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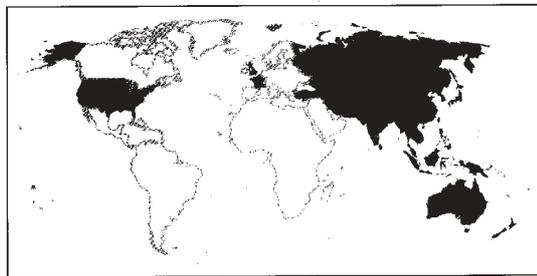


20th Anniversary Special



ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC

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The shaded areas of the map indicate ESCAP members and associate members.

COVER PHOTOGRAPH

The cover page of this issue of the *Asia-Pacific Population Journal* (designed by Han Htay Aung) depicts the *Journal's* various cover pages over the past two decades.

Unfailingly for the past two decades, the *Asia-Pacific Population Journal* has been taking the pulse of population issues unfolding in the region, publishing forward-looking and action-oriented research findings on population policies and programmes, along with clear policy recommendations.

In print since March 1986, our publication marks its 20th anniversary this year! Among other activities to celebrate this landmark anniversary, this commemorative issue has been prepared on the topic of 20 years of progress in the field of population and development.

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This Journal is published three times a year in English by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP). The publication of this Journal is made possible with financial support from ESCAP and the United Nations Population Fund (UNFPA), through project number RAS5P203.

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Asia is holding its own in mortality improvement. In the 20 years of the Asia-Pacific Population Journal's existence the life expectancy of its population has risen by 5.4 years. The gains were greater outside East Asia where mortality levels were already low, and are now at the level reached by the developed world around 1980.

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Central to improving reproductive and sexual health is a greater focus on promoting reproductive and sexual health rights. Women and men of all ages, and of all social positions, must be aware of their rights to information and quality services.

By Philip Guest

Foreword

This year marks the twentieth anniversary since the launch of the first issue of the Asia-Pacific Population Journal in March 1986. Launching of the Journal by the Economic and Social Commission for Asia and the Pacific (ESCAP), with financial support from the United Nations Population Fund (UNFPA), was an important strategy to facilitate the exchange of information, knowledge and experience among ESCAP member and associate member countries and address the multifaceted issues of population and development. The Journal has evolved over the years and has gained a high level of recognition among its readership, composed of planners, policy makers and academics.

The Asian and Pacific region has witnessed significant developments during the last two decades. Important among them is the progress made by countries in the region in addressing the issues of population and their impact on development. The Journal has strived to keep its readership informed about the development challenges brought about by changing demographic contexts.

During the past twenty years the population of the ESCAP region has increased from about 3 billion in 1986 to almost 4 billion in 2006 and is projected to increase to over 5 billion by 2050. Countries in the region have registered declines in mortality and fertility that are unprecedented in human history. They have moderated population growth – which twenty years ago was seen as an impediment to economic growth.

People in the region now live considerably longer and healthier, are better educated, have fewer children and are more mobile. Poverty has declined. While these are measures of progress, important challenges remain and new ones have emerged that affect development and quality of life, including sexual and reproductive health, reproductive rights, HIV/AIDS, population ageing, management of migration, etc.

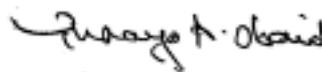
This special commemorative issue of the Asia-Pacific Population Journal includes a number of papers that are forward looking. They review the progress made and identify important issues, opportunities and challenges that lie ahead in meeting the Millennium Development Goals and those contained in the Programme of Action adopted at the International Conference on Population and Development (Cairo, 1994) and the Plan of Action on Population and Poverty adopted at the Fifth Asian and Pacific Population Conference (Bangkok, 2002).

ESCAP and UNFPA have been partners in launching the Journal and in nurturing it as an important medium for sharing information and research findings relevant to population and development policies and programmes. The Journal will continue to keep its readership informed of developments and challenges as they emerge.



Kim Hak Su

*Under-Secretary-General and
Executive Secretary
Economic and Social Commission
for Asia and the Pacific*



Thoraya Ahmed Obaid

*Under-Secretary-General and
Executive Director
United Nations Population Fund*

**Special Issue
Twenty Years of Progress
in the Field of Population and Development: 1986-2006**

Abstracts

Reaching the MDGs: Why Population, Reproductive Health and Gender Matter 9

The 2005 World Summit was an important event for those working to realize the commitments made at the International Conference on Population and Development (ICPD) held in Cairo in 1994. At the World Summit, leaders resolved to achieve universal access to reproductive health by 2015, promote gender equality and end discrimination against women – the pillars of the ICPD Programme of Action.

Yet the World Summit's success does not mean the challenges to achieve the goals contained in the ICPD Programme of Action have ended. The ideological and conservative opposition remains.

The United Nations Population Fund (UNFPA), together with many Governments and development partners in the developing and industrialized world, firmly believes that no initiative to end poverty, whether focused at the national or household level, can ignore the importance of reproductive health, gender and population dynamics.

This paper brings attention to the centrality of women and young people as catalysts for development, and describes ways in which to address their needs and bring them to the forefront of development efforts. Among others, it also urges

countries in South Asia to reap the benefits of this “window of opportunity” to fuel economic growth by making the necessary investments to promote health, education and employment opportunities, as well as improve gender equality.

From Mexico to Cairo and Beyond: Twenty Years of Population Challenges and Development Goals 21

Since the convening of the World Population Conference in 1974, Governments have become increasingly concerned with the consequences of population trends, have been more inclined to view population as a legitimate area of government action and have formulated and implemented policies addressing the issue.

The 1994 International Conference on Population and Development (ICPD) moved population policy and programmes away from a focus on human numbers to that on human lives. The 20-year Programme of Action (PoA) adopted by 179 Governments built on the successes of the previous decades while addressing the needs of the twenty-first century. The PoA recommended a set of interdependent goals and objectives to be attained by 2015 involving universal access to comprehensive reproductive health services, including family planning and sexual health; reductions in infant, child and maternal mortality; universal access to basic education, especially for girls; and gender equality, equity and women’s empowerment. Many of the ICPD goals were incorporated into the Millennium Development Goals (MDGs) adopted during the Millennium Summit held in September 2000. Many of the PoA goals are essential for meeting the MDGs to reduce widespread poverty, hunger, disease and gender inequality by the year 2015.

The progress made, and the constraints encountered, by countries in their efforts to implement specific actions of the PoA spelled out in this article are based on the 2003 Global Survey report completed by UNFPA. The Global Survey results showed that many countries had taken action on internal and international migration, on population and the environment, and on ageing. They had also strengthened national capacities for collecting, processing, analysing and utilizing population data. Constraints mentioned included shortage of funds, too little

trained or qualified staff, inefficient institutional capacity, deficient awareness and understanding of the issues, scarcity of data, inadequate coordination among institutions and ministries, religious opposition, and absence of political will.

Important Issues in the Continuing Mortality Revolution in the Asian and Pacific Region 47

This paper concentrates on mortality decline over the last 20 years but also compares that performance with the preceding three decades. The treatment is mostly a macroscopic one, but there is also an examination of recent changes in the slums of Dhaka. There is an emphasis on poor mortality records where improvement should be sought. That includes potential dividends in the areas of gender imbalance, economic performance and educational advance. Former Union of Soviet Socialist Republics (USSR) Asian countries need to restore important areas of their pre-existing health systems and to improve male health behaviour. South Asia should put more resources into the obstetric system in order to improve both maternal and infant mortality. A major effort is needed to improve health in urban slums by establishing health services even in areas of illegal settlement. The conclusion is that advances against mortality in the Asian and Pacific region have been commendable over the last two decades, but further advances can be made. There is a need to find the best mix of public and private health initiatives, while not abandoning what the public sector does best.

Age-Structure Transition and Development in Asia and the Pacific: Opportunities and Challenges 65

During the second half of the twentieth century countries in Asia and the Pacific have experienced unparalleled declines in mortality and fertility. Consequently, the age structure of their populations is in rapid transition from

“young” to “old”, with some countries are at different stages in this transition. Ageing is the final stage and inevitable consequence of this phenomenon.

The changing age structure of the population provides a “window of opportunity” from which to benefit. Given a favourable policy environment, arise in the proportion of the working age population, resulting from age structure transition, can contribute significantly to economic growth.

This paper examines patterns of age structure transition, by subregions and in selected countries of Asia and the Pacific and their implications for labour supply and ageing. It reviews the findings of various studies on the contribution of age structure transition to economic growth in East Asian Miracle economies, and the policies that helped those countries benefit from it. It also highlights the factors that have stymied economic growth in other subregions and countries.

As age structure transition is still underway in most countries of Asia and the Pacific, many countries are experiencing rapid increases in their working age population and declining dependency ratios, thus providing them with the opportunity to benefit from this window of opportunity. Accrual of this benefit is not automatic, however, policies to enhance human capital, enhance economic growth and create employment are critical. This strengthening will also help better manage the needs of an ageing population.

Progress and Prospects in Reproductive Health in the Asian and Pacific Region

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Progress on a range of reproductive health indicators can be documented for Asia and the Pacific in the period since the International Conference on Population and Development (ICPD) in 1994. Rates of contraceptive use have increased concurrent with improvements in access to a wider variety of contraceptive methods. Child mortality has decreased as has, to a lesser extent, maternal morbidity. Issues of sexual health are being addressed more vigorously and adolescent sexual and reproductive health is now on most national agendas. There is, however, no room for complacency. While international attention is focused on achieving the Millennium Development Goals (MDGs), it is clear that

further improvement of reproductive health programmes is essential for reaching the targets of the MDGs. Reproductive health programmes in the Asian and Pacific region need to improve the quality of care, popularize and support reproductive and sexual health rights, assist women and men communicate with each other about their reproductive and sexual health needs, and more actively serve the needs of young people. More effective reproductive health programmes based on a respect for reproductive health rights will help alleviate poverty, promote gender equity, improve maternal and child health, and reduce the burden of HIV.

