The Platform for Action of the Fourth World Conference on Women called on governments to "consider reviewing laws containing punitive measures against women who have undergone illegal abortions".[23]

At the ICPD+5, governments agreed that to reduce the maternal deaths caused by unsafe abortion, "in circumstances where abortion is not against the law, health systems should train and equip health service providers and should take other measures to ensure that such abortion is safe and accessible."[24]

Effective post-abortion care would significantly reduce maternal mortality rates by as much as one fifth in many low-income countries.[25]

BOX 9

The Toll of Abortion

In Latin America, unsafe abortion accounts for about half of all maternal deaths. In Romania, before abortion was legalized in 1992, an estimated 86 per cent of maternal deaths were due to unsafe abortions. In the first year after legalization, maternal deaths fell to 40 per cent of the 1989 total.

At least one fourth of all unsafe abortions are to girls aged 15-19. Adolescents tend to delay obtaining an abortion until after the first trimester and often seek help from non-medical providers, leading to higher rates of complications. Self-induced abortion is also common among adolescents in many countries.

In Chile and Argentina, more than one third of maternal deaths among adolescents are a direct result of unsafe abortions. In Peru, one third of the women hospitalized for abortion complications are aged 15 to 24. The World Health Organization (WHO) estimates that in sub-Saharan Africa, up to 70 per cent of women hospitalized for abortion complications are under 20. In a Ugandan study, almost 60 per cent of abortion-related deaths were among adolescents.

A number of countries, particularly in Africa and Latin America, are focusing on reducing the health impact of unsafe abortion by providing post-abortion care. This effort involves strengthening the capacity of health institutions to offer: emergency treatment for complications of spontaneous or unsafely induced abortion; post-abortion family planning counselling and services; and links between emergency post-abortion treatment and reproductive health care.[26] Countries such as Ghana have trained midwives and other providers to offer post-abortion care.

Some countries have promoted the use of manual vacuum aspiration to treat incomplete abortion; this method has proven safer, more cost-effective and acceptable than curettage.

Sexually Transmitted Diseases, Including HIV/AIDS

Women are more vulnerable than men to STDs, for both biological and cultural reasons.

HIV/AIDS continues to be a critical public health issue, particularly in Africa, which is facing the worst effects of the epidemic. HIV/AIDS is now the leading cause of death in Africa and the fourth most common cause of death worldwide. At the end of 1999, 34.3 million men, women and children were living with HIV or AIDS, and 18.8 million had already died from the disease. In 1999, there were 5.4 million new infections worldwide; 4.0 million were in sub-Saharan Africa; and around 1 million were in South and South-east Asia, where prevalence is increasing rapidly in some countries.[27]

The AIDS pandemic is causing untold suffering in individuals, families and societies. By the end of the year 2000, an estimated 13.2 million children, most of them in Africa, will have lost their mothers or both of their parents to AIDS.[28] Women are rapidly reaching and surpassing the number of men infected with HIV. In Africa, HIV-positive women now outnumber infected men by 2 million.

Because of culture as well as biology, women are more vulnerable to STDs than men. The burden of disease for women from STDs excluding AIDS is more than three times higher than for men.[29] Anatomical differences make reproductive tract infections more easily transmissible to women but more difficult to diagnose. STDs are more frequently asymptomatic in women than in men, and when symptoms do occur in women, they are more subtle. Because of their lower social status and their economic dependence on men, women may be unable to negotiate the use of condoms as an STD-prevention measure.[30]

Studies by the International Center for Research on Women illustrate the critical role of gender and sexuality in influencing sexual interactions and men's and women's ability to practise safe behaviours. The studies, conducted in 10 countries in Africa, Asia and Latin America and the Caribbean, help define complex concepts like gender, sexuality and power. They also highlight the importance of increasing women's access to information and education, skills, services and social support in order

BOX 10

AIDS Is Now the Number One Killer in Africa

AIDS is now among the greatest threats to Africa's social and economic development. The epidemic has spread beyond all predictions. In the hard-hit countries, where up to one quarter of all adults are infected, AIDS is wiping out development gains achieved over many decades. Life expectancy is dropping in some countries to levels not seen since 1960, hard-won gains in child survival are being reversed, and the limited pool of skilled workers is being decimated.

Resources currently allocated to combat the epidemic are grossly inadequate. AIDS is spreading three times faster than the funding to control it.

Experience from some African countries shows that the rate of new infections can be slowed and societies can begin to cope effectively with the HIV/AIDS epidemic when governments commit their own political prestige and financial resources; involve civil society fully; undertake a wide range of prevention, care, and support activities; and thus attract more external resources.

Studies suggest that an additional $1 billion a year is needed, at minimum, to meet the HIV/AIDS prevention and care needs of Africa. Some of these funds will have to be generated through non-traditional sources such as the business community and foundations, and redirected from social funds, sector-reform projects and debt-relief operations. The International Partnership Against AIDS in Africa is sponsoring efforts to mobilize both national and regional resources.

to reduce their vulnerability to HIV/AIDS and to improve their reproductive health outcomes.[31]

Recognizing that the HIV/AIDS pandemic is far more serious than had been understood at the ICPD, the ICPD+5 document reiterates the importance of providing access to male condoms, calls for wide provision of female condoms, and urges governments to enact legislation and adopt measures to prevent discrimination against people living with HIV/AIDS and those vulnerable to HIV infection. The document calls on governments, where feasible, to make antiretroviral drugs available to women during and after pregnancy, and to provide counselling so that mothers living with HIV/AIDS can make free and informed decisions about breastfeeding.[32]

Reproductive health programmes can reduce levels of STDs, including HIV/AIDS, by providing information and counselling on critical issues such as sexuality, gender roles, power imbalances between women and men, gender-based violence and its link to HIV transmission, and mother-to-child transmission of HIV; distributing female and male condoms; diagnosing and treating STDs; developing strategies for contact tracing; and referring people infected with HIV for further services.

The ICPD advocated the integration of family planning and STD/HIV/AIDS services within reproductive health services. Integration of these components is considered a potentially cost-effective way to reach sexually active women and their partners with information and services that can help prevent and treat infections. However, a study based on situation-analysis findings from several countries in Africa found insufficient infrastructure on which to base the promotion of clinic-based, integrated family planning and STD services.[33] Many family planning clinics were not equipped to offer STD services, and the staffs were not sufficiently trained. Other studies have also cited the lack of conclusive evidence of the benefits of integrating family planning and STD services.[34]

Though health workers do not generally receive sufficient training and support to provide STD/HIV/AIDS information and services, case studies in Burkina Faso, Côte d'Ivoire, Uganda and Zambia found that providers were willing to discuss sexuality and STDs with clients and could understand the need to identify individuals at risk of sexually transmitted infections.[35]

In the Philippines, UNFPA and the Women's Health Care Foundation are working together to improve access to reproductive health services with trained community health workers, street youth and street vendors. The Foundation provides STD/HIV/AIDS clinical services, including referrals for testing, and conducts education and counselling sessions for urban poor women and female sex workers. UNFPA supports training service providers and volunteer health workers in counselling and community education, and has funded a telephone hotline to answer questions on STDs and sexuality.[36]

The newly formed International Partnership against AIDS in Africa is working to build on existing global, regional and national structures to address the devastating effects of AIDS in Africa.[37] In mid-1999, finance ministers and other leaders from more than 20 African countries expressed their support, and about a dozen bilateral development agencies agreed to mobilize more resources to back the Partnership. Various African NGOs have also agreed to play an active role. The Partnership is strengthening national programmes by: encouraging visible and sustained political support; helping to develop nationally negotiated joint plans of action; increasing financial resources; and reinforcing national and regional technical capacity.

Half of all new HIV infections are in young people between ages 15 and 24.[38] According to a 1997 Joint United Nations Programme on HIV/AIDS (UNAIDS) review, high-quality sex education helps adolescents delay sexual intercourse and increase safe sexual practices.[39] Since the ICPD, support has been provided in 64 countries for the integration of HIV/AIDS prevention into in-school and out-of-school education programmes.

Uganda, for example, has taken a direct and comprehensive approach to addressing the problem of STDs and HIV/AIDS, in particular among young people; HIV prevalence rates among youth are now stabilizing. In Swaziland, the Swaziland Schools HIV/AIDS and Population Education Programme (SHAPE) was launched in 1990 to prevent the spread of HIV/AIDS and to reduce pregnancy in school pupils aged 14 to 19. In 1997, the programme was introduced in primary schools. The programme has improved knowledge and attitudes more than behaviour.[40]

At ICPD+5, governments agreed that youth (aged 15-24) are at high risk of HIV infection, and set goals for reducing prevalence in this age group (see Box 7).

Female Genital Mutilation

Many societies in Africa and Western Asia practise FGM, often referred to as female circumcision. Worldwide, some 130 million girls and young women have undergone this dangerous and painful practice, with an additional 2 million at risk each year.

FGM is practised in about 28 countries in Africa — where the prevalence varies widely, from 5 per cent in the Democratic Republic of

the Congo to 98 per cent in Somalia — and in the Arabian Peninsula and the Gulf region. It also occurs among some minority groups in Asia, and among immigrant women in Europe, Canada and the United States.

FGM refers to the removal of all or part of the clitoris and other genitalia. Those who perform the more extreme form, infibulation, remove the clitoris and both labia and sew together both sides of the vulva. This leaves only a small opening to allow passage of urine and menstrual blood. Infibulation accounts for an estimated 15 per cent of all cases of FGM, and 80-90 per cent of cases in Djibouti, Somalia and the Sudan.

Other, less extreme, forms involve removing all or part of the clitoris (clitoridectomy), or the clitoris and inner lips (excision). About three quarters of all young girls subjected to this degrading procedure have undergone one or another of these less radical forms.[41]

This terrible violation of girls' and young women's human rights is based on prevailing beliefs that female sexuality must be controlled, and the virginity of young girls preserved until marriage. Men in some cultures will not marry uncircumcised girls because they view them as "unclean" or sexually permissive.[42]

Genital mutilation is nearly always carried out in unsanitary conditions without anaesthetic. It is also extremely painful and may result in severe infection, shock or even death. If the girl survives, she may experience painful sexual intercourse, degrading the quality of her life.[43] The reduction of a woman's sexual experience by FGM is both a physical and mental health problem for women and an impediment to the development of deeper and more satisfying relationships between the partners.

The immediate health risks of FGM include haemorrhage of the clitoral artery, infection, urine retention, and blood poisoning from unsterile, often crude, cutting implements. Later complications are mainly due to the partial closing of the vaginal and urethral openings, which trigger chronic urinary tract infections, repeated reproductive tract infections and back and pelvic pain. Particularly where the more drastic forms of this practice have been carried out, the girl will be at increased risk of experiencing a difficult delivery and dying in childbirth.

In some cases, FGM can lead to sterility. A study carried out in the Sudan found that women who had undergone FGM were twice as likely to be infertile as women who had not.[44] This is due to pelvic inflammatory disease caused by repeated infections as a result of the retention of urine or menstrual blood that spread throughout the reproductive tract, causing inflammation and scarring of the fallopian tubes. In traditional societies, infertility is a particularly devastating condition, since a woman's worth in many of these cultures is measured by her ability to bear children.[45]

BOX 11

Sri Lanka Succeeds in Promoting Women's Health

Sri Lankan women, with a life expectancy of 74 years, enjoy the best health status of women in any country in South Asia. The reasons are complex but include "the development of the health system, and public health measures that have reduced maternal mortality as well as socio-economic changes that have changed female status and the value to parents, both the mother and the father, of girls relative to boys." Absolute levels of mortality among girls and boys are lower than in other South Asian countries, partly because of "the key role of women in looking after the family's health and their relative autonomy, as well as Sri Lanka's general overall social development in health services and education."

Reproductive Health Programme Issues

Public Health Concerns

Improving women's and men's reproductive health requires a community-oriented public health approach, emphasizing prevention. Poor reproductive health is directly related to gender-based inequality in the distribution of social power and resources.

Community involvement can help to counter this — by ensuring that men and women are equal partners in social and economic development, and that women's voices are heard along with men's voices in the community,[46] by ensuring that girls as well as boys are raised in healthy environments and have equal opportunities to go to school and to develop physically before they take on the role of parenthood; by guaranteeing women's rights to live free of sexual coercion and the threat of violence, and to have sex without the fear of infection and unwanted pregnancy; and by providing all women with access to safe pregnancy care, including emergency obstetric care if their pregnancies or deliveries face trouble.

Although reproductive health is not part of every country's essential services package, Bangladesh, India, Mexico, Senegal, South Africa, Uganda and Zambia, among others, include it. For example, Bangladesh's package includes maternal health (antenatal, delivery, and post-natal care, menstrual regulation, and post-abortion complication care); adolescent

health; family planning; management and prevention/control of reproductive tract infections, STDs and HIV/AIDS; and child health.[47]

Cultural Restrictions Limit Choice

Beliefs about appropriate behaviour can reduce access to health information and care and impair its quality. Direct taboos and indirect restrictions deter women from discussing their health needs and risks, while women who cannot read or readily associate with others have difficulty finding health information.

These restrictions mean that women are dependent on the decisions of others about medical attention; whether to delay or prevent pregnancy; have antenatal exams during pregnancy; arrange for a skilled delivery attendant; or obtain transport in an obstetric emergency.

It can be difficult for women to raise reproductive health concerns: topics such as menstrual bleeding irregularities are especially hard to discuss. Women may be unable to get their problems addressed until their conditions are serious and treatment options are more restricted or costly.

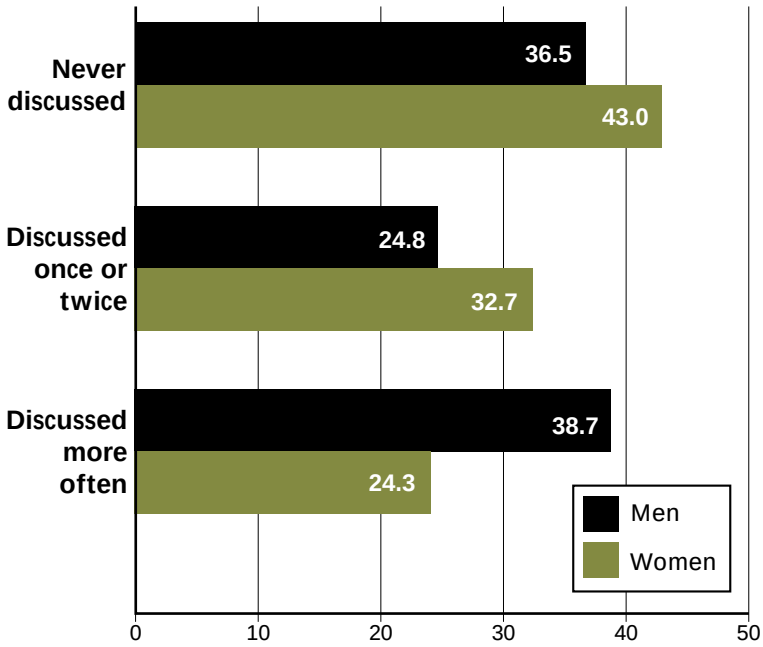
Couples and families who discuss family planning are more likely to use the services. Where discussion is proscribed, some women will resort to covert use. Even when "covert use" is really a shared secret, this restriction inhibits close and supportive relationships. Whether mutually agreed or covert, the choice of contraception can be affected by cultural rules and preferences.

Quality programmes recognize and are responsive to cultural understandings. Programme developers are becoming more sensitive to the need to work within the cultural context of client's lives. A programme in Tunisia draws on the local custom of ending a new mother's seclusion on the 40th day after childbirth, to provide post-partum and family planning services to women and neonatal care for infants in a single clinic visit.[48] A study in 1987 found that 84 per cent of mothers came in for the 40th-day visit, and 56 per cent of these women began to use a method of contraception.

Professional Roles and Gender Roles

It is hard for women to discuss their reproductive health needs frankly with male professionals, for reasons of both gender and status. Women service providers may be easier to talk to, but there is still a difference in status, especially for poor women. Moreover, certain procedures (for example, IUD insertion or pill prescription) may be restricted to doctors, who are usually men.

Figure 3: How Often Couples Have Discussed Family Planning, as Reported by Men and Women, Malawi, 1992 (per cent)



Source: United Nations Population Division. 2000. *World Population Monitoring, 2000: Population, Gender and Development.*

Where cultural rules forbid men (even physicians) from directly examining women patients, the quality of care suffers greatly.

Men are frequently unwilling to go to public clinics for reproductive health services since they are defined as "women's places", largely used by women for maternal and child health services. Where possible, having a separate space for men (for example, a separate entrance, waiting area and cashier with shared staff) even within a joint facility can increase use.[49] Integration of STD/AIDS-prevention and treatment activities with family planning programmes can also help make clinics more male-friendly.

Adolescent Reproductive and Sexual Health and Behaviour

Young men and women face different social pressures affecting their ability to approach sexuality responsibly. Boys often face pressure to become sexually active to prove their manhood and be accepted by their friends.[50] Girls may face pressure not to seek information about sexual matters for fear of being thought "loose", or alternatively to have sexual intercourse in return for benefits.

BOX 12

Sexual Activity Differs among Young Men and Women

Worldwide, the vast majority of sexually experienced males aged 15-19 are unmarried, while two thirds or more of sexually experienced young women in the same age group are married. The timing of teenage sexual initiation varies widely by country and gender.

Among females, the proportion having first intercourse by age 17 in Mali (72 per cent), Jamaica (53 per cent), Ghana (52 per cent), the United States (47 per cent) and the United Republic of Tanzania (45 per cent) is 7 to 10 times that in Thailand (7 per cent) and the Philippines (6 per cent). The proportion of males who have had intercourse before their 17th birthday in Jamaica (76 per cent), the United States (64 per cent) and Brazil (63 per cent) is about 10 times the level reported in the Philippines (7 per cent).

Differences between young men and women are very large in both Ghana and Mali, where higher proportions of females than of males become sexually active early; and in Brazil, Costa Rica, the Dominican Republic, Peru and Thailand, where the reverse is true.

Pressures on young people also come from within. They wish to become men or women and so may pattern their behaviour on male and female stereotypes learned from the media, adults and their peers. Following these gender stereotypes can result in risky behaviour.

For example, young men who believe strongly in male stereotypes have more sexual partners, a lower level of intimacy with partners, a higher level of adversarial sexual beliefs, lower consistency of condom use, and a higher concern about condoms reducing male pleasure. They also put less value on partner appreciation of condom use, feel a lower level of responsibility for preventing pregnancy, and have a greater belief that pregnancy validates masculinity.[51]

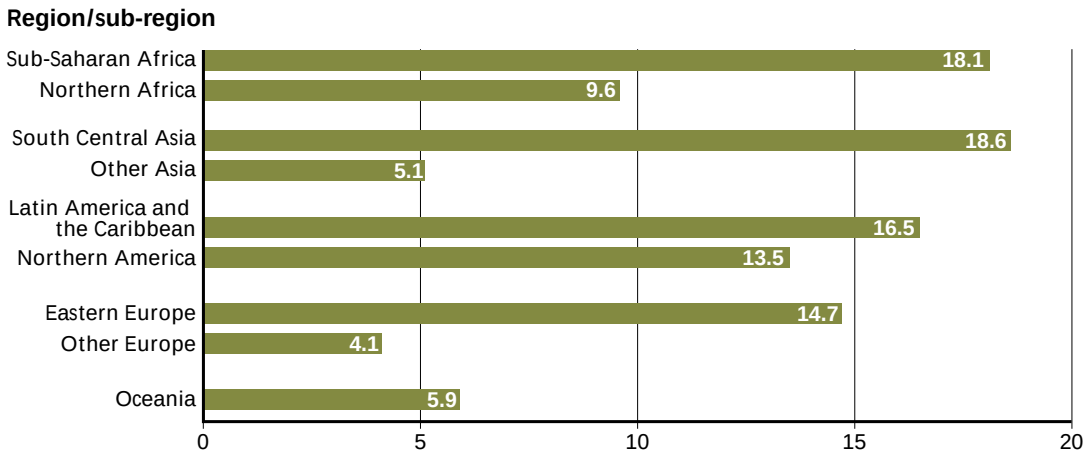
In Mexico and the United States, adolescent girls who sought contraceptive methods had a weaker association with traditional female sex roles than similar girls who became pregnant.[52] In Thailand, Zimbabwe and many other places, the admired stereotype of quiet, innocent "good" girls prevents girls from negotiating condom use.[53]

Both boys and girls often share beliefs in a double standard that can lead to poor reproductive health behaviour. Many surveyed adolescents in India and Thailand supported multiple sexual partners for males but not for females, and premarital sexual intercourse for males but not for females.[54] Often both adolescent males and females reported that young men who did not initiate and control sex were weak — an attitude that sometimes leads boys to coerce girls into sexual relations.[55]

Parents need to be more involved. Parents say they would like their children to be taught about sex, but most fail to do so. Many feel ill-informed or embarrassed talking about the subject, and they fear being asked a question they cannot answer.[56]

Girls do talk with their mothers about menstruation and pregnancy but rarely about communicating with a sexual partner. Boys receive even less information from their parents, certainly not as much as they would like.[57] Fathers are often silent or absent and thus provide an

Figure 4: Percentage of All Births to Women under Age 20, by Region/subregion



Source: United Nations Population Division. 2000. *World Population Monitoring, 2000: Population, Gender and Development.*

uncaring male role model. Indeed, a study from Zimbabwe reported that fathers were "frequently absent from the home environment and were usually viewed as remote, fearsome, moody, and unpredictable people whom it is safest to avoid."[58]

Social and sexual inequalities learned during childhood and adolescence increase girls' vulnerability to pregnancy and HIV infection because they cannot negotiate safe sex as equals in a relationship.[59] Girls are also at greater risk than boys of sexual abuse and physical violence from a partner.

Young married women may be at a particular disadvantage. Young brides who would prefer to wait before having children may find that their husbands, families, even some health providers will not give them contraceptives until they have a child.[60] Where women are dependent on their husbands, they may also lack the power to negotiate safe sexual practices.[61]

Programmes Can Help Change the Rules

These attitudes can change and programmes can help. Of course, programmes are only one of many factors that influence gender norms, but they are a place to start.

Sometimes simply calling attention to unequal gender norms can lead to improvements. At local fairs in India, the Centre for Health Education, Training and Nutrition Awareness presented dramas that illustrated how assumptions that women should not travel without permission and should do all the housework could interfere with families' getting good health care. Local leaders commented that they had never thought about these issues and strongly supported changes that gave women more freedom.[62]

Helping young people become aware of their gender assumptions can lead to better cooperation. In Thailand, the Bangkok Fights AIDS Project used focus groups of young men and women to discuss condom use. They found that Thai men and women viewed sex differently. While the girls wanted romance, the boys wanted sexual intercourse and sometimes forced the girls to have unprotected sex. Based on their findings, the project printed separate pamphlets for young men and women. Each pamphlet included a description of what the other sex wanted and expected as well as ways to talk about these issues.[63] The pamphlets were so popular that other projects bought thousands of copies.

Some programmes look at young people who do have good communication and cooperation skills to see what they are doing right. In Brazil, some boys do *not* act according to the prevalent cultural stereotypes of aggressive, uncommunicative males. These boys all had a relative or friend who set an alternative example. Boys who could reflect on their lives or who were seen as competent in some realm of their lives — school, work, sports or music — were better able to ignore traditional male stereotypes. Programme responses might include working with young men to reflect on their actions, offering them mentors who promote safe sex, providing them with skills, and helping them to question traditional role models.[64]

The experience of past programmes indicates that young people need programmes that are accessible, non-judgemental, and responsive to what young people want.[65] Because there are so many kinds of youth — male and female, married and unmarried, sexually active and inactive — no single approach will suit them all.[66] Although there should be separate efforts to meet the needs of boys and girls, having them listen to one another is epecially effective in facilitating open communication between partners.

Training young people to be peer educators can legitimize discussions of sexual responsibility. Young men meet others like them who speak easily and openly about sexuality and promote responsible behaviour as an attractive "male" quality. Being a peer educator can also allow girls to talk about sex without risking being called promiscuous.[67]

Programmes can meet the needs of young people at lower cost if they avoid treating adolescent sexuality as a medical issue. Many,

BOX 13

Gender Norms Can Prevent Safe Sex

In Brazil, boys learn that being sexually active is an important part of being a man. A "man" must be sexually active and financially secure. For most boys, becoming sexually active is easier than finding a job, so sexual conquests are one of the few ways they can assert their masculinity. Boys learn about male norms from other males. Friends, uncles, male neighbours, even fathers tease and encourage boys to become sexually active and refer to them as homosexuals if they do not.

Girls in Brazil get a different message. A woman should be more fragile than a man, less aggressive and better able to control her sexuality. Before marriage she should not be sexually active or know about sexual matters. After marriage her husband will teach her whatever she needs to know.

These gender norms lead to poor cooperation and communication around sex. Girls say they cannot suggest condom use or carry condoms for fear of being thought promiscuous. Boys say they cannot agree to abstain for fear of being thought weak. Girls risk disgrace if they seek information about sexuality or show an interest in it. Boys risk ridicule if they limit themselves to one partner.

perhaps most, young people need only information, life skills and sound advice. These needs can be met in the community settings that young people prefer. The resources will differ for boys and girls, young and old, and may include sports clubs, scouting groups, pharmacies and workplaces.[68] Health services can support these efforts.[69]

Programmes also need to be directed at adults so that they do not prevent youth from practising sexual responsibility by limiting their access to information and health services. For example, health care personnel often refuse to treat young people who seek health care, parents fail to inform their children, and teachers omit material on sexual health.

In a Kenyan study, 71 per cent of parents reported having talked with their children about school work in the past year, but only 28 per cent had talked with them about sexual behaviour.[70] Parents need to examine their own assumptions about gender and sexuality and decide whether these are the values they wish their children to have. Once parents recognize the importance of their own role in the education process, programmes can focus on providing information and helping parents develop approaches for talking with their children.

Parents are not the only adults who should be involved. The United Nations Children's Fund (UNICEF) in Uganda uses a broad definition of parents — all adults who care for children: mothers, fathers, grandparents, aunts, uncles, step-parents, guardians and family friends. Health workers, teachers, coaches and others who work with young people can also become effective sources of information for youth. As with parents, these adults need insight into their own assumptions as well as access to accurate information.

Several kinds of programmes teach intergenerational communication around sexuality. In Kenya, for instance, the Family Planning Association is testing a parent-centred model for expanding information and services to young people living in the town of Nyeri. Through the programme, parents are trained to be friends to their children, to provide adolescents and other parents with information, basic counselling and referrals. In addition, private and public providers are trained to receive referrals of those adolescents who need more advanced information, counselling or clinical care.[71]

UNFPA has supported several parent education projects in Africa and elsewhere. In Malawi, for example, one project is working to integrate parent education into a community-based training programme. In Egypt, a UNFPA-supported interregional project has successfully trained Muslim theologians to conduct non-formal education and counselling of parents on reproductive health, sex education and family planning. In Mexico, *Gente Joven* aims at improving inter-generational communication and developing among adults and parents a clear and positive attitude towards the sexuality of young people. The programme offers basic courses in sexual guidance for parents of youth 11-20 years old. The training was also provided for 110,000 youth promoters in 1991.

BOX 14

Gates Foundation Helps Protect African Youth against HIV/AIDS

In April 2000, the Bill & Melinda Gates Foundation announced a $57 million grant for programmes to protect young people in Botswana, Ghana, Uganda and the United Republic of Tanzania against HIV/AIDS. Preventing deadly diseases among poor children is a central priority of the United States-based foundation.

The five-year grant will be used to expand national campaigns aimed at educating youth about HIV/AIDS prevention and ensuring that youth can protect themselves. The countries' governments will implement the programmes in partnership with UNFPA, two international NGOs with extensive experience in sub-Saharan Africa—the Program for Appropriate Technology in Health (PATH) and Pathfinder International—and local groups.

The four countries were chosen based on need and on their demonstrated commitment to HIV/AIDS prevention among youth. Field staffs of UNFPA, PATH and Pathfinder have developed projects that include rural and urban education programmes, peer counselling for young people in and out of school, accessible reproductive health services (provided in youth centres, for example), and job training for disadvantaged youth.

The supported programmes will also serve as models for other hard-hit countries and international aid efforts. A regional support network will facilitate the sharing of national experiences.

Policies Promoting Partnerships

Current social norms support withholding accurate information from young people, while popular culture glorifies and encourages sexual activity.[72] Policy makers can help change these norms. They can pass and enforce laws that protect girls and boys from adult abuse and early marriage. Working with health professionals, they can give adolescents access to information, skills, and services if needed. They can support efforts to keep young people, especially girls, in school.

Most important, policy makers and political leaders can become new role models validating capable women and compassionate men. Through their actions, they can demonstrate that men and women can, and do, communicate and cooperate.

Men's Reproductive Health Needs

While women are at higher risk of reproductive illnesses than men, men are also subject to sexually transmitted infections and suffer from other reproductive health problems such as impotence or infertility. The death or illness of their wives resulting from inadequate reproductive health care is also a burden affecting many men.

It has been estimated that more than 1.9 million disability-adjusted life years of men aged 15-59 will be lost each year to STDs, excluding HIV/AIDS, and another 16.8 million to HIV/AIDS itself.[73] Infertility, frequently a consequence of untreated STDs, affects millions of men, but statistics are poor since male reproductive health is often not medically assessed and is under-studied.[74]

Men as well as women want to space their children or limit their family size, but their needs are not being met. In some developing countries, for example, between one quarter and two thirds of men say that they do not want to have any more children, but neither they nor their wives are using contraception.[75]

Reproductive health services directed towards men have concentrated on STD treatment and control. Efforts have also been made in many countries to provide information and services to military recruits.[76] UNFPA-supported programmes in Bolivia, Ecuador, Nicaragua, Paraguay and Peru are generating greater awareness within the armed forces and police forces on the sexual and reproductive health of men, unequal gender relations and violence against women.[77]

The proportion of contraceptive use attributed to men (including condoms, withdrawal, periodic abstinence and vasectomy) has been falling in recent years. It has reached 26 per cent, a drop of 11 per cent since 1987 and 5 per cent since 1994.[78] Vasectomy (male sterilization) is a safer and less invasive procedure than its female counterpart (tubectomy), but it is much less widely practised.

Potential users cite various reasons for finding particular methods unacceptable (for example, concerns about permanence or reversibility, interruption of spontaneity, adverse affects on libido or sexual performance). But these methods offer benefits: HIV prevention in the case of condoms, the permanence of many vasectomies, and financial cost-freedom for abstinence and withdrawal.

Information on avoiding pregnancy and preventing HIV/AIDS and other STDs is still limited among unmarried men in many countries. Sexually active unmarried men report some use of condoms (from 7 to 50 per cent in sub-Saharan Africa and from 27 to 64 per cent in Latin America).[79] However, information gaps, embarrassment and provider reluctance block greater use.

Programmes to affect male attitudes and support for reproductive health including family planning, and to teach gender sensitivity[80] have shown progress. Peer counselling programmes have been especially useful in addressing male adolescents.

The Planned Parenthood Federation of Ghana has increased men's interest in using contraception with an approach that combines media efforts with clinic staff outreach to promote a broad range of reproductive health concerns, including impotence and infertility.[81]

In Mexico and Colombia, peer counselling has increased acceptance of vasectomy. Training of counsellors and paramedical staff in Mexico has increased acceptance by 25 per cent, reducing reliance on female sterilization. In Turkey, counselling couples about vasectomy following an abortion has promoted acceptance and reduced recourse to abortion.

Reproductive Health Needs of Migrants and Refugees

Attending the health needs, including the reproductive health needs, of people that normal infrastructure does not or cannot reach is a priority public health concern. These include people affected by war or natural disaster, remote populations and other communities living in poverty, or countries adversely affected by economic setbacks or transition. Women and children make up a disproportionately large share of these communities, increasingly as heads of households.

Worldwide, it has been estimated that there are currently about 125 million international migrants and 15 million refugees seeking better lives for themselves and their families abroad, or fleeing wars, civil strife, famine and environmental destruction. Another 20 million people are classified as internally displaced within their own countries. Most of these migrants and refugees end up in urban areas and most of them — up to 80 per cent in some areas — are women and children.[82]

Nearly all refugees and half of all migrants live in developing countries, where services are usually woefully inadequate to meet their reproductive health needs. Even more than other groups, migrants and refugees need reproductive health care, including protection from HIV/AIDS and other sexually transmitted infections, safe motherhood, and freedom from

Men, like women, want to space their children, but their needs are not being met.

sexual and gender violence. All too often they lack access to these important services. Clustered on the margins of cities, housed in temporary camps in remote areas, many without any place to call home, these groups are among society's most vulnerable people.[83]

Since migrant families in developing countries are usually poor, living in squalid conditions in shanty towns, squatter settlements or on the streets, they are more at risk than the general population from unwanted pregnancies, complications and domestic violence. Women and children are also at risk from sexual exploitation, STDs (including HIV/AIDS) and gender violence.[84] Women and adolescent girls often fall prey to the sex trade.

Through the Office of the United Nations High Commissioner for Refugees (UNHCR), the international community is working to restore the lives of displaced persons, particularly women and children. Through job and skills training, and access to tools, equipment and credit programmes, women and their families are rebuilding their lives.[85] Similarly reproductive health programmes must reach women — and men — in transitional societies and in refugee situations with services to protect them from unwanted pregnancy and disease and to help them ensure healthy childbearing.

People displaced from their homes as a result of civil conflict, war or natural disaster are often vulnerable to reproductive health risks and without regular access to services and information. In such situations, many women find themselves as heads of households or alone without family protection, increasing their vulnerability to sexual exploitation and the accompanying dangers.

Sexual violence is common in many armed conflicts, especially where combatants mix with civilian populations. In several recent conflicts, large numbers of rapes have been documented. There is, therefore, a critical need to provide women and young people who have been subjected to sexual violence with treatment, counselling and services including emergency contraception, prevention of STDs, including HIV/AIDS, and the management of deliveries and of abortion complications.

BOX 15

UNFPA and Reproductive Health Needs in Emergency Situations

Since 1994, UNFPA has actively focused international attention on the reproductive health and rights of refugees and displaced people, supporting emergency reproductive health projects in more than 30 countries. These projects provide: personal hygiene care; antenatal care, safe delivery and post-natal care; treatment of complications associated with pregnancy, delivery and the post-partum period; family planning information and services; prevention and management of reproductive tract infections and STDs, including prevention of HIV/AIDS; and the management of consequences of sexual violence.

In 1995, UNFPA and UNHCR, with the collaboration of UNICEF and WHO, organized a symposium for humanitarian agencies. This resulted in the creation of an Inter-Agency Working Group on Reproductive Health Needs in Refugee Situations, and the production of *An Inter-Agency Field Manual on Reproductive Health in Refugee Situations* which has been used widely by many agencies in subsequent emergencies. The most recent version of the manual was launched in June 1999 by WHO, UNHCR and UNFPA.

The working group continues to be an active coordinating body for international agencies in this area, providing a vehicle for sharing operations information, setting standards of care, guiding research, and coordinating training and advocacy efforts.

The working group also helped to develop and refine the contents of a set of 12 emergency obstetric and reproductive health kits which can be airlifted to crisis zones before more comprehensive programmes can be established. UNFPA organizes these kits and makes them available upon request to agencies and national governments in emergency situations. The Fund has provided such equipment and supplies as well as technical support for reproductive health services in Afghanistan, Albania, Bosnia and Herzegovina, East Timor, Eritrea, Guinea-Bissau, Kosovo, Mongolia, Mozambique, Rwanda, the United Republic of Tanzania and Zimbabwe.

In 1999 and the early months of 2000, UNFPA responded to a number of natural disasters, including earthquakes in Turkey; landslides in Venezuela; a cyclone in India; and floods in Madagascar, Mozambique and Zimbabwe.

UNFPA collaborates closely with other international agencies and organizations as well as local groups. It has signed partnership agreements with UNHCR, the International Organization for Migration and the International Federation of Red Cross and Red Crescent Societies. The Fund regularly provides expertise in documenting demographic aspects of crises as part of United Nations inter-agency humanitarian needs assessments and planning.

Partnerships for Reproductive Health and Family Planning

Governments can promote community participation in improving reproductive health, and can make public-sector programmes more gender sensitive. A number of guides and curricula have been developed towards these aims, and some countries have expanded related training for programme staff.[86] Non-governmental organizations often have more flexibility than government services in this regard, and often find it easier than governments to work in sensitive areas such as adolescent health and gender-based violence.

Networks

One of the great strengths of NGOs is their ability to form partnerships and alliances among themselves and with governments and others. These networks of organizations apply a variety of perspectives and types of expertise to common concerns.

In **Brazil**, the *Rede Nacional Feminista de Saude e Direitos Reprodutivos* is a nationwide network of 60 NGOs and women's groups, 20 university groups working on gender and health issues, female legislators, health and law professionals and human rights activists. Since the ICPD, this network has facilitated women's participation in formulating and implementing policies on women's and adolescents' reproductive health and rights, strengthening the gender perspective and helping to create a new vision and new health indicators.

The **International Planned Parenthood Federation** (IPPF) unites family planning associations in 150 countries. IPPF's Sexual and Reproductive Rights Charter, developed in 1995, is used worldwide to revise legislation and undertake advocacy on sensitive issues such as unsafe abortion and unwanted pregnancies.

Health Empowerment Rights and Accountability (HERA) is an international NGO network of researchers and women's organizations formed during the ICPD process to advocate for gender equality and reproductive health and rights. Coordinated by the International Women's Health Coalition in New York, HERA's updates, briefing cards, consultations and workshops have been influential in making the international community aware of the importance of gender and women's rights in population and development strategies.

The **International Reproductive Rights Research Action Group**, established in 1992, collaborates with other women's networks such as the **Development Alternatives with Women for a New Era**, the **Latin American and Caribbean Women's Health Coalition** and the **Women's Global Network for Reproductive Rights**. Their policy influence is evident in the seven countries where they undertook research work (Brazil, Egypt, Malaysia, Mexico, Nigeria, the Philippines and the United States) as well as internationally, where they have helped to put the cultural, political and economic facets of reproductive rights on the intergovernmental agenda.

The **Global Fund for Women** was established in the mid-1980s to assist women and women's organizations in transforming their societies. The Global Fund studied the impact of its grants in eight countries, including the impact on women's attitudes towards family planning and contraceptive use. The study found that "participating in the activities of the organizations empowers women (through increased self-esteem, knowledge, skills and economic autonomy). This, in turn, has an impact on reproductive health and behaviour. For many women, it increases both their desire to use contraception and their ability to gain access to it."[87]

National NGOs and Community Health Services

National NGOs are promoting reproductive health and women's well-being, providing health care and social services, and participating actively in health-reform processes. In Bangladesh, for example, NGOs carry out 25 per cent of reproductive health activities. One is the Bangladesh Rural Advancement Committee, founded in 1972, which has a staff of over 20,000 and reaches 2.1 million women and girls in 65,000 villages and 34,000 schools.

In **Bangladesh, Colombia, Jamaica, Mexico, Peru** and **Zambia**, NGOs have taken the lead in expanding services — particularly in providing family planning in the context of reproductive health, and in offering services to men and adolescents. Profamilia, an IPPF affiliate in Colombia, provides more than 60 per cent of national family planning services. Since 1994 it has broadened its provision of reproductive health services, in addition to other women's empowerment activities. In Peru, the women's NGO Manuela Ramos is working with nearly 90 community-based women's organizations through a project called *ReproSalud*.[88]

In **China**, the Ford Foundation supported the Women's Reproductive Health and Development Programme to address women's reproductive health in the broader social and economic context that shapes their overall health.[89] The programme enabled poor rural women to better understand, articulate and act on their health

NGOs often find it easier than governments to work in sensitive areas such as adolescent health.

BOX 16

Using Networks to Promote Reproductive Health

The ACCESS project of the Centre for Development and Population Activities (CEDPA) provides community-based family planning and reproductive health services in Nigeria, working with 10 women-focused organizations in several states. All are state chapters of larger national networks, including the National Council of Women's Societies, the Christian Health Organization of Nigeria, the Country Women Association of Nigeria, Women in Nigeria, and the Grassroots Health Organization of Nigeria. The organizations work with 500 local societies providing integrated services through more than 2,000 agents, market vendors and traders. The strength of such networks comes from their national legitimacy and credibility and, most important, their local relevance and ability to collaborate with and support local government programmes.

needs. Communities were involved in decision-making and programme design. The effort also trained national and local professionals to use a "bottom-up" approach to meeting individual and community needs.

Some IPPF-affiliated family planning associations are working to help communities identify their reproductive health problems, thereby building trust within the community for health care providers and ensuring that new services meet community needs. In Madras, **India**, this approach has fostered stronger communication skills among women, enabling them to talk to their husbands and to take a larger role in ensuring their children's well-being.[90]

NGOs and Adolescents' Reproductive Health

NGOs are working to involve adolescents in meeting their sexual and reproductive health needs. Giving girls a space to talk about their feelings and expectations on reproduction, health and sexuality is an important strategy towards better reproductive health and gender equality.

Traditional groups such as the World Association of Girl Guides and Girl Scouts are also advocating for girls' reproductive rights. Grassroots NGOs such as *Red de Salud de las Mujeres Latinoamericanas y del Caribe* (Latin American and Caribbean Women's Health Network), CEDPA in **India**, Arrow in **Malaysia,** ISIS International–Manila in the **Philippines**, Tanzania Media Women's Association in the **United Republic of Tanzania** and the Women's Health Project in **South Africa** are using peer group discussions and gender-training techniques to encourage girls to talk about sexual and reproductive health and to be more assertive in their relationships with boys.

The Programme for Enhancing Adolescent Reproductive Life in **Uganda**, a UNFPA-supported, community-based programme aimed primarily at out-of-school youth, works to create a safe environment for adolescents that combines recreational activities with reproductive health counselling and services. Although targeted at adolescents, the programme also makes parents and religious and community leaders aware of the importance of providing such counselling and services.

Other groups such as the Women's Rehabilitation Centre in **Nepal** and members of the Women's Global Network for Reproductive Rights in more than 23 countries are tackling the difficult issue of improving the health, well-being and choices of rescued child sex workers.

CHAPTER 3

Ending Violence against Women and Girls

A Human Rights and Health Priority

PHOTO: Indian prostitutes. Many women and girls are lured into prostitution by traffickers who target the poor and vulnerable.

Bartholomew/Liaison

"[Violence against women] cuts across social and economic situations and is deeply embedded in cultures around the world — so much so that millions of women consider it a way of life."[1]

Gender-based violence — in various forms including rape, domestic violence, "honour" killings and trafficking in women — exacts a heavy toll on mental and physical health. Increasingly, gender-based violence is recognized as a major public health concern and a serious violation of basic human rights.[2]

Around the world, at least one in every three women has been beaten, coerced into sex, or abused in some other way — most often by someone she knows, including by her husband or another male family member; one woman in four has been abused during pregnancy.[3]

Millions of women require medical attention or otherwise suffer the impact of gender-based violence; fear of violence inhibits discussion and constrains the health choices and life opportunities of many millions more.

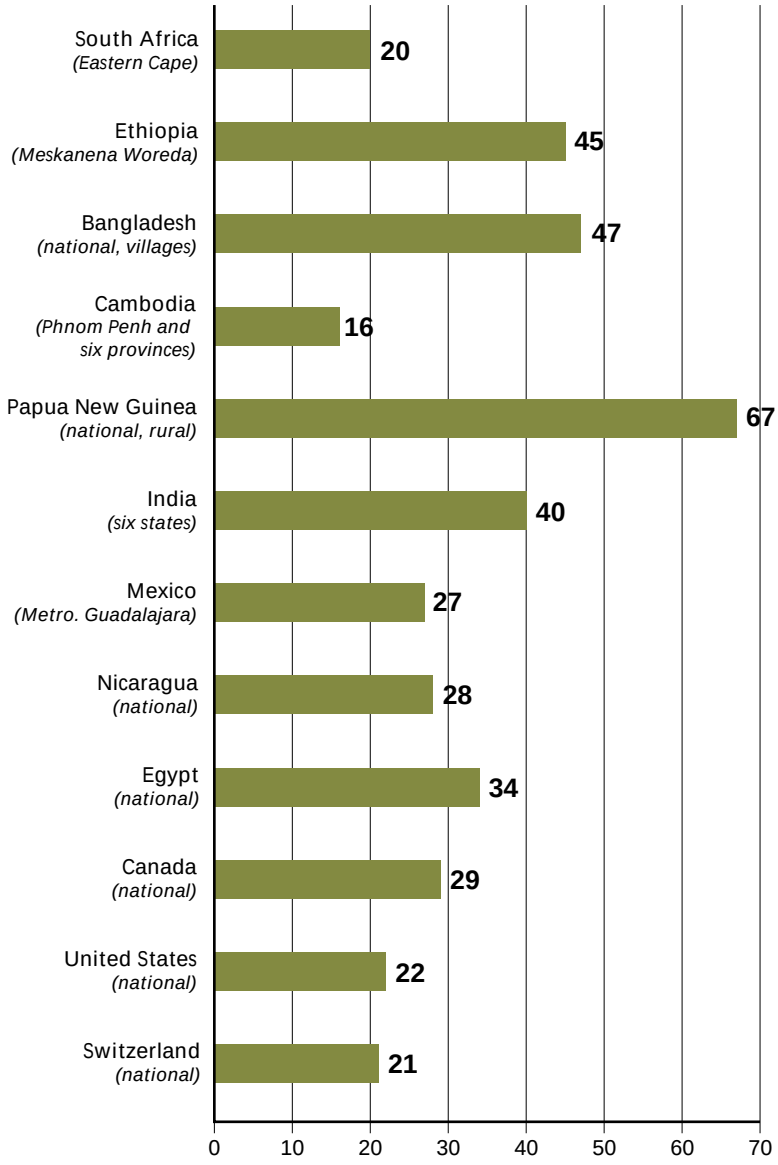
Psychological abuse almost always accompanies physical abuse. In addition, one third to one half of all cases involve sexual abuse. A high proportion of women who are beaten are subjected to violence repeatedly.[4]

Violence against women is a pervasive yet under-recognized human rights violation. Accordingly, the 1993 World Conference on Human Rights, Vienna, and the 1995 Fourth World Conference on Women, Beijing, gave priority to this problem.

Violence against women and girls takes many forms:

- At least 60 million girls who would otherwise be expected to be alive are "missing" from various populations, mostly in Asia, as a result of sex-selective abortions, infanticide or neglect;
- Studies suggest domestic violence is widespread in most societies and is a frequent cause of suicides among women;

Figure 5: Percentage of Adult Women Reporting Physical Assault by a Male Partner
(In any intimate relationship; Selected studies)



Source: Heise, L., M. Ellsberg and M. Gottemoeller, 1999. "Ending Violence against Women." *Population Reports,* Series L, No. 11, Baltimore: Johns Hopkins School of Public Health, Population Information Program.

- Rape and other forms of sexual violence are increasing. Many rapes go unreported because of the stigma and trauma associated with them and the lack of sympathetic treatment from legal systems. Estimates of the proportion of rapes reported to authorities vary — from less than 3 per cent in South Africa to about 16 per cent in the United States;

- Two million girls between ages 5 and 15 are introduced into the commercial sex market each year;

- At least 130 million women have been forced to undergo female genital mutilation or cutting; another 2 million are at risk each year from this degrading and dangerous practice;

- So-called "honour" killings take the lives of thousands of young women every year, mainly in Western Asia, North Africa and parts of South Asia. At least 1,000 women were murdered in Pakistan in 1999.

In the United States, a woman is battered, usually by her intimate partner, every 15 seconds.[5] Physical violence is nearly always accompanied by psychological abuse, which can be just as demeaning and degrading. Among 613 abused women in Japan, for instance, close to 60 per cent had suffered from physical, psychological and sexual abuse at the hands of their partners; only 8 per cent had experienced physical abuse alone.[6] Similarly, in Leon, Nicaragua, researchers found that of 188 women abused by their partners, only 5 had not been sexually assaulted.[7]

Measuring acts of violence against women and girls does not, of course, describe the atmosphere of terror that often permeates abusive relationships. For instance, in a nationwide domestic violence survey in Canada in 1993, researchers discovered that a full one third of all women who had been subjected to domestic violence had feared for their lives at some point in the relationship.[8] Women often assert that prolonged psychological abuse and degradation are more difficult to bear than physical pain.[9]

Many cultures condone or at least tolerate a certain amount of violence against women. In parts of South Asia, Western Asia and Africa, for instance, men are seen as having a right to discipline their wives as they see fit. The right of a husband to beat or physically intimidate his wife is a deeply held conviction in many societies.

Even women often view a certain amount of physical abuse as justified under certain conditions. For instance, 80 per cent of women surveyed in rural Egypt said that beatings were common and often justified, particularly if the woman refused to have sex with her partner.[10]

Justification for violence stems from gender norms — distorted views about the roles and responsibilities of men and women in relationships.

Worldwide, studies have shown a consistent pattern of events that trigger violent responses. These include: not obeying the husband, talking back, refusing sex, not having food ready on time, failing to care for the children or home, questioning the man about money or girlfriends or going somewhere without his permission.[11]

Impacts on Reproductive Health

Violence in all its forms causes immense damage to the reproductive health and well-being of women and girls throughout the world, in direct and indirect ways:

- Unwanted pregnancies and restricted access to family planning information and contraceptives;
- Unsafe abortion or injuries sustained during a legal abortion after an unwanted pregnancy;
- Complications from frequent, high-risk pregnancies and lack of follow-up care;
- Sexually transmitted diseases, including HIV/AIDS;
- Persistent gynaecological problems;
- Psychological problems, including fear of sex and loss of pleasure.

Violence as a barrier to family planning

Though most contraceptive use is accepted by both partners, researchers have found that abused women tend not to use family planning services, even if readily available, for fear of reprisals from husbands. Women in Zimbabwe and Kenya, for instance, often hide their contraceptive pills because they are terrified of the consequences should their husbands discover that they no longer control their wives' fertility.[12] Similarly, abused women who participated in focus group discussions in Peru and Mexico said they did not discuss contraceptive use with their husbands out of fear that the men would turn violent.[13]

In a study in Ghana, close to half of all women and 43 per cent of men said a man was justified in beating his wife if she used a family planning method without his expressed consent.[14]

Abortion

Women who are abused or afraid to raise the issue of family planning with their partners are at risk of repeated unwanted pregnancies. Many abused women seek abortions.

High-risk pregnancies

Violence has been linked with increased risk of miscarriages, premature labour, foetal distress and low birth weight.[15] A study in Leon, Nicaragua, found that violence against pregnant women was associated with a threefold increase in low birth-weight babies.[16] Blunt abdominal trauma can lead to foetal death or

BOX 17

Killings in Sweden Spark Debate about Domestic Violence

Calls for action to stop domestic violence against women escalated in Sweden in October 1999, after the fourth case in a month in which police questioned or charged a man after his wife or partner's death.

A 32-year-old woman died after falling from a fifth-floor balcony. Police questioned her husband, 35, after neighbours reported seeing the couple fighting on the balcony before the fall. In one week in September, three other women were murdered and their partners were the prime suspects. One man admitted he had killed his wife. A 19-year-old was beaten to death in her home after having reported her former boyfriend for threatening her.

In Sweden, about 16 women are killed by their partners every year, about one sixth of all murders. Some 20,373 cases of abuse of women were reported between January and September 1998.

Research into domestic violence in 1991-1996 showed that men who killed their wives or partners were often drunk or had psychological problems. Jealousy and separation were the most common reasons.

Authorities are being urged to pay more heed to warning signs. "In many cases neighbours and friends know that the man is beating the woman, and the woman has even reported threats or assault to the police, but not enough is done," said a spokesman from the National Council for Crime Prevention.

BOX 18

Women's Attackers Seldom Punished in Pakistan

"Women in Pakistan face spiralling rates of gender-based violence, a legal framework that is deeply biased against women, and a law enforcement system that re-traumatizes female victims instead of facilitating justice," according to a 1999 report by Human Rights Watch. Citing domestic violence rates as high as 90 per cent, at least eight reported rapes every 24 hours nationwide, and an alarming rise in so-called "honour" killings, the report states that such crimes continue to be perpetrated with near total impunity.

The report says law enforcement authorities routinely dismiss domestic violence as private disputes. Female victims attempting to register complaints of abuse are invariably turned away, and are regularly advised and sometimes pressured by the police to reconcile with their abusive spouses or relatives.

Women who report rape or sexual assault by strangers are often disbelieved and treated with disrespect. They must contend with abusive police, forensic doctors who focus on their virginity status instead of their injuries, untrained prosecutors, sceptical judges, and a discriminatory and deficient legal framework. "Only the most resilient and resourceful complainants can manoeuvre such hostile terrain," says the report. "And those who do seldom see their attackers punished."

Pakistan's rape law, the Offence of Zina Ordinance, allows marital rape, does not establish the crime of statutory rape, and in some cases does not permit the female victim to testify.

The report says women's rights advocacy organizations have been subjected to intimidation, including government surveillance and threats that they would be banned.

low birth weight by provoking pre-term delivery.[17] Violence may also affect the outcome of pregnancies indirectly by increasing a woman's likelihood of engaging in harmful behaviour such as smoking and alcohol and drug abuse, all of which have been linked to pregnancy complications and low birth weight.[18] Stress and anxiety brought on by persistent violent behaviour during pregnancy can reduce a woman's ability to obtain adequate nutrition, rest, exercise and medical care; this may retard foetal growth.[19]

Violence causes immense damage to women's reproductive health and well-being.

Violence and STDs

Forced or unprotected sex puts women at risk of acquiring STDs, including HIV/AIDS. Many STDs and reproductive tract infections could be prevented if men routinely wore condoms when engaging in sex and refrained from having sex when the woman complained of soreness or other problems. Many women are afraid to ask their partners to wear condoms during sex for fear of violent reactions.

Rape victims are especially at risk of infection. Up to 30 per cent of women raped in the United States every year, for instance, develop an STD as a result.

Molestation of young girls is another profoundly disturbing aspect of this problem. A study in Zaria, Nigeria, for example, found that 16 per cent of hospital patients with sexually transmitted infections were under age 5.[20] At the Genito-Urinary Centre in Harare, Zimbabwe, doctors discovered that more than 900 children under age 12 had been treated for an STD in 1990 alone.[21]

Persistent gynaecological problems

Physical and sexual abuse also increases a woman's risk for a number of common gynaecological disorders, including chronic pelvic pain. In many countries, chronic pelvic pain accounts for up to 10 per cent of all visits to gynaecologists and one quarter of all hysterectomies.[22] Although chronic pelvic pain is normally caused by adhesions, endometriosis or infections, about half the cases treated have no identifiable pathology. A number of studies have found that women suffering from pelvic pain are consistently more likely to have a history of childhood sexual abuse, sexual assault or physical and sexual abuse by their partners.[23]

Other gynaecological problems associated with sexual violence include vaginal bleeding, vaginal discharge, painful menstruation, pelvic inflammatory disease and sexual dysfunction.[24] Sexual assault also increases the risk for premenstrual distress, a condition that affects up to 10 per cent of menstruating women and causes physical, mood and behavioural changes.[25]

Psychological problems

Violence distorts the emotional lives of women and families. In Nicaragua, for instance, focus group studies found that many women considered the persistent psychological effects of domestic violence to be more severe and debilitating than the physical ones. Violence can also lead to suicide.[26]

Table 1: Gender Violence throughout a Woman's Life

Phase	Type of Violence
Prenatal	Sex-selective abortions, battering during pregnancy, coerced pregnancy (rape during war)
Infancy	Female infanticide, emotional and physical abuse, differential access to food and medical care
Childhood	Genital mutilation, incest and sexual abuse, differential access to food, medical care and education, child prostitution
Adolescence	Dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, forced prostitution
Reproductive	Abuse of women by intimate partners, marital rape, dowry abuse and murders, partner homicide, psychological abuse, sexual abuse in the workplace, sexual harassment, rape, abuse of women with disabilities
Old Age	Abuse of widows, elder abuse (which affects mostly women)

Source: Heise, L. 1994. *Violence Against Women: The Hidden Health Burden*. World Bank Discussion Paper. Washington. D.C.: The World Bank.

Serious episodes of depression affect about one third of battered women in the United States.[27] One study found that one fourth of all suicide attempts were preceded by abuse. Data in the United States suggest that women who were sexually abused as children tend to end up in abusive relationships and have a higher than normal risk of becoming involved in prostitution and drugs.[28]

Another U.S. study found that women who had been sexually molested as children were three times more likely to be pregnant by age 18 than women who had not been abused. Women who had been abused as children were also twice as likely to put themselves at risk of acquiring an STD or HIV infection by having unprotected sex with multiple partners.[29]

Trafficking in Women and Girls

An estimated 4 million women and girls are bought and sold worldwide, either into marriage, prostitution or slavery.[30] Many are lured into the hands of traffickers by promises of jobs. In some countries, traffickers target poor, vulnerable communities. They may arrive during a drought or before the harvest, when food is scarce, and persuade poor families to sell their daughters for small amounts of money.

Each year, at least 10,000 girls and women enter Thailand from poorer neighbouring countries and end up in commercial sex work, according to UNICEF. Some 5,000 to 7,000 Nepali girls are trafficked across the border to India each year, mostly ending up as sex workers in Mumbai or New Delhi.[31]

Although the greatest volume of trafficking occurs in Asia, Eastern European women are increasingly vulnerable.

"Honour" Killings

Throughout the world, perhaps as many as 5,000 women and girls a year are murdered by members of their own families, many of them for the "dishonour" of having been raped, often as not by a member of their own extended family.

Many forms of communally sanctioned violence against women, such as "honour" killings, are associated with the community's or the family's demand for sexual chastity and virginity. Perpetrators of such wanton acts often receive light sentences or are excused by the courts entirely because defence of the family's honour is treated as a mitigating circumstance.

"Honour" killings are on the rise worldwide, according to Asma Jahangir, the United Nations special rapporteur on extrajudicial, summary and arbitrary executions. Ms. Jahangir is working closely with United Nations special investigators on violence against women and on the independence of judges and lawyers to address the issue.

"The perpetrators of these crimes are mostly male family members of the murdered women, who go unpunished or receive reduced sentences on the justification of having murdered to defend their misconceived notions of 'family honour,'" Jahangir wrote in her 2000 annual report to the Commission on Human Rights.[32] Such killings have been reported in

BOX 19

Trafficking in the United States Rarely Punished, Report Says

As many as 50,000 women and children from Asia, Latin America and Eastern Europe are brought to the United States under false pretences each year and forced to work as prostitutes, abused labourers or servants, according to a report by the U.S. Central Intelligence Agency. But over the past two years, the Government prosecuted cases involving no more than 250 victims.

Based on interviews with officials, law enforcement officers, victims and legal experts, the report says there has been evidence for years of widespread trafficking in immigrant women and children, some as young as 9 years old. Officers generally do not like to take on these cases because they are difficult to investigate and prosecute and penalties often are insubstantial.

The report describes case after case of foreign women who answered advertisements for au pair, sales clerk, secretarial or waitress jobs in the United States but found, once they arrived, that the jobs did not exist. Instead they were taken prisoner, held under guard and forced into prostitution or peonage. Some of them were sold outright to brothel owners. The primary sources for traffickers are Thailand, Viet Nam, China, Mexico, Russia and the Czech Republic, the report says.

BOX 20

Two "Honour" Killings in Jordan

Kifaya, a Jordanian girl of 12, was intelligent and full of curiosity. But when she returned home one evening from a walk in the neighbourhood with some friends, she was confronted by her enraged father. Shouting that she had dishonoured the entire family, her father proceeded to beat Kifaya with sticks and iron chains until she was dead. He told police he killed his only daughter because she went for walks without his permission.

About the same time, Hanan, 34, was shot dead by her brother for the "crime" of marrying a Christian. Her brother left her body in the street and smoked a cigarette while he waited for the police to arrive. Every year between 25 and 50 women and girls are the victims of "honour" killings in Jordan.

Bangladesh, Brazil, Ecuador, Egypt, India, Israel, Italy, Jordan, Morocco, Pakistan, Sweden, Turkey, Uganda and the United Kingdom, according to the report.

On the order of clerics, an 18-year-old woman was flogged to death in Batsail, Bangladesh, for "immoral" behaviour, according to the report. In Egypt, a father paraded his daughter's severed head through the streets shouting, "I avenged my honour."

The report says that "honour" killings tend to be more prevalent in, but are not limited to, countries with a majority Muslim population. It adds, however, that Islamic leaders have condemned the practice and say it has no religious basis.

NGOs Work against Gender Violence

NGOs' work worldwide on violence against women is one of the most important contributions to ending gender-based oppression.

Through the work of African NGOs, with the support of international organizations, FGM is being challenged and the practice outlawed, giving millions of girls and women hopes for a life with rights, health and security. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, a network of affiliates in 26 African and 3 European countries, has led the increasingly successful fight against FGM through public awareness campaigns and training in schools and communities, with traditional and trained medical staff.

BOX 21

Women Foreign Ministers Seek End to Human Trafficking

In October 1999, 14 women foreign ministers wrote to United Nations Secretary-General Kofi Annan seeking to end the widespread practice of trafficking in women and children.

"On the edge of the 21st century, it is unacceptable that human beings around the world are bought and sold into situations—such as sexual exploitation, domestic servitude and debt bondage—that are little different from slavery," wrote the ministers from the Bahamas, Barbados, Bulgaria, El Salvador, Finland, Liechtenstein, Luxembourg, Madagascar, Mexico, Mongolia, Niger, South Africa, Sweden and the United States.

"We recognize the importance of close international cooperation to defeat the traffickers at every stage of their criminal activities," the letter stated. The ministers pledged their governments' support for the proposed convention against Transnational Organized Crime and the protocol on trafficking in persons, both of which are currently under negotiation.

NGOs are also on the front line in work with women survivors of violence and rape in war. The *Corporación Grupo de Apoyo* in Bosa, **Colombia**, shelters women suffering from domestic violence and sexual violence so they can rebuild their self-esteem and reassert their own power. In San Cristóbal de las Casas, a city in the Chiapas highlands of **Mexico**, the *Centro de Apoyo a la Mujer* (Women's Support Centre) provides training and support for women living in extreme poverty and uncertainty, seeking particularly to change practices such as forcing girls as young as 10 to marry and traditions that condone wife abuse, domestic violence and incest.

In **Bosnia,** where after years of conflict women suffer not only sexual violence but also mental and physical damage and stress, a German gynaecologist set up *Medica Zenica*. In its first five years it has provided 20,000 women and children with counselling, and reached women in isolated villages through a mobile outpatient clinic. Isis–Women's International Cross Cultural Exchange in **Uganda** supports survivors of sexual violence in Burundi, Rwanda, the Sudan and Uganda through an exchange programme in which women share their experiences in a supportive and healing atmosphere.

NGOs campaigning against gender-based violence are increasingly using the Internet. For example, in Rajasthan, **India,** when members of the Bal Rashmi Society — which actively opposes sexual exploitation, rape, and dowry-related deaths and torture — were jailed, an Internet alert led to suspension of their trials.

B.a.B.e., a strategic lobbying group in **Croatia**, has used the Internet to raise awareness of women's experience of violence during war, and to bring about a new family law that includes restraining orders against men in domestic rape cases. Women's International Network–Emergency and Solidarity uses the Internet to share experiences among women working in situations of conflict, war, ecological disaster or extreme poverty.

Women Living Under Muslim Law has mounted a World Wide Web campaign around the denial of women's rights in Islamic societies; it directs support to the Association of the Women of Afghanistan, among others. WomenNet in **South Africa** used the Internet for a Stop Rape campaign supported by international signatories.

In the **Philippines**, women's NGOs initiated the National Family Violence Prevention Programme; it promotes the innovative "Voices of 2001: Breaking the Silence Campaign", which has collected stories of 2,001 women's experiences.

CHAPTER 4

Men, Reproductive Rights and Gender Equality

Equality between men and women is a matter for society at large, but it begins in the family. Understanding gender discrimination means understanding opportunities and constraints as they affect men as well as women. Men's attitudes and behaviours are strongly influenced by societal expectations about what it means to be a man.

In particular, the assumption that contraception, pregnancy, childbirth and prevention of sexually transmitted diseases are exclusively women's concerns reinforces men's lack of involvement in safeguarding reproductive health — both their own and that of their partners.

Definitions of masculinity are often rigidly stereotypical. In many settings, for example:

- A "real man" acts, he is not the object of action: he is demanding or aggressive in articulating his desires and striving towards his goals. His proper sphere of action is economic or political, not domestic or familial;
- A "real man" is the head of his family. He provides for his household, but he is entitled to use his resources as he chooses. He may choose personal pleasure above family expenses;
- A "real man" is strong. He does not recognize or admit uncertainty — a sign of weakness;
- Emotion may also be a sign of weakness. A "real man" therefore admits little concern for his partner's wishes, pleasure or well-being. He does not readily attend to the emotional, as opposed to the instrumental, aspects of relationships.

These stereotypes and others like them do not match reality, either for men or for those who depend on them. Men who — consciously or unconsciously — measure their lives against such stereotypes set themselves up for failure, difficulty in family relationships and unreasonable stress.

In cultures where patriarchy is accepted as the only proper family structure, men and women may be trapped in a pattern of relationships and dependencies that can frustrate them both. A woman without a husband may have no social standing, and have difficulty even finding the means of survival: but a man too may find life hard without a wife to do "woman's work" — grow food, cook and bring up children.

PHOTO: How men behave in their families is strongly influenced by expectations about what it means to be a "real man".

Shehzad Noorani/Still Pictures

UNICEF / 0789 / Nicole Toutounji

Responsible fatherhood can advance gender equality and improve families' welfare.

Men who cannot live up to expectations that men should be powerful and competent may respond by retreating into passivity and escape through drugs or alcohol, by resorting to violence towards those still weaker, or by exhibiting exaggerated bravado and risk-taking.

Men's Roles and Changing Realities

Particularly among men who are poor, undereducated, underemployed and marginalized, attempts to live up to ideals of "masculinity" are frequently compromised by harsh and changing realities.

A detailed analysis of gender relations in the Kisii District of Kenya[1] shows how men's self-esteem can be undermined. Most men in Kisii can no longer aspire to be owners of large amounts of land and many cattle, husbands of multiple wives and fathers of many children.[2] At the same time, they are acutely aware of the extent to which they depend on women's homestead farming and of the increasing cost of living.