Reaching the MDGs: Why Population, Reproductive Health and Gender Matter

There is widespread agreement that reproductive health bears directly on the three MDGs of reducing child mortality, improving maternal health, and combating HIV/AIDS, and is deeply related to the achievement of the MDG on gender equality.

By Thoraya Ahmed Obaid*

The 2005 World Summit was an important event for those of us working to realize commitments made at the International Conference on Population and Development (ICPD) held in Cairo over ten years ago to improve the lives of poor women and men in the developing world. At the United Nations Headquarters in

* Executive Director, United Nations Population Fund (UNFPA).

New York, the largest ever gathering of world leaders in history convened in September 2005 resolved to achieve universal access to reproductive health by 2015, promote gender equality and end discrimination against women – the pillars of the ICPD Programme of Action (United Nations, 2005a).

The World Summit's success does not mean the challenges to achieve the goals contained in the ICPD Programme of Action have ended. Ideological and conservative opposition remains. In some countries where the right policies and effective models are in place, resource and capacity constraints make it difficult to scale-up, monitor and coordinate development programmes. In addition, in places where development programmes have shown demonstrable results, the development community has had limited success in reaching and transforming the lives and futures of the poorest and most disadvantaged (Weiss, 2005).

Increasingly, the success of our development efforts will depend on how good we are at reaching the poor. We live in a time in world history with the resources and means to eradicate extreme poverty. We have clear objectives for this effort, crystallized in the eight Millennium Development Goals (MDGs) that address poverty in its many dimensions – income-poverty, hunger, disease, and lack of access to health, education, shelter and basic needs – while promoting gender equality and environmental sustainability. Those time-bound goals and quantified targets constitute the touchstone against which the successes and failures of international development will be measured.

The United Nations Population Fund (UNFPA), together with many Governments and development partners in the developing and industrialized world, firmly believes that no initiative to end poverty, whether focused at the national or household level, can ignore the importance of reproductive health, gender and population dynamics. The World Summit's Outcome only reinforced this belief.

With the ICPD defining its mandate, UNFPA has worked with Governments in developing countries to translate this vision into population policies framed in the context of sustainable development and poverty reduction, as well as reproductive health programmes that are rights-based and reach those most in need. At the global, regional and national level, UNFPA has examined linkages between demographic factors, poverty and reproductive health. What makes UNFPA's efforts significant – and perhaps somewhat unique – is that it has focused its analysis both at the macro and the household level.

UNFPA and ESCAP recently published “Implementing the ICPD Agenda: 10 years into the Asia-Pacific Experience”, a report which examined the extent to

which commitments made at the ICPD have resulted in changes in policies, programmes and laws based on the principles and vision of the Cairo Conference. The report, based on a global survey conducted by UNFPA, indicated significant progress on many fronts in the region, including girls education and increased access to reproductive health and family planning services. The report also reveals how much more needs to be done. Women's economic and political participation levels remain low, gender-based violence is still insufficiently addressed, and in many countries, the unmet need for family planning remains high. While the reproductive health needs of adolescents and unmarried young people are on the national agenda in most countries, the vast majority continues to lack access to reproductive health information and services.

Poverty, population and development

Over the past three decades, the Asian and Pacific region has undoubtedly made remarkable progress in reducing hunger and extreme poverty, in expanding access to basic services, health and education, and in promoting industrial growth and food security. Unprecedented economic growth rates in the region show that many countries have reaped the benefits of globalization.

However, despite buoyant economic growth, inequality in some countries is rising. For the very poor, little progress has been made and large numbers of people have become newly impoverished as social and economic support systems are dismantled due to integration into the global economy. Furthermore, this region is enormously diverse, with significant variations among different subregions within Asia and the Pacific, in addition to variations within countries themselves. In countries with booming economies, pockets of deprivation and marginalized communities remain.

Population and development are connected in many different ways, some of which are better understood than others. Through much of the 1990s, population aspects were nearly absent in mainstream policy discussions on poverty reduction and economic development. After the ICPD, UNFPA, as well as other organizations working in the population field, focused closely on promoting reproductive health and rights for men, women and young people.

In the decade since the ICPD, new evidence and research has improved our understanding of how demographic factors affect development and contribute to poverty reduction. Considerable recent research has focused on the "demographic bonus" provided by changing age structures as a result of fertility transition. Studies attribute a large part of the East and South-East Asian success to investment in ensuring that the large cohort of working age people had both skills

and employment opportunities (Chu and Lee, 2000). This positive “population effect” on economic development was realized in large part due to investments in health, including reproductive health, and education, as well as greater opportunities for women to participate in the economy (UNFPA, 2002).

The East and South-East Asian experience indicates that it is now a particularly critical time for South Asia, as the window of opportunity for economic growth that gave East Asia its edge opens in the coming years. Provided countries make the investments necessary to promote health, education, and employment opportunities, as well as improve gender equality, the demographic bonus offers a unique opportunity for nations and households to escape poverty and spur growth. For countries in the Asian and Pacific region where fertility remains high, such as Afghanistan, Lao People’s Democratic Republic, Pakistan and Timor-Leste, unless critical investments are made now, this window will open at a later stage. Drawing on a growing body of empirical research, population experts have suggested that countries should study the likely contribution of the demographic bonus to economic growth and trigger this window with programmes to lower fertility by meeting the unmet need for family planning (Hayes, 2005).

Urbanization once helped to reduce fertility rates because it improved access to services. According to the United Nations Population Division (2001), by 2030 over 60 per cent of the world’s population will be urban, and almost all urban growth will occur in the developing countries. Rapid urbanizations is a particularly significant development trend in Asia. The world’s largest urban population will be in Asia, and over half of people living in cities will live in slums and informal settlements, lacking access to essential services such as health and family planning. We are increasingly fighting the battle against poverty in an urbanized environment (ESCAP, 2002; World Bank, 2003).

Most Asian countries are experiencing only the beginning of this remarkable shift of people and economic activity from villages to cities and towns. The urban populations of both China and India will grow by more than 340 million in the next three decades. Even a small country such as the Lao People’s Democratic Republic, which is relatively non-urbanized, is projected to add 3.2 million to its urban population by 2030. In many countries in Asia, urban growth rates are up to twice as high as overall population growth rates. In fact, urban migration in Asia is the most rapid movement of the largest number of people over the shortest period of time in human history. Furthermore, reports indicate a significant increase in the proportion of young people, especially young women, migrating to urban areas (Gultiano and Xenos, 2004; Dang, 2005). Migration data is rarely disaggregated by age. Recent statistics suggest that an estimated 26 million migrants globally, or

around 15 per cent of the total, are youth (United Nations, 2005b). Given the scale and impact of urbanization, it will be necessary to improve and standardize data collection and projection methods in order to integrate trends, patterns and issues related to urban migration into development planning.

Drawing on new thinking and research, UNFPA works with national Governments in the region to address emerging population and development challenges, such as changing demographic structures and migration and urbanization. The Fund helps developing countries to analyse questions related to the level, direction and intensity of the interdependence between demographic factors and poverty reduction, in order to integrate those factors into development planning and policy. Furthermore, UNFPA works in partnership with United Nations agencies to help promote social and economic investments and policies that will enable countries to take advantage of the demographic bonus to overcome the poverty trap and reach sustainable levels of economic and social development. These include pro-poor policies and programmes and investments in young people.

Poverty and reproductive health linkages at the household level

An important new study from the World Bank (Merrick and Greene, 2005), which reviews key findings about links between reproductive health and poverty, concludes that poor reproductive health outcomes undermine the chances of the poor to escape poverty.

I must stress here that though poor reproductive health may contribute to individual and household poverty, it operates in conjunction with many other associated factors. Therefore, simply removing this cause will not help an individual or family rise out of poverty. However, improving access to reproductive health can facilitate and accelerate the move out of poverty when combined with other pro-poor developmental and poverty reduction programmes (Merrick and Greene, 2005). To quote a recent UNFPA technical paper on the role of population and reproductive health policy in reaching the MDGs in East and South-East Asia, “In some cases, it may provide the “extra-push” that makes the decisive difference” (Hayes, 2005).

Conceptually, arguments can be made that poor reproductive health outcomes – early pregnancy, unintended pregnancy, poorly managed obstetric complications – adversely affect the chances of poor women, their children and families to escape poverty. In both developing and industrialized countries, reproductive health status is related to economic levels. Fertility differences between the poorest and richest strata in many countries are among the largest of

any health indicator, and early childbearing in poor families perpetuates an intergenerational cycle of poverty (UNFPA, 2002).

In Asia and the Pacific, where remarkable progress has been made in reducing extreme poverty and hunger and advancing universal primary education, progress towards achieving targets on improving maternal health remains unsatisfactory. ESCAP's report on "Promoting the Millennium Development Goals in Asia and the Pacific," rates progress made towards MDG Goal 5 on maternal health as "poor" and its achievement in 2015 as "unlikely", because "many countries pay insufficient attention to women's health issues" (ESCAP, 2003). This failure to improve maternal health is unconscionable in a region which has seen such rapid progress over the past decades, particularly because interventions needed are cost effective and the programme components needed to prevent maternal deaths are well understood and proven (UN Millennium Project, 2005).