They are now required to pay for their children's education and health care, formerly free or provided at a nominal charge. Their wives' demands for money and support regularly remind men of their reduced ability to satisfy expectations.[3] Their paternal authority is further weakened by changing circumstances and new values: land fragmentation, increased migration to cities, fewer arranged bride-wealth marriages, stronger local women's associations, and their children's expectations as a result of education.

Women and men both feel the stress. Even if they understand its causes, they have no means of coping with it. As a result, wives are increasingly vocal about their frustration; husbands are withdrawing from family responsibilities; many households are becoming violent battlegrounds; and the number of "broken homes" is increasing.[4]

Changing circumstances are producing similar strains in Latin American households, where persistent ideals of *machismo* — a conception of masculinity based on male control and force — pose problems for family relations, adolescent socialization and women's self-realization.[5]

Over the past three generations, expectations of men as rulers and protectors of the household have changed. Husbands today give greater recognition to their wives' perspectives and sexuality, and fatherhood is more important to their self-esteem. A recent public opinion poll in two Peruvian cities, Lima and Callao, concluded that the ideal of fatherhood now values affection towards and communication with children.[6]

A study in Peru showed that when men and women talk about relationships, women recognize great variety in how they interact with men.[7] Men, however, see their sexual roles only in terms of the extent to which they are dominant or passive. This difference hinders communication and change.

The internal tensions that undermine impossible ideals of male performance and competence can allow men to seek new role models and forms of behaviour.

Violence

Male violence against women is increasingly recognized and acknowledged. It results from a complex web of causes, including family and cultural traditions, the breakdown of protective traditions and institutions, and male frustration and disempowerment.

One analysis of North American culture sees traditional masculinity as involving:

> *suppression of a range of emotions, needs and possibilities, such as pleasure*

in caring for others, receptivity, empathy, and compassion, which are experienced as inconsistent with masculine power. The emotions and needs do not disappear but are not allowed expression. The persistence of emotions and needs not associated with masculinity is in itself a great source of fear. Such hidden pain may be expressed in aggression against others or against themselves.[8]

A study in the Philippines found that 13 per cent of married women had experienced physical violence by their husbands.[9] Violence was found to be more likely in urban areas, when men were unemployed, in households where the wife considered earnings inadequate, and where women earned more than 50 per cent of the income.[10] The probability of violence was also greater when men kept most or all of their earnings; men who turned over all of their earnings to their wives (as is customary) were only half as likely to hit their wives as men who did not.

Violence was least prevalent in households where spouses communicated and shared responsibility for decisions.[11] Where no decisions were made jointly, 25 per cent of couples reported that the husband had hit the wife. Where all decisions were made jointly, the incidence of domestic violence was 6 per cent.

This study affirms that helping men and women to communicate about their family roles and responsibilities — including contraceptive decisions and reproductive health care — is important to strengthening relationships, eliminating gender inequality and reducing recourse to violence.

Gender Inequality and Cultural Expectations

It is taken for granted that change in the public sphere — economic growth, political transformation, and new means of communication and transport — will be reflected in changes in individual attitudes and behaviours. But this expectation does not extend to the private sphere, where basic issues of identity and family are involved. Society may change, but gender roles are not expected to change with it.

This anomaly is at the root of continuing gender inequality. Many cultures maintain a traditional patriarchal system in which men are the primary decision makers in family and social relationships. Although the result is generally not to their advantage, women may acquiesce to keep their place within the community, and eventually to earn the respect due to a mother or an elder.

The view that family, home and private life are the province of women's authority and concern restricts women's opportunities and subjects them to control by men. However, it also offers rewards: it "protects" women from external violence, assigns them a recognized position, and offers them an arena in which to exercise particular skills and capacities.

In many cultures, increased status and rewards accrue to women later in life, after they have ceased to bear children. This can result in compliance from older women, while the expectation of future benefits can mute younger women's dissatisfaction. Alternatively, fear of family or community disapproval may compel women's acquiescence, particularly when it is reinforced by threats of physical punishment or expulsion.

The traditional arrangement reinforces men's sense of power and competence. This may become more important when men face external challenges, as in periods of rapid social and economic change. For men of relatively low status in their societies, control over women offers a position of power denied in other parts of their lives.

Myths and misconceptions perpetuate the power structure and weaken women. For example, in parts of India, family members encourage women to eat little during pregnancy, believing that they will have smaller babies and easier deliveries.[12] Nutritious food such as eggs or milk may be associated with supposed malign influences over the mother or foetus. There may be prejudice against exercise, employment outside the home and even education, because they will make women "too much like men". Women's sexuality is often feared and is the subject of bizarre and ferocious myth; severe female genital mutilation is only the most extreme means taken to control it, short of murder.

Jorgen Schytte/Still Pictures

Mexican parents. Gender equality in health care is important throughout the life cycle.

Ignorance of alternatives and fear of the unknown reinforce traditional behaviours and attitudes, and make change difficult for men. Better information and open discussion can help the transition, but the best route to change is through example and leadership.

Men's Support for Sexual and Reproductive Health

Men, who are more likely than women to be literate and to have better access to information, are often in a better position than women to inform themselves about reproductive health. They lack interest, however, because reproductive health — including everything to do with contraception, pregnancy, childbirth and STDs — is considered to be a woman's concern. "Real men" do not concern themselves with such matters. (Even if they acquire an infection, a woman is blamed, and sometimes a woman is seen as the "cure". The belief that sex with a virgin can cure AIDS is responsible for an unknown number of infections among young women.)

Men often lack interest in reproductive health because it is considered a woman's concern.

This can be changed. With the correct timing and approach, informing men about reproductive health, maternity and child care leads to more support for safe pregnancy and delivery and breastfeeding.[13] A successful project in Egypt has demonstrated that men are eager to know what they can do to help their wives after a miscarriage, and are willing to learn about reproductive health.[14]

Dr. Leela Visaria, long active in reproductive health policy in India, concludes that "research needs to go beyond estimations of incidence and prevalence and probe into power relations between partners", including the negotiation and decision-making process.[15]

Various efforts have been made to increase men's interest in their own and their partners' reproductive health. Community-based approaches have addressed a range of concerns. Programmes have worked with groups of men, creating opportunities for easier communication. Traditional authorities have been enlisted to motivate men. Better ways for men to find accurate information have been created.

Lessons from India

Several projects in India demonstrate some generally valid points about securing men's involvement in reproductive health issues.[16]

Men and women often perceive reproductive health issues differently. Among married adolescent couples interviewed in one study,[17] the men described the positive effects of marriage on their daily lives, and indicated they believed their wives shared their opinion. Wives had a more mixed assessment of marriage, as they adjusted to the burden of their multiple responsibilities.

Men's illnesses were immediately apparent because of their impact on wages; wives' illnesses became known only when they told their husbands or when the household routine was disturbed; women were more likely to conceal their health needs because of the expense. Women felt strong pressure to conceive early in marriage. Men did not know much about family planning, and were aware of their lack of information.

Men accompanied their wives to their first check-ups to confirm a pregnancy, but wives did not expect or want further visits with their husbands. Clinic workers seeking to shield other women did not encourage them.

Husbands ignored women's health care during pregnancy except for appreciating the need for a nutritious diet. While they advised women to reduce their workload, they generally did nothing to help, except in some cases where they assisted with household chores. Childbirth was seen as women's concern, and men were generally unaware of any problems.

Discussion of reproductive health concerns offers the prospect of change.

Traditional beliefs can undermine reproductive health. One project found that traditional beliefs about semen and sexuality led to reduced protection from STDs. Traditional beliefs about such matters as erectile dysfunction impeded reproductive health care. Concerns about sexual inadequacy among a minority of young men led to family violence and discouraged them from using contraception.

Efforts to involve men in reproductive health must include education about gender relations and shared opportunities. The NGO Social Action for Rural and Tribal Inhabitants of India (SARTHI) has worked in traditional settings to improve women's status and reproductive health. The group's initial work on women's health was found to improve men's awareness and sensitivity to gender issues. Contrary to expectations, men did not feel threatened by women's meetings, and even volunteered to take on domestic chores so that their wives could participate. SARTHI then began to include men of all ages in the programme, and began training men as health workers in a new community health programme serving men and children.

After several years, SARTHI recognized that work to empower women needs to be accompanied by action to sensitize men about gender relations, to free them from patriarchal definitions of masculinity. Personal transformation is necessary before male health workers can become good community role models.

Another NGO, the Centre for Health Education, Training and Nutrition Awareness (CHETNA), started working to involve men in its reproductive health programmes in the early 1990s, when it realized the extent of husbands' domination and neglect of their wives, and the effect this had on women's health; women said they were not even free to decide how much food they ate. CHETNA now concentrates on involving men in early childhood care, including teaching them about nutrition and growth monitoring; teaching adolescent boys about sexual and reproductive health; and using trained male health workers to motivate men to take an interest in women's health.

These efforts have shown that training is crucial — poorly trained men can perpetuate harmful behaviours and beliefs — and that programmes to encourage men's participation need to involve members of their extended families. Otherwise, the men may face criticism and ridicule when they help with housework or take on some of their wives' responsibilities.

Creative adaptations of existing institutions can create new opportunities to effect change. Family Welfare Education and Services (FWES) organizes men's and mothers-in-law clubs to support reproductive health.[18] The men discuss issues such as alcoholism, smoking, malnutrition, family planning and women's literacy. Mothers-in-law in India exercise great influence in the household; the project encourages them to promote proper nutrition and childcare and to motivate their sons to treat their wives better, because "only a healthy and happy mother produces a healthy child".

Two local health centres offer services for adolescents, and a letterbox has been set up for their questions about sex and reproduction. There has been a definite change in young people's awareness and perspectives in the five years since the project began. Boys now ask fewer questions about girls' virginity, and more about the involvement of men in raising children. Questions about STDs, AIDS, contraception and safe sex are also frequently asked. Boys express increasing concern about girls' problems and are now more likely to ask about menstruation. More young people now view sex as not merely about pleasure or procreation, but as a part of "expressing and sharing love". More girls want to share household chores and child-rearing with their future partners.

In FWES project villages, girls' enrolment in schools has increased and sex ratios for newborns have not changed, unlike neighbouring villages, where girls' enrolment has decreased and female births have declined sharply. However, the clubs have not caught on in other villages and involvement has reached a plateau.

Other NGO Efforts to Involve Men

In Mali, the *Association de Soutien au Développement des Activités de Population* worked with a Centre for Development and Population Activities/ACCESS project to expand community-based family planning services and encourage men's participation. With the backing of traditional leaders, male volunteers were trained to distribute contraceptives and provide information about reproductive health, including STD/AIDS prevention, high-risk behaviours and condom use. The project increased men's interest in the health of mothers and children, and led to greater interest in modern methods of child-spacing.[19]

In Nicaragua, the NGO Cantera offers workshops on masculinity and sexuality; gender, power and violence; unlearning *machismo*; and communication skills. During a 1997 evaluation, many men reported that Cantera courses had changed their lives: two thirds reported that they had a different self-image, and more than two thirds said they were less violent. Nearly half the women said their partners were significantly less violent after their training, and an additional 21 per cent said that they were a little less violent. Both men and women reported that the men were significantly more responsible sexually.[20]

Various programmes focus on adolescent boys' roles and responsibilities. In Brazil, the NGO Citizen Studies, Information and Action targets teenage fathers in a campaign involving radio, television and comics. Save the Children UK has supported the making of four films in Bangladesh, India, Nepal and Pakistan; the project "Let's Talk Men" uses the films to build awareness on gender relations, so boys will adopt more responsible attitudes about women and sexual relations.

A Common Agenda

The effort to involve men in reproductive health programmes is picking up momentum, and useful programme models have been developed. In developing these activities, programme design must take care to ensure that they do not divert scarce resources from activities directed towards women, as some women's NGOs fear. Greater involvement of men in reproductive health decisions should give more power to women, not less.

Men's and women's different needs should not be in competition for resources. The common aim is the well-being of all family members.

Men can advance gender equality and improve their family's welfare by:

Involving men in reproductive health decisions should give more power to women, not less.

BOX 22

Men Can Change Course of AIDS Epidemic, UNAIDS Reports

Engaging men as partners in fighting AIDS is the surest way to change the course of the epidemic, according to a March 1999 report by the Joint United Nations Programme on HIV/AIDS (UNAIDS). The Programme's year 2000 World AIDS Campaign aims at bringing about a new focus on men in national responses to the crisis, complementing prevention programmes for women and girls.

Women are at special risk of HIV: they often have less control over when, where and whether sex takes place. But cultural beliefs and expectations about "manhood" also encourage risky sexual and drug-taking behaviour in men. This puts them — and their partners — at heightened risk.

The UNAIDS report contends that changing many commonly held attitudes and behaviours, including the way adult men regard risk and sexuality and how boys are socialized to become men, must be part of the effort to curb the AIDS epidemic. "The time is ripe to start seeing men not as some kind of problem, but as part of the solution," said Dr. Peter Piot, Executive Director of UNAIDS.

HIV infections and AIDS deaths among men outnumber those among women on every continent except sub-Saharan Africa. Young men are more at risk than older ones: about one person in four with HIV is a young man under age 25.

Without men, the virus would have little opportunity to spread. More than 70 per cent of HIV infections worldwide occur through sex between men and women, and a further 10 per cent through sex between men. Another 5 per cent or so take place among people who inject drugs, four fifths of whom are men.

All over the world, men tend to have more sex partners than women, thereby increasing their own and their partners' risk of contracting HIV, a risk compounded by the secrecy, stigma and shame surrounding HIV. Male sexual violence against women and girls further drives the spread of HIV.

Special circumstances place many men at especially high risk of contracting HIV. Those who migrate for work and live apart from their families may pay for sex and use substances, including alcohol, as a way to cope with the stress and loneliness of living far from home; men in all-male environments, such as the military, may be influenced by a culture that reinforces risk-taking; in prisons, men who normally prefer women as sex partners may have sex with other men.

"Too often, it is seen as 'unmanly' to worry about avoiding drug-related risks, or to bother with condoms," said Dr Piot. "These attitudes seriously undermine AIDS-prevention efforts."

At the same time, men have the potential — as politicians, as front-line workers, as fathers, as sons, as brothers and friends — to make a difference against the epidemic, the report says. Men need to be encouraged to adopt positive behaviours, and to play a much greater part in caring for their partners and families, particularly in light of the millions of children orphaned by the AIDS epidemic who need adult help to grow up clothed, housed and educated.

It has already been demonstrated that men's behaviour can change, and that such change in turn alters the epidemic. In parts of Africa, Central America and Asia, long-distance lorry drivers have been encouraged to reduce their sexual partners and practise safe sex. Thailand has had successful prevention programmes for army recruits. And in the United States, college students are beginning to delay the onset of sex and are using condoms more consistently.

- **Protecting their partners' health and supporting their choices** — adopting sexually responsible behaviour; communicating about sexual and reproductive health concerns and working together to solve problems; considering adopting male methods of contraception (including vasectomy and condoms); and paying for transport to services and for service costs;

- **Confronting their own reproductive health risks** — learning how to prevent or treat sexually transmitted infection, impotence, prostate cancer, infertility, sexual dysfunction and violent or abusive tendencies;

- **Refraining from gender violence** themselves and opposing it in others,[21] and promoting non-aggressive conceptions of male sexuality and masculinity;

- **Practising responsible fatherhood** — supporting their partners in child-rearing and household tasks; protecting their children's health and investing in their future; teaching their sons respect for women's needs and perspectives; developing open and supportive relationships with their daughters; and providing their children with accurate and sensitive information;

- **Promoting gender equality, health and education** — supporting the education and training of girls and women; promoting women's participation in health, education and economic activity; lobbying for increased funding for basic social services and working to improve the quality of programmes; and demanding that family life education be taught in schools.

The State of World Population 2000

CHAPTER 5

Counting the Cost of Gender Inequality

Women's second-class status carries a financial and social cost, and not just for women. Men, and society in general, also pay a price.

For this reason empowering women is a central aim of sustainable development. As Nobel laureate Amartya Sen has observed, the "overarching objective" of development is to maximize people's "capabilities" — their freedom to "lead the kind of lives they value, and have reason to value".[1] It is not only a matter of economics: as Dr. Nafis Sadik has said, "Better health and education, and freedom to plan their families' future, will widen women's economic choices; but it will also liberate their minds and spirits."

Empowerment and equality are important human rights aims in themselves, and an exclusively economic analysis of gender inequality would result in "commodification" of women and men.[2] However, the economic dimension should not be ignored: promoting gender equality also promotes the stable growth and development of economic systems, with social as well as strictly economic benefits.

Much of women's work, paid and unpaid, has an economic impact, though their contribution is rarely noticed or fully quantified. If it were recognized for what it is and supported accordingly, its increased value would offset any costs or supposed savings derived from inequality, for example, in women's unpaid farm labour.

Inequality between men and women results in lost opportunities and prevents mutual gain. In general, discrimination:

- **Diverts resources** from women's activities, sometimes in favour of less productive investment in men;
- **Rewards** men, but also some women, blinding them to productive alternatives;
- **Obstructs** social as well as economic participation and closes off possible partnerships;
- **Reduces** women's effectiveness by failing to support them in meeting their responsibilities, challenges and burdens.

One of the keys to sustainable development will be recognizing the costs of discrimination, making them visible to policy makers and families, and designing ways to eliminate them.

PHOTO: Slum in Haiti. Men, and society in general, pay a price for women's second-class status.

UNICEF/0749/Nicole Toutounji

BOX 23

Development and Human Rights

Do democracy and basic political and civil rights help to promote the process of development? According to economist Amartya Sen, the question is misguided, since "the emergence and consolidation of these rights can be seen as being *constitutive* of the process of development".

As Sen notes with regard to education, "If education makes a person more efficient in commodity production, then this is clearly an enhancement of human capital. This can add to the value of production in the economy and also to the income of persons who have been educated. But even with the same level of income, a person may benefit from education — in reading, communicating, arguing, in being able to choose in a more informed way, in being taken more seriously by others and so on . . . . We must go *beyond* the notion of human capital . . . to take note also of the instrumental role of capability expansion in bringing about *social* change. . . ."

BOX 24

Women's Work Is Under-rewarded

Much of women's work is unpaid, and even when cash exchanges are involved, the contribution of women is not included or is discounted in national statistics. For example, in rural areas, women not only prepare but also grow most of the family food, and it is primarily girls and women who collect water, fuel for cooking and fodder for domestic animals.

In West Africa, the Caribbean and Asia, between 70 and 90 per cent of all farm and marine produce is traded by women. Street and market stands are part of an under-recorded informal economy that generates an estimated 30 per cent of all urban wealth.

It is estimated that women's unpaid household labour accounts for about one third of the world's economic production. In developing countries, when unpaid agricultural work and housework are considered along with wage labour, women's work hours are estimated to exceed men's by 30 per cent.

Discrepancies in pay are often more entrenched in developed countries. For example, in Kenya women's average wages in non-agricultural employment are 84 per cent of men's, while in Japan women earn only 51 per cent of what men earn.

It is clear from several studies that increased earning power of women has a greater and more immediate effect on family welfare than increased earnings for men. A study in South India, for example, found that while women kept barely any income for their exclusive personal use, men kept up to 26 per cent.

The Costs of Economic Invisibility

Women's economic contributions are undercounted because they are often in the "informal" sector where reporting is less systematic. Better accounting would make women's economic activity more clearly visible, and the benefit of supporting it could be compared with other opportunities for investment.

Women are often ignored in allocating resources. After the land is first cleared for subsistence agriculture, women do most of the work; but women seldom own the land, and loans and extension services go to landholders. Agricultural outreach programmes directed to women could significantly improve outputs, income and family welfare. One study concluded that giving women farmers in Kenya the same support as that given men could increase their yields by more than 20 per cent.[3]

Eliminating discrimination would increase national income as well as the income of women. A study in Latin America estimated that ending gender inequality in the labour market could increase women's wages by 50 per cent while increasing national output by 5 per cent.[4]

Women's position as managers of household resources magnifies the impact of economic inequality. Reduced education, economic opportunity, control of resources and access to reproductive health services have an immediate effect on children's nutritional status, health and development, on the mother's health and on the size of the family.[5]

The Costs of Denying Health Care

Some 30 per cent of the per capita economic growth in Great Britain between 1780 and 1979 has been attributed to improvements in health and nutritional status. Similar estimates have been claimed from cross-national studies for more recent times.[6]

On the other hand, under-investment in health care exacts considerable costs from both men and women. Life expectancy is shorter in poorer countries and among the poor in all countries. Ill-health reduces income and increases stress.

Public investment in primary health care in many countries shrank as a proportion of government expenditures during the 1990s, and costs were shifted to clients. But poor people, especially women, cannot afford fees and depend on public services.

The effects of cuts, including those related to health-sector reform, can be measured.[7] In Indonesia after the late-1990s economic crisis, use of health care declined and health outcomes worsened, mostly for women and particularly the poor.[8] A controlled experiment demonstrated that health centre use declined in areas where fees were imposed, more recovery time was needed after illness and labour force participation dropped — particularly among the poor, men over 40, and women in households with low economic and educational status.

Globally, girls have a greater chance of surviving childhood than boys, except where sex discrimination is greatest.[9] But the gap between children in poor and non-poor households is more pronounced for girls: boys in poor households are 4.3 times more likely to die than boys in non-poor households. Girls in poor households are 4.8 times more likely to die; their greater susceptibility probably reflects their lower chance of receiving medical care.[10]

The contrast at older ages is different. Fully 19 per cent of non-poor men are likely to die between ages 15 and 59, compared to 9 per cent of non-poor women. But the risk of death in poor households compared to non-poor households is 2.2 times greater for men and 4.3 times greater for women. Limited access to health care among the poor has a greater relative impact on women than men. In particular, poor women are more likely to die as a result of pregnancy.

Health care systems reflect different gender roles within the health professions. Nurses or paramedics, including midwives, and outreach health workers are more likely to be women. Most doctors and decision makers — ministers, civil servants, senior practitioners and hospital administrators — are men; they may be more amenable to dealing with men's health problems, or more likely to discount women's problems.

A disproportionate share of research has focused on diseases that are major killers of men. In pharmaceutical research and development, clinical trials often do not fully explore the efficacy, side-effects and contraindications for women.[11]

Men's health can also be harmed by gender-related factors, particularly by unreasonable expectations about the ability to withstand pain as part of "masculinity". This can lead men to delay seeking medical attention. Late detection of many diseases can increase their severity and the likelihood of disability or death.

Maternal Mortality and Morbidity

The cost of a lost life cannot be sensibly calculated.[12] Maternal deaths and illness affect women, children, spouses, extended families and communities in many ways. The economic costs of a mother's death include her lost contributions (monetary and non-monetary) to the family and its survival, increased mortality among her children, increased burdens of home maintenance and childcare to her survivors, and additional impacts on communities and society.[13]

The direct effects on children's well-being have been strongly documented. Children are more likely to die if either parent dies, but much more likely if it is the mother. A woman's death[14] also has a bigger negative impact on children's growth, and on school enrolment rates, particularly in poor families;[15] younger children enrol later, and those aged 15-19 drop out earlier.

A study in India found that when women died, the survival of the household was often challenged because men were unaccustomed to managing the household budget and affairs. Older children often dropped out of school to help support the family or were sent off to live with grandparents. Traditional extended family structures help the affected to cope with an adult death, but nuclear families are increasingly the norm, particularly in cities and among the middle-class.[16]

The Economic Cost of HIV/AIDS

High rates of HIV/AIDS infection, due in part to gender inequality (Chapter 2) and a failure to invest in prevention, have severely damaged economic and social prospects in many countries. The concentration of deaths in the early to mid-adult years has taken many trained workers, depleting workforces and requiring duplicate investments of scarce resources in personnel development. The international community has belatedly come to recognize the threat.[17]

In highly affected countries, HIV/AIDS has reduced per capita GDP growth by 0.5 per cent a year.

In highly affected countries, it is estimated that the pandemic has reduced per capita GDP growth by 0.5 per cent a year.[18] Where growth is already slow, this is a major impact; the health system and the poor suffer most. The epidemic is also imposing substantial additional costs on health systems. In some of the most affected countries, infected persons occupy more than half the available hospital beds.

The pandemic exacts its costs in different ways. Stalled or reversed development in low-income countries is hard to quantify and harder to restore. Social support networks have been strained beyond bearing. Many of the millions of AIDS orphans live without adequate education, health care or nutrition. Many are hard-pressed to support themselves, their siblings and their over-burdened adoptive families.

UNAIDS estimates that $1 billion a year is needed for HIV/AIDS prevention and care in sub-Saharan Africa alone. The ICPD Programme of Action estimated that the global costs of key elements of an HIV/AIDS prevention package would cost $1.3 billion this year, increasing to $1.5 billion by 2010.[19]

Gender-based Violence

The global costs of gender violence and abuse are difficult to assess. They include the direct

costs of, for example, treating the health effects of violence; ill-health; missed work; law enforcement and protection; shelter; marital dissolution; child support; and all the other consequences of adapting to or escaping abuse. They also include the indirect costs of preventing women from working or contributing in other ways, and of missed education, including holding young girls out of school to avoid exposure to boys.

In poor communities, the costs are reckoned largely in development opportunities missed. Elsewhere, the direct costs are equally important and often substantial. Some estimates are available, particularly for more developed countries. The World Bank estimates that in industrialized countries sexual assault and violence take away almost one in five healthy years of life of women aged 15-44.

In the United States employers pay an estimated $4 billion a year for absenteeism, increased health care expenses, higher turnover and lower productivity.[20] In Canada, annual health-related costs of violence against women are estimated at $900 million. However, in British Columbia alone, one study estimated selected costs at $385 million a year.[21]

These estimates include the costs of policing, corrections, compensation for criminal injury, victim assistance and counselling costs, partial estimates of mental health care, income assistance to affected families, safe houses and other transition facilities, lost work time and treatment for men who commit assault. They do not include costs of emergency medical treatment (whose relation to violence is often concealed by the victims) or intergenerational effects (such as treatment for children of abused mothers and support costs for dissolved abusive relationships).

Similar studies are available for Germany, the Netherlands, New Zealand, Switzerland and the United Kingdom.[22]

Gender discrimination is a lifelong tax on women's self-esteem and capabilities.

Psychological Costs

Gender discrimination is a lifelong tax on women's self-esteem and capabilities. Gender discrimination thwarts women's aspirations and restricts their opportunities. It denies them the experience that will build competence and self-direction, and enable equal partnerships with men.

The restrictions placed on women can produce a state of "learned helplessness" typical of clinical depression. Women suffer disproportionately from depressive syndromes, which are the most important contributors to the global burden of ill-health.[23]

Few experiences are as devastating to women's sense of personal competence as unwanted sexual experiences, especially repeated ones, and their consequences. Unwanted pregnancies and later responsibilities in child-rearing create unlooked-for obligations and restrict women's options. An unwanted pregnancy can create lifelong resentment which is often passed on to the child.[24] The extent to which women will go to avoid this outcome is clearly shown in the extent of their recourse to abortion, even when they know it to be illegal and probably unsafe.

Conversely, inflated expectations of independence and mastery confine men's potential and choices. The physical risks men feel expected to take are reflected, for example, in the high loss of life among young males from road accidents, the world's ninth leading cause of lost years of life. Occupational injuries are also a major risk factor for death and disability.[25] While men are more commonly in occupations that involve physical risks (for example, mining, operation of heavy machinery and trucking), definitions of masculinity increase their vulnerability.

The psychological cost to men of gender inequality has never been assessed, nor until recently even thought of. Traditional gender power relationships, however limiting, may have created relatively few psychological conflicts in men because of their strong validation by societal norms, but the rapid changes which most societies are now undergoing challenge these norms. The result is to create doubt, uncertainty and inner conflict among men of all generations.

Education: Costs of the Gender Gap

Denying education to women has slowed social and economic development. In countries where the ratio of female-to-male primary or secondary enrolment is less than 0.75, GNP per capita is roughly 25 per cent lower than elsewhere.[26] This is most apparent in parts of Africa and South Asia, where inequities are acute. Economic advances in East and South-east Asia, on the other hand, were facilitated and reinforced by progress in women's education (see below).

Investment in women's education is an efficient economic choice. It has been estimated that a 1 per cent increase in female secondary schooling results in a 0.3 per cent increase in economic growth.[27] The relationship between female secondary education and economic growth is also strong (when male and female secondary enrolment is included in analyses,[28] only female secondary schooling shows a

strong and consistent relationship). Economic returns on investment in women's education are found to exceed those for men.[29] One reason is that women who use their skills to increase their income invest more in child health and education.[30]

Educated parents are more likely to invest in their children's education, and educated mothers support educating their daughters.[31]

Most regions have seen progress, though uneven, in primary and secondary enrolment. Some of the most rapid increases have taken place in South Asia and Africa, but levels remain low in these regions. War, economic adjustment and increased expenses for families in some countries have reduced educational opportunities, especially among the poor.

Enrolment has generally improved more for girls than for boys, so the gender gap in schooling is closing in most regions. Nevertheless, the gap is still wide in many countries. In 22 African and 9 Asian countries, enrolment for girls is less than 80 per cent that for boys.[32] The divide is largest in South Asia and sub-Saharan Africa, particularly for secondary education; fewer than 40 per cent of secondary students are women. Girls outnumber boys where overall access to basic education is higher, in Southern Africa, Latin America and most of East Asia.

Educational access is lower in rural areas for both boys and girls, but particularly for girls. In Niger, for instance, in cities there are 80 girls in school for every 100 boys, but in rural areas only 41 girls in school for every 100 boys.[33] These differences reflect the lower value that parents place on education compared with household activities for girls, and their expectations of future returns from their investments.

Parents may not want their daughters to encounter boys or men in classrooms or on the way to school or may fear for their safety, making distance an important factor. In Pakistan, where schools are sex-segregated, 21 per cent of girls in rural areas — more than twice the proportion of boys — do not have a school within 1 kilometre of their homes.[34]

Micro-credit: Investing in Women

The impact of micro-credit programmes clearly demonstrates the positive effects of providing women access to resources and control over their life choices.

Micro-finance schemes help empower women in their families and communities by making low-cost loans to small, women-run businesses. Revolving credit funds for women are supported by the World Bank,[35] regional lending institutions, national credit organizations (such as Grameen Bank in Bangladesh) and non-governmental organizations.[36]

BOX 25

Gender Inequality in Education Persists

Studies repeatedly show that investment in educating girls and women raises every index of progress towards sustainable economic growth and development. Despite this, an estimated two thirds of the 300 million children without access to education are girls, and two thirds of the some 880 million illiterate adults are women.

In 1996, 29 per cent of the world's females over age 15, compared to 16 per cent of males, were illiterate. In the past few decades, all regions expanded primary education, though in Africa, progress began to slow in the 1980s because of higher costs for parents and declining school quality. In the developing countries as a whole, the gender gap at the primary level has narrowed significantly, although it persists in sub-Saharan Africa, North Africa and South Asia. Female representation decreases at the secondary and post-secondary levels, but the gender gap has narrowed somewhat in recent decades.

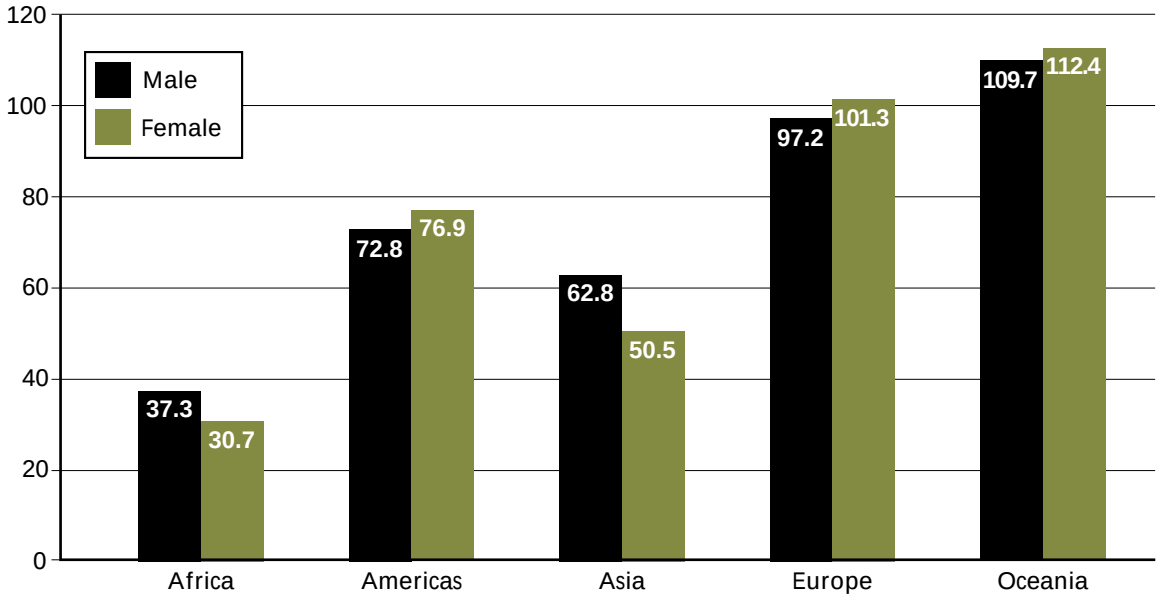
Larger gender gaps are observed in regions with lower overall levels of education. Faced with a choice, some parents choose to educate sons because there are more and better-paying jobs for men than for women. Some girls are taken out of school to work at home. Some families are not willing to educate girls if the school is distant or the teachers are male. Some parents invest less in girls' education because economic returns will go to their future husbands' families after marriage.

Once girls reach puberty, pregnancy may prevent them from staying in school. Students who become pregnant often drop out of school, or school authorities expel them. Mothers' unwanted pregnancies may lead them to withdraw daughters from school to help at home.

Family size influences educational attainment: children of either sex from small families have better educational opportunities. One study in Thailand found that with other factors being equal (income, religion, residence, parents' educational attainment and parents' ambitions for their children), in families with four or fewer children 31 per cent went to upper secondary school. In families with more than four children only 14 per cent went to upper secondary school. Similarly, a study in Bangladesh found that children in small families stayed in school longer because they were not called upon to care for younger siblings at home. However, in both the Thailand and Bangladesh studies, boys had a higher level of educational attainment than girls.

Education, in particular that of women, has a larger impact on infant and child mortality than the combined effects of higher income, improved sanitation and modern-sector employment. Botswana, Kenya and Zimbabwe, with the highest levels of female schooling in sub-Saharan Africa, show the lowest levels of child mortality. In Kenya, for example, 10.9 per cent of children born to women with no education will die by age 5, compared with 7.2 per cent of the children of women with primary school education and 6.4 per cent of the children of women with a secondary school education.

Figure 6: **Gross Enrolment Rates in Secondary School, by Sex and Region, 1997**



Source: United Nations Population Division. 2000. *World Population Monitoring, 2000: Population, Gender and Development* (see Technical Notes).

BOX 26

New Information Technologies and Women's Empowerment

New information technologies present many opportunities for empowering women, despite gender inequality in their accessibility and use.

Most of those involved in the design, development, marketing, selling, installation, management and servicing of new technologies are men, reflecting an implicit assumption that only men are technologically capable. Women are concentrated in low-skilled assembly jobs.

Surveys of Internet users indicate that about 35 per cent are women — mostly in North America, Europe and Australia, which in 1999 accounted for 80 per cent of all Internet use — although the percentage of women is increasing. A survey of women's groups and individual women around the world found that women often mentioned lack of training and the cost of equipment as obstacles to using the Internet.

Even so, many women around the world are using the new technologies effectively, understanding both their capacity and their potential for transforming women's lives. For example, women used the Internet to build extensive international and local lobbying networks for the various global conferences of the 1990s.

New technologies can be used to help poor women. In Bangladesh, a Grameen Bank project leases cellular phones to women, each of whom serves as her village's telephone operator — earning an income, raising her status and increasing the community's access to information of various kinds. These "telephone ladies" can link villages to distant information sources. For example, farmers can gain better prices for their products and avoid exploitation by middlemen when they are aware of the prices at city markets. Such advantages reward communities far more than the $30-40 per month of profit the telephone ladies reap.

(Selected Internet sites devoted to gender equality, reproductive health and population issues can be found in the online version of this report, at www.unfpa.org.)

These lending programmes have proven financially viable (with higher repayment rates than more conventional commercial lending and with viable and competitive interest rates). They can also create an important channel for nutritional and health information, including reproductive health information, and serve as training grounds for community leaders.

Micro-credit programmes have been shown to contribute to reproductive health when provided with proper technical support. Increased income and autonomy for women can result in the adoption of new health and family planning practices.

Micro-credit alone will not create equality of economic opportunity. Critics of the micro-credit pioneer, Grameen Bank, have suggested that men actually control, and sometimes divert, a share of the loans intended for women.[37] Some men feel threatened as their wives gain greater economic independence, and violence can result unless the men too are drawn into the scheme and its benefits. Other analysts emphasize that credit is also needed to help women move from small-scale to larger enterprises.[38]

Demography and Gender: Costs and Opportunities

Besides affecting fertility, health and mortality (Chapter 2), women's opportunities and choices strongly influence the future impact of two other demographic developments: the unprecedented numbers of young adults of working and childbearing age, and the ageing of populations.

The Demographic Bonus

Enabling women and men to choose the number, timing and spacing of their children accelerates the "demographic transition" from high fertility and mortality to low fertility and mortality. Industrial countries have already gone through this transition, and it is well under way in many other countries. Most of the least developed countries have yet to experience it.

The transition brings tangible economic benefits. Among them is a temporary "demographic bonus", as the numbers of dependent children rapidly decline in relation to the working-age population; this creates an opportunity for countries to invest more in stimulating economic growth. To take advantage of this opportunity, countries need to invest in education, training and employment for young people and in health, including reproductive and sexual health. Slower fertility decline dilutes the effect of the bonus.

The economies of several East and Southeast Asian countries grew at unprecedented rates from the 1960s through the 1980s, averaging as much as 8 per cent a year. This process benefited greatly from early investments in health and education, especially for women. Fertility fell rapidly, and in the 1980s these countries were able to reap many of the advantages of the demographic bonus. Analyses ascribe 30 per cent of this growth in the "Asian

BOX 27

Benefits of Micro-credit Are More than Economic

Micro-credit schemes linked to reproductive health education and services give women more control over their income, a greater voice in family decision-making, improved confidence and increased participation in community matters, according to a UNFPA review of projects in six countries.

These results were strongest when income-generation efforts were accompanied by the encouragement of gender awareness and social and economic justice.

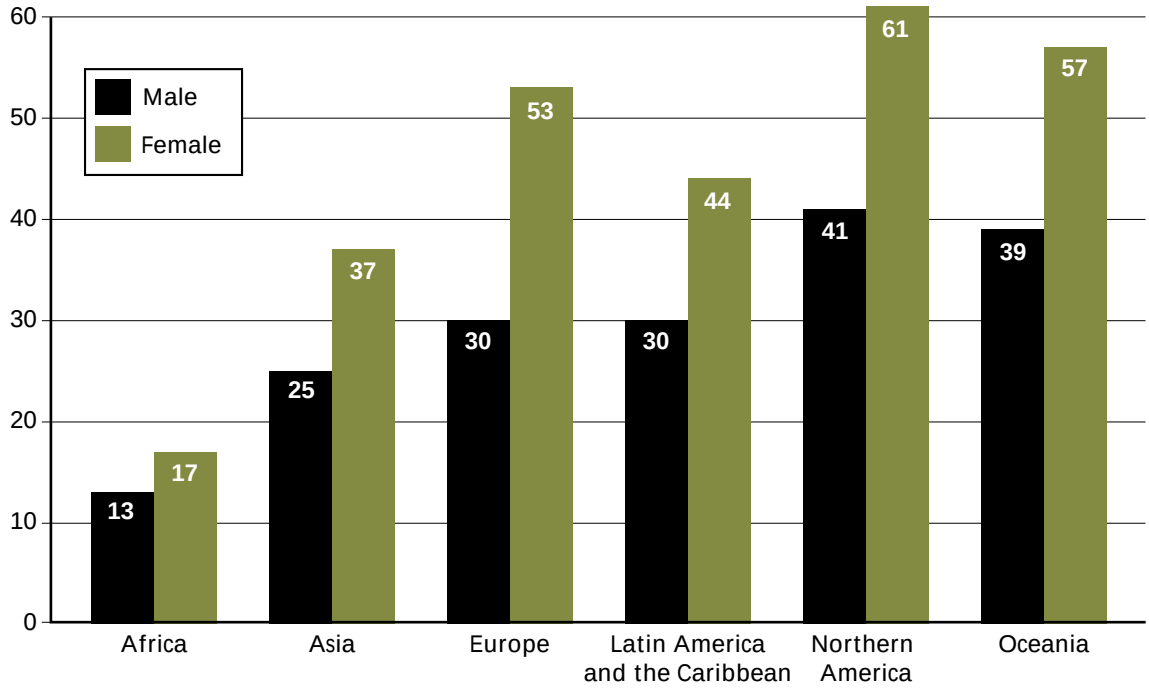
Participants said that after joining the projects, they were able to express their opinions and ideas more freely. One woman in the Philippines stated: "My husband used to decide about buying household goods and just inform me about his decisions. Now, he asks for my opinion and if I say no, he will not buy them."

Another remarked: "Before the project I was involved mainly in household work. My husband used to treat me as a household good. After I joined the project I participated in the training programme and was selected as the president of the women's group. Now I conduct meetings and my husband respects me."

In India, one woman from Madras (in the Working Women's Forum project) noted her group's work in the community: "We have been trying to keep our neighbourhood clean; we sent a petition to the municipal corporation against contaminated water . . . . We also sent a petition to the governor to ban liquor stores." Women in Dindigul organized a protest march to get a water pump for their village. And women in Kancheepuram sent a petition to the municipal corporation for a day-care centre.

5

Figure 7: Percentage of Men and Women Expected to Survive to Age 80, by Region (Among people born 1995-2000)



Source: United Nations Population Division. 2000. *World Population Monitoring, 2000: Population, Gender and Development.*

tigers" to the changing age structures that resulted from mortality and fertility declines. This amounts to the equivalent of $1,525 per capita in economic advance over a 30-year period.[39]

Despite the demonstrated economic benefits of public investment in education and primary health care, during the 1990s in many countries spending in these areas shrank as a proportion of government expenditures.

In the high-fertility countries of sub-Saharan Africa and South Asia, investment in education and health, including satisfying the unmet need for family planning, could help move more countries into a rapid demographic transition and offer them an opportunity for the demographic bonus as fertility declines.

The Impact of Ageing

During this century, the age structure of world population will gradually shift upwards as the proportion of older people grows. This can already be seen in the more developed regions, where low fertility and low mortality are well established. It is proceeding rapidly in countries where fertility has declined very rapidly and life expectancy is longer. In countries where fertility and mortality are still high, the ageing of the population will happen more slowly.

Older women are more likely to be poor than older men.

In more developed regions, as population growth levels off or starts declining, policy makers are increasingly concerned about the financial and health needs of older populations. Attention is turning to retirement arrangements for older people (including the possibility of continuing work), reform of pension systems, review of health care and long-term care programmes, and building community support systems for older persons. The extension of public pensions is often overshadowed by concerns for their fiscal sustainability.

Action against gender discrimination is needed throughout the life cycle. The ageing of populations has different implications for men and women:

Women over age 60 outnumber men. Women live longer than men, and women's life expectancy has increased faster then men's. The difference between male and female life expectancy is the result of a combination of biological differences, such as lower susceptibility to heart disease in women before menopause, and cultural influences, such as greater male exposure to occupational hazards.[40] Men who are married live longer than those who are not.[41]

Public pension systems have been designed with an expectation that men would be the primary economic providers. Despite their larger numbers, women receive less old-age support from public programmes than men do because they are less likely to have been in the formal labour force. Some countries used to provide pension benefits to mothers without reference to economic participation, but most have curtailed or eliminated these benefits as they reformed public systems.[42] Pensions for women are in effect linked to the contributions of husbands. Even when women have also contributed to public social security systems, joint benefits may be capped below the full value of the husband and wife's inputs and may be reduced disproportionately, or eliminated, at the husband's death.

Women who are widowed are more likely to live alone than men who are widowed. Widowhood is everywhere more prevalent among women because they live longer and marry men older than themselves. Whether by choice or custom, women are also less likely than men to remarry after the death of a spouse, and often live alone. In North Africa, 59 per cent of women over 60 are widowed. Widowhood is also high in Central Asia, which has high levels of male mortality.[43] In some developing countries, the incidence of elderly women living alone is approaching the rate in industrial countries.

The burden of care-giving for the elderly falls more heavily on women than men. Women look after older family members in addition to their spouses and children. In developed countries, working women have as much care-giving responsibility as non-working women. Where the eldest son is expected to care for elderly parents, the actual burden generally falls on his wife.

Women without old-age support are more likely than men to be blamed for their circumstances; those with support face more precarious situations. Though women tend to live longer than men, older women often receive less support from their families,[44] and there is often an underlying assumption that they do not deserve support. Older men are more likely to have supporting family members living under their roof, whereas women tend to be guests in their children's homes.[45]

Women suffer from high rates of disability at older ages, reflecting burdens that accumulate over the life cycle. Longer lifespans do not generally increase the years of disability late in life.[46] However, particularly where gender inequity is substantial, older women's health status is affected by their lack of health care, education and nutrition earlier in life.

Older women are more likely to be poor than older men. The accumulated impact of lower lifetime earnings, lower pensions, lower social status, and weaker access to property and to inheritance contributes to disproportionate poverty

among older women. Never-married or widowed older women are most severely affected.

The attention given to these issues in the International Year of Older Persons in 1999 has increased awareness of these facts and stimulated policy discussion and development.[47]

Measuring Gender Inequalities

Choices about what indicators to use in measuring progress towards social development goals reflect development priorities. Recently, increased attention has been given to gender equality and protection of women's rights. Where women and their rights are systematically undervalued, almost any specific measure will reveal it. Where women are active and valued participants, their contributions are appreciated no matter what sphere of activity is examined.

Several composite measures are used to assess gender bias. Variation is considerable, but all agree to a large extent on the relative standing of countries and localities.

Most standard indicators do not adequately reveal the nature, extent or impact of gender imbalances or how they are produced. For example, the proportion of women in paid employment fails to reflect women's work in the home or the informal sector. At low levels of employment, it reveals women's restricted social mobility and opportunity, but progressively higher workforce participation does not indicate increasing empowerment. At some point, for both men and women, it indicates that people have no choice but work.

Indices and Other Indicators

Despite their imperfections, the international community accepts some measures as broadly indicative. The Human Development Index (HDI), pioneered by the United Nations Development Programme (UNDP),[48] captures health status and service access by including

Table 2: Gender Equality Index

Area of life concern	Indicator(s)
Autonomy of the body	• Legal protection against and incidence of gender-based violence • Control over sexuality • Control over reproduction
Autonomy within the family and household	• Freedom to marry and divorce • Right to custody of children in case of divorce • Decision-making power and access to assets within the household
Political power	• Decision-making in supra-household levels (e.g., municipalities, unions, government, parliament) • Proportion of women in high managerial positions
Social resources	• Access to health • Access to education
Material resources	• Access to land • Access to houses • Access to credit
Employment and income	• Distribution of paid and unpaid labour • Gendered wage differentials • Division of formal and informal labour by gender
Time	• Relative access to leisure and sleep
Gender identity	• Rigidity of sexual division of labour

Source: Wieringa, Saskia. 1999. "Women's Empowerment in Japan: Towards an Alternative Index on Gender Equality." Paper presented at the First Global Forum on Human Development, sponsored by the Human Development Report Office, United Nations Development Programme, New York, 29-31 July 1999.

life expectancy, economic prospects by using GDP per capita, and educational endowments by combining adult literacy and school enrolment rates.

In 1996, UNDP introduced two new indices to capture the gender-differentiated nature of human development. The first, the Gender Development Indicator (GDI), uses the same components as the HDI but differentiates them by gender.[49] The second, the Gender Empowerment Measure (GEM), uses a set of measures: seats in parliament held by women; the proportion of administrators and managers who are women; the proportion of professional and technical workers who are women;[50] and woman's share of earned income.

While these are important indicators, they do not measure the full range of women's possible options. The Gender Equality Index (GEI), developed under the auspices of the International Statistical Institute, seeks to be more comprehensive (Table 2).

Not all countries have the necessary data, however, which has prevented the full elaboration of this index.

Standard development indicators do not reveal the nature, extent or impact of gender imbalances.

Some attempts have been made to measure women's status using existing data sets, notably the Demographic and Health Surveys (DHS) undertaken in more than 60 countries by the end of 1999.[51] The broad range of topics covered and detailed household descriptions allow a variety of studies.

One such indicator, the Threshold Measure of Women's Status (TMWS), identifies six areas of life concern — socio-economic status, female household headship, education and exposure, employment and workload, marriage and childbirth, and ascribed status — and defines thresholds of successful performance on specific indicators in each area.[52] TMWS has a finer mesh than other summary or aggregate measures. But it still does not capture many details of decision-making within families; that would require survey questions about who decides about household purchases, for example, or whether a woman needs permission to travel outside the home.[53]

Where data allow a comparison of all three approaches, the overall rankings of countries on the GDI, GEM and TMWS are about the same. But for many countries, the indicators differ about what areas need most attention.

An analysis, similar to the GEM and GEI, of indicators in sub-Saharan Africa also showed general consistency but wide variation on specific measures, and did not find simple causal linkages between different measures.[54] Relatively high levels of education, for example, were not clearly associated with higher levels of political power-sharing.

Other Efforts to Monitor Progress

UNFPA has identified a range of demographic, health and programme indicators that capture gender dimensions of country programmes.[55] The Fund has also selected goal indicators,[56] including reducing the gender gap in primary and secondary school enrolment; increasing the proportion of parliamentarians who are women; and increasing adult female literacy rates.

The United Nations system's common indicator framework is similar, but substitutes women's share of paid non-agricultural employment for the adult literacy indicator.[57] An assessment of progress by the United Nations Development Fund for Women (UNIFEM) is sobering: "To date, only six countries have achieved approximate gender equality in secondary school enrolment plus at least a 30 per cent share for women in seats in parliaments or legislatures plus an approximate share of nearly 50 per cent of paid employment in non-agricultural activities."[58]

The World Bank is also developing a set of measures for a gender profile of countries. These include: the proportion of the population that is female; sex-specific life expectancies; female proportion of the labour force; sex-specific primary school enrolment, progression, and youth illiteracy rates; fertility rates; contraceptive prevalence; birth attendance; and maternal mortality rates.[59] The Bank has also produced more qualitative descriptions of key issues and progress for a variety of countries.[60]

Health-sector reform, a key World Bank initiative, is being implemented using the measure of Disability Adjusted Life Years to decide service priorities. Some critics, however, contend that the measure suffers from gender bias, particularly since it does not consider how families are harmed by the illness of women, the primary caregivers.[61]

CHAPTER 6

Women's Rights Are Human Rights

PHOTO: Judge in Ghana. Human rights treaties provide a legal foundation for ending gender-based human rights violations.

Jorgen Schytte/Still Pictures

A series of human rights treaties and international conference agreements, forged over several decades by governments — increasingly influenced by a growing global movement for women's rights — provides a legal foundation for ending gender discrimination and gender-based rights violations. These agreements affirm that women and men have equal rights, and oblige states to take action against discriminatory practices.

The starting point is found in the principles of the United Nations Charter and the Universal Declaration of Human Rights, to which all member states of the United Nations subscribe. Specific descriptions of rights and freedoms have been elaborated since these two instruments were written in the 1940s, but every subsequent human rights treaty has been rooted in the founders' explicit recognition of equal rights and fundamental freedoms for individual men and women, and their emphasis on protecting the basic dignity of the person.

As expressions of the world's conscience, the consensus decisions of international conferences are also powerful instruments for promoting change both within countries and internationally. The Vienna Declaration and Programme of Action, the Programme of Action of the International Conference on Population and Development and the Platform for Action adopted at the Fourth World Conference on Women (FWCW) are international consensus agreements that strongly support gender equality and women's empowerment.

In particular, the ICPD and FWCW documents, drawing on human rights agreements, clearly articulate the concepts of sexual and reproductive rights — including the right to sexual and reproductive health; voluntary choice in marriage, sexual relations and childbearing; freedom from sexual violence and coercion; and the right to privacy[1] — which are essential to gender equality.

Human Rights Treaties

The Preamble of the **United Nations Charter**, adopted in 1945, reaffirms "faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small". The Charter recognizes that one purpose of the United Nations is "to achieve international cooperation in . . . promoting and encouraging respect for human rights and for fundamental

freedoms for all without distinction as to race, sex, language, or religion".

The **Universal Declaration of Human Rights**, adopted in 1948, further elaborated the scope of human rights. Article 1 summarizes all of the subsequent articles and succeeding treaties and conventions when it says, "All human beings are born free and equal in dignity and rights." In some matters, such as marriage rights, the declaration goes into some detail in specifying the ways in which men and women should be treated. It specifies that "men and women of full age, without any limitation due to race, nationality or religion, have the right to marry and to found a family. They are entitled to equal rights as to marriage, during marriage and at its dissolution. Marriage shall be entered into only with the free and full consent of the intending spouses."

Universal Declaration of Human Rights, 1948: "All human beings are born free and equal in dignity and rights."

More than 20 years after adopting the Universal Declaration of Human Rights, the international community agreed on two covenants spelling out in more detail the rights embodied in the declaration. These were the **International Covenant on Civil and Political Rights** (often referred to as the political covenant) and the **International Covenant on Economic, Social and Cultural Rights** (often referred to as the economic rights covenant). Both entered into effect in 1976. These are legally binding on states that have ratified them. However, many member states have not done so, and many others have done so only with substantial reservations. (States can make reservations to treaty articles that they do not wish to be bound by, as long as these are not contrary to the meaning of the treaty.)

Both covenants incorporated understandings based on the declaration, many of which have important implications with regard to gender and reproductive rights; these include the right of women to be free of all forms of discrimination, the right of freedom of assembly and association, and family rights. The political covenant, among other things, recognizes the rights to "liberty and security of the person" (Article 9) and "freedom of expression", including "freedom to seek, receive and impart information and ideas of all kinds" (Article 19); and affirms that "no marriage shall be entered into without the free and full consent of the intending spouses" (Article 23).

Convention on the Elimination of All Forms of Discrimination against Women

The Convention on the Elimination of All Forms of Discrimination against Women was adopted by the General Assembly in 1979 and had 165 states parties as of January 2000. The Convention seeks to address pervasive social, cultural and economic discrimination against women, declaring that states should endeavour to modify social and cultural patterns of conduct that stereotype either sex or put women in an inferior position. It also declares that states should ensure that women have equal rights in education and equal access to information; eliminate discrimination against women in access to health care; and end discrimination against women in all matters relating to marriage and family relations. The Convention declares that states must act to eliminate violations of women's rights whether by private persons, groups or organizations.

The Convention sets clearer definitions and standards than the earlier covenants with respect to gender equality and expands the protections against discrimination. In particular, it recognizes that because socially defined gender roles differ, provisions against discrimination and abuse cannot simply require equal treatment of men and women; there must be a more positive definition of responsibilities that applies appropriate rights standards to all. The Convention recognizes the need to examine rules and practices concerning gender in society to make sure that they do not weaken rights guarantees ensuring the equality of the two sexes in all aspects of their lives.

Nearly all states have ratified the **Convention on the Rights of the Child**, making it a strong tool for holding governments accountable on human rights issues. In addition to upholding specific rights of children, this Convention, adopted in 1989, deals more broadly with gender relations. It reaffirms, for example, the right to family planning services, recognized by prior conventions and conferences.

Article 24 obligates states "to ensure appropriate prenatal and post-natal health care for mothers". It also calls on them to take "all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children"; this is an explicit recognition of the deleterious effects of such practices as female genital mutilation. Article 34 says that states must "undertake to protect the child from all forms of sexual exploitation and sexual abuse". Article 17 states that the child should have access to information "aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health".

Applying the Convention, the Committee on the Rights of the Child has, for example: recommended that specific laws be enacted and enforced to prohibit FGM (1997); called on Kuwait to take action to prevent and combat early marriage (1998); and called on Mexico to raise and equalize the minimum legal ages for marriage of boys and girls (1999).

Human Rights Treaty Bodies: Reports and Recommendations

Countries that have ratified human rights treaties are required to report regularly on actions they have undertaken to ensure the exercise and enjoyment of the specified rights. Established bodies monitor the implementation of rights instruments. For example, the Human Rights Committee monitors compliance with the International Covenant on Civil and Political Rights and receives complaints from individuals whose rights have been violated, while the Committee on Economic, Social and Cultural Rights monitors implementation of the economic rights covenant.

Treaty bodies offer recommendations and interpretations to assist in monitoring, reviewing and evaluating the international human rights treaties. Their recommendations can take several forms. Some clarify treaty provisions, for example, by specifying actions that states, groups or individuals should take. These monitoring bodies can also define standards and recommend actions needed to protect or expand a right. NGOs may also submit "shadow reports" when a state is before a treaty body.

The **Committee on Economic, Social and Cultural Rights** has issued a number of recent rulings on reproductive rights. For instance, it has called on Cameroon to eliminate the practices of polygamy, forced marriages and FGM, and bias in favour of the education of boys (1999); noted with concern the high incidence of pregnancies among females of school age in Saint Vincent and the Grenadines (1997); and noted that Switzerland's Parliament had not yet recognized the right of pregnant women to maternity benefits as Article 10 requires (1998).

Concerned about the high number of suicides of adolescent girls, "which appear in part to be related to the prohibition of abortion," the **Human Rights Committee** called on Ecuador to help adolescents facing unwanted pregnancies to obtain adequate health care and education (1998). Regarding Poland, the committee voiced concern about: strict abortion laws leading to high numbers of unsafe clandestine abortions; limited access for women to affordable contraceptives; the elimination of sexual education from schools; and the insufficiency of public family planning programmes (1999).

In March 2000, the committee adopted a comprehensive new General Comment on gender equality, spelling out what Article 3 of the political covenant entails and what information states parties are expected to provide in their reports. It states that gender equality applies to the enjoyment of all rights — civil, cultural, economic, political and social — and is not merely a right to non-discrimination; affirmative action is required. States parties are obliged to prohibit discrimination on grounds of sex, and to "put an end to discriminatory actions both in the public and the private sector".

The **Committee on the Elimination of Discrimination against Women** monitors implementation of the Convention on the Elimination of All Forms of Discrimination against Women. At its January 1992 session, the committee adopted General Recommendation 19 on violence against women, which states that "gender-based violence which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms is discrimination" within the treaty's purview.

In 1994, the committee found that violence against women within families constituted a violation of the "right to non-discrimination against women in all matters relating to marriage and family relations". It called for: criminal penalties and civil remedies in domestic violence cases; outlawing the "defence of family honour" as a justification for assault or murder; services to ensure the safety of victims of family violence; rehabilitation programmes for perpetrators of domestic violence; and support services for families where incest or sexual abuse had occurred.

The committee subsequently decried the high incidence of teenage pregnancy in Belize, which it linked to a lack of adequate family planning information and contraceptive use; it also expressed concern that schools are free to expel girls because of pregnancy, and that only a few allow girls to continue their education after pregnancy (1999). It ruled that in Chile, "deep-rooted social and cultural prejudices" hold back the achievement of equality for women; it expressed concern at high rates of teenage pregnancy, which it linked to sexual violence; and it urged the Government to revoke laws imposing criminal penalties on women who undergo abortions and requiring health professionals to report them (1999).

It urged Nepal to amend discriminatory laws on property and inheritance, marriage, nationality, birth registration and abortion; and to punish persons who procure women for prostitution or for trafficking; and it expressed concern about harmful traditional customs and practices, such as child marriage, dowry, polygamy, and ethnic and religious practices that force girls to become prostitutes (1999). The committee expressed concern about Peru's high incidence of domestic violence, including incest, and sexual violence against rural and indigenous women, including teenagers; it recommended that the Government review its law on abortion and ensure that women have access to

Countries that have ratified human rights treaties are required to report regularly on progress.

BOX 28

The Right to Reproductive Health Care

Access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women. Article 12 requires states to eliminate discrimination in access to health services throughout the life cycle, particularly in the areas of family planning, pregnancy and confinement, and the post-natal period.

In 1999, the Committee on the Elimination of Discrimination against Women elaborated a general recommendation on Article 12 of the Convention. Key points include:

"States parties should implement a comprehensive national strategy to promote women's health throughout their lifespan. This will include interventions aimed at both the prevention and treatment of diseases and conditions affecting women, as well as responding to violence against women, and will ensure universal access for all women to a full range of high-quality and affordable health care, including sexual and reproductive health services.

"States parties should allocate adequate budgetary, human and administrative resources to ensure that women's health receives a share of the overall health budget comparable with that for men's health, taking into account their different health needs."

States parties to the Convention are urged, in particular, to:

- Place a gender perspective at the centre of all policies and programmes affecting women's health and involve women in planning, implementing and monitoring the provision of health services to women;
- Remove all barriers to women's access to health services, education and information, including in the area of sexual and reproductive health, and allocate resources for programmes to prevent and treat sexually transmitted diseases including HIV/AIDS among adolescents;
- "Prioritize the prevention of unwanted pregnancy through family planning and sex education and reduce maternal mortality rates through safe motherhood services and prenatal assistance. When possible, legislation criminalizing abortion should be amended, in order to withdraw punitive measures imposed on women who undergo abortion;
- "Monitor the provision of health services to women by public, non-governmental and private organizations, to ensure equal access and quality of care;
- "Require all health services to be consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice;
- "Ensure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence."

complete health services which include safe abortion and to emergency medical attention when complications arise from abortions (1998).

Only a small number of countries report to the committee each year. The impact of recommendations and rulings gains from their general relevance and cumulative application.

On 10 December 1999, Human Rights Day, the **Optional Protocol** to the Convention on the Elimination of All Forms of Discrimination against Women was opened for signature, ratification and accession. As of 28 March 2000, 33 countries had signed the protocol and some had started parliamentary procedures required before ratification; 10 ratifications are needed for the protocol to enter into force. The Optional Protocol is a legal instrument that will enable victims of gender discrimination to submit complaints to the Committee on the Elimination of Discrimination against Women. By accepting the protocol, a state would recognize the committee's competence to receive and consider complaints from individuals or groups of individuals within its jurisdiction in cases where they have exhausted domestic remedies.

The Optional Protocol also enables the committee to initiate inquiries into situations of grave or systematic violations of women's rights. Although the protocol allows states upon ratification or accession to declare that they do not accept the inquiry procedure, it explicitly provides that no reservations may be entered to its terms. Upon its entry into force, the protocol will put the Convention on an equal footing with other human rights instruments that have individual complaints procedures, such as the International Covenant on Civil and Political Rights.

The **Committee on the Elimination of Racial Discrimination** in April 2000 adopted a general recommendation which recognized that some forms of racial discrimination have unique and specific impacts on women. The committee resolved to take gender factors into account when examining racial discrimination.

In addition to the work of the treaty monitoring bodies, the **Commission on Human Rights** monitors states' compliance with international human rights law and investigates alleged rights violations. Operating through special rapporteurs and working groups, the Commission sends fact-finding missions to developing and developed countries in all parts of the world. There is, for example, a special rapporteur on violence against women.

In April 1999, the commission adopted consensus resolutions that called on governments to take effective action to combat trafficking in women and girls and violence against women. It also urged that all treaty bodies, special procedures and other United Nations human rights mechanisms systematically take a gender perspective into account in implementing their mandates.

International Conference Consensus Agreements

While agreements reached at international conferences are not legally binding, the human

rights treaty monitoring bodies can take their recommendations into account, for example, in setting standards and in making interpretations and recommendations. As expressions of international consensus, the conference agreements are also strong advocacy tools that can and do influence the formulation of national laws and policies. Several of the major conferences of the 1990s addressed issues of gender equality and women's rights.

The **World Conference on Human Rights**, held in Vienna in 1993, declared human rights to be a universal norm, independent of the standards of individual states. The Vienna Declaration emphasizes that the rights of women and girls are "an inalienable, integral and indivisible part of human rights", requiring special attention as part of all human rights activities.

The conference urged that increased priority be given to eradicating all forms of discrimination on grounds of sex; to ensuring women's full and equal participation in political, civil, economic, social and cultural life; and to ending all forms of gender-based violence. Countries agreed that women's enjoyment of rights — including equal access to resources — is both an end in itself and essential to their empowerment, to social justice, and to overall social and economic development.

The Vienna Declaration also affirms that women should enjoy the highest standards of physical and mental health throughout their lifespans. It reaffirms the principle of equality between men and women, and the right to equal access to all levels of education. And it acknowledges women's right to accessible and adequate health care and the widest range of family planning methods and services.

As a result of the Vienna recommendations, the General Assembly in December 1993 adopted by consensus the **Declaration on the Elimination of Violence against Women** — which stipulates that all states parties, in accordance with national legislation, should prevent, investigate and punish acts of violence against women, whether perpetrated by the state or private persons — and appointed a special rapporteur to monitor implementation of measures designed to end violence against women.

International Conference on Population and Development

The 1994 ICPD recognized that empowering women and improving their status are important ends in themselves and essential for achieving sustainable development. The ICPD Programme of Action[2] affirmed that universally recognized human rights standards apply to all aspects of population programmes.

The Programme of Action sets out the context and content of reproductive rights. Paragraph 7.3 spells out the underlying precepts:

> *[R]eproductive 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.*

Another landmark event in efforts to achieve full equality for women was the **Fourth World Conference on Women**, held in Beijing in 1995. The Platform for Action[3] adopted by the FWCW affirms that women's human rights are inalienable, universal, indivisible and interdependent. It puts forth the principle that rights for all must be defended in order that rights for any are preserved. It calls on all governments, organizations and individuals to promote and protect the human rights of women, through the full implementation of all relevant human rights instruments, especially the Convention on the Elimination of All Forms of Discrimination against Women, and to work to ensure that equality of the sexes and non-discrimination based on gender exist both in the law and in practice.