Complications from pregnancy and childbirth continue to be among the leading causes of death and disability of young women in the developing world. These maternal deaths are heavily concentrated amongst the poor, reflecting the significant internal disparities that exist even in countries that have seen remarkably high rates of economic growth (UNFPA, 2005). Fortunately, the overall dismal picture on maternal health, has also seen some exemplary cases. Experience from Bangladesh and Sri Lanka has shown that maternal mortality can be reduced in low-income environments – by increasing access to skilled attendants, emergency obstetric care and family planning programmes (United Nations, 2005c).

The Millennium Project identifies gender biases in public resource distribution and social and economic policies, as well as a pervasive neglect of the needs of the next generation in life skills, nutrition, information, education and employment opportunities, and sexual and reproductive health information and services as critical barriers to achieving the MDGs. The costs of gender inequities and discrimination are highest for poor countries and poor families. Gender discrimination squanders human capital by making inefficient use of individual abilities and limiting the contribution of women (World Bank, 2001).

Gender equity and equality increases the economic participation and earning capacity of women. In addition, as women tend to reinvest these gains in their children and families, investing in women has a multiplier effect on poverty reduction and national development. The ability to make free and informed choices in their reproductive life, including those involving child-bearing, underpins

self-determination in all other areas of women's lives. Because these issues affect women so profoundly, reproductive health cannot be separated from the wider goal of gender equality (UNFPA, 2005).

The Asian and Pacific region's pervasive gender inequity and inequality has serious consequences on population structures, and has led to sex-ratio imbalances in several Asian countries, with female population declining relative to male population. The 2000 census in China reported a sex-ratio of 116.9 males to 100 females, more than five percentage points higher than the figure of 111.3 males recorded in the previous census in 1990 (UNFPA China, 2004). In India, there are similar trends of declining sex-ratios. Explanations for this decrease are disturbing, pointing to pervasive discrimination and neglect of girls and a preference for sons. Prenatal sex selection occurs in several Asian countries, and girl babies have been allowed to die after birth. In India, the child sex ratio, estimated for age group 0-6 years dropped by 4.5 per cent between the censuses of 1981 and 2001, or from 971 to 927 girls per 1,000 boys (UNFPA India, 2005).

HIV/AIDS is also a serious concern in the region and is closely associated with poverty and gender inequities. Despite low prevalence rates at the national level across much of the Asian and Pacific region, the figures hide localized, subnational epidemics. Due to the large population numbers in the region, the actual number of people living with HIV in several Asian countries is very high (China and India combined have more than one third of the world's population). India, for example, with approximately 5.7 million people living with HIV (UNAIDS, 2006) has more HIV infections than any other country in the world. In 2005 in Asia, an estimated 8.3 million adults and children were living with HIV and 930,000 people were newly infected (UNAIDS, 2006). Women and girls are at particular risk of HIV infection as a result of biological factors, as well as poverty, inequality, gender-based violence and early marriage.

Many HIV-positive women in Asia are married and have had only one partner – their husbands. The perception that marriage protects young women is far from true. In fact, young married women may be particularly at risk. In India, for example, where the majority of women marry young, 90 per cent of women with HIV reported having been faithful to their husbands (UNFPA, 2005).

With no cure in sight, prevention is the first line of defence. Large-scale prevention programmes have helped stem the spread of the epidemic in Thailand and Cambodia, and offer lessons and models for other Asian and Pacific countries. The majority of HIV infections are either sexually transmitted or transmitted from mother to child through pregnancy, childbirth and breast-feeding. Stronger linkages between HIV/AIDS and sexual and reproductive health, at the policy and

advocacy level through programme development and implementation, should result in important public health benefits (IPPF, UNFPA, WHO, UNAIDS, 2005). With effective monitoring and evaluation, as well as research, these linkages can be better articulated, documented, adapted and applied to suit national and local situations.

Investing in young people

My final point is a call for increased investments in young people as agents of development. Today, close to 70 per cent of the over 1.5 billion young people aged 10-24 in the world live in Asia and the Pacific. In many Asian countries, young people make up from one third to one half of the population. The demographic surge of young people in the region presents a serious challenge in terms of education, employment, health, stability and human rights. It also presents a tremendous opportunity for increased productivity, savings and economic growth. Whether or not a country can take advantage of this opportunity, however, depends on whether young people entering the workforce are educated, healthy, skilled and optimistic about their future. Thus, it is imperative that young people are recognized to be major assets to their countries, whose potential should be realized rather than perceived as problems and threats to security and stability.

In addition, the childbearing decisions of young people will determine the future of our planet. Providing them with information and the means to delay pregnancy is not only a health and human rights imperative, it is also a key to slowing the momentum of population growth and allowing developing countries to reap the economic benefits that lower fertility rates can bring.

Young people are at the centre of the HIV/AIDS epidemic in Asia. Over half of new infections in the region are among those aged 15 to 24. There are many reasons why young people are particularly vulnerable to HIV/AIDS. They are increasingly migrating from rural to urban areas, as well as across borders, in search of economic opportunities. Many others are victims of trafficking, sex work and forced labour. In some parts of Asia economic growth has been accompanied by rapid changes in culture and attitudes, and an increasing exposure to global youth culture. In other parts of the region, gender inequality and traditional practices such as child marriage mean that girls and young women have little access to educational opportunities and lack basic information about reproductive health.

Young people have traditionally been ignored by public sector programmes and budgets, which tend to focus mainly on children under 10 first, and then on adults. Young people, particularly young women, must be a priority in the effort to

eradicate poverty and achieve the Millennium Development Goals in Asia and the Pacific. According to the United Nations Millennium Project, no countries in the region are on track to meet MDG health-related Goals, and sexual and reproductive health is one of the key areas in which adolescents are widely underserved (UN Millennium Project, 2005).

Governments in Asia and the Pacific are beginning to pay more attention to young people, as evidenced by the mention and/or inclusion of youth in a range of policies, including specific youth policies or devoted sections of reproductive health/population policies. Furthermore, multilateral donors such as the World Bank have increased investment and programmes for youth. The World Development Report for 2007 of the World Bank (World Bank, forthcoming) will focus on youth, and the Bank is working more closely with United Nations agencies on young people's health, development and protection to promote peer education, life skills, and youth-friendly health services. UNFPA has also collaborated with development partners to emphasize the importance of working with young people today if we are to reach the MDGs within the next 10 years.

Conclusion

There is widespread agreement that reproductive health bears directly on the three MDGs of reducing child mortality, improving maternal health, and combating HIV/AIDS, and is deeply related to the achievement of the MDG on gender equality. However, the evidence to support the argument that reproductive health-related policies and programmes promote poverty reduction needs strengthening. Reproductive health practitioners must make it a priority to marshal and demonstrate the evidence that supports what we know to be true on the ground – that access to quality reproductive health services gives poor women greater control over their lives.

The Millennium Declaration and the associated Millennium Development Goals have generated an unprecedented common purpose and urgency for the elimination of extreme poverty. Their achievement will depend largely on whether the present generation of young people living in poverty has access to the opportunities and services they need to build a better life.

Throughout this paper, I have sought to bring attention to the centrality of women and young people as catalysts for development in Asia and the Pacific, and describe ways in which to address their needs and bring them to the forefront of development efforts. I end with a quote from the Millennium Report (United Nations, 2000).

“Young People are a source of creativity, energy and initiative, of dynamism and social renewal. They learn quickly and adapt readily. Given the chance to go to school and find work, they will contribute hugely to economic development and social progress”.

*“We the Peoples”: The Role of the United Nations
in the 21st Century, 2000*

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From Mexico to Cairo and Beyond: Twenty Years of Population Challenges and Development Goals

In the two decades since the Mexico Conference, the world, particularly the Asian and Pacific Region, has moved on, in terms of both its economic and demographic situations. The demographic transition in Asia and the Pacific has progressed significantly.

By Mercedes B. Concepcion*

According to the United Nations, world population numbered 6.5 billion in 2005 and is currently growing at about 1.2 per cent annually (United Nations, 2005). The 7 billion mark is projected to be reached in 2012, just six years from

* University Professor Emeritus, College of Social Science and Philosophy, University of the Philippines, Quezon City, Philippines, e-mail: concepcion_mercedes@yahoo.com.

today. Long-range population projections reveal that the world's population could ultimately stabilize at about 9 billion people.

World population is continuing to grow due to the large size of the current population and the youthfulness of populations in developing regions and in least-developed countries. However, considerable dissimilarity exists in the expected population growth of countries. The populations of many African and Asian countries are estimated to expand greatly in the coming decades. By contrast, due to below-replacement fertility levels, some developed countries are anticipated to undergo notable population decline.

The world's urban population is increasing rapidly and is predicted to grow from today's 3.2 billion persons to about 5 billion in 2030. It is predicted that half of the world's population will live in towns and cities by 2007, a year from now.

The number of massive urban agglomerations is also rising. Tokyo, Mexico City, New York-Newark, Mumbai, Sao Paulo and Delhi all contain more than 15 million persons. However, about one in two urban dwellers live in small settlements with fewer than half a million inhabitants.

The proportion of older persons is estimated to increase well into the twenty-first century. As the pace of population ageing is faster in the developing countries than in the developed ones, the former will have less time to adjust to the consequences of the changing age structure. Moreover, population ageing in the developing countries is taking place at much lower levels of socio-economic development.

Most developed countries have fertility levels at or below the replacement level. Although many developing countries have advanced in the transition from high to low fertility, some African countries still have high fertility levels.

Contraceptive use had intensified notably during the 1990s, from 54 per cent in 1990 to 63 per cent in 2000. Short-acting and reversible methods are favoured in the developed countries, while longer-acting methods are more in demand in developing countries.

During the last century, mortality underwent the most rapid reduction in the history of humankind, due to better hygiene, improved nutrition and scientifically-based medical practices. Until recently, mortality was thought likely to continue falling in all countries. However, HIV/AIDS has already increased mortality in Africa, the region most affected by the disease.

About 175 million persons reside in a country other than their country of birth. Between 1960 and 2000, the number of migrants more than doubled with three fifths residing in the more developed regions of the world. International migration policies are currently being re-examined, as these policies affect countries of origin, transit and destination.

Developed and developing countries have wide variation in their population concerns. For developing countries, the most significant population concern is high mortality, particularly infant and child mortality, maternal mortality and mortality related to HIV/AIDS. Developed countries are concerned with low fertility and its consequences, including population ageing and the shrinking of their workforce.

The current population picture is one of dynamic population change, reflected in new and diverse patterns of childbearing, mortality, migration, urbanization and ageing. The continuation and consequences of these population trends present opportunities as well as challenges for all societies in the twenty-first century.

Since the convening of the World Population Conference in 1974, Governments have become increasingly concerned with the consequences of population trends. Moreover, Governments are more inclined to view population as a legitimate area of action and to act upon those concerns by formulating and implementing policies addressing these issues.

This paper will discuss the gradual changes in emphases in population and development programmes over the past two decades, beginning with the International Conference on Population (ICP) held in Mexico in 1984 and continuing with the United Nations conferences during the 1990s, including the 1994 International Conference on Population and Development (ICPD) held in Cairo. This paper will also describe the impact the action plans of those conferences has for the attainment of universally agreed development goals, specifically the Millennium Development Goals (MDGs) contained in the United Nations Millennium Declaration of September 2000. Key population trends relevant for development, and the human rights basis that underpins key conference objectives and recommendations for action, will be summarized. This paper will rely heavily on the findings of the 2003 Global Survey conducted by the United Nations Population Fund (UNFPA), as contained in the report entitled *Investing in People - National Progress in Implementing the ICPD Programme of Action 1994-2004* (UNFPA, 2004), as well as *World Population Prospects, The 2004 Revision* (United Nations, 2005) and the monitoring of population policies at

the international level undertaken by the United Nations Population Division summed up in *World Population Policies 2005* (United Nations, 2006).

The 1984 International Conference on Population

The International Conference on Population held in Mexico in 1984 reaffirmed the principles and objectives as well as the validity of the World Population Plan of Action (WPPA) adopted at Bucharest in 1974. The Mexico Conference specified a series of activities which needed to be undertaken at national, regional and global levels to improve the standards of living and quality of life of the world's people. The ICP laid out a population strategy in its 88 recommendations spanning such diverse matters as socio-economic development and the environment, the role and status of women, development of population policies, population growth, morbidity and mortality, reproduction and the family, population distribution and migration, international migration, population structure, data collection and analysis, research, management, training, information, education and communication as well as the role of national Governments and international cooperation in the implementation of the recommendations.

The major substantive shifts of emphasis in the Mexico document from the recommendations contained in the Bucharest WPPA are in the areas of integration of population and development, formulation and implementation of policies, the role and status of women, the importance of changes in socio-economic and demographic structures and the focus on urbanization and population distribution.

The dissimilar experiences of countries in policy formulation and implementation during the period 1974-1984, the varied facets of demographic transition that were observed in developing countries, and the thrust on integration of population and development that was strongly endorsed at the Mexico Conference involved some modifications of existing population policies and programmes. It is necessary for population policies to be increasingly based on sound scientific research and effective strategies; more focused on the effects of such variables as mortality, nuptiality, fertility, family planning, migration, urbanization, ageing and other compositional influences; and more effective in their harmonization with development policies.

The resolution of these policy changes involved, among other requirements, stronger national commitment to policy formulation and implementation; more competent research and analysis of population issues; and committed financial, institutional and humanpower support for policies and programmes.

At the time of the Mexico Conference, the world population numbered approximately 4.8 billion, growing at an estimated 1.72 per cent annually with a yearly increment of 80 million people. During the decade between 1980-1985 and 1990-1995, the world's average total fertility rate (TFR) dropped by 17 per cent, from 3.6 to 3.0 births per woman (United Nations, 1998). Undoubtedly, government views and policies concerning fertility contributed to the fertility decline in developing countries. In 1986, 41 per cent of Governments viewed fertility in their countries as too high (United Nations, 2006). Unlike in the past, when perceptions of high fertility were usually not accompanied by policy intervention, after the Mexico Conference 54 per cent of the countries intervened to modify their fertility levels. This figure represented more than half (53 per cent) of the African countries and 71 per cent of the countries in Asia.

Government policies on providing access to contraceptive methods are an important determinant of reproductive behaviour, as well as of maternal and child health. In 1986, 98 countries in the less developed regions provided direct support for contraceptive methods, as compared to 74 countries a decade earlier. Among the least developed countries, the corresponding figures were 35 and 18, respectively (United Nations, 2006).

The International Conference on Population and Development

The International Conference on Population and Development held in Cairo in September 1994 was the largest intergovernmental conference on population and development ever held. The Conference moved population policy and programmes away from a focus on human numbers to a focus on human lives. It emphasized improvement in the lives of individuals and increasing respect for their human rights. The 20-year forward-looking Programme of Action adopted by 179 Governments built on the success of the previous decades while addressing the needs of the twenty-first century. The ICPD Programme of Action recommended a set of interdependent goals and objectives to be attained by 2015. Those included: universal access to comprehensive reproductive health services, including family planning and sexual health; reductions in infant, child and maternal mortality; universal access to basic education, especially for girls; and gender equality, equity and women's empowerment. The Programme of Action underscored the integral and mutually reinforcing linkages between population and development. It urged the empowerment of women both as a highly important end in itself and as a key to improving the quality of life for everyone.

In 1999, the United Nations General Assembly convened a Special Session (known as the ICPD+5) to examine the progress made in meeting the ICPD goals.

The review reaffirmed the ICPD Programme of Action, adopted *Key Actions* for its further implementation, sought to improve monitoring, facilitated the setting of priorities, and underscored the importance of tackling such emerging issues as HIV/AIDS, population ageing and adolescent reproductive health. The ICPD+5 adopted a new set of benchmarks in four areas: (a) education and literacy; (b) reproductive health-care and unmet need for contraception; (c) maternal mortality; and (d) HIV/AIDS.

Many of the ICPD goals were incorporated into the Millennium Development Goals (MDGs), which were adopted during the Millennium Summit in September 2000. Many of the ICPD goals are essential for meeting the MDGs to reduce widespread poverty, hunger, disease, and gender inequality by the year 2015.

The ICPD Programme of Action reached its midpoint in 2004. This was a good opportunity for countries to take stock of the progress that had been made in achieving its goals. A comprehensive review and appraisal of the implementation status of the ICPD Programme of Action was undertaken by the UNFPA in 2003.

The following paragraphs will describe the progress made and the constraints encountered by countries in their efforts to implement specific actions of the Programme of Action based on the report of the 2003 Global Survey (UNFPA, 2004). Illustrative examples of specific actions taken by selected Asian and Pacific countries will be presented. The Survey aimed to document the actions, measures or initiatives taken by countries to address particular issues or concerns as well as obstacles encountered. One questionnaire was sent to 165 developing countries and countries in transition consisting of nine topics: population and development; gender equality, equity and women's empowerment; reproductive rights and reproductive health; adolescent youth; HIV/AIDS; behaviour change and advocacy; data and research; partnerships and resources; and best practices and emerging issues. A shorter one intended for 22 developed countries belonging to the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee comprised five topics: population concerns, gender issues, reproductive health (including HIV/AIDS), partnerships with civil society, and international assistance to population and reproductive health programmes. The questions were designed to elicit information on the challenges faced by donor countries in mobilizing resources to support the implementation of the ICPD Programme of Action and on how countries link ICPD goals with international development frameworks and processes.

1. Population and development

The Global Survey revealed that 115 out of 149 reporting countries (77 per cent) had adopted multiple measures to integrate population concerns into their development strategies. Only 52 per cent of developing countries had reported doing so a decade earlier.

Almost four out of five countries (79 per cent) reported integrating population factors into local development plans and local structures. This represents significant progress from a decade earlier, when decentralization was a relatively new and still-evolving process. More than half (52 per cent) established local governance structures while half of the countries had integrated population factors into local social plans, and to a lesser extent, into economic and environmental plans.

Nearly three in five countries (57 per cent) reported taking multiple measures in integrating population factors in poverty reduction strategies as compared to 13 per cent in 1994. For example, Bangladesh's poverty reduction strategy visualizes that by the year 2015, the nation will reduce its poverty level by eradicating hunger, chronic food insecurity and extreme destitution. Close to two thirds (65 per cent) of countries with both a high poverty level (40 per cent) and higher population growth rate (1.47 per cent) had a higher action rate compared to only 40 per cent for countries with the lowest levels of poverty (20 per cent) and lower population growth rate (1.47 per cent).

Half of the countries had acted strongly to address issues of population and environment with most of them developing programmes, policies and/or laws on the issue. In Indonesia, sectoral development plans aim to empower local communities to manage natural resources and the environment through religion, customs and cultural approaches. When the level of poverty and the population growth rate (PGR) are factored in, countries with a higher level of poverty or a higher PGR are more likely to have adopted multiple measures. Almost twice the number of countries (60 per cent) with high poverty and high population growth had adopted multiple measures compared to those countries with lower poverty levels and PGR (33 per cent).