The Beijing platform identifies "12 critical areas" of action needed to empower women

BOX 29

The ICPD Programme of Action and Gender Equality

Principle 4 of the ICPD Programme of Action states: "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community."

and ensure their human rights: women and poverty; education and training of women; women and health; violence against women; women and armed conflict; women and the economy; women in power and decision-making; institutional mechanisms for the advancement of women; human rights of women; women and the media; women and the environment; and the girl-child.[4]

The FWCW reaffirmed and strengthened the consensus that had emerged at the ICPD in Cairo the year before. Much of the ICPD language on reproductive rights was incorporated directly into the Platform for Action. Paragraph 92 states: "Good health is essential to leading a productive and fulfilling life, and the right of all women to control all aspects of their health, in particular their own fertility, is basic to their empowerment." Paragraph 96 states: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence."

Following the FWCW, the **Commission on the Status of Women** was mandated to regularly review the Platform for Action's critical areas of concern and play a catalytic role in follow-up to the conference. The Commission, established in 1946, meets annually to make recommendations and reports promoting equal rights for women and men in political, economic, civil, social and educational fields. Among other things, it ensured that the Universal Declaration on Human Rights included provisions on gender equality.

Five-year Reviews

The consensus documents of the ICPD and other conferences are intended to lead to action. Five-year reviews have assessed progress towards the agreed goals, identified obstacles and set new benchmarks

The "ICPD+5" follow-up, for example, took place in 1998 and 1999 in a series of events[5] culminating in a special session of the General Assembly. The special session adopted a document on key actions for the further implementation of the ICPD Programme of Action. While endorsing all of the provisions of the ICPD Programme of Action, it went beyond that document in certain areas, including the reproductive rights of adolescents and of women in emergency situations.

The special session called on governments to respect, protect and promote the human rights of women and girls — particularly freedom from coercion, discrimination and violence, including harmful practices and sexual exploitation — by developing, implementing and effectively enforcing gender-sensitive policies and legislation. It called for intensified action on: reproductive and sexual health; maternal mortality; the reproductive health needs of adolescents; reducing abortion and addressing the health consequences of unsafe abortion; prevention of HIV/AIDS; gender issues and education (Boxes 4 and 7).

Governments were encouraged to sign, ratify and implement the Convention on the Elimination of All Forms of Discrimination against Women; to remove reservations incompatible with the convention's objective and purpose; and to consult with civil society in the human rights treaty-reporting process. United Nations bodies responsible for indicators relating to women's human rights were urged to incorporate sexual and reproductive health issues.

The "Beijing+5" review, entitled "Women: 2000: Gender Equality, Development and Peace for the 21st Century", took place 5-10 June 2000. The General Assembly session assessed progress in implementing the Nairobi Forward-looking Strategies for the Advancement of Women, adopted in 1985, and the FWCW Platform for Action, and considered future actions and initiatives (Box 5).

For the rights written into treaties and consensus documents to become a reality, they need to be incorporated into national laws, policies and programmes. The monitoring mechanisms growing out of the international conferences have made it much easier than in the past to keep abreast of national progress in turning ideals into realities.

Understandings about what human rights entail, and how they should be protected and monitored, are developed in a variety of processes, internationally and within countries. Consideration of gender factors needs to become an integral and systematic part of all these processes. Despite important progress, this largely remains to be achieved.

CHAPTER 7

Working Towards a Better Future

The Role of Governments

In many ways, governments create the conditions for gender equality. They can remove legal barriers and change the law to promote gender justice; they can pay attention to gender equality in the design of policies and programmes; and they can encourage supportive institutional environments. As the biggest direct and indirect employers, government can set standards and provide an example to others. Finally, political leaders can advocate and promote gender equality, and encourage their followers at all levels to do so.

Governments agreed in the ICPD Programme of Action on the need to increase domestic allocations to health care, including reproductive health, and contributions to international assistance. They agreed that greater participation in technical cooperation and support among developing countries would more broadly disseminate lessons learned from successful programmes.

PHOTO: Training programme for office workers in Ghana. Governments can train men and women to use new technologies.

Jorgen Schytte/Still Pictures

Legal Support for Gender Equality

Many legal or administrative codes contain barriers to women's access to resources and property, to basic information about and access to services (including health and education), to basic decisions concerning their family status,[1] to protection from violence, and to freedom of association. Even where supportive legislation exists, these legal rights may be weakly enforced or overridden by customary law.

Reproductive rights are guaranteed in **South Africa's** Constitution, but their exercise has been restricted by appeals to customary law. This is being adjudicated, and policy makers' attention has been drawn to the need for clarification.

UNFPA has sponsored discussions among parliamentarians in the Arab states and Africa of changes in personal status laws needed to protect the exercise of reproductive and other rights.

More than two thirds of the countries in the world, including almost all of Latin America, have modified legislation to improve women's access to resources, education and health services, and their decision-making power in families.[2]

In **Ecuador**, the National Constitutional Assembly has discussed incorporating sexual and reproductive rights in the Constitution. Women's groups, including the national council

BOX 30

Women in Decision-making

Women have always been leaders in community and non-governmental organizations, but are under-represented at most levels of government, especially in ministerial and other executive bodies. A dozen countries still have no women in parliament, and in at least eight countries, women cannot even vote.

Women are 13 per cent of the world's parliamentarians, up from 7 per cent in 1975. Only in nine countries is the proportion of women in the national parliament 30 per cent or above (the target set by the Fourth World Conference on Women): Denmark, Eritrea, Finland, Germany, Iceland, the Netherlands, Norway, South Africa and Sweden (with more than 40 per cent).

In some countries, the constitution mandates quotas for women's seats in parliament. In others, political parties may agree to quotas or set targets for the proportion of candidates for election who are women.

In Eastern Europe and Mongolia, for example, the elimination of quotas that accompanied the shift to democratic political systems resulted in dramatic falls in women's share of parliamentary seats. In South Africa, by contrast, the proportion of women rose from 1 per cent to 30 per cent following the end of apartheid.

Several other developing countries have seen dramatic increases in the past 25 years, including Uganda (1 per cent to 18 per cent), Ecuador (1 per cent to 17 per cent), Bahamas (4 per cent to 20 per cent) and Barbados (4 per cent to 20 per cent).

Women hold 30 per cent or more of ministerial level positions in just six countries — Barbados, Eritrea, Finland, Liechtenstein, Seychelles and Sweden. Ten other Western European and Caribbean countries have a level of 20-29 per cent. Some 48 countries have no women ministers.

for women, led the consultations and lobbying. In **Venezuela**, the Network on Population, with UNFPA support, promoted the incorporation of sexual and reproductive rights and gender equity into the new Constitution, approved in December 1999.[3]

Female genital mutilation has been outlawed in **Ghana** (1994); **Djibouti** (1995); **Burkina Faso** (1996); **Côte d'Ivoire, Togo** and the **United Republic of Tanzania** (1998); and **Senegal** (1999). A 1996 Ministry of Health decree in **Egypt** banned FGM except in cases of medical necessity; in 1997, the highest administrative court upheld the ban after a legal challenge.[4]

New Legislation

In the years 1997-1999, a number of countries enacted or amended legislation in various areas to reflect the major goals of the ICPD and FWCW.[5]

Reproductive health

Mexico and Peru enacted comprehensive legislation to increase access to reproductive health services of all kinds. Guinea's new Public Health Code made family planning services a priority. Georgia's law on health care stipulated that all citizens have the right to determine the number and spacing of their children. Portugal amended its Constitution to specify that the State has to guarantee the right to family planning. Ecuador's new Constitution guaranteed the right of persons to decide on the number of children that they want.

Peru guaranteed the right to choose sterilization as a method of family planning. Brazil approved sterilization for persons aged 25 or under 25 with two children. Paraguay issued a National Family Planning Manual authorizing sterilization. Thailand authorized employees to take leave in order to be sterilized.

The Japanese Ministry of Health and Welfare approved the sale of low-dosage oral contraceptives in 1999, almost 40 years after the first efforts to obtain such approval.

Cambodia enacted comprehensive abortion legislation, liberalizing the circumstances under which abortions can be performed.

Improvement of women's status

Albania, Burkina Faso, Ecuador, Fiji, Madagascar, Poland and the Sudan adopted or amended their constitutions to prohibit discrimination on the basis of sex. France amended its Constitution to promote equal access of women and men to electoral powers and elected office. Luxembourg criminalized discrimination based on sex in most aspects of society.

Cape Verde and the Czech Republic enacted new family codes guaranteeing equality of rights and duties in marriage. South Africa mandated the equal status of spouses in customary marriages. Other countries adopted less comprehensive legislation in this area.

In Pakistan, the High Court of Lahore ruled that the consent of both parties is an indispensable condition for the validity of marriage and that a guardian has no right to grant such consent on the behalf of a woman without her approval. Burkina Faso's Constitution affirmed that marriage is founded on the free consent of man and woman.

Gender-based violence

Botswana, China, Colombia, Dominica, Peru, the Philippines, the United Kingdom and Viet Nam increased penalties for various sexual offences or broadened protection against sexual violence. Cape Verde, Cuba, Thailand, Ukraine, the United Republic of Tanzania and Viet Nam outlawed trafficking of women and children. Canada, Italy and the United Kingdom criminalized sexual tourism with minors. Bolivia no longer requires that a woman be found to be "honest" in order to be the victim of certain

sexual offences. Germany criminalized rape by a husband against his wife.

Belgium, Bermuda, the Dominican Republic, Honduras, Mauritius, Mexico, Peru, Portugal, South Africa and Venezuela adopted various forms of domestic violence legislation. Bermuda prohibited stalking, while New Zealand and the United Kingdom established measures to counteract harassment.

Labour relations and employment

Cambodia, Ecuador, Indonesia, the Republic of Korea, Senegal and Tajikistan enacted new labour codes broadly prohibiting discrimination against women in the workplace; Cambodia, Ecuador and Swaziland also guaranteed pay equity, and all but Tajikistan now provide protection against the dismissal of women who are pregnant or on maternity leave. In Senegal, a working woman no longer needs her spouse's consent to join a labour union. In Ecuador, employers must employ women as a certain percentage of the work force. Thailand requires employers to treat male and female employees equally and prohibits sexual harassment in the workplace.

The United Republic of Tanzania prohibited dismissal for reasons of sex or pregnancy. Chile, Cyprus, the Sudan and Zambia outlawed discrimination on the basis of pregnancy or childbirth. Chile also prohibited requiring a pregnancy test as a condition of employment. The Republic of Korea banned gender discrimination in labour unions. Fiji outlawed sexual harassment and discrimination in employment applications. Several other countries strengthened existing protections against sex discrimination.

Design of Policies and Programmes

Several Latin American countries have begun to analyse differences in the impact of their programmes on men and women. Most countries now have plans of action for implementing the ICPD Programme of Action and the FWCW Platform for Action. Almost all African countries have a ministry, bureau, department or unit responsible for gender equality issues.

Governments can design policies and programmes with attention to their diverse impacts on men and women, encouraging participatory feedback and local monitoring. They can reward institutions that promote equality in staffing and allocating resources.

National plans for implementing conference recommendations must be specific about responsibilities, both inside and outside government, and incorporate the views of the different groups concerned. New policy and administrative bodies or gender focal points in existing institutions may be needed.

Key Policy Issues

Policies and institutional changes

Countries may need to formulate or revise official policies intended to promote gender equality. Policy makers need to be able to analyse the different impacts programmes have on men and women, and how well they respond to their different needs. Institutional changes may also be required, such as identifying focal points to monitor progress. Also needed are improved mechanisms for reporting and for receiving feedback from civil society, including women's groups.

Training

Policy makers and programme staff need training about gender issues to promote gender equality. International and local NGOs and networks, development assistance offices, international financial institutions and national offices have all prepared training materials. In **Colombia**, for

BOX 31

Egyptian Women Gain Divorce Rights Similar to Men's

A law that took effect in March 2000 allows Egyptian women to seek a unilateral, no-questions-asked divorce, making Egypt the second country in the Arab world after Tunisia to give women divorce rights similar to those of men.

"This is basically a revolution," said Mona Zulfukar, a lawyer and activist who helped win a 15-year campaign for family law reform that also made child support and alimony easier to collect and consolidated several separate proceedings under the purview of a single judge.

A diverse coalition backed the reform, including activists interested in making the legal system more efficient, civil libertarians and supporters of women's rights, and Muslim scholars who agreed there was justification within Islam for the proposed changes. Egyptian activists argued that the Prophet Mohammed clearly meant divorce to be an equal — or at least nearly equal — opportunity for men and women to dissolve unhappy marriages. Scholars at Al Azhar University, the Muslim world's oldest seat of religious learning, agreed.

Opposition from religious conservatives and men who saw their domination of family life threatened required some compromise. As the legislation progressed, a provision allowing women to travel without a husband's or father's permission was eliminated.

Even with the reform, a husband can still end a marriage far more easily than a wife — as little as an hour with the local marriage registrar is all it takes; the wife does not have to be informed. Court-supervised mediation is required before a divorce is granted at the woman's request, and then she must return any cash or property provided by her husband under their marriage contract.

In an earlier legal reform, the Egyptian Government in 1999 repealed a controversial part of the criminal code that allowed rapists to avoid imprisonment if they offered to marry their victims.

example, training for reproductive health clinic workers has improved the flow of information, reduced waiting time, and increased staff involvement and client satisfaction.

Monitoring

Resource allocations need to be monitored to ensure that they promote gender equality and address the needs of both men and women. Schools, for example, must be equally accessible to boys and to girls, and pupils safe from abuse. Programme indicators need to be made gender-sensitive, and gender-disaggregated databases must become standard instruments of assessment. Qualitative indicators should supplement quantitative approaches.

Accountability

Codes of conduct for health programmes should ensure respect for the rights, needs, perceptions and opportunities of clients. Ombudsman systems and other means for soliciting feedback and participatory input are needed to ensure accountability to programme beneficiaries.

BOX 32

Monitoring and Evaluation Improve Programmes and Promote Gender Sensitivity

Monitoring the reproductive health needs of populations and the impact of gender discrimination and biased power relations is vital to designing strategies for improvement. Public databases that contain sex-disaggregated information need to be supported and easily accessible to policy makers, programme implementers, advocates and local decision makers.

The five-year review of ICPD Programme of Action implementation noted the need for qualitative indicators of success, particularly for measuring the social context of reproductive health. Notably missing are good indicators to measure changes in gender roles and women's empowerment in public and private spheres. Indicators can also help monitor the degree to which programmes are themselves being run in a gender-sensitive way.

The Interagency Gender Working Group affiliated with the United States Agency for International Development is working to produce indicators for measuring gender-related issues in reproductive health. It is also developing a process for programmes to define their own gender indicators. The process analyses gender-related obstacles to achieving programme objectives, identifies activities to counter the obstacles, and suggests indicators and data sources for measuring their success.

IPPF has designed a monitoring tool for programmes to assess the quality of care of their reproductive health services from a gender-based perspective.

UNFPA, in consultation with other international and academic institutions, has developed a set of indicators to measure reproductive health. These indicators are intended to standardize data collection across United Nations agencies and to provide countries with indicators they may choose to use in their own programmes. Specific indicators monitor progress towards gender equality; gender-sensitivity was a concern in the selection of all measures.

Health-sector reform and structural adjustment

Analyses in South-east Asia and in sub-Saharan Africa have shown that adjustment programmes, including decentralization of services, can weaken education and health programmes and undermine efforts to eradicate poverty and improve the quality of life. Governments should monitor the impact of reform programmes to ensure that education and health services continue to reach the poor, particularly women and girls.

Quality of care

Service providers need training and support to provide sensitive care to both women and men. Improvements are needed in the quality of care in health systems, and particularly in sexual and reproductive health. International and bilateral donor agencies, including UNFPA, have increased emphasis on quality of care initiatives as part of their support to reproductive health programmes.

Gender-sensitive budget analysis

National budgets should be examined to see how they respond to the needs and interests of women, tracing the effect of expenditure and revenue policies and especially how they affect poor women.[6] Resources from public, private and community sources are needed to ensure that protections for gender equity are strictly enforced. **Cuba, Ecuador and El Salvador** have increased their budgetary allocations for women's programmes since the ICPD and FWCW.[7] Since the mid-1980s, **Australia** has been conducting regular analyses of how women have benefited from federal and state government expenditures.[8] The Commonwealth Secretariat has supported governments including **Barbados, Fiji**, **St. Kitts and Nevis, South Africa** and **Sri Lanka** in a gender budget initiative.[9]

Research

The different needs of women and men, the impacts of gender inequality, and barriers to improvement need to be better assessed, to inform programming and advocacy. Since the most debilitating gender discrimination is in the family, support should be given to collecting data on, and monitoring changes in, families.

Programmes aimed at men

Programmes are needed to address men's reproductive health needs, foster their active support for women's health, and engage them in dialogues on gender inequality and its costs to women, men and society as a whole.

Prevention of violence

Protecting women against gender-based violence requires action in many areas: advocacy; legal changes; improved enforcement; safe alternatives for victims; reporting systems; mediation and counselling services; and funding for local support groups.

Poverty eradication

Attention to meeting the needs of the poorest of the poor has become a priority in international development assistance. In **India**, for instance, the United Nations Development Assistance Framework (UNDAF), developed by government and international organizations, outlines a coordinated approach to development assistance, with attention to poverty eradication and gender concerns.[10]

Hiring barriers and pay differentials

To eliminate gender discrimination in hiring, employers should be barred from requiring women job seekers to prove they are using contraceptives or are not pregnant. Wage differentials between men and women should be analysed and made part of the public debate about gender equality and justice, the meaning of "equivalent" work, the importance of women's reproductive and productive roles, and related questions.[11]

Human rights education

Campaigns in support of basic human rights for men and women, including rights to sexual and reproductive health, should take into account the different perspectives of men and women. Messages should be appropriate for various ages and situations. Civil society organizations have developed a variety of human rights education syllabi and training materials.[12]

Advocacy

Media, including film, radio, TV and increasingly the Web, can encourage positive images and role models. Education for policy makers, local leaders and the community can spur communities and families to act against inequities. Better access to new information technologies will allow open exchange of information on best practices and different approaches.

UNFPA Support for Gender Equality

As the lead organization in the United Nations system supporting implementation of the ICPD Programme of Action, the United Nations Population Fund assists developing countries and those with economies in transition in ensuring

BOX 33

Legal Reforms in India against Rape

India's Law Commission has called for widespread reforms to the country's rape laws. The commission's report, which focuses on abuse within families, says rape and sexual assault cases should be tried in special courts, where the needs of victims would be paramount. But few women or children would want the exposure and ordeal of a trial, and even if a case goes forward, the burden of proof is usually on the woman.

The Law Commission also recommended harsher punishments for sex offenders, particularly those who prey on children. Sexual assault on children causes "lasting psychic damage," the commission said in its report.

Statistics on rape and child sexual abuse in India have recently emerged, and the figures are grim. The Indian Ministry of Women and Child Development says that on average, one woman is raped every hour in India. Fourteen wives are murdered by their husbands' families every day, the agency says.

Women's groups say deeply conservative attitudes about sex and privacy within families have contributed to brutally ineffective rape laws. A raped woman also faces being cast out from her family and community.

BOX 34

Legal and Professional Action against Rape in South Africa

Rape is a significant problem in South Africa, where 52,000 women annually report being raped, and police officials estimate only one in every 36 victims reports the attack.

Women who are urban, white and educated are more likely to take their cases to police, but many poor, black women, especially those who are raped by someone they know, usually do not report the rape to authorities. Myths surrounding AIDS also perpetuate the problem—many men believe that sex with a virgin can cure the disease.

The problem appears to be bigger in South Africa, with 129 reported rapes per 100,000 people a year, than almost anywhere else in the world—in the United States, 36.1 women per 100,000 people were raped in 1996, and in the United Kingdom, 8.7.

South Africa is now setting up 20 specialized "rape courts", the first such initiative in the world. Canada is helping to fund the programme, while the United States Department of Justice and the Federal Bureau of Investigation are training prosecutors and investigators.

Journalist and rape activist Charlene Smith, who has written about her own rape, has urged the South African Medical Association to sensitize doctors, and the group is creating a "rape protocol". In April 2000, her rapist was sentenced to 15 years in prison.

She vows to keep pressing the issue. "We did it with apartheid," Smith said. "We can do it again with the problems of rape and HIV."

universal access to reproductive health, including family planning and sexual health, and in implementing population and development strategies in support of sustainable development. The Fund also works to promote awareness of population and development issues and advocates for the mobilization of the resources necessary to meet the goals of the ICPD.

A commitment to reproductive rights, gender equality, male responsibility and women's empowerment underpins UNFPA programming in each of these areas.

Support to Governments

In **Mexico,** with UNFPA support, the National Population Council has trained its technical staff and the staff of 10 state population councils on how population programmes and policies can promote gender equality. The five poorest states in Mexico now have plans for gender equality in their population programmes. The next stage will be to include a gender perspective in monitoring and evaluation.

UNFPA has provided training and technical assistance, for example, in **Angola** for the Ministry of Family and Promotion of Women and in **Swaziland** for the Gender Office in the Ministry of Home Affairs.[13]

Countries are starting to give more attention to adolescent reproductive health.

In **Peru**, profiting from experience elsewhere in the region, UNFPA supported the creation of the Ministry for the Promotion of Women and Human Development. In the **Dominican Republic,** UNFPA provided expert advice for legislation creating the new Secretariat for Women.

In **Ecuador**, **Peru** and the **Dominican Republic**, where health services have been decentralized, UNFPA has supported municipalities to promote reproductive rights and women's active participation in decision-making.

The Fund is also actively addressing a wide range of specific gender-related issues.

Adolescent Reproductive Health

Countries have given more attention to adolescent reproductive health since the Cairo and Beijing conferences. UNFPA offers technical and financial assistance for national programmes.

In Latin America, the NGO-led Journeys of Conversation on Affection and Sexuality encourages teenagers to discuss their experiences and develop their own alternatives. The methodology was developed with UNFPA support in **Chile** by the National Service for Women, the National Institute for Youth, and the Ministries of Health and Education; **Argentina, Bolivia, Brazil, Costa Rica and Uruguay** have adopted it. UNFPA has given additional support for programmes addressing adolescent needs in **Chile**, **Colombia**, **the Dominican Republic, Ecuador**, **Haiti**, **Honduras**, **Nicaragua**, **Panama**, **Paraguay**, **Peru** and **Venezuela**. A UNFPA-supported project for rural adolescents in **Nicaragua** focuses on the poor and those excluded from formal education.

In **Egypt**, UNFPA has supported the training of young men and women as peer educators to develop their leadership skills. Activities include self-awareness development, life and career planning and a focus on reproductive behaviour, parenthood, STDs and family planning.[14]

Gender Violence

UNFPA has supported training for health workers on intervention in cases of gender-based violence, as well as on laws, enforcement and counselling. In **the Dominican Republic, Ecuador, Honduras, Mexico** and **Venezuela**, it has provided support to governments, parliaments and civil society organizations to make, reform or enforce laws punishing violence against women; and has helped develop reports on sexual abuse of girls in **Chile, Nicaragua** and **Panama**.

In **the Dominican Republic**, the Fund has supported the creation of police department offices to handle accusations of violence against women and girls, and helped prepare publications on prevention of gender violence and laws against it. In **Haiti**, UNFPA has supported women's groups lobbying to improve the administration of justice in cases of rape, and helped train members of the national police force in preventing and managing gender-based violence. In **Peru**, UNFPA, UNICEF and the Pan American Health Organization support the national commission for the prevention of intra-family violence, which includes government departments, the national association of municipalities and women's organizations.

The Fund has also been part of a United Nations public education campaign against violence to women and girls in **Latin America and the Caribbean,** headed by UNIFEM in collaboration with UNFPA, UNICEF, UNDP and UNAIDS. In various countries, UNFPA has supported marches, press conferences, meetings and discussion panels.

Male Involvement

UNFPA has supported various regional conferences on male involvement, a variety of regional approaches in **sub-Saharan Africa**, and the creation of men's groups in **Bolivia**, **Colombia**, **Honduras**, **Nicaragua**, **Peru** and **Uruguay**.

In the armed forces and police of **Bolivia**, **Ecuador**, **Nicaragua, Paraguay and Peru**, the

Fund is supporting activities to generate greater awareness about the sexual and reproductive health of men, unequal gender relations and violence against women.

In the northwest region of **Namibia**, UNFPA is supporting discussion groups for men on family planning, STDs and gender inequality. Male nurses, members of the police and defence forces, the Evangelical Lutheran Church and a soccer club are participating.[15]

Other Areas of Assistance

HIV/AIDS prevention

UNFPA works with UNAIDS, WHO and other agencies to ensure gender equity in programmes for preventing HIV/AIDS and STDs. UNFPA and IPPF are developing a training module in HIV/AIDS prevention for family planning associations and other service providers.

Research and training

With UNFPA support, **Nicaragua** has established an international masters' programme in reproductive health and rights with a gender perspective. In **Bolivia**, UNFPA helps train reproductive health providers about service quality, rights and publication of qualitative research.[16] UNFPA has supported research in **Argentina**, **Bolivia**, **Brazil**, **Colombia**, **El Salvador**, **Guatemala**, **Honduras**, **Jamaica**, **Mexico** and **Peru** to identify specific needs of women in sexual and reproductive health, particularly in relation to health policies and their impact, maternal mortality, and women's employment.[17] In **Panama**, UNFPA has supported research on the links between population, gender and poverty, and trained NGOs and government organizations to prepare gender-sensitive projects linking population and poverty reduction.

Advocacy

In **Haiti**, UNFPA is helping the Ministry for the Status of Women and Women's Rights to design and manage advocacy strategies on women's rights. In **Bolivia**, UNFPA supports the development of educational television programmes on health and gender equity.[18] In **Mexico**, UNFPA supports Comunicación e Información de la Mujer, a national network of newspaper writers committed to gender equality and women's empowerment. In **Chile**, the Fund has supported *Fempress*, the magazine of the Latin American and Caribbean Women's Health Network.

Women's political participation

In **Bolivia**, **Ecuador**, **El Salvador**, **the Dominican Republic** and **Venezuela**, UNFPA has supported training for women's political leadership and participation in legislative processes as well as for local policy and management.

UNFPA has supported women's networks and indigenous groups in **Bolivia, Ecuador, Peru** and **Central America,** and also the Afro-Caribbean network.

UNICEF/1220/Cindy Andrew

Schoolgirls in Malawi. UNFPA supports advocacy efforts aimed at keeping girls in school.

Girls' education

UNFPA supports advocacy activities aimed at retaining girls in the school system and improving their social status, in support of the Plan of Action of the 1990 World Conference on Education for All. The Fund collaborated with the United Nations Educational, Scientific and Cultural Organization (UNESCO), UNDP, UNICEF and the World Bank in an evaluation of the Plan of Action, culminating in a World Education Forum in Dakar, Senegal, in April 2000.

Micro-credit

Governments increasingly support micro-credit institutions, directly, through subsidies, or through supportive regulation. To be effective in empowering women, these programmes should provide literacy, numeracy and family life education, and if possible encourage the transition to formal businesses. UNFPA has supported a variety of these programmes, for example, in **Yemen**.[19] In **Viet Nam**, UNFPA has supported the creation of more than 500 women's savings groups, providing assistance to agricultural and community improvement projects, campaigns to improve water and sanitation, and a network of community-based health volunteers.[20]

Data collection

UNFPA provides technical assistance to countries to increase awareness about gender inequities, and to generate and analyse gender-sensitive

data for planning and evaluating policies and programmes. **Bolivia, Haiti, Honduras** and **Venezuela** are being assisted in preparing national population censuses, applying an analysis that addresses gender equity.

The Role of Donors

The international donor community has strongly supported efforts to promote gender equality. The commitment of donor organizations is clear in policy statements,[21] in institutional mechanisms[22] and in reporting[23] since the ICPD and FWCW, but this commitment is not yet backed by adequate resources.

The ICPD agreed that $5.7 billion in international assistance would be needed for reproductive health and population programmes in the year 2000, rising to $7.2 billion a year in 2015. Only about $2.1 billion a year is currently being made available.[24]

Better collaboration among donors is needed to reduce duplication and share expertise, in line with reforms of United Nations development assistance.

UNIFEM and UNFPA have signed a memorandum of understanding increasing cooperation in support of national efforts. UNFPA gender specialists give support to UNIFEM projects and training activities around the world.

UNFPA has adopted programming guidelines on gender equality and sensitivity[25] and operational guidance for its field offices on promoting women's empowerment and human rights.[26] Other organizations of the United Nations system, including UNICEF, UNDP, WHO, the International Labour Organization and the World Food Programme, have also prepared guidelines and manuals on the subject.

The World Bank has produced a *Policy Research Report on Gender and Development*,[27] analysing the importance to development of gender issues and women's empowerment, and has reported on lending programmes and projects funded by World Bank loans.[28] The Bank is developing strategies and reviews of gender concerns in sectoral programmes.[29]

Agencies will need to continue and intensify these efforts.

Private foundations, including the Ford Foundation, the Bill & Melinda Gates Foundation, the William and Flora Hewlitt Foundation, the John D. and Catherine T. MacArthur Foundation, the David and Lucile Packard Foundation, the Rockefeller Foundation, the Summit Foundation, the Wallace Global Fund and the United Nations Foundation, are playing an increasingly important role in supporting national programmes to promote reproductive health and gender equality.

Increased support from the donor community will encourage national and local efforts.

The Challenges Ahead

Social change is always difficult, particularly when the basic relations between men and women in families and society are involved. The past several decades have seen greater attention and some progress towards the empowerment of women. There has also been a growing recognition of how the rules governing men and women's opportunities, social endowments and behaviours affect the prospect for accelerated development and justice.

The changes in these relationships, and the systems of power and belief that support them, are no less sweeping and important than changes under way in spheres such as globalization, governance, information technology and urbanization. Societies need their own solutions, grounded in a vision of justice and gender equality and consistent with their cultures and conditions, to provide a better life for both women and men.