About two out of five responding countries (39 per cent) addressed the special needs of the elderly as compared to 21 per cent in 1994. India formulated a comprehensive National Policy on Older Persons (NPCP) in 1999. A national scheme of monthly old-age pensions for widows over 60 years of age and for all persons 75 years and over was introduced in Nepal. Countries with higher levels

of population ageing (7per cent) were almost twice as likely to have adopted major initiatives (58 per cent) than those with lower levels of ageing (30 per cent).

The Global Survey results showed that 64 per cent of countries took action on internal migration as compared to 41 per cent a decade earlier. Governments had developed plans to promote resettlement schemes, redistributed population by establishing new economic growth centres, decentralized social and economic planning as well as political activities and formulated programmes and strategies to resettle and rehabilitate internally displaced persons.

International migration issues were addressed by nearly three in four countries (73 per cent) reporting in 2003 in contrast to only 18 per cent in 1994. The most common measure adopted was formulating plans, programmes or strategies on international migrants and/or refugees (45 per cent), followed by the enactment of laws or legislation on international migrants and migrant workers (37 per cent), adoption of a migration policy (33 per cent), the undertaking of efforts to enforce international conventions on refugees, asylum-seekers and migrants (11 per cent), and the passing of laws on the trafficking of humans, especially women and children (10 per cent). A growing number of countries have established coordination across agencies within Governments, between and among Governments, NGOs, donors and others.

The ICPD Programme of Action had emphasized that valid, reliable, timely, culturally sensitive, sex-disaggregated and internationally comparable data should form the basis of all policy and programmes. The ICPD+5 *Key Actions* re-emphasized this point by identifying the need to strengthen national information systems to produce reliable statistics on a broad range of population, environment and development indicators in a timely manner. These indicators are relevant to all the international frameworks, including the MDGs and the 2002 World Summit on Sustainable Development. The Global Survey found that 93 countries had strengthened their capacity for collecting, processing, analyzing and utilizing population data; 75 had developed national databases and management information systems; 61 had trained staff on database management and another 61 had created/strengthened national statistical service. China's higher education institutions had trained a large number of professionals in the areas of population and development. In India, the Central Statistical Organisation drew up a national training strategy for skills upgrading and capacity-building in data collection, analysis and utilization.

Monitoring and evaluating the implementation of international development frameworks, including the ICPD Programme of Action (PoA) and the MDGs, are essential for assessing progress in meeting development targets and identifying best practices and constraints. In 1998, only 43 countries had reported taking significant measures to establish monitoring mechanisms for assessing the achievement of the goals contained in the ICPD PoA. Five years later, this figure had increased to 131 out of 151 reporting countries with 82 providing information on the mechanisms used.

The constraints affecting policy development and the implementation of the population and development strategies cited were: (a) financial constraints; (b) lack of trained or qualified staff; (c) insufficient institutional capacity; (d) deficient awareness and understanding of the issues; (e) scarcity of data; (f) inadequate coordination among institutions and ministries; (g) religious opposition; and (h) absence of political will.

The emerging issues in population and development identified by responding countries were: (a) population ageing; (b) poverty alleviation; (c) internal and external migration; (d) improving the situation of refugees/internally displaced persons; and (e) the need to strengthen population data collection, especially censuses, and to improve overall data quality.

2. Gender equality, equity and empowerment of women

To remove obstacles to gender equality and to improve the lives of girls and women, the ICPD PoA defined a set of strategic objectives and spelled out corresponding actions to be taken by Governments and other development partners. Five specific areas were covered in the Global Survey responses: (a) protecting the rights of girls and women; (b) women's empowerment; (c) gender-based violence (GBV); (d) gender-based disparities in education; and (e) men's support for women's rights and empowerment.

Protecting the rights of girls and women Almost all responding countries adopted legislation and formulated national laws on the rights of girls and women, ratified related United Nations conventions and implemented the ICPD PoA. More than a third of the countries had formulated policies to remove gender discrimination and less than a third provided constitutional protection to girls and women.

Women's empowerment – All but one of the countries surveyed had taken steps to empower women, the most common of which was promoting increased women's participation in governance. Providing women with economic opportunities and

with education and training, adopting laws and legislation for women's empowerment and promoting women's increased participation in the political process were also mentioned. Indonesia had formed Women in Development management teams at regional and provincial levels to coordinate empowerment activities.

Gender-based violence (GBV) – Two thirds of the countries had adopted laws and legislation on GBV while two in five responding countries had provided support for the victims. Some 37 per cent of the countries surveyed had conducted Information Education and Communication (IEC) and advocacy on GBV and established national commissions while 24 per cent had trained service providers and government officials on handling GBV. Another 24 per cent had set up institutional mechanisms for GBV monitoring and reporting. For example, Iran (Islamic Republic of) had established special centres for female police officers in metropolitan police departments to assist victims of violence against women. The Government supported the setting up of hotlines within police departments.

Gender-based disparities in education – The PoA had set universal primary education as a goal for all countries before 2015. Of the 129 responding countries who reported some progress in addressing the gender gap in education, 22 per cent indicated that the ratio of girls to boys at the primary level was increasing. At the secondary level, 16 per cent of countries reported that the girls-to-boys ratio was rising. Measures initiated by Governments to close the gender gap in education included: (a) providing incentives to poor families to send girls to school; (b) undertaking Information Education and Communication and advocacy campaigns on gender equality in education; (c) promulgating laws and legislation for equal education of girls and boys; (d) incorporating gender issues into school curricula; and (e) setting up an increased number of girls' schools at the secondary level.

Concerning access to primary and secondary education, the most common measure cited was providing free public schooling (40 per cent), followed by declaring compulsory primary education for boys and girls (32 per cent). Other measures taken were furnishing incentives to poor families to send their children to school (20 per cent) and supplying free secondary education (19 per cent).

Men's support for women's rights and empowerment – The majority of responding countries took steps to ensure that boys are instilled with attitudes respectful of women and girls. More than half of the countries developed, reviewed and revised textbooks and curricula to incorporate gender equality concerns; about one third conducted IEC/advocacy campaigns on gender equality; over a fourth advocated gender equality in organizations and one in six developed

reproductive health (RH) education plans and programmes for adolescents and youth.

Government actions taken to enable men to support women's rights and their empowerment consisted of IEC/advocacy campaigns on men supporting women (54 per cent) and the formulation of plans and programmes encouraging male involvement in RH (42 per cent).

3. Reproductive rights and reproductive health

Ensuring universal access to a full range of RH care information and services by 2015 is central to the ICPD Programme of Action. Among the 151 countries surveyed, 145 replied to the question on enforcement of reproductive rights, 131 of them having adopted policy measures, laws or institutional changes at the national level to enforce reproductive rights (RR).

Some countries have set up national human rights institutions, including national commissions to monitor the implementation of human rights. Others have human rights ombudsmen and many rely on the monitoring procedures of legally binding international human rights treaties ratified by their Governments.

Of the 151 countries, 136 had integrated RH service components into their primary health-care systems. Of these 136, 81 indicated that they introduced these measures after the ICPD. In the last 10 years, many countries embarked on health sector reform to improve efficiency, affordability, quality and client responsiveness. Of the 120 countries implementing health-sector reforms, 106 had included aspects of RH as part of the package. Some countries recognized the needs of a specific clientele, e.g., adolescents and youth (73 countries); women, in particular pregnant women (58 countries); or women, men and youth (44 countries). Twenty countries reported that the package included IEC on RR and RH. Two countries reported that the RH inclusion in the package allowed them to increase budget allocations for RR and RH.

The Global Survey asked about key measures taken by Governments to increase access to high-quality RH services. Malaysia reported that even before the ICPD, core RH service components, including obstetric care, had already been integrated into their primary health-care system. Following ICPD, the treatment of reproductive tract infections and infertility and the screening for cervical cancer were added. The Philippines includes access to high-quality RH service as a key component of its Women's Health Development Programme. All but two of the 151 countries surveyed responded to the question and 143 indicated having taken measures. These countries emphasized the need to correct shortages of trained staff, particularly in midwifery and essential obstetric care. Kiribati opened a

School of Midwifery while Palau provides continuing education for young local physicians. The Fiji School of Medicine conducts regular training programmes for Pacific Islanders. A number of countries (Bangladesh, the Democratic People's Republic of Korea and Mongolia) have introduced protocols for standardizing quality service delivery, while many others have also worked to upgrade their RH facilities.

In terms of expanding contraceptive choice measures, 143 out of 151 countries responded with 126 taking at least one key measure while 88 had taken multiple measures. Progress since 1994 and since ICPD+5 is significant, both in the number of countries taking major measures, and in the variety of measures taken to increase information and access to contraceptives, as well as to increase contraceptive choice.

The ICPD Programme of Action stressed the need to make quality services affordable and accessible to all who need and want them, including a reliable and adequate supply of a range of contraceptive methods and other RH commodities. Responses to the Global Survey revealed that 119 countries had taken one or more measures to improve RH commodity security and 56 reported multiple measures a significant improvement from 1998. The Pacific Plan for Commodity Security was adopted by the Cook Islands, Fiji, Samoa, Solomon Islands, Tonga and Tuvalu in response to a resolution passed by the Commonwealth Health Ministers Meeting in 2002. The Plan calls for establishing regular warehousing with coordinated and effective storage and distribution systems as well as appropriate mechanisms for cost recovery and sustainability. It also provides an independent budget line for commodity security. India has a division dedicated to RH commodity security and has appointed two national agencies for procurement. Indian manufacturers produce, supply and even export the country's own RH commodities.