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73. Murray, Christopher J. L., and Alan D. Lopez (eds.). 1996. *The Global Burden of Disease.* Global Burden of Disease and Injury Series, vol. 1. Boston: Harvard University Press. It should be noted that the HIV/AIDS impact projections were made prior to improvements in the UNAIDS database and are likely conservative.
74. Murray and Lopez 1998.
75. Ezeh, A. C., M. Seroussi, and H. Raggers. 1996. *Men's Fertility, Contraceptive Use, and Reproductive Preferences*. Demographic and Health Surveys. Comparative Studies. No.18. Calverton, Maryland: Macro International. Cited in: Upadhyay, U. D., and B. Robey. 1999. "Why Family Planning Matters." *Population Reports.* Series J. No. 49. Baltimore, Maryland: Population Information Program, Johns Hopkins School of Public Health.
76. A programme was recently established in Turkey to provide information, education and communication on reproductive health. This is but one component of Turkey's active approach to reproductive health concerns. (See: Akin, Ayşe, and Şevkat Bahar Özvariş. 1999. "Spotlight on Turkey." *Entre Nous* 45: 6-7. Copenhagen: The Women's and Reproductive Health Unit, Regional Office for Europe, World Health Organization, and UNFPA.) Other countries have provided information and services to their military for many years. The Nigerian public programme in family planning, for example, received an important early boost from service provision for soldiers.
77. These efforts and other positive programmes are referenced in: UNFPA. 1999b. "Contributions of the United Nations Population Fund to the Execution of the Platform for Action of the Fourth World Conference on Women: A Review of Latin America and the Caribbean Five Years after the Cairo and Beijing Conferences." Paper prepared for the Eighth Regional Meeting on Women of Latin America and the Caribbean, and the review process of the United Nations Beijing+5, Lima, Peru, 8-10 February 2000.
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79. See citations in: Upadhyay and Robey 1999.
80. Manuals for training adolescents and adults have been developed by many organizations, including the Centre for Development and Population Activities (CEDPA).
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86. For instance, the World Health Organization; the Women's Health Project, South Africa; and the Harvard School of Public Health, United States of America, have developed a core curriculum in gender and reproductive health. See also: Swedish International Development Cooperation Agency (SIDA). 1997. *Handbook for Mainstreaming a Gender Perspective in the Health Sector*. Stockholm: Swedish International Development Cooperation Agency; Pfannenschmidt, Susan, Arlene McKay, and Erin McNeil. 1997. *Through a Gender Lens: Resources for Population, Health and Nutrition.* Washington, D.C.: Interagency Gender Working Group, United States Agency for International Development (USAID); and AIDS Control and Prevention Project (AIDSCAP). 1997. *A Transformation Process: Gender Training for Top-Level Management of HIV/AIDS Prevention*. Training Manual. Arlington, Virginia: AIDS Control and Prevention Project, Family Health International.
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88. Galdos, S., and B. Feringa. 1998. "Creating Partnerships at the Grassroots Level: The Reprosalud Project, Peru." In: Health Empowerment Rights and Accountability (HERA) 1998, pp. 26-32.
89. Li, Virginia C., and Shaoxian Wang. 1998. *Collabouration and Participation: Women's Reproductive Health of Yunnan, China.* Beijing: Beijing Medical College.
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Chapter 3

1. Johnson, Cate. 1997. "Violence Against Women: An Issue of Human Rights." *Genderaction* 1(4): 1-4. Washington, D.C.: Office of Women in Development, United States Agency for International Development.
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10. El-Zanaty, F., et al. 1996. *Egypt Demographic and Health Survey 1995*. Calverton, Maryland: Macro International.
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Chapter 4

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2. Silberschmidt 1999, pp. 117f, shows that this ideal is also reinforced by some government pronouncements. Despite a growing and increasingly successful family planning programme and a continuing reduction in stated family size desires, there remains considerable ambivalence about the value of large families.
3. Men in this study, as in others, cite women's "nagging" as a cause of acts of verbal and physical abuse against them.
4. Silberschmidt's (1999, pp. 118f) nuanced and documented analysis is a devastating counter-argument to those who suggest that adaptive responses to improve family life (such as lowered fertility desires and adoption of contraception) are the "cause" of family breakup.
5. The literature on *machismo* is extensive. A useful compilation (with extensive references) is the report of a regional conference supported by UNFPA and Facultad Latinoamericana de Ciencias Sociales (FLACSO Chile), "La Equidad de Genero en America Latina y el Caribe: Desafíos Desde las Identidades Masculinas" (Gender Equality in Latin America and the Caribbean: Challenges from Masculine Identities), Santiago, Chile, 8-10 June 1998. Published as: Valdés, Teresa, and José Olavarría (eds.). 1998. *Masculinidades y equidad de género en América Latina* (Masculinities and Gender Equality in Latin America). Santiago, Chile: Facultad Latinoamericana de Ciencias Sociales. Analysts suggest that *machismo* evolved in response to historical changes that placed special burdens on men. See: Fuller, Norma. 1998. "Reflexiones sobre el *machismo* en América Latina" (Thoughts about *Machismo* in Latin America). In: Valdés and Olavarría 1998, pp. 258-267. This study argues that *machismo* allowed a retention of male pride after the colonial conquest of the indigenous cultures. The paper presents, additionally, an analysis of the impact of recent social and economic changes on the *machismo* ideal.
6. Research cited in the pre-publication version of the paper presented by Fuller (1998).
7. Shepard, Bonnie. 1998. "The Masculine Side of Sexual Health." *Sexual Health Exchange* 2: 6-8
8. Kaufman, Michael. 1997. "Contradictory Experiences of Power among Men (Las experiencias contradictorias del poder entre los hombres)." In: *Masculinidad/es: poder y crisis* (Masculinity/ies: Power and Crisis), pp. 63-81, edited by Teresa Valdés and José Olavarría. Ediciones de las Mujeres No. 24. 1997. Santiago, Chile: Isis Internacional.
9. Hindin, Michelle J., and Linda S. Adair. 2000 "Women's Autonomy, Men's Autonomy and Gender Violence in the Philippines: The Case for Promoting Couple Communication." Paper presented at the Annual Meeting of the Population Association of America, Los Angeles, California, 23-25 March 2000.
10. This relation was likely due to men feeling the strain of failing to meet expectations. Focus group discussions found that the reasons given for the violence were: wife talks back (27 per cent), wife nags (24 per cent), jealousy (18 per cent), husband drunk (13 per cent), fight over children (9 per cent) and multiple reasons (10 per cent).
11. Decisions included: buying the wife shoes, buying the children's clothes, the children's schooling, taking children to the doctor, gifts for relatives, major household purchases, buying or selling land, the wife working outside the home, the wife travelling outside of Cebu, using family planning and choice of family planning method.
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13. Upadhyay, U.D., and B. Robey. 1999. "Why Family Planning Matters." *Population Reports*. Series J. No. 49. Baltimore, Maryland: Population Information Program, Johns Hopkins School of Public Health.
14. Tawab, Nahla Abdel, et al. 1997. *Counseling the Husbands of Postabortion Patients in Egypt: Effects on Husband Involvement, Patient Recovery and Contraceptive Use.* New York: Asia and Near East Operations Research and Technical Assistance Project, The Population Council, and Egyptian Fertility Care Society.
15. Raju and Leonard 2000.
16. Ibid.
17. Verma, Ravi K., et al. 2000. "Men's Sexual Health Problems in a Mumbai Slum Population." In: Raju and Leonard 2000.
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20. See: Norori Muñoz, V., and J. Muñoz Lopez. 1998. "Conceptualizing Masculinity through a Gender-based Approach." *Sexual Health Exchange* 2: 3-6.
21. A recommendation in: International Planned Parenthood Federation/Western Hemisphere Region and AVSC International. 1999. *Memorias del Simposio sobre Participación Masculina en la Salud Sexual y Reproductiva: Nuevos Paradigmas*. Report of a Meeting in Oaxaca, México, 11-14 October 1998. New York: AVSC International.

Chapter 5

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2. This complaint was a common thread in many responses to the concept paper of the World Bank's *Policy Research Report on Gender and Development*. Forthcoming. Washington, D.C.: The World Bank. Draft available on: <www.worldbank.org/gender>).
3. Research by Saito and Spurling. 1992. Cited in: United Nations. 2000a. *The World's Women 2000: Trends and Statistics.* Social Statistics and Indicators. Series K. No. 16. New York: Statistics Division, Department of Economic and Social Affairs, United Nations.
4. United Nations 2000a.
5. A detailed analysis of these multiple linkages is presented in: Seligman, Barbara, et al. 1997. *Reproductive Health and Human Capital: A Framework for Expanding Policy Dialogue*. POLICY Occasional Papers. No. 1. Washington, D.C.: The POLICY Project, The Futures Group International.
6. World Health Organization. 1999. *World Health Report 1999: Making a Difference*, pp. 8f. Geneva: World Health Organization.
7. A review of the complex pattern of observed effects is presented in: UNFPA. 1999. *The State of World Population 1999: 6 Billion: A Time for Choices.* New York: UNFPA; and Hardee, Karen, and Janet Smith. 2000. *Implementing Reproductive Health Services in an Era of Health Sector Reform*. POLICY Occasional Papers. No. 4. Washington, D.C.: The POLICY Project, The Futures Group International.
8. UNFPA and the Australian National University. 1999. *Southeast Asian Populations in Crisis: Challenges to the Implementation of the ICPD Programme of Action*. New York: Data Communique.
9. See this report's statistical tables. For an extended discussion, see: United Nations. 2000b. *World Population Monitoring: 2000: Population, Gender and Development* (ESA/P/WP.159). Draft paper. New York: Population Division, Department of Economic and Social Affairs, United Nations.
10. Estimates for around 1990, presented in: World Health Organization 1999.
11. United States General Accounting Office. 2000. *Women's Health: NIH Has Increased Its Efforts to Include Women in Research* (GAO/HEHS-00-96).

Report to Congressional Requesters. Washington, D.C.: United States General Accounting Office.

12. Various methodologies have been devised to monetize lost life. These frequently rely on calculations of the market value of labour contributions foregone. As women's work is already insufficiently compensated such methodologies fail. Whether for men or women, such approaches miss the range of non-monetary contributions to household and family welfare.
13. For detailed discussion, see: Reed, Holly E., Marjorie A. Koblinsky, and W. Henry Mosley (eds.). 2000. *The Consequences of Maternal Morbidity and Maternal Mortality: Report of a Workshop*. Committee on Population, Commission on Behavioral and Social Sciences and Education, National Research Council. Washington, D.C.: National Academy Press.
14. Family well-being is strongly affected by the death of a prime-aged female adult in a household, even if she is not the mother.
15. Ainsworth, M., and I. Semali. 1998. "The Impact of Adult Deaths on the Nutritional Status of Children." In: *Coping with AIDS: The Economic Impact of Adult Mortality on the African Household*, ch. 9, by the World Bank. Washington, D.C.: The World Bank. Cited in Reed, Koblinsky, and Mosley 2000.
16. Basu, Alaka. 1998. "The Household Impact of Adult Mortality and Morbidity." Unpublished paper presented at the Workshop on the Consequences of Pregnancy, Maternal Morbidity, and Mortality for Women, Their Families, and Society, Committee on Population, Washington, D.C., 19-20 October 1998. Ithaca, New York: Division of Nutritional Sciences, Cornell University.
17. United Nations. 2000c. "General Committee Recommends Agenda Item on HIV/AIDS" (GA/9708). Press release. New York: United Nations.
18. The World Bank. 1997. *Confronting AIDS: Public Priorities in a Global Epidemic*. A World Bank Policy Research Report. New York: Oxford University Press.
19. The estimated package included mass media and in-school education programmes, promotion of voluntary abstinence and responsible sexual behaviour and expanded distribution of condoms. It did not include the costs of ensuring a safe blood supply and targeted outreach to high-risk populations. Costs related to the cure of STDs (including mother-to-child transmission) were included in the basic reproductive health package. Care for those infected was recognized as an additional cost but specific estimates were not produced (paragraph 13.17).
20. Figures cited by: the End-Violence Discussion "Virtual Working Group" Web forum moderators, 16 July 1999. See: <www.globalknowledge.org/discussion.html>.
21. Figures are in U.S. dollars. See: Kerr, Richard, and Janice McLean. 1996. *Paying for Violence: Some of the Costs of Violence Against Women in B. C.: Prepared for the Ministry of Women's Equality: Province of British Columbia: May 1996*. Victoria, British Columbia: Ministry of Women's Equality, Government of British Columbia. Web site: <www.weq.gov.bc.ca/paying-for-violence>.
22. See, respectively: Kavemann, B. 1997. "Gesellschaftliche Folgekosten sexualisierter Gewalt gegen Mädchen und Jungen." In: *Bundesverein zu Prävention, Prävention — Eine Investition in die Zukunft*, by B. Kavemann, pp. 215-256; Korf, D. F., et al. 1996. *Economishe Kosten van Thisgeweld Gegen Vrouwen*; Snively, S. 1994. *The New Zealand Economic Costs of Family Violence*. Auckland, New Zealand: Coopers and Lybrand; Yadanis, C. L., et al. 1999. *Report on the Economic Costs of Violence Against Women*. Fribourg, Switzerland: University of Fribourg; Stanko, A., et al. 1998. *Counting the Costs: Estimating the Impact of Domestic Violence in the London Borough of Hackney*. London: Crime Concern.
23. Murray, Christopher J. L., and Alan D. Lopez (eds.). 1996. *The Global Burden of Disease*. Global Burden of Disease and Injury Series, vol. 1. Cambridge, Massachusetts: Harvard University Press.
24. "Abortion regret" must be set against the impact of unwanted pregnancies and childbearing on both mothers and their children. For studies on the long-term consequences for a child of being unwanted, see: Montgomery, Mark R., et al. 1997. *The Consequences of Imperfect Fertility Control for Children's Survival, Health, and Schooling*. Demographic and Health Survey. Analytical Report. No. 7. Calverton, Maryland: Macro International; Myhrman, Antero, et al., 1994. "Does the Wantedness of a Pregnancy Predict a Child's Educational Attainment?" *Family Planning Perspecives* 27(3): 116-119. New York: The Alan Guttmacher Institute; Baydar, Nazli. 1995. "Consequences for Children of Their Birth Planning Status." *Family Planning Perspectives* 27(6): 228-234, 245. New York: The Alan Guttmacher Institute; Brown, Sarah, and Leon Eisenberg (eds.). 1995. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*. Washington, D.C.: National Academy Press; and the more recent studies in: Kost, Kathryn, David J. Landry, and Jacqueline E. Darroch. 1998. "The Effects of Pregnancy Planning Status on Birth Outcomes and Infant Care." *Family Planning Perspectives* 30(5): 223-230. Prevention of unwanted pregnancy and unsafe abortion is an important public health goal.
25. These statistics are from: Murray and Lopez 1996. Their estimates for 1990 suggest that occupational risks are as large a contributor to global risk as unsafe sex.
26. Hill, M. Anne, and Elizabeth M. King. 1993. "Women's Education in Developing Countries: An Overview." In: *Women's Education in Developing Countries: Barriers, Benefits and Policies*, A World Bank Book, edited by Elizabeth M. King and M. Anne Hill. 1993. Baltimore, Maryland: Johns Hopkins University Press.
27. Dollar, David, and Roberta Gotti. 1999. *Gender Inequality, Income and Growth: Are Good Times Good for Women?* Policy Research Report on Gender and Development. Working Paper Series. No. 1. Washington, D.C.: The World Bank. Web site: <www.worldbank.org/gender/prr>.
28. These analyses also include now standard measures related to governance and openness of societies, initial income levels, fertility and life expectancy.
29. Difficulties in estimating these returns are found in the work of: Schultz, T. Paul. 1993. "Returns to Women's Education." In: King and Hill 1993; and Behrman, Jere R. 1996. "Measuring the Effectiveness of Schooling Policies in Developing Countries: Revisiting Issues of Methodology." Background paper prepared for the World Bank.
30. See, for example: Quisumbing, Agnes R., and John A. Maluccio. 1999. *Intrahousehold Allocation and Gender Relations: New Empirical Evidence*. Policy Research Report on Gender and Development. Working Paper Series. No. 2. Washington, D.C.: Development Research Group/Poverty Reduction and Economic Management Network, The World Bank.
31. Filmer, Deon, and Lant Pritchett. 1999. "The Effects of Household Wealth on Educational Attainment: Evidence from 35 Countries." *Population and Development Review* 25(1): 85-120. New York: The Population Council; and Filmer, Deon. 1999. *The Structure of Social Disparities in Education: Gender and Wealth*. Policy Research Report on Gender and Development. Working Paper Series. No. 5. Washington, D.C.: The World Bank. Web site: <www.worldbank.org/gender/publications>.
32. Information compiled for: United Nations 2000a.
33. Gardner, Robert. 1998. *Education*. Demographic and Health Surveys, Comparative Studies No. 29. Calverton, Maryland: Macro International.
34. Alderman, Harold, et al. 1996. "Decomposing the Gender Gap in Cognitive Skills in a Poor Rural Economy." *The Journal of Human Resources* 31(1): 229.
35. See: The World Bank. 2000. *Advancing Gender Equality: World Bank Action Since Beijing*. Washington, D.C.: The World Bank. Web site: <www.worldbank.org/gender/publications>.
36. Noteworthy among these being the International Center for Research on Women (ICRW) and the Centre for Development and Population Activities (CEDPA).
37. For various views, see: Hashemi, Syed M., and Sidney Ruth Schuler. 1997. "Sustainable Banking with the Poor: A Case Study of Grameen Bank." Report prepared for Grameen Trust and John Snow, Inc.; Rahman, Aminur. 1999. *Women and Microcredit in Rural Bangladesh: Anthropological Study of the Rhetoric and Realities of Grameen Bank Lending*. Boulder, Colorado: Westview Press; Pitt, Mark M., et al. 1999. "Credit Programmes for the Poor and Reproductive Behavior in Low-Income Countries: Are the Reported Causal Relationships the Result of Heterogeneity Bias?" *Demography* 36(1): 1-21; Mehra, Rekha, and Sarah Gammage. 1997. *Employment and Poor Women: A Policy Brief on Trends and Strategies*. Washington, D.C.: International Center for Research on Women (ICRW); and Khan, Mahmuda Rahman. 1996. *Empowering Women Through Wage Employment: The Impact on Gender Relations in Bangladesh*. ICRW Report-in-Brief. Washington, D.C.: International Center for Research on Women (ICRW).
38. Malhotra, Anju, and Rekha Mehra. 1999. *Fulfilling the Cairo Commitment: Enhancing Women's Economic and Social Options for Better Reproductive Health: Recommendations*. Washington, D.C.: International Center for Research on Women (ICRW); Mehra and Gammage 1997; and Khan 1996.
39. For the percentage due to population factors, see: Asian Development Bank. 1997. *Emerging Asia: Changes and Challenges*. Manila, the Philippines: Asian Development Bank; and, for the income growth in purchasing power parity dollars, see: Klasen, Stephan. 1999. *Does Gender Inequality Reduce Growth and Development: Evidence from Cross-Country Regressions*. Policy Research Report on Gender and Development. Working Paper Series. No. 7. Washington, D.C.: The World Bank. Web site: <www.worldbank.org/gender/prr>.
40. For an extended discussion of male and female longevity differences, see: United Nations 2000b.
41. The marriage benefit in life expectancy (as in life satisfaction and other subjective dimensions) is believed to be due in part to women's support to their partner's well-being.
42. These mothers' pension benefits have been restricted both in countries with large aged populations (such as Ecuador) and in those reforming their systems in anticipation of future fiscal challenges. Details are provided in the report of the ECLAC/PAHO/CELADE/UNFPA regional meeting, "The Latin American and Caribbean Symposium on Older Persons," Santiago, Chile, 8-10 September 1999.
43. Data from: United Nations 2000a.
44. This is reflected in many settings in lower rates of co-residence with children and, consequently, higher rates of single person residence among older women. In less-developed regions, extended family care may remain normative and common, though the quality of care for older women may suffer. Monitoring of the condition of older persons — women and men — needs to be improved. Individual country data, however, indicate a growing problem concerning the quality and reliability of old-age support (see, for example, studies in: International Research and Training Institute for the Advancement of Women (INSTRAW). 1999. *Ageing in a Gendered World: Women's Issues and Identities*. Dominican Republic: International Research and Training Institute for the Advancement of Women).
45. See: Varley, Ann, and Maribel Blasco. 1999. "Reaping What You Sow: Older Women, Housing and Family Dynamics in Urban Mexico." In: International Research and Training Institute for the Advancement of Women (INSTRAW) 1999, pp. 153-178.
46. See: United Nations 2000b; and UNFPA. 1998a. *The State of World Population 1998: The New Generations*. New York: UNFPA, and the references cited therein.
47. See the extended discussion in: United Nations 2000b, pp. 91-97.
48. This measure has undergone a series of technical revisions since it was first introduced. Measures from different time points are not, therefore, always directly comparable.
49. The income variable uses share of earned income going to men and women and is subject to considerable reporting difficulties.

50. These ratings use a standard international job classification of the International Labour Organization (ILO).
51. Not every country surveys identical issues. Core topics include: background characteristics; lifetime reproduction; contraceptive knowledge and use; maternity and breastfeeding; immunization of children; diarrhoea, fever and cough in children; height and weight of children; marriage; fertility preferences; husband's background; and woman's work status. Many studies undertaken under other programme auspices, including UNFPA-funded national and regional studies, have adopted elements of these core modules. Specialized modules have been developed for: consanguinity; domestic violence; female genital mutilation; health expenditures; HIV/AIDS; malaria; maternal mortality; pill failure and behaviour; social marketing of contraceptives; sterilization experience; verbal autopsy (i.e., causes of maternal mortality); and women's status.
52. Kishor, Sunita, and Katherine Neitzel. 1996. *The Status of Women: Indicators for Twenty-Five Countries.* Demographic and Health Surveys. Comparative Studies Series. No. 21. Calverton, Maryland: Macro International.
53. New modules to address these concerns have been developed and are available for adaptation and use in future surveys. (For further details, see the Web site for the Demographic and Health Surveys: <www.macroint.com/dhs/>).
54. Longwe, Sara, and Roy Clarke. 1999. "Towards Improved Leadership for Women's Empowerment in Africa: Measuring Progress and Improving Strategy." Final draft paper prepared for the Africa Leadership Forum, Accra, Ghana, April 1999.
55. UNFPA. 1998b. *Indicators for Population and Reproductive Health Programmes.* New York: UNFPA.
56. UNFPA. 2000. *The Multi-Year Funding Framework: 2000-2003: Report of the Executive Director* (DP/FPA/2000/6). New York: UNFPA.
57. See: United Nations Development Fund for Women. 2000. *Targets and Indicators: Selections from Progress of the World's Women.* New York: United Nations Development Fund for Women; and United Nations. 1999. "Guidelines: Common Country Assessment (CCA)." New York: United Nations Development Group.
58. United Nations Development Fund for Women 2000.
59. *The State of World Population* has regularly reported most of these measures in its statistical appendix for several years, as have other United Nations organization flagship reports.
60. Some profiles have been posted on their Web site: <www.worldbank.org/gender>.
61. Additional technical issues contribute to an underestimation of women's disease burden. See: Anand, Sudhir, and Kara Hanson. 1997. "Disability-adjusted Life Years: A Critical Review." *Journal of Health Economics* 16: 685-702.

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Chapter 7

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Monitoring ICPD Goals — Selected Indicators

	Indicators of Mortality			Indicators of Education				Reproductive Health Indicators				
	Infant mortality Total per 1,000 live births	Life expectancy M / F	Maternal mortality ratio	Primary enrolment (gross) M / F	Proportion reaching grade 5 M / F	Secondary enrolment (gross) M / F	% Illiterate (>15 years) M / F	Contraceptive knowledge % knowing method	Contraceptive knowledge % knowing source	Births per 1,000 women aged 15-19	Contraceptive prevalence Any method	Contraceptive prevalence Modern methods
World Total	**57**	**63.3 / 67.6**								**65**	**58**	**50**
More-developed regions (*)	**9**	**71.1 / 78.7**								**31**	**70**	**51**
Less-developed regions (+)	**63**	**61.8 / 65.0**								**71**	**55**	**50**
Least-developed countries (‡)	**99**	**49.6 / 51.5**								**128**		
Africa (1)	**87**	**50.0 / 52.8**								**119**	**20**	**16**
Eastern Africa	**101**	**44.4 / 46.4**								**132**		
Burundi	119	41.0 / 43.8		55 / 46	76 / 78	8 / 5	44 / 61	70	62	55	9	1
Eritrea	91	49.3 / 52.4	1,000	59 / 48	73 / 67	24 / 17	34 / 57			119	5	4
Ethiopia	116	42.4 / 44.3		55 / 30	51 / 50	14 / 10	57 / 68	63		152	4	2
Kenya	66	51.1 / 53.0	590	85 / 85	60 / 62	26 / 22	12 / 25	96	88	95	33	28
Madagascar	83	56.0 / 59.0	490	92 / 91	49 / 33	16 / 16	27 / 41		45	137	17	5
Malawi	138	38.9 / 39.6	620	140 / 127	38 / 48	21 / 12	26 / 55	90	80	162	22	14
Mauritius (2)	16	67.9 / 75.1	50	106 / 106	98 / 99	63 / 66	12 / 19	100		37	75	49
Mozambique	114	43.9 / 46.6		70 / 50	52 / 39	9 / 5	41 / 73			128	6	6
Rwanda	124	39.4 / 41.7		83 / 80	58 / 60	12 / 9	27 / 41	98	86	56	21	13
Somalia	122	45.4 / 48.6								213		
Uganda	107	38.9 / 40.4	510	81 / 68	82 / 73	15 / 9	23 / 44	82	74	180	15	8
United Republic of Tanzania	82	46.8 / 49.1	530	67 / 66	78 / 84	6 / 5	16 / 34	74	66	125	18	13
Zambia	82	39.5 / 40.6	650	91 / 86	89 / 84	34 / 21	15 / 30	89	81	134	25	14
Zimbabwe	69	43.6 / 44.7	400	115 / 111	78 / 79	52 / 45	8 / 16	96	93	89	48	42
Middle Africa (3)	**95**	**48.6 / 51.7**								**196**		
Angola	125	44.9 / 48.1		96 / 88		18 / 9				219		
Cameroon	74	53.4 / 56.0	430	93 / 84	64 / 69	32 / 22	19 / 32	72	54	140	16	4
Central African Republic	98	42.9 / 46.9	1,100	69 / 45	39 / 32	15 / 6	41 / 67			142	15	3
Chad	112	45.7 / 48.7	830	76 / 39	62 / 53	15 / 4	50 / 68			185		
Congo, Democratic Republic of (4)	90	49.2 / 52.3		86 / 59	68 / 58	32 / 19				217	8	2
Congo, Republic of	90	46.3 / 50.8		120 / 109	40 / 78	62 / 45	14 / 27			141		
Gabon	87	51.1 / 53.8			58 / 61					172		
Northern Africa (5)	**52**	**63.3 / 66.4**								**50**		
Algeria	44	67.5 / 70.3		113 / 102	93 / 95	65 / 62	23 / 44	99		25	52	49
Egypt	51	64.7 / 67.9	170	108 / 94	95 / 93	83 / 73	34 / 57	100	93	65	47	46
Libyan Arab Jamahiriya	28	68.3 / 72.2	75	110 / 111		61 / 57	10 / 33			56	40	26
Morocco	51	64.8 / 68.5	230	97 / 74	76 / 74	44 / 34	39 / 65	99	94	50	50	42
Sudan	71	53.6 / 56.4		55 / 47	90 / 95	23 / 20	31 / 55	71	60	52	8	6
Tunisia	30	68.4 / 70.7	70	122 / 114	90 / 92	66 / 63	20 / 41	99	97	13	60	51
Southern Africa	**62**	**51.5 / 57.5**								**71**		
Botswana	59	46.2 / 48.4	330	107 / 108	87 / 93	61 / 68	26 / 21	95	95	78	33	32
Lesotho	93	54.7 / 57.3		102 / 114	72 / 87	25 / 36	28 / 7	79		86	23	19
Namibia	65	51.8 / 53.0	230	129 / 132	76 / 82	58 / 67	18 / 20	89	78	105	29	26
South Africa	59	51.5 / 58.1		135 / 131	72 / 79	88 / 103	14 / 16			68	50	49
Western Africa (6)	**90**	**48.6 / 51.3**								**136**		
Benin	88	51.7 / 55.2	500	98 / 57	64 / 57	26 / 11	45 / 76	40		116	16	3
Burkina Faso	99	43.6 / 45.2		48 / 31	74 / 77	11 / 6	67 / 87	66	30	157	8	4
Côte d'Ivoire	87	46.2 / 47.3	600	82 / 60	77 / 71	34 / 16	46 / 63	26		133	11	5
Ghana	66	58.3 / 61.8		81 / 69	81 / 79	44 / 28	21 / 39	76	70	113	20	10
Guinea	124	46.0 / 47.0		68 / 41	85 / 68	20 / 7				193	2	1
Guinea-Bissau	130	43.5 / 46.5	910	79 / 45		10 / 4	42 / 82			190		
Liberia	116	46.1 / 48.5		51 / 28		31 / 13	31 / 64	72	48	213	6	5
Mali	118	52.0 / 54.6	580	58 / 40	87 / 82	17 / 8	53 / 67	42	30	181	7	5
Mauritania	92	51.9 / 55.1		84 / 75	61 / 68	21 / 11	48 / 68	61		135	3	1
Niger	115	46.9 / 50.1	590	36 / 23	72 / 73	9 / 5	77 / 92	76	33	199	4	2
Nigeria	81	48.7 / 51.5		109 / 87		36 / 30	29 / 46	46	34	121	6	3
Senegal	63	50.5 / 54.2	560	78 / 65	89 / 85	20 / 12	54 / 73	74	44	119	13	8
Sierra Leone	170	35.8 / 38.7		60 / 41		22 / 13		78		202		
Togo	84	47.6 / 50.1	480	140 / 99	74 / 58	40 / 14	27 / 60	94	81	120	12	3
Asia	**57**	**64.8 / 67.9**								**57**	**60**	**56**
Eastern Asia (7)	**38**	**68.8 / 73.4**								**5**		
China	41	67.9 / 72.0	65	122 / 123	93 / 94	74 / 66	9 / 25			5	83	83
Democratic People's Republic of Korea	22	68.9 / 75.1	110							2	62	53
Hong Kong, China (8)	6	75.8 / 81.4		93 / 95	99 / 100	71 / 76	4 / 10	98		7	86	79
Japan	4	76.8 / 82.9	8	101 / 101	100 / 100	103 / 104				4	59	53

Monitoring ICPD Goals — Selected Indicators

	Indicators of Mortality			Indicators of Education				Reproductive Health Indicators				
	Infant mortality Total per 1,000 live births	Life expectancy M / F	Maternal mortality ratio	Primary enrolment (gross) M / F	Proportion reaching grade 5 M / F	Secondary enrolment (gross) M / F	% Illiterate (>15 years) M / F	Contraceptive knowledge % knowing method	Contraceptive knowledge % knowing source	Births per 1,000 women aged 15-19	Contraceptive prevalence Any method	Contraceptive prevalence Modern methods
Mongolia	51	64.4 / 67.3	150	86 / 91		48 / 65				47	61	25
Republic of Korea	10	68.8 / 76.0	20	94 / 95	98 / 99	102 / 102	1 / 4	100	94	4	79	69
South-eastern Asia	**46**	**63.7 / 67.8**								**48**		
Cambodia	103	51.5 / 55.0		123 / 104	51 / 46	31 / 17				14		
Indonesia	48	63.3 / 67.0	450	115 / 110	88 / 89	55 / 48	9 / 19	95	93	58	55	52
Lao People's Democratic Republic	93	52.0 / 54.5	650	123 / 101	57 / 54	34 / 23	37 / 68			104	19	15
Malaysia	11	69.9 / 74.3	39	101 / 101	98 / 100	59 / 69	9 / 17	99	94	25	48	31
Myanmar	79	58.5 / 61.8	230	122 / 117		29 / 30	11 / 20			26	17	14
Philippines	36	66.5 / 70.2	170	115 / 113	75 / 75	77 / 78	5 / 5	97	93	43	40	25
Singapore	5	74.9 / 79.3	6	95 / 93	100 / 100	69 / 65	4 / 12	98	95	7	74	73
Thailand	29	65.8 / 72.0	44	98 / 96		57 / 56	3 / 7	100	99	70	74	72
Viet Nam	38	64.9 / 69.6	160	115 / 111		48 / 46	5 / 9	95		27	65	44
South Central Asia	**73**	**61.8 / 62.9**								**103**		
Afghanistan	152	45.0 / 46.0		64 / 32	86 / 80	32 / 12	49 / 79	4		153	2	2
Bangladesh	79	58.1 / 58.2	440	77 / 66	18 / 26	25 / 13	48 / 71	100	98	115	49	41
Bhutan	63	59.5 / 62.0			81 / 84					71	19	
India	72	62.3 / 62.9	410	109 / 90	62 / 55	59 / 39	32 / 56	95		112	41	37
Iran (Islamic Republic of)	35	68.5 / 70.0	37	102 / 95	92 / 89	81 / 73	17 / 31	91		29	65	45
Nepal	83	57.6 / 57.1	540	129 / 96	52 / 52	51 / 33	42 / 77	93	80	120	29	26
Pakistan	74	62.9 / 65.1		101 / 45		33 / 17	41 / 70	78	46	90	18	13
Sri Lanka	18	70.9 / 75.4	60	110 / 108	83 / 84	72 / 78	6 / 11	99	98	20	66	43
Western Asia (9)	**51**	**65.9 / 70.2**								**57**		
Iraq	95	60.9 / 63.9		92 / 78	84 / 84	51 / 32	35 / 55			45	14	11
Israel	8	75.7 / 79.7	5	96 / 96		89 / 87	2 / 6			19		
Jordan	26	68.9 / 71.5	41		98 / 99		6 / 17	100	95	43	35	27
Kuwait	12	74.1 / 78.2	5	78 / 77		64 / 66	16 / 21			34	35	32
Lebanon	29	68.1 / 71.7	100	113 / 108		78 / 84	8 / 20	91		26	53	18
Oman	25	68.9 / 73.3	19	78 / 74	96 / 96	68 / 66	21 / 41			80	22	19
Saudi Arabia	23	69.9 / 73.4		77 / 75	87 / 92	65 / 57	17 / 34			113		
Syrian Arab Republic	33	66.7 / 71.2		106 / 96	93 / 94	45 / 40	12 / 41	78		44	36	28
Turkey (10)	45	66.5 / 71.7		111 / 104	92 / 93	68 / 48	7 / 24	99	95	44	63	35
United Arab Emirates	16	73.9 / 76.5	3	91 / 87	98 / 98	77 / 82	26 / 22			73	27	24
Yemen	80	57.4 / 58.4	350	100 / 40		53 / 14	34 / 76	60	27	102	13	10
Europe	**12**	**69.2 / 77.4**								**25**	**72**	**46**
Eastern Europe	**18**	**63.3 / 73.9**								**38**		
Bulgaria	17	67.6 / 74.7	15	100 / 98	91 / 90	77 / 76	1 / 2			49	76	7
Czech Republic	6	70.3 / 77.4	9	105 / 103		97 / 100				23	69	45
Hungary	10	66.8 / 74.9	15	104 / 102	98 / 98	96 / 99	1 / 1			28	73	59
Poland	15	68.2 / 76.9	8	97 / 95		98 / 97	0 / 0			23	75	26
Romania	23	66.2 / 73.9	41	104 / 103		79 / 78	1 / 3			36	57	14
Slovakia	11	69.2 / 76.7	9	102 / 102		92 / 96				32	74	42
Northern Europe (11)	**8**	**73.5 / 79.5**								**24**		
Denmark	7	73.0 / 78.3	10	102 / 101	100 / 99	120 / 122				9	78	71
Estonia	19	63.0 / 74.5	50	95 / 93	96 / 97	100 / 108				38	70	56
Finland	6	73.0 / 80.6	6	98 / 99	100 / 100	110 / 125				10	80	77
Ireland	7	73.6 / 79.2	6	105 / 104	100 / 100	113 / 122				19		
Latvia	18	62.5 / 74.4	45	98 / 93		82 / 85	0 / 0			27	48	39
Lithuania	21	64.3 / 75.6	18	99 / 96		85 / 88	0 / 1			37	59	20
Norway	5	75.2 / 81.1	6	100 / 100	100 / 100	121 / 116				13	74	69
Sweden	5	76.3 / 80.8	5	106 / 107	97 / 97	128 / 153				7	78	71
United Kingdom	7	74.5 / 79.8	7	115 / 116		120 / 139				29	82	78
Southern Europe (12)	**10**	**73.7 / 80.1**								**14**		
Albania	30	69.9 / 75.9		106 / 108	81 / 83	37 / 38	8 / 24			34		
Bosnia & Herzegovina	15	70.5 / 75.9	10							28		
Croatia	10	68.8 / 76.5	12	88 / 87		81 / 83	1 / 3			19		
Greece	8	75.6 / 80.7	1	93 / 93	99 / 100	95 / 96	2 / 4			13		
Italy	7	75.0 / 81.2	7	101 / 100	98 / 99	94 / 95	1 / 2			7	78	32
Macedonia (Former Yugoslav Republic of)	23	70.9 / 75.3	11	100 / 98	95 / 95	64 / 62				42		
Portugal	9	71.8 / 78.9	8	131 / 124		106 / 116	6 / 11			20	66	32
Slovenia	7	70.6 / 78.2	11	98 / 98		90 / 93	0 / 0			17		
Spain	7	74.5 / 81.5	6	109 / 108	98 / 99	116 / 123	1 / 3			8	59	37
Yugoslavia	18	70.2 / 75.5	10	69 / 70		60 / 64				39	55	12

Monitoring ICPD Goals — Selected Indicators

	Indicators of Mortality			Indicators of Education				Reproductive Health Indicators				
	Infant mortality Total per 1,000 live births	Life expectancy M / F	Maternal mortality ratio	Primary enrolment (gross) M / F	Proportion reaching grade 5 M / F	Secondary enrolment (gross) M / F	% Illiterate (>15 years) M / F	Contraceptive knowledge % knowing method	Contraceptive knowledge % knowing source	Births per 1,000 women aged 15-19	Contraceptive prevalence Any method	Contraceptive prevalence Modern methods
Western Europe (13)	**6**	**74.1 / 80.8**								**10**		
Austria	6	73.7 / 80.2		100 / 100		105 / 102				18	71	56
Belgium	7	73.8 / 80.6		104 / 102		142 / 151				11	79	75
France	6	74.2 / 82.0	10	106 / 104		112 / 111				9	75	70
Germany	5	73.9 / 80.2	8	104 / 104		105 / 103				11	75	72
Netherlands	6	75.0 / 80.7	7	109 / 107	93 / 96	134 / 129				4	79	76
Switzerland	6	75.4 / 81.8	5							4	71	65
Latin America & Caribbean	**36**	**66.1 / 72.6**								**76**	**66**	**57**
Caribbean (14)	**36**	**66.3 / 71.0**								**74**		
Cuba	9	74.2 / 78.0	27	108 / 104		76 / 85	3 / 4	100		65	70	68
Dominican Republic	34	69.0 / 73.1		94 / 94		47 / 61	17 / 17	100	96	89	64	60
Haiti	68	51.4 / 56.2		49 / 46	47 / 46	21 / 20	49 / 53	81	66	70	18	13
Jamaica	22	72.9 / 76.8		100 / 99	93 / 98	63 / 67	18 / 10	99		91	62	58
Puerto Rico	12	69.4 / 78.5					7 / 6			70	64	57
Trinidad & Tobago	15	71.5 / 76.2		99 / 98	98 / 99	72 / 75	1 / 3	97	96	40	53	45
Central America	**33**	**68.4 / 74.0**								**81**		
Belize	29	73.4 / 76.1		123 / 119	70 / 71	47 / 52	7 / 7	95		99	47	42
Costa Rica	12	74.3 / 78.9	29	104 / 103	86 / 89	47 / 52	5 / 4	100	99	85	75	65
El Salvador	32	66.5 / 72.5		98 / 96	76 / 77	35 / 39	19 / 24	98		95	53	48
Guatemala	46	61.4 / 67.2	190	93 / 82	52 / 47	27 / 25	24 / 40	70	64	119	31	26
Honduras	35	67.5 / 72.3	220	110 / 112	45 / 51	29 / 37	26 / 26	95		115	50	41
Mexico	31	69.5 / 75.5	48	116 / 113	85 / 86	64 / 64	7 / 11	91	72	70	67	58
Nicaragua	43	65.8 / 70.6	150	100 / 102	52 / 57	52 / 62	33 / 30	97		152	49	45
Panama	21	71.8 / 76.4	85	108 / 104	80 / 84	61 / 65	8 / 9	95		82	58	54
South America (15)	**37**	**65.3 / 72.3**								**73**		
Argentina	22	69.7 / 76.8	38	114 / 113		73 / 81	3 / 3			65		
Bolivia	66	59.8 / 63.2	390	99 / 90	63 / 58	40 / 34	8 / 21	73	66	79	45	17
Brazil	42	63.1 / 71.0	160	107 / 98		31 / 36	15 / 15	100	95	72	77	71
Chile	13	72.3 / 78.3	23	103 / 100	100 / 100	72 / 78	4 / 5			49		
Colombia	30	67.3 / 74.3	80	113 / 112	70 / 76	64 / 69	8 / 9	98	94	88	72	59
Ecuador	46	67.3 / 72.5	160	134 / 119	84 / 86	50 / 50	7 / 11	89	88	72	57	46
Paraguay	39	67.5 / 72.0	190	112 / 109	77 / 80	46 / 48	6 / 8	98	90	76	56	41
Peru	45	65.9 / 70.9	270	125 / 121	78 / 74	72 / 67	6 / 15	96	89	58	64	41
Uruguay	18	70.5 / 78.0	21	109 / 108	96 / 99	75 / 90	3 / 2			70		
Venezuela	21	70.0 / 75.7	65	90 / 93	86 / 92	33 / 46	7 / 8	98	68	98	49	37
Northern America (16)	**7**	**73.6 / 80.2**								**56**	**71**	**68**
Canada	6	76.1 / 81.8		103 / 101		105 / 105				23	75	74
United States of America	7	73.4 / 80.1	8	102 / 101		98 / 97				59	71	67
Oceania	**24**	**71.4 / 76.3**								**28**	**29**	**22**
Australia-New Zealand	6	75.2 / 80.9								22	76	72
Australia (17)	6	75.5 / 81.1		101 / 101		150 / 155				20	76	72
Melanesia (18)	53	59.9 / 62.2								34		
New Caledonia	11	69.2 / 76.3		127 / 123	96 / 94	95 / 106				55		
New Zealand	7	74.1 / 79.7	15	101 / 101	99 / 99	110 / 116				34	75	72
Papua New Guinea	61	57.2 / 58.7		87 / 74	72 / 74	17 / 11	30 / 44			24	26	20
Vanuatu	39	65.5 / 69.5		101 / 94	90 / 91	23 / 18				74		
Countries with Economies in Transition of the Former USSR (19)												
Armenia	26	67.2 / 73.6	35	87 / 91		100 / 79	1 / 2			41		
Azerbaijan	36	65.5 / 74.1	37	108 / 105		73 / 81				17		
Belarus	23	62.2 / 73.9	22	100 / 96		91 / 95	0 / 1			36	50	42
Georgia	20	68.5 / 76.8	70	89 / 88		78 / 76				47		
Kazakhstan	35	62.8 / 72.5	70	97 / 98		82 / 91				54	59	46
Kyrgyzstan	40	63.3 / 71.9	65	105 / 103		75 / 83				40		
Republic of Moldova	29	63.5 / 71.5	42	98 / 97		79 / 82	0 / 2			32	74	50
Russian Federation	18	60.6 / 72.8	50	108 / 107		84 / 91	0 / 1			45		
Tajikistan	57	64.2 / 70.2	65	96 / 94		83 / 74	0 / 1			35		
Turkmenistan	55	61.9 / 68.9	110							20		
Ukraine	19	63.8 / 73.7	25	87 / 87		88 / 95	0 / 1			36		
Uzbekistan	44	64.3 / 70.7	21	79 / 77		100 / 88	7 / 16			35	56	52

Demographic, Social and Economic Indicators

	Total population (millions) (2000)	Projected population (millions) (2025)	Avg. pop. growth rate (%) (1995-2000)	% urban (1995)	Urban growth rate (1995-2000)	Population/ ha arable and perm. crop land	Total fertility rate (1995-2000)	% births with skilled attendants	GNP per capita PPP$ (1998)	Per capita central govt. expenditures (PPP$) Education	Health	External population assistance (US$,000)	Under-5 mortality M / F	Per capita energy consumption	Access to safe water
World Total	**6,055.0**	**7,823.7**	**1.3**	**45**	**2.5**		**2.71**	**58**				**(1,632,053)**	**80 / 80**		
More developed regions (*)	**1,188.0**	**1,214.9**	**0.3**	**75**	**0.7**		**1.57**	**99**					**13 / 10**		
Less developed regions (+)	**4,867.1**	**6,608.8**	**1.6**	**38**	**3.3**		**3.00**	**53**					**87 / 88**		
Least developed countries (‡)	**644.7**	**1,092.6**	**2.4**	**22**	**5.2**		**5.05**						**160 / 151**		
Africa (1)	**784.4**	**1,298.3**	**2.4**	**34**	**4.3**		**5.06**	**42**				**463,855**[20]	**146 / 133**		
Eastern Africa	**247.0**	**426.2**	**2.6**	**22**	**5.3**		**5.79**	**34**					**169 / 154**		
Burundi	6.7	11.6	1.7	8	6.4	5.2	6.28	24	561	22.4	3.5	5,530	189 / 168		58
Eritrea	3.9	6.7	3.8	17	4.7	6.9	5.70	21	984	17.4	24.1	4,459	154 / 137		7
Ethiopia	62.6	115.4	2.5	13	5.1	4.6	6.30	8	566	22.5	9.8	29,130	193 / 174	284	26
Kenya	30.1	41.8	2.0	28	5.6	4.8	4.45	45	964	63.0	21.1	29,270	107 / 101	476	45
Madagascar	15.9	29.0	3.0	27	5.6	3.6	5.40	57	741	14.2	8.6	11,162	123 / 110		16
Malawi	10.9	20.0	2.4	14	4.6	4.6	6.75	55	551	29.6	14.9	22,654	223 / 217		60
Mauritius (2)	1.2	1.4	0.8	41	1.6	1.4	1.91	97	8,236	378.1	156.3	324	22 / 13		100
Mozambique	19.7	30.6	2.5	34	7.1	4.5	6.25	44	740		16.3	22,119	193 / 173	481	24
Rwanda	7.7	12.4	7.7	6	4.7	4.7	6.20	26				5,586	213 / 191		
Somalia	10.1	21.2	4.2	26	4.7	6.0	7.25	2				2,906	212 / 195		
Uganda	21.8	44.4	2.8	13	5.4	2.4	7.10	38	1,072	27.6	19.3	31,133	181 / 164		42
United Republic of Tanzania	33.5	57.9	2.3	24	5.7	6.2	5.48	38	483		6.0	35,037	138 / 123	453	49
Zambia	9.2	15.6	2.3	43	3.3	1.2	5.55	47	678	14.8	16.3	19,954	149 / 144	628	53
Zimbabwe	11.7	15.1	1.4	32	4.4	2.2	3.80	69	2,489		82.6	23,301	123 / 111	929	77
Middle Africa (3)	**95.7**	**184.7**	**2.7**	**33**	**4.5**		**6.17**	**42**					**158 / 139**		
Angola	12.9	25.1	3.2	32	5.6	2.4	6.80	17	999		71.1	5,443	217 / 199	532	32
Cameroon	15.1	26.5	2.7	45	4.7	1.1	5.30	58	1,395		15.0	6,647	120 / 109	369	41
Central African Republic	3.6	5.7	1.9	39	3.5	1.3	4.90	46	1,098		21.7	2,546	172 / 141		23
Chad	7.7	13.9	2.6	21	4.1	1.7	6.07	15	843	14.2	20.8	4,024	184 / 164		24
Congo, Democratic Republic of (4)	51.7	104.8	2.6	29	4.3	3.9	6.43		733		9.9	1,945	148 / 130	305	
Congo, Republic of	2.9	5.7	2.8	59	4.2	6.3	6.06	50	846	51.6	18.1	1,021	147 / 116	457	
Gabon	1.2	2.0	2.6	50	4.2	1.0	5.40	80	5,615	162.3	38.9	677	143 / 127	1403	67
Northern Africa (5)	**173.3**	**249.1**	**2.0**	**46**	**3.1**		**3.58**	**64**				**79,216**[21]	**73 / 67**		
Algeria	31.5	46.6	2.3	56	3.5	0.9	3.81	77	4,595	235.3	158.1	1,354	57 / 45	842	
Egypt	68.5	95.6	1.9	45	2.6	7.6	3.40	46	3,146	150.7	54.7	36,092	65 / 64	638	84
Libyan Arab Jamahiriya	5.6	8.6	2.4	86	3.9	0.2	3.80	94				11	32 / 31	2,935	95
Morocco	28.4	38.7	1.8	48	2.9	1.1	3.10	40	3,188	159.7	43.0	31,192	74 / 62	329	57
Sudan	29.5	46.3	2.1	25	4.7	1.0	4.61	86	1,240	10.8		3,931	115 / 108	397	60
Tunisia	9.6	12.8	1.4	57	2.6	0.5	2.55	81	5,169	397.0	162.1	2,797	38 / 36	735	90
Southern Africa	**46.9**	**55.9**	**1.6**	**48**	**3.3**		**3.43**	**79**					**102 / 82**		
Botswana	1.6	2.2	1.9	28	6.3	2.0	4.35	77	5,796	500.8	165.8	2,505	112 / 101		70
Lesotho	2.2	3.5	2.2	23	5.8	2.4	4.75	50	2,194	185.0	60.2	1,050	132 / 127		62
Namibia	1.7	2.3	2.2	37	5.3	1.0	4.90	68	5,280	479.9	195.2	2,265	125 / 119		60
South Africa	40.4	46.0	1.5	51	3.0	0.4	3.25	82	8,296	659.5	271.5	20,263	98 / 76	2,482	59
Western Africa (6)	**221.7**	**382.5**	**2.5**	**37**	**4.9**		**5.47**	**35**					**162 / 149**		
Benin	6.1	11.1	2.7	31	4.6	2.0	5.80	60	857	27.2	13.7	5,808	142 / 124	341	72
Burkina Faso	11.9	23.3	2.7	27	8.9	3.0	6.57	41	866	12.8	10.7	9,133	176 / 166		
Côte d'Ivoire	14.8	23.3	1.8	44	4.7	1.0	5.10	45	1,484	74.3	22.4	8,279	144 / 129	382	72
Ghana	20.2	36.9	2.7	36	4.4	2.3	5.15	44	1,735	72.2	31.4	16,050	107 / 95	380	65
Guinea	7.4	12.5	0.8	30	5.5	4.2	5.51	31	1,722	32.7	21.8	10,443	207 / 208		55
Guinea-Bissau	1.2	1.9	2.2	22	4.6	2.7	5.75	25	573		6.9	1,802	214 / 192		53
Liberia	3.2	6.6	8.2	45	4.5	5.1	6.31	58				934	184 / 163		
Mali	11.2	21.3	2.4	27	5.4	1.9	6.60	24	673	14.9	13.7	12,779	244 / 227		48
Mauritania	2.7	4.8	2.7	54	4.3	2.6	5.50	40	1,500	75.9	28.5	1,045	155 / 142		64
Niger	10.7	21.5	3.2	17	5.8	1.7	6.84	15	729	16.9	10.0	6,473	198 / 181		48
Nigeria	111.5	183.0	2.4	39	4.8	1.2	5.15	31	740	5.2	1.4	18,678	154 / 140	722	50
Senegal	9.5	16.7	2.6	42	4.0	2.9	5.57	47	1,297	48.5	33.9	9,571	117 / 112	302	50
Sierra Leone	4.9	8.1	3.0	36	4.4	5.2	6.06	25	445		7.8	400	277 / 248		34
Togo	4.6	8.5	2.6	31	4.8	1.1	6.05	32	1,352	61.0	15.3	2,073	137 / 120		55
Asia	**3,682.6**	**4,723.1**	**1.4**	**35**	**3.2**		**2.60**	**54**				**365,118**	**71 / 77**		
Eastern Asia (7)	**1,485.2**	**1,695.4**	**0.9**	**37**	**2.9**		**1.77**	**86**					**39 / 50**		
China	1,277.6	1,480.4	0.9	30	3.6	6.3	1.80	85	3,051	71.1	61.2	4,110	43 / 54	902	83
Democratic People's Republic of Korea	24.0	29.4	1.6	61	2.3	3.7	2.05	100				2,337	27 / 25	1,063	100
Hong Kong, China (8)	6.9	7.7	2.1	95	0.5	6.0	1.32	100	20,763	606.3	436.4	19	8 / 6	1,931	
Japan	126.7	121.2	0.2	78	0.4	1.4	1.43	100	23,592	849.3	1,362.0	(93,760)[22]	6 / 5	4,058	96

Demographic, Social and Economic Indicators

	Total population (millions) (2000)	Projected population (millions) (2025)	Avg. pop. growth rate (%) (1995-2000)	% urban (1995)	Urban growth rate (1995-2000)	Population/ ha arable and perm. crop land	Total fertility rate (1995-2000)	% births with skilled attendants	GNP per capita PPP$ (1998)	Per capita central govt. expenditures (PPP$) Education	Health	External population assistance (US$,000)	Under-5 mortality M / F	Per capita energy consumption	Access to safe water
Mongolia	2.7	3.7	1.7	61	2.9	0.5	2.60	99	1,463	83.0	66.9	971	72 / 75		54
Republic of Korea	46.8	52.5	0.8	81	2.1	2.5	1.65	95	13,286	488.9	341.7	119	13 / 13	3,576	83
South-eastern Asia	**518.5**	**683.5**	**1.5**	**34**	**3.7**		**2.69**	**54**					**66 / 57**		
Cambodia	11.2	16.5	2.3	21	5.6	2.0	4.60	31	1,246	35.7	7.3	19,756	141 / 127		13
Indonesia	212.1	273.4	1.4	35	4.1	3.0	2.58	36	2,407	33.2	16.7	32,152	69 / 56	672	65
Lao People's Democratic Republic	5.4	9.7	2.6	22	5.7	4.5	5.75	30	1,683	35.9	21.5	3,409	154 / 146		51
Malaysia	22.2	31.0	2.0	54	3.4	0.5	3.18	98	7,699	381.1	108.0	843	16 / 13	1,950	89
Myanmar	45.6	58.1	1.2	26	3.7	3.1	2.40	57				884	121 / 104	294	60
Philippines	76.0	108.3	2.1	54	3.7	3.1	3.62	53	3,725	127.4	59.4	47,906	49 / 38	528	83
Singapore	3.6	4.2	1.4	100	0.8	7.0	1.68	100	25,295	753.8	274.3	8	6 / 6	7,835	100
Thailand	61.4	72.7	0.9	20	2.8	1.5	1.74	71	5,524	266.2	90.3	8,490	37 / 33	1333	89
Viet Nam	79.8	108.0	1.6	21	3.5	7.3	2.60	79	1,689	51.2	6.6	16,358	54 / 57	448	47
South Central Asia	**1,490.8**	**2,049.9**	**1.8**	**29**	**3.4**		**3.36**	**34**					**91 / 101**		
Afghanistan	22.7	44.9	2.9	20	7.7	1.8	6.90	8				1,060	257 / 257		
Bangladesh	129.2	178.8	1.7	18	5.2	8.7	3.11	8	1,407	31.4	21.3	93,145	106 / 116	197	84
Bhutan	2.1	3.9	2.8	6	6.3	11.4	5.50	12	1,438			1,076	98 / 94		
India	1,013.7	1,330.4	1.6	27	3.0	3.2	3.13	35	2,060	65.5	13.4	45,648	82 / 97	476	85
Iran (Islamic Republic of)	67.7	94.5	1.7	59	3.0	1.0	2.80	74	5,121	205.3	88.1	1,791	52 / 51	1,491	90
Nepal	23.9	38.0	2.4	14	6.5	7.0	4.45	9	1,181	37.5	15.0	16,948	110 / 124	320	59
Pakistan	156.5	263.0	2.8	35	4.6	3.5	5.03	18	1,652	44.6	15.9	15,967	108 / 104	446	62
Sri Lanka	18.8	23.5	1.0	22	2.8	4.6	2.10	94	2,945	101.3	42.3	2,186	22 / 20	371	70
Western Asia (9)	**188.0**	**294.3**	**2.2**	**66**	**3.4**		**3.77**	**74**				**33,421**	**69 / 61**		
Iraq	23.1	41.0	2.8	75	3.7	0.4	5.25	54				481	119 / 114	1,174	77
Israel	6.2	8.3	2.2	91	1.6	0.4	2.68	99	16,861	1,274.7	1,219.1	28	11 / 9	2,843	99
Jordan	6.7	12.1	3.0	71	4.1	1.4	4.86	97	2,615	177.3	123.9	7,869	32 / 31	1,040	98
Kuwait	2.0	3.0	3.1	97	3.4	2.6	2.89	98				304	16 / 14	8,167	100
Lebanon	3.3	4.4	1.7	87	2.3	0.5	2.69	89	4,144	104.4	129.8	608	39 / 31	1,164	94
Oman	2.5	5.4	3.3	13	7.4	14.1	5.85	91				352	35 / 24	2,231	88
Saudi Arabia	21.6	40.0	3.4	80	3.9	0.6	5.80	90	10,498	791.6	650.1		31 / 24	4,753	93
Syrian Arab Republic	16.1	26.3	2.5	52	4.3	0.8	4.00	77	2,702	83.8		2,678	47 / 33	1,002	88
Turkey (10)	66.6	87.9	1.7	69	3.5	0.7	2.50	76	6,594	146.4	187.2	6,725	67 / 52	1,045	
United Arab Emirates	2.4	3.3	2.0	84	2.5	1.6	3.42	99	18,871	337.8	797.3		21 / 17	13,155	98
Yemen	18.1	39.0	3.7	34	5.9	5.6	7.60	43	658	46.0	14.8	10,508	112 / 114	187	39
Europe	**728.9**	**702.3**	**0.0**	**74**	**0.5**		**1.42**	**99**					**16 / 12**		
Eastern Europe	**307.0**	**287.5**	**-0.2**	**70**	**0.5**		**1.36**	**99**				**22,533**[21, 23]	**25 / 18**		
Bulgaria	8.2	7.0	-0.7	71	0.3	0.2	1.23	100	4,683	148.9	153.0	362	23 / 16	2,705	
Czech Republic	10.2	9.5	-0.2	65	0.4	0.3	1.19	99	12,197	625.7	794.4	3	9 / 7	3,917	
Hungary	10.0	8.9	-0.4	65	0.4	0.3	1.37	99	9,832	455.2	419.3	78	13 / 10	2,499	
Poland	38.8	39.1	0.1	65	0.9	0.6	1.53	99	7,543	563.5	318.0	226	18 / 14	2,807	
Romania	22.3	19.9	-0.4	55	0.6	0.4	1.17	99	5,572	201.1	164.0	2,740	39 / 26	2,027	62
Slovakia	5.4	5.4	0.1	59	1.2	0.3	1.39	95	9,624	479.3	500.2		14 / 12	3,266	
Northern Europe (11)	**94.4**	**95.9**	**0.2**	**84**	**0.4**		**1.69**	**99**					**10 / 8**		
Denmark	5.3	5.2	0.3	85	0.2	0.1	1.72	100	23,855	1,944.2	1,625.5	(46,990)	10 / 7	4,346	
Estonia	1.4	1.1	-1.2	73	-0.1	0.2	1.29	95	7,563	543.8	388.2		33 / 17	3,834	
Finland	5.2	5.3	0.3	63	1.0	0.2	1.73	100	20,641	1,539.8	1,192.4	(17,335)	7 / 6	6,143	98
Ireland	3.7	4.4	0.7	58	0.8	0.3	1.90	99	17,991	1,072.3	1,045.2		9 / 7	3,293	
Latvia	2.4	1.9	-1.5	73	-0.2	0.2	1.25	98	5,777	362.2	227.7	768	31 / 18	1,674	
Lithuania	3.7	3.4	-0.3	72	0.7	0.2	1.43	95	6,283	342.4	464.6	24	29 / 18	2,414	
Norway	4.5	4.8	0.5	73	0.7	0.3	1.85	100	26,196	1,951.6	1,627.0	(54,296)	7 / 6	5,284	100
Sweden	8.9	9.1	0.3	83	0.5	0.1	1.57	100	19,848	1,643.4	1,480.1	(53,177)	7 / 6	5,944	
United Kingdom	58.8	60.0	0.2	89	0.4	0.2	1.72	98	20,314	1,082.7	1,198.6	(117,431)	9 / 8	3,992	100
Southern Europe (12)	**144.2**	**135.0**	**0.1**	**65**	**0.6**		**1.31**	**98**					**13 / 11**		
Albania	3.1	3.8	-0.4	37	2.2	2.2	2.50	99	2,864	89.7	76.1	1,426	46 / 39	362	76
Bosnia & Herzegovina	4.0	4.3	3.0	49	6.1	0.4	1.35	97				635	19 / 15	777	
Croatia	4.5	4.2	-0.1	64	0.9	0.3	1.56		6,698	353.6	543.6	116	14 / 11	1,418	63
Greece	10.6	9.9	0.3	65	1.0	0.4	1.28	99	13,994	433.8	732.2		9 / 8	2,328	
Italy	57.3	51.3	0.0	67	0.2	0.3	1.20	100	20,365	993.8	1,092.7	(2,203)	9 / 8	2,808	
Macedonia (Former Yugoslav Republic of)	2.0	2.3	0.6	60	1.5	0.5	2.06	93	4,224	216.3	330.5		27 / 24		
Portugal	9.9	9.3	0.0	36	1.4	0.5	1.37	98	14,569	839.2	690.8	(414)	12 / 10	1,928	82
Slovenia	2.0	1.8	-0.1	64	1.2	0.2	1.26	100	14,400	825.1	969.5		9 / 8	3,098	98
Spain	39.6	36.7	0.0	76	0.4	0.2	1.15	96	15,960	798.0	912.1	(7,438)	9 / 7	2,583	
Yugoslavia	10.6	10.8	0.1	57	0.9	0.6	1.84					18	28 / 23	1,364	

Demographic, Social and Economic Indicators

	Total population (millions) (2000)	Projected population (millions) (2025)	Avg. pop. growth rate (%) (1995-2000)	% urban (1995)	Urban growth rate (1995-2000)	Population/ ha arable and perm. crop land	Total fertility rate (1995-2000)	% births with skilled attendants	GNP per capita PPP$ (1998)	Per capita central govt. expenditures (PPP$) Education	Health	External population assistance (US$,000)	Under-5 mortality M / F	Per capita energy consumption	Access to safe water
Western Europe (13)	**183.3**	**183.9**	**0.3**	**81**	**0.4**		**1.48**	**100**					**8 / 6**		
Austria	8.2	8.2	0.5	56	0.7	0.3	1.41	100	23,145	1,261.4	1,381.5	(577)	8 / 7	3,373	
Belgium	10.2	9.9	0.1	97	0.3	0.3[24]	1.55	100	23,622	732.3	1,577.6	(9,814)	9 / 7	5,552	
France	59.1	61.7	0.4	73	0.5	0.1	1.71	99	21,214	1,281.3	1,511.2	(16,500)	8 / 7	4,355	100
Germany	82.2	80.2	0.1	87	0.3	0.2	1.30	100	22,026	1,059.4	1,830.0	(122,462)[25]	7 / 6	4,267	
Netherlands	15.8	15.8	0.4	89	0.6	0.6	1.50	100	22,325	1,131.9	1,362.9	(146,428)	9 / 7	4,885	99
Switzerland	7.4	7.6	0.7	61	1.3	1.2	1.47	99	26,876	1,462.1	1,802.2	(16,626)	10 / 7	3,622	100
Latin America & Caribbean	**519.1**	**696.7**	**1.6**	**74**	**2.3**		**2.70**	**80**				**208,676**	**49 / 39**		
Caribbean (14)	**38.1**	**47.3**	**1.1**	**62**	**2.0**		**2.55**	**72**					**57 / 48**		
Cuba	11.2	11.8	0.4	76	1.2	0.4	1.55	99				935	13 / 10	1,448	91
Dominican Republic	8.5	11.2	1.7	65	2.7	1.1	2.80	96	4,337	99.3	71.3	6,772	51 / 41	652	73
Haiti	8.2	12.0	1.7	32	4.1	5.5	4.38	20	1,379		18.2	16,137	112 / 97	268	39
Jamaica	2.6	3.2	0.9	54	1.7	2.0	2.50	92	3,344	249.2	77.5	5,088	28 / 25	1,465	93
Puerto Rico	3.9	4.5	0.8	73	1.4	1.7	2.11	99					15 / 13		97
Trinidad & Tobago	1.3	1.5	0.5	72	1.8	1.0	1.65	98	7,208	262.4	206.7	59	19 / 12	6,081	96
Central America	**135.2**	**188.5**	**1.9**	**68**	**2.6**		**3.05**	**70**					**45 / 38**		
Belize	0.2	0.4	2.4	47	2.6	0.8	3.66	79	4,367			79	37 / 37		
Costa Rica	4.0	5.9	2.5	50	3.2	1.7	2.83	97	5,812	314.4	415.5	520	16 / 13	657	100
El Salvador	6.3	9.1	2.0	45	2.9	2.6	3.17	87	4,008	100.2	104.7	5,872	45 / 37	700	53
Guatemala	11.4	19.8	2.6	41	4.1	2.9	4.93	35	3,474	57.7	51.5	5,568	65 / 57	510	67
Honduras	6.5	10.7	2.8	44	4.3	1.1	4.30	55	2,338	84.6	66.0	7,422	54 / 43	503	77
Mexico	98.9	130.2	1.6	75	2.4	0.9	2.75	75	7,450	362.8	218.4	23,326	41 / 34	1,525	95
Nicaragua	5.1	8.7	2.7	63	4.0	0.4	4.42	61	1,896	73.6	94.4	11,529	64 / 53	525	62
Panama	2.9	3.8	1.6	53	2.4	1.0	2.63	84	4,925	251.7	314.2	388	29 / 26	853	84
South America (15)	**345.8**	**460.9**	**1.5**	**78**	**2.2**		**2.58**	**86**					**50 / 39**		
Argentina	37.0	47.2	1.3	88	1.5	0.1	2.62	97	11,728	405.8	483.6	1,652	28 / 22	1,673	65
Bolivia	8.3	13.1	2.3	61	3.8	1.6	4.36	46	2,205	107.2	24.5	21,718	92 / 83	479	70
Brazil	170.1	217.9	1.3	78	2.3	0.5	2.27	88	6,460	327.5	222.1	20,543	54 / 41	1,012	69
Chile	15.2	19.5	1.4	84	1.6	1.0	2.44	99	8,507	303.7	213.9	4,354	17 / 13	1,419	91
Colombia	42.3	59.8	1.9	73	2.2	2.0	2.80	85	5,861	241.5	297.1	2,559	43 / 35	799	75
Ecuador	12.6	17.8	2.0	58	3.1	1.2	3.10	64	3,003	104.2	76.6	5,446	66 / 54	731	55
Paraguay	5.5	9.4	2.6	53	3.8	0.9	4.17	61	4,312	172.1	110.3	1,994	54 / 43	865	39
Peru	25.7	35.5	1.7	72	2.5	1.8	2.98	56	4,180	122.9	94.9	29,564	71 / 58	582	66
Uruguay	3.3	3.9	0.7	90	0.8	0.3	2.40	96	8,541	284.4	162.1	314	23 / 17	912	89
Venezuela	24.2	34.8	2.0	93	2.4	0.7	2.98	97	5,706	295.0	172.5	497	27 /22	2,463	79
Northern America (16)	**309.6**	**363.6**	**0.9**	**76**	**1.2**		**1.94**	**99**					**9 / 7**		
Canada	31.1	37.9	1.0	77	1.2	0.0	1.55	100	22,814	1,576.5	1,505.8	(34,520)	8 / 6	7,880	99
United States of America	278.4	325.6	0.8	76	1.2	0.0	1.99	99	29,240	1,567.3	1,913.8	(662,360)	10 / 8	8,051	73
Oceania	**30.4**	**39.6**	**1.3**	**70**	**1.4**		**2.38**	**65**					**31 / 32**		
Australia-New Zealand	**22.7**	**27.8**	**1.0**	**85**	**1.2**		**1.83**	**99**					**8 / 6**		
Australia (17)	18.9	23.1	1.0	85	1.2	0.0	1.79	100	21,795	1,187.8	1,240.0	(45,235)	8 / 6	5,494	99
Melanesia (18)	6.5	10.0	2.2	21	3.6		4.28						68 / 73		
New Caledonia	0.2	0.3	2.1	62	2.2		2.70	98					16 / 15		
New Zealand	3.9	4.7	1.0	86	1.3	0.1	2.01	95	16,084	1,177.4	1,013.5	(1,806)	9 / 8	4,388	90
Papua New Guinea	4.8	7.5	2.2	16	4.0	5.3	4.60	53	2,205		61.7	5,158	79 / 88		31
Vanuatu	0.2	0.3	2.4	19	3.9		4.30	79	2,892			202	54 / 42		
Countries with Economies in Transition of the Former USSR (19)															
Armenia	3.5	3.9	-0.3	69	1.6	0.9	1.70	95	2,074	40.6	64.8	2,040	35 / 30	474	
Azerbaijan	7.7	9.4	0.5	56	1.7	1.1	1.99	99	2,168	65.2	26.8	1,247	55 / 44	1,570	
Belarus	10.2	9.5	-0.3	71	0.8	0.2	1.36	100	6,314	373.2	309.0	25	36 / 20	2,386	
Georgia	5.0	5.2	-1.1	58	1.1	1.0	1.92	95	3,429	176.9	25.1	1,018	27 / 20	291	
Kazakhstan	16.2	17.7	-0.4	60	1.4	0.1	2.30	99	4,317	190.4	94.1	1,270	46 / 36	2,724	
Kyrgyzstan	4.7	6.1	0.6	39	2.4	0.9	3.21	98	2,247	120.0	62.7	1,730	56 / 44	645	81
Republic of Moldova	4.4	4.5	0.0	52	1.8	0.5	1.76	95	1,995	212.0	92.8	583	39 / 25	1,064	56
Russian Federation	146.9	137.9	-0.2	76	0.3	0.1	1.35	99	6,180	218.8	289.1	6,783	25 / 19	4,169	
Tajikistan	6.2	8.9	1.5	32	3.2	2.4	4.15	92	1,041	22.4	69.1	943	88 / 73	594	69
Turkmenistan	4.5	6.3	1.8	45	2.5	0.9	3.60	90			88.6	1,012	86 / 69	2,646	60
Ukraine	50.5	45.7	-0.4	70	0.6	0.3	1.38	100	3,130	227.6	130.0	1,956	30 / 20	3,012	55
Uzbekistan	24.3	33.4	1.6	41	2.8	1.4	3.45	98	2,044	157.6	67.7	2,849	69 / 56	1,826	57