The ICPD recognized complications related to pregnancy and childbirth as among the leading causes of mortality for women of reproductive age in many developing countries. Among the key measures taken to reduce maternal mortality and morbidity, a large number (113 out of 151 countries) reported training health-care providers, improving prenatal and post-natal services, establishing a network of RH/family planning clinics, providing maternal health services for vulnerable groups or those in remote areas and refining data collection and record keeping.

A great many countries (135) had taken the following measures to prevent and manage sexually transmitted infections (STIs): (a) prevention, treatment and management service provision; (b) IEC/advocacy campaigns on prevention and treatment; (c) government establishment of a national commission/agency/

ministry/desk; (d) monitoring surveillance systems; (e) educational initiatives that target vulnerable populations; and (f) social marketing of condoms and STI medication. As part of its National AIDS and STI Prevention and Control Programme, the Philippines is integrating the syndromic approach in public sector outlets; collaborating with private clinics in STI diagnosis, treatment and surveillance; promoting 100 per cent condom use; providing STI drugs through social marketing; and collaborating with NGOs on peer education for condom promotion and STI prevention. A National Reference Laboratory on STIs and AIDS has been established, with offices in strategic parts of the country.

Of the 151 countries surveyed, 117 reported that they had taken measures to prevent and manage complications of unsafe abortion. Some countries strengthened their family planning services to prevent unsafe abortions. Others prepared guidelines, conducted training, and provided facilities to improve access to post-abortion services, both to manage complications and to prevent the repeat of unsafe abortions.

Of the 137 countries, 124 indicated they had taken measures to involve beneficiaries. Some had assessed the population's needs and opinions by means of public hearings or consumer surveys, or by involving community and civil society in policy and/or programme formulation. Countries also established action groups at the local level, trained community RH workers to involve beneficiaries and meet their needs, and conducted information and advocacy activities aimed at informing and involving beneficiaries.

Although the 2003 Global Survey disclosed that countries were making undiminished progress in RH services and information and in RR issues, the Survey also emphasized the challenges involved in integrating RH in primary health-care systems, especially in the context of health-sector reform. Constraints common to all regions included: (a) insufficient financing and lack of sustainability (64 countries); (b) inadequate number of trained health-care providers (38 countries); (c) absence of equipment and facilities (33 countries); (d) difficulties in accessing services, particularly in remote areas, often due to insufficient decentralization (22 countries); and (e) poor communications (19 countries). Countries also cited gender inequality and problems in providing services for men and adolescents.

4. Adolescent reproductive health and youth

Among the reporting countries, 92 per cent had taken at least one measure to address the RH and RR of adolescents, including access to information on these issues. In terms of policy and legislative measures, 34 per cent of countries had

developed and implemented policies sensitive to adolescent RH; 27 per cent had formulated and implemented laws and/or legislation on adolescent RR and RH needs; and 9 per cent had ratified United Nations conventions. With regard to programmatic and strategic measures, 62 per cent had formulated national plans and programmes including the RR and RH needs of adolescents; 33 per cent had utilized IEC and advocacy campaigns on adolescent issues; 26 per cent had integrated RH education into school curricula and 22 per cent had established a national commission on adolescents and youth.

The 2003 Survey results showed that 140 out of 151 countries had taken at least one measure to introduce health education into school curricula and out-of-school youth programmes. The most common measures undertaken were the provision of: (a) school curricula that included RH and life skills (89 per cent); (b) out-of-school programmes and clinics (39 per cent); (c) training on RH for teachers and other school staff (26 per cent); and (d) peer education programmes (19 per cent).

Of the 151 country respondents, 133 had provided access to information on RH to adolescents. Among the measures taken were: (a) IEC/advocacy (54 per cent); (b) formulation and implementation of national education plans, programmes and strategies (35 per cent); (c) provision of peer education programmes (29 per cent); and (d) use of media such as TV and radio to convey RH information (28 per cent).

Ensuring adolescent access to affordable, confidential, gender-sensitive and youth-friendly RH services was one clear recommendation of the ICPD Programme of Action. Close to three in five countries (57 per cent) established youth-friendly services; formulated plans and programmes for the provision of RH services to adolescents (34 per cent); counseled adolescents on RH (27 per cent); and undertook IEC/advocacy on RH services for adolescents (27 per cent).

Life-skills training for adolescents and youth were also supplied by Governments. The measures reported in support of the comprehensive development of young people included the provision of: (a) relevant education system and education in vocational and entrepreneurial skills (61 per cent of the countries); (b) vocational and entrepreneurial education to out-of-school youth (55 per cent); (c) government jobs for youth (33 per cent); and (d) entrepreneurial training for youth by NGOs (18 per cent). The Government of Pakistan is addressing small and medium enterprises (SMEs) development and information technology (IT) with soft loans extended to young people to promote self-employment, as well as greater access for women to microcredit through the Women's Bank and Agricultural Development Board.

Since the Cairo Conference, the participation of young people in policy and programme development has been encouraged. Of the 151 countries surveyed, 64 per cent had engaged adolescents and youth in project formulation and implementation; 47 per cent had included adolescents in policy development; 28 per cent had established fora for youth to elicit information; and 19 per cent had promoted youth organizations or associations as a channel for their participation.

Religion as a factor promoting Adolescent Reproductive Health (ARH) was reported by some countries. Some religions include RH information as part of their religious teaching. When asked how the cultural context constrained the promotion of ARH within the country, 43 per cent of the countries underscored the lack of information available to the youth and reported that open discussion on sexual behaviour and RH issues with adolescents and youth is considered inappropriate or simply not done. Moreover, 23 per cent reported that religious opposition can sometimes prevent youth from seeking RH services.

5. HIV/AIDS

The number of people living with HIV and AIDS continues to grow, most markedly in sub-Saharan Africa. However, with the epidemics expanding in Asia, the Pacific, Eastern Europe and Central Asia, more than five million people became newly infected – half of them young people between the age of 15 and 24 – and are now part of today's 40 million people across the globe living with HIV/AIDS. As HIV/AIDS is a key component of RH and a critical factor influencing the achievement of ICPD goals and the MDGs, the 2003 Survey asked countries to describe successful strategies used to address the HIV/AIDS pandemic. The collective findings are categorized into three distinct groupings: (a) plan, policy or strategy formulation; (b) adoption of prevention approaches; and (c) support activities. Three fourths of the countries reported adopting a national strategy on HIV/AIDS, over a third stated they had specific strategies aimed at vulnerable and high-risk groups, two in nine had adopted a specific policy on HIV/AIDS and one in six passed laws or legislation in support of HIV/AIDS efforts.

Based on the survey responses, a large proportion of countries are addressing prevention as part of their response to HIV/AIDS. Among those measures are: (a) IEC; (b) blood safety; (c) voluntary counselling and testing; (d) prevention and treatment for HIV/AIDS and other STIs; (e) promotion of condom use; (f) surveillance (both epidemiological and behavioural); (g) harm reduction; (h) care, treatment and support of those infected and affected; (i) capacity-building combined with strengthening the health infrastructure; (j) elimination of stigma and discrimination; (k) increased involvement of people

living with HIV/AIDS; (l) advocacy and other supportive measures; and (m) monitoring and evaluation.

A total of 131 countries targeted interventions to high-risk groups such as sex workers (73 per cent); injecting drug users (31 per cent) and long-distance truck drivers (24 per cent). Vanuatu is gathering baseline data and information on services for sex workers and their clients. Popular artists in Bhutan have recorded IEC messages in the form of songs for distribution to truck and taxi drivers. Among the vulnerable groups, the highest percentage of action targeted adolescents and youth (62 per cent), followed by pregnant women and their spouses (28 per cent), women (14 per cent) and street children (5 per cent). Soldiers and uniformed service personnel and migrant workers were targeted by 18 and 12 per cent of countries, respectively. Since January 2000, the Bangalore Oniyawara Seva Costa Organization in India has initiated interventions aimed at street and working children with the help of the Karnataka State AIDS Control Society. To date, 1,000 street children have been provided with interpersonal counselling and all STI cases have been referred to local hospitals for treatment.

Cultural practices and other country-specific factors play either a facilitating or constraining role in confronting the HIV/AIDS pandemic. Among facilitating factors, 73 countries cited culture; 35 reported that social and cultural attitudes promoted community involvement; 24 stated that religious beliefs in their countries had the potential to reduce risky behaviours in the population; while 14 felt that culture promoted delay in the onset of sexual activity. Another eight stated that the extended family system of their culture has helped in the care and support of HIV-positive individuals in their population.

Some 121 countries reported that social and cultural factors in their countries had a constraining influence on addressing the HIV/AIDS pandemic. The factors cited were: (a) absence of open discussion and dialogue on HIV issues; (b) difficulty in reaching those affected because of stigma and exclusion of people with HIV/AIDS; (c) lack of perception on the risk of HIV/AIDS in their countries; (d) obstructive traditional social and cultural practices; and (e) the impediment posed by women's low status.

6. Advocacy, education and behaviour change communication

A great many countries (92 per cent) reported having taken one or more successful advocacy strategies and other measures to promote responsible and healthy RH behaviours, especially among high-risk groups. Included among the measures were advocacy, IEC and behaviour change communication (BCC) campaigns (68 per cent), activities targeting vulnerable groups of young people,

women and men (32 per cent) and media campaigns using radio and television (23 per cent). These measures were often complemented by educational efforts such as peer education on RH issues (23 per cent) and the introduction of health education in school curricula. Changes in population policies relating to gender equality and RH (especially for adolescents) were introduced in Viet Nam through education and advocacy activities in the mass media and in schools.