Selected Indicators for Less-Populous Countries/Territories

Monitoring ICPD Goals — Selected Indicators

	Indicators of Mortality		Indicators of Education		Reproductive Health Indicators		
	Infant mortality Total per 1,000 live births	Life expectancy M / F	Primary enrolment (gross) M / F	Secondary enrolment (gross) M / F	Births per 1,000 women aged 15-19	Contraceptive prevalence Any method	Modern method
Bahamas	16	70.5 / 77.1	92 / 104	77 / 97	69	62	60
Bahrain	17	71.1 / 75.3	105 / 106	91 / 98	22	61	30
Barbados	12	73.7 / 78.7	90 / 91	89 / 80	44	55	53
Brunei Darussalam	10	73.4 / 78.1	109 / 104	72 / 82	33		
Cape Verde	56	65.5 / 71.3	150 / 147	54 / 56	79		
Comoros	76	57.4 / 60.2	84 / 69	24 / 19	83	21	11
Cyprus	9	75.5 / 80.0	100 / 100	95 / 99	17		
Djibouti	106	48.7 / 52.0	44 / 33	17 / 12	31		
East Timor	135	46.7 / 48.4			37		
Equatorial Guinea	108	48.4 / 51.6			178		
Fiji	20	70.6 / 74.9	128 / 128	64 / 65	48	41	35
French Polynesia	11	69.3 / 74.6	118 / 113	69 / 86	68		
Gambia	122	45.4 / 48.6	87 / 67	30 / 19	155	12	7
Guadaloupe	9	73.6 / 80.9			29	44	31
Guam	10	73.0 / 77.4			96		
Guyana	58	61.1 / 67.9	97 / 96	71 / 76	58	31	28
Iceland	5	76.8 / 81.3	98 / 98	109 / 108	24		
Luxembourg	7	73.3 / 79.9		85 / 90	12		
Maldives	50	65.7 / 63.3	130 / 127	67 / 71	54		
Malta	8	74.9 / 79.3	108 / 107	86 / 82	12		
Martinique	7	75.5 / 82.0			27	51	37
Micronesia (26)	34	67.6 / 71.4			56		
Netherlands Antilles	14	72.5 / 78.4			35		
Polynesia (27)	17	69.3 / 74.2			55		
Qatar	17	70.0 / 75.4	87 / 86	80 / 79	66	32	29
Reunion	9	70.9 / 79.8			20	67	62
Samoa	23	69.3 / 73.6	101 / 100	59 / 66	37		
Solomon Islands	23	69.7 / 73.9	103 / 89	21 / 14	94		
Suriname	29	67.5 / 72.7			22		
Swaziland	65	57.9 / 62.5	120 / 114	55 / 54	90	20	17

Demographic, Social and Economic Indicators

	Total population (thousands) 2000	Projected population (thousands) 2025	% urban (1995)	Urban growth rate (1995-2000)	Total fertility rate (1995-2000)	% births with skilled attendants	GNP per capita PPP$ (1998)	Under-5 mortality M / F
Bahamas	307	415	86.5	1.9	2.60	100	13,990	20 / 15
Bahrain	617	858	90.3	2.7	2.90	98	11,556	26 / 17
Barbados	270	297	47.4	1.7	1.50	98		14 / 15
Brunei Darussalam	328	459	57.8	2.2	2.80	98	24,886	11 / 11
Cape Verde	428	671	54.3	5.5	3.56		3,192	68 / 60
Comoros	694	1,176	30.7	5.6	4.80	52	1,400	112 / 101
Cyprus	786	900	54.1	1.9	2.03	98	17,599	10 / 9
Djibouti	638	1,026	82.8	2.6	5.30	79		182 / 166
East Timor	885	1,185	7.5	1.7	4.35			205 / 196
Equatorial Guinea	453	795	42.2	5.2	5.58	5		184 / 169
Fiji	817	1,104	40.7	2.5	2.73	100	4,094	28 / 18
French Polynesia	235	324	56.4	2.2	2.85	98	20,586	14 / 14
Gambia	1,305	2,151	25.5	5.3	5.20	44	1,428	212 / 194
Guadaloupe	456	569	99.4	1.6	1.90			12 / 9
Guam	168	228	38.2	2.4	3.40	100		11 / 13
Guyana	861	1,045	36.2	2.9	2.32	93	3,139	90 / 65
Iceland	281	328	91.6	1.2	2.10	100	24,774	6 / 6
Luxembourg	431	463	89.1	1.4	1.67	100	36,703	8 / 8
Maldives	286	501	26.8	4.3	5.40	90	3,436	53 / 80
Malta	389	430	89.3	0.9	1.89	98	22,901	11 / 8
Martinique	395	450	93.3	1.3	1.75			10 / 8
Micronesia (26)	543	960	42.7	3.2	4.08			47 / 40
Netherlands Antilles	217	258	69.5	1.3	2.20	98		20 / 12
Polynesia (27)	631	909	41.3	2.6	3.38			20 / 21
Qatar	599	779	91.4	2.1	3.74	97		27 / 18
Reunion	699	880	67.8	2.3	2.10	97		11 / 9
Samoa	180	271	21.0	2.4	4.15	52	3,854	25 / 29
Solomon Islands	444	817	17.1	6.3	4.85	85	1,904	32 / 22
Suriname	417	525	50.4	2.5	2.21	91		39 / 28
Swaziland	1,008	1,785	31.2	5.7	4.70	56	4,195	109 / 91

The designations employed in this publication do not imply the expression of any opinion on the part of the United Nations Population Fund concerning the legal status of any country, territory or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

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

(*) More-developed regions comprise North America, Japan, Europe and Australia-New Zealand.

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

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

(1) Including British Indian Ocean Territory and Seychelles.

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

(3) Including Sao Tome and Principe.

(4) Formerly Zaire.

(5) Including Western Sahara.

(6) Including St. Helena, Ascension and Tristan da Cunha.

(7) Including Macau.

(8) On 1 July 1997, Hong Kong became a Special Administrative Region of China.

(9) Including Gaza Strip (Palestine).

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

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

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

(13) Including Leichtenstein and Monaco.

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

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

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

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

(18) Including New Caledonia and Vanuatu.

(19) The successor States of the former USSR are grouped under existing regions. Eastern Europe includes Belarus, Republic of Moldova, Russian Federation and Ukraine. Western Asia includes Armenia, Azerbaijan and Georgia. South Central Asia includes Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan.

(20) Regional total, excluding subregion reported separately below.

(21) These subregions comprise the UNFPA Arab States and Europe region.

(22) Estimates based on previous years' reports. Updated data are expected.

(23) Total for Eastern Europe includes some South European Balkan States and Northern European Baltic States.

(24) This figure includes Belgium and Luxembourg.

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

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

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

Technical Notes

The statistical tables in this year's *State of World Population* report once again give special attention to indicators that can help track progress in meeting the quantitative and qualitative goals of the International Conference on Population and Development in the areas of mortality reduction, access to education, and access to reproductive health services, including family planning. Future reports will include different process measures when these become available, as ICPD follow-up efforts lead to improved monitoring systems. Improved monitoring of the financial contributions of governments, non-governmental organizations and the private sector should also allow better future reporting of expenditures and resource mobilization for ICPD implementation efforts. The sources for the indicators and their rationale for selection follow, by category.

Monitoring ICPD goals

Indicators of Mortality

Infant mortality, male and female life expectancy at birth. Source: United Nations Population Division. 1999. *World Population Prospects: The 1998 Revision* (Data diskettes, "Demographic Indicators 1950-2050"). New York: United Nations. These indicators are measures of mortality levels, respectively, in the first year of life (which is most sensitive to development levels) and over the entire lifespan.

Maternal mortality ratio. Source: Data compiled from WHO, UNICEF, the World Bank and national sources as published in The World Bank. 2000. *World Development Indicators 2000*. Washington, D.C.: Oxford Press. This indicator presents the number of deaths to women per 100,000 live births which result from conditions related to pregnancy, delivery and related complications. Precision is difficult, though relative magnitudes are informative. Estimates below 50 are not rounded; those 50-100 are rounded to the nearest 5; 100-1,000, to the nearest 10; and above 1,000, to the nearest 100. Several of the estimates differ from official government figures. The estimates are based on reported figures wherever possible, using approaches to improve the comparability of information from different sources. See the source for details on the origin of particular national estimates. Estimates and methodologies are being reviewed by WHO, UNICEF, UNFPA, academic institutions and other agencies and will be revised where necessary, as part of the ongoing process of improving maternal mortality data.

Indicators of Education

Male and female gross primary enrolment ratios, male and female gross secondary enrolment ratios. Source: Spreadsheets provided by UNESCO; data published in the *World Education Report* series; as updated in *1999 UNESCO Statistical Yearbook*. Paris: UNESCO Institute for Statistics. Gross enrolment ratios indicate the number of students enrolled in a level in the education system per 100 individuals in the appropriate age group. They do not correct for individuals who are older than the level-appropriate age due to late starts, interrupted schooling or grade repetition.

Male and female adult illiteracy. Source: Spreadsheets provided by UNESCO; data published in the *Education for All: Status and Trends* series; Paris: UNESCO. Illiteracy definitions are subject to variation in different countries; three widely accepted definitions are in use. In so far as possible, data refer to the proportion who cannot, with understanding, both read and write a short simple statement on everyday life. Adult illiteracy (rates for persons above 15 years of age) reflects both recent levels of educational enrolment and past educational attainment. The above education indicators have been updated using the UN Population Division estimates from *World Population Prospects (The 1998 Revision)*. Education data are most recent, ranging from 1982-1998.

Per cent reaching grade 5 of primary education. Source: Spreadsheets provided by UNESCO; data are published in the *World Education Report* series. Paris: UNESCO Institute for Statistics. Studies of patterns of drop-out show high consistency between completing 5th grade and completing primary school. We report the former, following our source (identified as "Survival rate to grade 5"). Data are most recent within the years 1980-1998.

Indicators of Reproductive Health

Contraceptive knowledge. Source: United Nations Population Division. 1996. *World Population Monitoring 1996*. New York: United Nations. These indicators, derived from sample survey reports, estimate the proportion of women who have knowledge of a method of family planning and know a source from which contraceptives can be obtained. All contraceptive methods (medical, barrier, natural and traditional) are included in the first indicator; source information is more relevant to medical and barrier contraceptives and to modern periodic abstinence methods. These numbers are generally but not completely comparable across countries due to variation in populations surveyed by age (15- to 49-year-old women being most common) and marital status (e.g., currently or ever-married women, or all women) and in the timing of the surveys. Most of the data were collected during 1987-1994.

Births per 1,000 women aged 15-19. Source: United Nations Population Division. 1999. *World Population Prospects: The 1998 Revision* (Data diskettes, "Demographic Indicators 1950-2050"); and United Nations Population Division. 1998. *Age Patterns of Fertility: The 1998 Revision*. New York: United Nations. This is an indicator of the burden of fertility on young women. Since it is an annual level summed over all women in the age cohort, it does not reflect fully the level of fertility for women during their youth. Since it indicates the annual average number of births per woman per year, one could multiply it by five to approximate the number of births to 1,000 young women during their late teen years. The measure does not indicate the full dimensions of teen pregnancy as only live births are included in the numerator. Stillbirths and spontaneous or induced abortions are not reflected.

Contraceptive prevalence. Source: United Nations Population Division. 1998. *Contraceptive Trends and Levels 1998* (wallchart). New York: United Nations. These data are derived from sample survey reports and estimate the proportion of married women (including women in consensual unions) currently using, respectively, any method or modern methods of contraception. Modern or clinic and supply methods include male and female sterilization, IUD, the pill, injectables, hormonal implants, condoms and female barrier methods. These numbers are roughly but not completely comparable across countries due to variation in populations surveyed by age (15- to 49-year-old women being most common; slightly more than half of the database), in the timing of the surveys, and in the details of the questions. All of the data were collected in 1975 or later. The most recent survey data available are cited; nearly 80 per cent of the data refer to the period 1987-1996.

Demographic, Social and Economic Indicators

Total population 2000, projected population 2025, average annual population growth rate for 1995-2000. Source: United Nations Population Division. 1999. *World Population Prospects: The 1998 Revision*. (Data diskettes, "Demographic Indicators 1950-2050"); and United Nations Population Division. 1998. *Annual Populations 1950-2050: The 1998 Revision*. New York: United Nations. These indicators present the size, projected future size and current period annual growth of national populations.

Per cent urban, urban growth rates. Source: United Nations Population Division. 1996. *World Urbanization Prospects: The 1996 Revision*. New York: United Nations. These indicators reflect the proportion of the national population living in urban areas and the growth rate in urban areas projected for 1995-2000.

Agricultural population per hectare of arable and permanent crop land. Source: Data provided by Food and Agriculture Organization, using agricultural population data based on the total populations from United Nations Population Division. 1999. *World Population Prospects: The 1998 Revision*. New York: United Nations. This indicator relates the size of the agricultural population to the land suitable for agricultural production. It is responsive to changes in both the structure of national economies (proportions of the workforce in agriculture) and in technologies for land development. High values can be related to stress on land productivity and to fragmentation of land holdings. However, the measure is also sensitive to differing development levels and land use policies. Data refer to the year 1997.

Total fertility rate (period: 1995-2000). Source: United Nations Population Division. 1999. *World Population Prospects: The 1998 Revision*. (Data diskettes, "Demographic Indicators 1950-2050".) New York: United Nations. The measure indicates the number of children a woman would have during her reproductive years if she bore children at the rate estimated for different age groups in the specified time period. Countries may reach the projected level at different points within the period.

Access to basic care. Note: This indicator has been omitted from this year's report due to interagency concern about its reliability and validity. Consultations about an appropriate alternate indicator of access to health care are anticipated.

Births with skilled attendants. Source: World Health Organization; updated information provided by WHO. This indicator is based on national reports of the proportion of births attended by "skilled health personnel or skilled attendant: doctors (specialist or non-specialist) and/or persons with midwifery skills who can diagnose and manage obstetrical com-

plications as well as normal deliveries". Data estimates are the most recent available.

Gross national product per capita. Source: 1998 figures from: The World Bank. 2000. *World Development Indicators 2000*. Washington, D.C.: The World Bank. This indicator measures the total output of goods and services for final use produced by residents and non-residents, regardless of allocation to domestic and foreign claims, in relation to the size of the population. As such, it is an indicator of the economic productivity of a nation. It differs from gross domestic product by further adjusting for income received from abroad for labour and capital by residents, for similar payments to non-residents, and by incorporating various technical adjustments including those related to exchange rate changes over time. This measure also takes into account the differing purchasing power of currencies by including purchasing power parity (PPP) adjustments of "real GNP". Some PPP figures are based on regression models; others are extrapolated from the latest International Comparison Programme benchmark estimates; see original source for details.

Central government expenditures on education and health. Source: The World Bank. 2000. *World Development Indicators 2000*. Washington, D.C.: The World Bank. These indicators reflect the priority afforded to education and health sectors by a country through the government expenditures dedicated to them. They are not sensitive to differences in allocations within sectors, e.g., primary education or health services in relation to other levels, which vary considerably. Direct comparability is complicated by the different administrative and budgetary responsibilities allocated to central governments in relation to local governments, and to the varying roles of the private and public sectors. Reported estimates are calculated from source data on public education spending as a share of GNP, per capita health expenditures (in PPP adjusted dollars) and the share of health expenditure from public sources. Data refer to the most recent estimates 1990-1998.

External assistance for population. Source: UNFPA. 1999. *Global Population Assistance Report 1997*. New York: UNFPA. This figure provides the amount of external assistance expended in 1997 for population activities in each country. External funds are disbursed through multilateral and bilateral assistance agencies and by non-governmental organizations. Donor countries are indicated by their contributions being placed in parentheses. Future editions of this report will use other indicators to provide a better basis for comparing and evaluating resource flows in support of population and reproductive health programmes from various national and international sources. Regional totals include both country-level projects and regional activities (not otherwise reported in the table).

Under-5 mortality. Source: United Nations Population Division, special tabulation based on United Nations. 1999. *World Population Prospects: The 1998 Revision*. New York: United Nations. This indicator relates to the incidence of mortality to infants and young children. It reflects, therefore, the impact of diseases and other causes of death on infants, toddlers and young children. More standard demographic measures are infant mortality and mortality rates for 1 to 4 years of age, which reflect differing causes of and frequency of mortality in these ages. The measure is more sensitive than infant mortality to the burden of childhood diseases, including those preventable by improved nutrition and by immunization programmes. Under-5 mortality is here expressed as deaths to children under 5 per 1,000 live births in a given year. The estimate refers to the period 1995-2000.

Per capita energy consumption. Source: The World Bank. 1999. *World Development Indicators 1999*. Washington, D.C.: The World Bank. This indicator reflects annual consumption of commercial primary energy (coal, lignite, petroleum, natural gas and hydro, nuclear and geothermal electricity) in kilograms of oil equivalent per capita. It reflects the level of industrial development, the structure of the economy and patterns of consumption. Changes over time can reflect changes in the level and balance of various economic activities and changes in the efficiency of energy use (including decreases or increases in wasteful consumption). Data are for 1996.

Access to safe water. Source: WHO/UNICEF. *Water Supply and Sanitation Sector Monitoring Report 1996*. This indicator reports the percentage of the population with *access* to an *adequate amount* of *safe* drinking water located within a *convenient distance* from the user's dwelling. The italicized words use country-level definitions. It is related to exposure to health risks, including those resulting from improper sanitation. Data are from 1990-1994.

THE STATE OF WORLD POPULATION 2000

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PRESS SUMMARY

Men and Women in a Time of Change

Inequality between women and men limits the potential of individuals, families, communities and nations. Ending gender discrimination is an urgent human rights and development priority, says *The State of World Population 2000* report from the United Nations Population Fund (UNFPA).

Despite the tremendous changes of the 20th century, discrimination and violence against women and girls remain firmly rooted in cultures around the world. Passed down from one generation to the next, ideas about "real men" and "a woman's place" are instilled at an early age and are difficult to change.

These restrictions take a heavy toll. Girls and women the world over are denied access to education and health care. Millions are subjected to abuse and violence. Women's legal rights are not protected. Their medical concerns are given less attention than men's are. They are denied opportunities in the workplace and receive less pay than men for the same work.

Men, and societies, also pay a price. Yet, until recent years, gender discrimination was considered either unimportant or non-existent, either accepted or ignored, without even the statistics to describe it. While many countries have started taking steps to protect women's rights and promote equality, actual progress has been slow.

Gender discrimination will not end until all eyes are open to its inherent contradictions, and countries, communities and families act to end it.

Gender and Health

Gender inequality harms women's health and prevents many women from participating fully in society. Unequal power relations between men and women often limit women's control over sexual activity and their ability to protect themselves against unwanted pregnancy and sexually transmitted diseases (STDs), including HIV/AIDS. Teenage girls are particularly vulnerable.

Inadequate reproductive health care for women also results in high rates of unwanted pregnancy, unsafe abortion and preventable death and injury as a result of pregnancy and childbirth. Gender-based violence — including rape, wife beating and female genital mutilation — hurts women's health, well-being and social participation.

Universal access to sexual and reproductive health care, including family planning services, was a central objective of the 1994 International Conference on Population and Development (ICPD) in Cairo. Countries agreed that empowering women and meeting people's needs for education and health were necessary for individual advancement and balanced development.

At the 1999 fifth-year review of the Conference (ICPD+5), governments agreed on these new benchmarks, among others: to halve the 1990 illiteracy rate for women and girls by 2005; to halve unmet need for family planning by 2005 and to eliminate it altogether by 2015; to reduce HIV infection in youth by one quarter by the year 2010, by providing information and services to reduce their risk; and to ensure that by 2015, 90 per cent of all births are assisted by skilled attendants. They also agreed that where abortion is legal, it should be safe and accessible.

Providing family planning to everyone who wants it is a significant challenge. Today about one third of all pregnancies — 80 million a year — are believed to be unwanted or mistimed. If women could have the number of children they wanted, the average family size in many countries would fall by nearly one child.

Over the next 15 years — assuming services can be provided — the number of contraceptive users in developing countries is expected to increase by more

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UNFPA
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than 40 per cent to 742 million due to population growth and increased demand for contraception.

Providing women with safe options for pregnancy and childbirth is another priority. Today, some 500,000 maternal deaths occur each year in developing countries, where only 53 per cent of all births are professionally attended. This lack of care translates into the neglect of 52.4 million women annually. Nearly 30 per cent of women who give birth in developing countries, some 38 million each year, receive no antenatal care.

Quality care before, during and after birth is essential to safe motherhood. The best way to prevent maternal deaths, however, is to provide emergency obstetric care. Rapid transport to a medical facility is crucial to saving mothers who are facing complications.

Each year, women undergo an estimated 50 million abortions, 20 million of which are unsafe, resulting in the deaths of 78,000 women and the suffering of millions more. At least one fourth of all unsafe abortions are to girls aged 15-19. Increased access to family planning is clearly the best way to reduce abortion. Care for women who have undergone abortion is also an important way to reduce maternal mortality.

At the end of 1999, 34.3 million men, women and children were living with HIV or AIDS, and 18.8 million had already died from the disease. HIV/AIDS is now the leading cause of death in Africa and the fourth most common cause of death worldwide. In 1999, there were 5.4 million new infections, 4.0 million of them in sub-Saharan Africa. In Africa, HIV-positive women outnumber men by 2 million. Programmes that address gender inequality and engage men as partners in fighting AIDS can help slow the spread of the disease.

Another health, and human rights, concern is female genital mutilation (FGM), which affects over 100 million women and girls, mostly in Africa and Western Asia. Since it is nearly always carried out in unsanitary conditions without anaesthetic, FGM can result in severe infection, shock or even death, and there are lifetime health consequences including an increased risk of experiencing a difficult delivery and dying in childbirth.

Gender-sensitive reproductive health programmes are essential to counter inequality and protect women's health. Programmes are beginning to address the dynamics of knowledge, power and decision-making in sexual relationships, between providers and clients, and between community leaders and citizens. Non-governmental organizations (NGOs) are increasingly playing important roles in providing services, for instance to address sensitive topics such as adolescents' needs.

Young men and women face different social pressures and expectations which may work against responsible sexual behaviour. Many girls are forced into early and unsafe sexual activity by abuse, child marriage or poverty. Both married and unmarried youth lack access to reproductive health information and services. Training young people as peer educators encourages responsible behaviour. Parents and other adults can learn to be sources of information and counselling.

Men also face reproductive health problems including sexually transmitted infections, impotence and infertility. Many men also say they want to limit or space their children, but neither they nor their wives are using contraception. Reproductive health services for men have concentrated on STDs. The proportion of contraceptive use attributable to men has fallen in recent years. Good programmes can increase men's knowledge of and use of contraception.

Gender-based Violence

At least one in three women has been beaten, coerced into sex, or abused in some way — most often by someone she knows. One woman in four is abused during pregnancy. At least 60 million girls are "missing", mostly in Asia, as a result of sex-selective abortion, infanticide or neglect.

Two million girls between ages 5 and 15 are introduced into the commercial sex market each year. Perhaps as many as 5,000 women and girls are murdered each year in so-called "honour" killings by members of their own families. Rape, battery and other forms of gender-based violence are widespread worldwide.

Many cultures condone or tolerate a certain amount of violence against women. In parts of the world, men are seen as having a right to discipline their wives as they see fit. Even women often view physical abuse as justified under certain conditions.

Justification for violence stems from distorted views about the roles and responsibilities of men and women in relationships. Events that may trigger violent responses include not obeying the husband, talking back, refusing sex, not having food ready on time, failing to care for the children or home, questioning the man about money or girlfriends or going somewhere without his permission.

Violence can cause immense damage to women's reproductive health and well-being, resulting in unwanted pregnancies; unsafe abortion; persistent gynaecological problems; sexually transmitted diseases, including HIV/AIDS; and psychological and emotional problems that can be more difficult to bear than physical pain.

NGOs are actively countering violence against women. African NGOs have led the increasingly successful fight against FGM. In Colombia, women's groups provide training and support for rape survivors. A Bosnian group has counselled 20,000 women and children who have suffered from sexual violence.

Men, Reproductive Rights and Equality

Discrimination against women and girls will never stop without the support and understanding of men, especially in the family.

Men's attitudes and behaviours are strongly influenced by stereotypical definitions of masculinity and what it means to be a "real man". These stereotypes, however, are unrealistic and set men up for failure, stress and difficulty in relationships. Men unable to live up to expectations that they should be powerful and competent may retreat into passivity, escape through drugs or alcohol, or resort to violence or exaggerated bravado and risk-taking.

Helping women and men to communicate about their family roles and responsibilities can strengthen families, protect reproductive health, and reduce gender inequality and gender-based violence. One study in the Philippines showed that domestic violence was least prevalent when the husband and wife communicated and shared responsibility for decisions.

Men's behaviour can change. In India, male health workers have motivated other men to take an interest in women's health and help with housework. In Mali, men's involvement in reproductive health has led to support for women's employment. And in Nicaragua, courses on gender and power have reduced gender-based violence and increased sexual responsibility.

Counting the Cost of Inequality

Just as substantial as the human suffering caused by gender discrimination are the social and economic costs. Inequality rewards men, and some women, blinding them to more productive alternatives. It obstructs social and economic participation and closes off possible partnerships. And it reduces women's effectiveness by failing to support their responsibilities, challenges and burdens.

Women's economic activity is undercounted because it is often in the informal sector. Better accounting could encourage investment and promote productivity. A study in Kenya found that giving women farmers the same support as men could increase yields by more than 20 per cent. In Latin America, eliminating gender inequality in the labour market could increase women's wages by half and national output by a full 5 per cent.

Girls in poor households are more likely to die than boys before age 5, even though globally girls have a better chance of surviving childhood. Inadequate health care in poor populations has a greater impact on women than men; in particular, poor women are more likely than other women to die as a result of pregnancy. The costs of the death of a mother include her lost contribution to the family and its survival, and increased mortality for her children.

High rates of HIV/AIDS infection, due in part to gender inequality and a failure to invest in prevention, have taken a tremendous toll in many nations. In some countries, it is estimated that the pandemic has reduced per capita GDP growth by 0.5 per cent annually. The impacts on the health system and on the poor are severe. In some of the most affected countries, infected persons occupy more than half the available hospital beds.

The global costs of gender violence and abuse include the direct costs of health care, missed work, law enforcement and protection, shelter and divorce. The World Bank estimates that in industrial countries sexual assault and violence take away almost one in five healthy years of life for women aged 15-44.

Denying education to girls slows social and economic development; investing in education pays off. One study concluded that, other factors being equal, countries having three female students or fewer for every four male students could expect 25 per cent less GNP per capita than countries with greater parity in education. The economic advances in some Asian countries from the 1960s through the 1980s hinged in part on smaller family sizes and increased investment in girls' education and health. Educated women with increased income invest more in their children's health and education.

The gender gap in schooling is closing in most of the world, but it remains large in South Asia and sub-Saharan Africa, where fewer than 40 per cent of secondary students are female.

Another cost, one that will rise in coming years as the number of older persons increases, is caring for the elderly. Everywhere, older women live longer than men do. But despite their longer life spans, public pension systems offer women less support because of women's lower formal labour force participation.

Women's Rights

A series of human rights treaties, starting with the United Nations Charter and the Universal Declaration of Human Rights, affirm the rights of girls and women. Forged over several decades by governments and influenced by the global women's movement, these agreements provide a legal foundation for ending gender discrimination and gender-based rights violations, and oblige governments to take action.

The 1979 Convention on the Elimination of All Forms of Discrimination against Women has 165 states parties. An Optional Protocol to the Convention was opened for signature in December 1999 and will enter into force with 10 ratifications. The Protocol will enable individuals and groups of women to submit discrimination complaints to the treaty monitoring body. It will also enable the Committee on the Elimination of Discrimination against Women to initiate inquiries into situations of grave or systematic violations of women's rights.

The Vienna Declaration and Programme of Action for human rights (1993), the Programme of Action adopted by the ICPD, and the Platform for Action adopted by the Fourth World Conference on Women (Beijing, 1995) also strongly support gender equality and women's empowerment. These agreements, while not legally binding, are powerful instruments for promoting change.

The agreements from the ICPD and the Beijing women's conference clearly spell out the components of reproductive rights. These include the right to sexual and reproductive health; voluntary choice in marriage, sexual relations and childbearing; freedom from sexual violence and coercion; and the right to privacy. All of these rights are essential to gender equality.

However, for women's rights to become a reality, they need to be taken seriously, especially by men. This requires education and awareness raising. Women's rights also need to be incorporated into national policies, laws and programmes.

In the past few years, many legal victories have been registered. Mexico and Peru, for example, have passed laws to increase access to reproductive health services. Portugal has amended its constitution to specify that the Government has to guarantee family planning. Botswana, China, Colombia, the United Kingdom and Viet Nam have increased penalties for various sexual offences. Bolivia no longer requires that a woman be found "honest" to be considered the victim of a sexual offence. Germany has criminalized rape by a husband against a wife. Several have outlawed female genital mutilation. But much more remains to be done.

Working Towards a Better Future

Governments have a key role to play in creating conditions for gender equality, by removing legal barriers and changing laws, policies and programmes. Political leaders can advocate and promote gender equality and encourage others to do so. Women's increased political participation is another important way to advance.

Governments have agreed that everyone should have access to reproductive health care by 2015. The key elements — family planning, services for safe motherhood and protection from sexually transmitted disease — are essential to the quality of life of both men and women.

Programmes are also needed to address men's reproductive health needs and foster their active support for women's health. Men should be engaged in dialogues on gender inequality and its costs to men, women and society at large.

Systematic gender analysis and monitoring can show what is needed to respond to the needs of both women and men and promote gender equality. Women's groups need to be involved in designing, implementing and monitoring programmes. Further improvements are needed in the quality of sexual and reproductive health care. Service providers need training and support to provide sensitive care to both women and men.

Needed action against gender-based violence includes advocacy, gender-sensitivity training, legal changes, improved enforcement, safe alternatives for victims, reporting systems, mediation and counselling services, and support for groups providing counselling and help.

Elimination of gender inequality in hiring, wages, benefits and job security should include ending requirements that women prove that they are using contraceptives or are not pregnant. Human rights and health education campaigns should take into account the different perspectives of men and women.

The long-term approach to ending gender discrimination requires efforts at all levels, including training children to see and avoid gender bias. Media, including film, radio, TV and the Internet, can encourage positive images and role models.

Stronger partnerships among governments, NGOs and local communities to monitor and promote compliance with human rights standards are also needed, as are stronger efforts to achieve universal primary education. The international development community, including UN agencies and the World Bank, needs to continue efforts to mainstream gender analysis into policies and programmes. Better collaboration among donors is needed to reduce duplication and share expertise.

Of the $5.7 billion per year that countries have agreed is needed from international sources for reproductive health and population programmes, only about $2.1 billion has been made available. Funding for education and women's empowerment is also inadequate. While international donors, including foundations, have strongly supported efforts to promote gender equality, sufficient resources do not yet back this commitment.

The last several decades have seen greater attention and some progress towards the empowerment of women. There has also been a growing recognition of how the rules governing men's and women's opportunities, social endowments and behaviours affect prospects for accelerated development and justice. But social change is often difficult, particularly when the basic relations between men and women are involved.

The changes in these relationships, and the systems of power and belief that support them, are no less sweeping than other changes already under way in urbanization, globalization and governance. In the end, societies need their own solutions to provide a better life for both women and men, consistent with their cultures and conditions, grounded in a vision of justice and gender equality.

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