Sixty countries reported lobbying for legislative changes and new laws related to the ICPD PoA while 45 established local advocacy bodies and 37 developed national and regional advocacy strategies. Four out of five countries (81 per cent) reported the use of electronic media (radio, TV and Internet) to address RH issues while 59 per cent used print-media materials such as newspapers, magazines, posters and fact sheets. In the Philippines, population-related IEC and advocacy materials are stored in digital form for easy retrieval and access. Messages were also conveyed through creative communication channels such as concerts, street plays, dramas and local seminars (32 per cent) as well as through the celebration of national awareness days (13 per cent). The Kalyani radio programme in India encourages debate through quizzes, discussions and real-life stories on RH themes. Folk music and drama-based serial programmes are broadcast in 13 languages. About a third of the countries mentioned training national and local media practitioners on RH issues.

Nearly 60 per cent of countries reported setting up hotlines or phone-in-radio and TV talk shows on RH issues. About 47 per cent of countries set up web sites for individuals to access information on RH-related topics. The establishment of village-level computer centres, as reported by 14 per cent of countries, enabled more people to access information on RH matters, including HIV/AIDS. Communication technologies have also helped disseminate information on RH during national awareness days and have been used to establish management information systems to support RH programmes and the empowerment of women and youth.

Policy and funding constraints, programme-related issues and sociocultural factors were mentioned by 45 countries as challenges to overcome in influencing attitude and behaviour change. Other constraints cited were lack of political will, religious opposition, insufficient human resources, absence of monitoring and evaluation mechanisms, deficient coordination between agencies and inadequate equipment and training.

7. Partnerships and resources

Building partnerships between Governments and civil society is also a key strategy and target of the MDGs; hence, efforts to achieve the ICPD PoA also contribute to the achievement of the MDGs. Ninety-five per cent of responding countries reported at least one successful effort to strengthen partnerships with civil society organizations in implementing the PoA. Partnership efforts that involved policy and programmatic measures included development of population and RH plans and programmes; capacity-building and training in population and RH issues such as those implemented in Papua New Guinea; establishment of parliamentary caucuses like in India and Indonesia; formulation of laws and legislation on RR and RH and population policy-making. Collaboration on the production of population research and census data was also cited by a few countries. The most common coordinating mechanisms for partnership efforts were partnerships between national population commissions and NGOs (39 per cent); national fora for NGOs (17 per cent); and partnerships between local governments and community-level NGOs (15 per cent).

Nine in ten responding countries in every region reported partnership efforts, more than double the number and proportion of countries that were reviewed in the 1999 ICPD+5 (49 out of 114 countries or 43 per cent).

Government partnerships with civil society organizations cover a wide variety of substantive issues. These include: attending to the special needs of older persons and internal and international migrants; protecting the rights of girls and women (Women's Crisis Centres in the Philippines, for example cater to women and children who are victims of domestic violence); monitoring human rights; expanding access to quality RH information, services and commodities (the Indonesian private sector provides RH services to the poor and to those living in rural and remote areas); reducing maternal morbidity and mortality; preventing HIV/AIDS (social marketing campaigns for male condoms were launched in Mongolia in May 2000 with over 2 million condoms supplied); and monitoring the progress of the ICPD and the MDGs at country-level.

In addition to building partnerships with civil society, Governments have been actively expanding their collaboration with the private sector. Only 8 per cent of countries responding in 1999 had taken significant measures to involve the private sector in population and RH activities. The corresponding figure in 2003 was 75 per cent, underscoring the spectacular development of government partnerships with the private sector.

The private sector played an important role in the provision of contraceptives and RH services (49 per cent); sponsorship of social marketing campaigns and outreach programmes (47 per cent); sponsorship of IEC and advocacy activities on RH issues (42 per cent); and private sector representation in government coordination bodies for population and RH issues (30 per cent). A smaller number of countries also reported private sector provision of financial assistance for RH activities.

The Global Survey asked Governments to report on the level of domestic and international resources available in their countries for population and RH programmes and to assess whether the resources were sufficient to meet their national RH needs. Countries were also asked to report on cost-recovery approaches, absorptive capacity maximization, and other ways to utilize available resources fully. Major constraints to making the most of available resources were also reported by countries.

Over 80 per cent of countries reported that available resources did not meet their countries' RH needs. They also noted that their absorptive capacities were often inadequate to maximize available resources. More than four in five countries attempted to increase domestic resources for population and RH programmes, underscoring their commitment to achieving the ICPD PoA. The Ministry of Health of Cambodia developed a Health Sector Strategic Plan that includes a medium-term expenditures framework to coordinate multi-year public expenditures based on sectoral financing needs and for the protection of the total amount of resources available from both domestic and external resources. Due to difficult economic circumstances, most countries were only able to make incremental funding increases .

In view of these shortfalls, many countries are looking for innovative strategies to maximize and augment available resources, including strengthening partnership efforts and implementing cost recovery and cost sharing strategies. The Government of the Philippines formulated the Philippine Investment Plan to estimate the budgetary requirements for the population programme over multiple years and to determine the budgetary allocation for each programme component as well as strategic action areas, including service delivery, IEC, advocacy and capacity-building.

More than four in five countries (84 per cent) responding to the Global Survey reported mobilizing international assistance for the implementation of population and RH programmes. Most countries tried to make the most of their resources through partnerships with international agencies (including members of

the United Nations), development banks, bilateral government agreements and donor country development organizations.

Over 67 countries reported facing constraining factors in attempting to maximize the impact of available resources for population and RH programmes. The most prevalent constraints were lack of financial resources (44 countries), insufficient human resources and professional training (28 countries) and absence of materials, equipment or facilities (13 countries).

8. Donor experiences

A shorter questionnaire was prepared for developed countries belonging to the OECD DAC, referred to here as *donor countries* as part of the 2003 Survey. The responses obtained from 18 donor countries covered: population issues and concerns they had faced since the ICPD and the measures enacted to address them; actions taken relating to gender equality and women's empowerment; measures carried out to increase access to RH services, including those adopted to reduce the spread of HIV/AIDS; and partnerships between donor countries and civil society organizations, as well as issues related to international assistance, including problems and challenges faced by those countries in mobilizing resources to support the implementation of the ICPD Programme of Action. The following paragraphs will also describe how these countries link ICPD goals with international development frameworks and processes. Several of them reported using the MDGs as a basis for the development of programmes and policies promoting the ICPD agenda.

All but two donor countries cited population ageing as an important issue confronting them. The formulation of effective policies, programmes and strategies to respond to the special needs of older persons poses a continuing challenge. The major initiatives taken on this issue by a number of donor countries since 1994 include framing policies, strengthening institutions, building capacity in the areas of continuing education and training, supporting research, and undertaking innovative projects, including those promoting alternative living arrangements. In 2002, the Danish Parliament adopted legislation introducing free choice in relation to the care of older persons and those with disabilities. Participants have a choice in the type of housing and in the home-based provider of personal and practical help. Austria believes that multigenerational housing promotes cohabitation among several generations not only within the family, but among people not related, and in addition it counters increasing isolation and loneliness among the elderly, especially in rural areas.

Responding countries raised a number of issues and concerns regarding international migration involving the social and economic integration of migrants (as in Switzerland and in Finland), family reunification, and issues relating to human trafficking, illegal immigrants, refugees and asylum-seekers. Steps taken include those aimed at promoting equality of opportunity in access to jobs, housing, health and education, along with other social services and amenities. Since the ICPD, a number of donor countries have introduced changes in their family-reunification policies such as Denmark, which no longer considers reunification with spouse a statutory right, and New Zealand, which has strengthened the legal obligations of sponsors to ensure that they take more responsibility for family members brought into the country. Developed countries have recently been viewing migration as a response to medium-term labour supply shortages. The actions have been directed exclusively towards highly skilled immigrants, reflecting a rising demand for skilled labour due to demographic changes and the increasing globalization process.

The spread in the trafficking of human beings is a major challenge to migration management. Nearly all countries had enacted laws and legislation to oppose trafficking and many had ratified international treaties. Half of the responding countries prepared specific programmes to cope with this issue. Norway undertakes information campaigns in sending countries aimed at curbing human trafficking and at reducing the number of illegal immigrants, as well as asylum-seekers. To address the problem more effectively, many countries examined its root causes. One half of the countries supplied international aid to work against the trafficking of women and children, while nearly all furnished services to victims.

The growing levels of illegal immigration and the unremitting flows of refugees, as well as asylum-seekers, remain major concerns. To manage migration effectively, greater international cooperation will be needed.

Since the ICPD Conference in Cairo, two thirds of the donor countries passed new laws and legislation protecting the rights of girls and women. These laws focused on the trafficking and exploitation of women, ensuring gender equality in society (including in education and in parliamentary representation), enforcing gender equality in the workplace (including parental work leave and equal wages), and restraining sexual harassment. The Netherlands and Luxemburg passed legislation requiring employers to protect their staff from sexual harassment. Some countries have established women's commissions or agencies within government structures.

In reference to national strategies to address GBV reported by donor countries, 12 had enacted laws and legislation on this issue, and many have established institutional mechanisms in their legal and judiciary systems. Australia's Family Violence and Prevention Legal Service Units are funded to work with victims and communities in a holistic manner to prevent domestic violence. Almost half of the responding countries provided services for GBV victims. Seven countries are raising awareness, providing BCC, as well as training service providers and government officials, on GBV. Denmark circulated a tool kit containing rules, legislation and advice related to GBV and provided training for service providers and government officials on GBV.

Since the ICPD, donor countries have addressed a range of RH issues reducing unwanted or unplanned pregnancies, meeting the need for counseling and services for high-risk groups, and preventing HIV/AIDS and other STIs. Norway's goal is to provide education, prevent high-risk behaviour, ensure that HIV-infected persons are properly diagnosed and counseled, combat discrimination against those infected and make sure that health-care and social workers have sufficient expertise. Most donor countries (94 per cent) reported that the quality standards with regard to RH service delivery have improved since the ICPD, especially in the areas of human capacity-building and institutional development. The Government of the United States of America is committed to provide underserved communities with improved quality and access to health care.

Donor countries continue to face adolescent and youth RH concerns, including adolescent fertility, the increasing incidence of STIs and substance abuse. Measures taken to address these issues include making contraceptives available for free or for a subsidized fee, providing counselling and youth-friendly RH information and services to adolescents and young people. The RH needs of migrants and indigenous populations are also being tackled. Sweden provides additional training for midwives serving migrant women.

Donor countries have developed national strategies and policies that consider the need for a multisectoral and comprehensive response to HIV/AIDS. These include availability of funding for research and prevention programmes, access to care and treatment, organized support networks, human rights advances and the use of new information technologies to raise awareness of HIV/AIDS and to disseminate relevant information. Donor countries have developed national strategies and policies that take into account the need for a multisectoral and comprehensive response. Many have partnered with local authorities, NGOs, medical experts, and international organizations to fight the spread of HIV.

High-risk groups were targeted through IEC campaigns and service-provision efforts. Laws and legislation were enacted to protect the rights of people with HIV/AIDS. Sexually transmitted infections (STIs) counselling and testing, family planning counselling, and antenatal care have been integrated into HIV/AIDS programmes aimed at reaching a greater number of people, reducing the stigma associated with HIV/AIDS and intensifying the efficient use of limited health-care resources.

Fifteen donor countries reported active partnerships with NGOs, a significant increase from 1998 when only half of the donor countries indicated measures on partnerships. Moreover, five countries reported that since 1994, NGOs have been playing more active roles in their partnerships with Governments, specifically on RH issues.

Since Cairo there appears to be continued momentum for the implementation of the PoA in donor countries. In sum, nearly all 18 donor countries have revitalized their RH programmes through increased attention paid to the RH needs of adolescents, young people, migrants and indigenous populations; availability of high-quality and comprehensive RH services; and training of health-care providers. However, donor countries continue to be concerned with such emerging issues as: (a) meeting the special needs of older persons; (b) the growing levels of illegal immigration; (c) the trafficking of human beings; and (d) the continuing flows of refugees and asylum-seekers.

The ICPD Programme of Action and the Millennium Development Goals

Many of the goals contained in the ICPD PoA and the ICPD+5 *Key Actions* parallel those of the MDGs. The PoA's focus on population-related efforts, such as increasing access to RH services, promoting gender equality, and nurturing a better understanding of the linkages between population dynamics and poverty, are essential to the achievement of the larger development goals of the MDGs, such as eradicating poverty and hunger. However, the MDGs are silent on the core ICPD goal of universal access to RH services by 2015, even though they contain targets related to RH components like maternal health and HIV/AIDS.

Both the ICPD and the MDGs prescribe targets for providing universal primary education, promoting gender equality and empowering women, reducing child mortality, ameliorating maternal health and hindering the spread of HIV/AIDS and other diseases. The PoA supports the MDGs' focus on ensuring environmental sustainability by recognizing the linkages between and among the

environment and internal and international migration, population growth rates and resource consumption.

Population policies and programmes in many countries have been reoriented towards the ICPD PoA, the *Key Actions* of the ICPD+5 review conducted in 1999 and the ICPD+10 review undertaken in 2004, as well as the series of regional conferences and reviews held in the wake of the ICPD. For example, in the area of family planning, policies focusing on women of reproductive age have given way to a life-cycle oriented RH approach embracing both sexes. Fertility reduction and contraceptive-use targets have given way to ones diminishing the unmet need for contraception. The current priorities are improving method choice and quality of care.

Fulfilling the PoA goals and objectives would ensure the achievement of equivalent MDGs, particularly in lowering child and maternal mortality, providing universal access to primary education, ensuring parity in access to secondary and higher education between girls and boys, minimizing the spread of HIV and achieving gender equality and women's empowerment. Further benefits would be gained due to the synergies between these and other universally agreed development goals.

Carrying out the PoA would lead to empowering women in every sphere of life and to greater men's involvement in the exercise of reproductive rights and responsibilities. Advancements in education, particularly of girls, would contribute to a decrease in poverty, hunger, child and maternal mortality, and the spread of HIV, as well as help bring about gender equality. Furthermore, a better-educated population would likely alter its demographic behaviour with regard to nuptiality, fertility, and health and migration in ways that would enhance its overall well-being.

The PoA offers guidance on ways of addressing the major challenges of the future, including increased urbanization and population ageing, so that its fulfillment would contribute to achieving objectives declared by both the United Nations Millennium Declaration and the Second World Assembly on Ageing. The PoA also focuses special attention on the needs of vulnerable groups, including children and youth, the elderly, the poor, the disabled and indigenous populations, and stresses the need to provide support and protection to families, especially single-parent families, and to vulnerable family members, such as orphans and widows. Implementing the PoA fully would benefit the whole of society, particularly the most vulnerable, and lessen inequality. It would also promote the equal participation and sharing of responsibility between women and men in all areas of family and community life.

Building a partnership for global development depends on the cooperation of all stakeholders – Governments, multilateral and donor agencies, civil society and the private sector – to realize the goals and objectives of the ICPD Programme of Action. It would validate the importance of the goals included in the United Nations Millennium Declaration and emphasize the paramount importance of international cooperation in carrying out population and development programmes, particularly in the least developed and other low-income developing countries.

Conclusion

In the two decades since the Mexico Conference, the world, particularly the Asian and Pacific Region, has moved on, in terms of both its economic and demographic situations. The demographic transition in Asia and the Pacific has progressed significantly. During the period 1980-1985, Asia's total fertility rate (TFR) stood at 3.7 children per woman. Two decades later, the TFR was around 2.5. Asia's life expectancy at birth for both sexes stood at 60.5 years during the period 1980-1985; the corresponding figure for 2000-2005 was 67.7 years. Moreover, there are few countries in the region where fertility has not fallen. In fact, there are some countries where fertility in the first half of the 1990s was already below replacement level and is now sinking to even lower levels. The Asian and Pacific region has experienced a clear shift to lower fertility and mortality levels, though within that shift there is considerable diversity among countries.

In terms of economic development, the region has seen impressive growth, again exhibiting wide variations between countries. This follows for poverty as well, although exact trends are debatable. In 2002, the Fifth Asian and Pacific Population Conference was convened under the theme Population and Poverty in Asia and the Pacific. Mrs. Thoraya Ahmed Obaid, (2002) Executive Director of the United Nations Population Fund (UNFPA), in an article featured in a special issue of the *Asia-Pacific Population Journal* (December 2002), wrote:

“To confront the challenges of the twenty-first century successfully, we must strive to promote, respect and protect all human rights: economic, social, civil and political. Asia has made excellent progress over the past 30 years and we must maintain the momentum. The Programme of Action of the International Conference on Population and Development and the Key Actions adopted at the review and appraisal of the Conference in 1999, remain feasible, affordable and effective. We must now increase our efforts. By giving greater policy attention and generating greater resources to population and reproductive health issues, we will

actually make greater progress in reducing poverty, maternal and child mortality, halting the spread of HIV/AIDS, increasing gender equality and equity and ensuring sustainable development, as world leaders agreed at the Millennium Summit”.

Steven W. Sinding (2005), then Director-General of International Planned Parenthood Federation, in his Viewpoint printed in the August 2005 issue of the same *Asia-Pacific Population Journal*, commented on the decline in funding for population activities. He concluded that in the face of competing demands for funding and ideological threats to reproductive health, he believed that “if the sexual and reproductive community pulls together, if reproductive health and AIDS organizations integrate their work, if we work together to prove the critical link between ICPD goals and fighting poverty, then and only then will we see donors recommitting to funding reproductive health. If not, we risk losing hard-won gains”.

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Important Issues in the Continuing Mortality Revolution in the Asian and Pacific Region

Asia is doing well in regards to mortality improvement. In the 20 years of the Asia-Pacific Population Journal's existence the life expectancy of its population has risen by 5.4 years. Gains have been greater outside East Asia, where mortality rates were already low, and are now at the level reached by the developed world around 1980.

By John C. Caldwell and Bruce K. Caldwell*

This study will focus on mortality changes in the ESCAP region over the last two decades, predominantly from 1980-1985 to 2000-2005, but will also compare this experience with that of the three preceding decades, 1950-1955 to 1980-1985, in order to achieve perspective. That perspective will be often confined to the 99 per cent of the ESCAP region's population that live in Asia, though we will

* John C. Caldwell, Emeritus Professor of Demography, Demography & Sociology Program, Research School of Social Sciences, e-mail: Jack.Caldwell@anu.edu.au and Bruce K. Caldwell, Research Fellow, National Centre for Epidemiology and Population Health, Australian National University, Canberra.

frequently employ figures for the whole of Asia. In contrast to a previous report on the ESCAP area, we will focus on anomalies in mortality change that offer the possibility of improving the mortality experience.

The comparison of the mortality experience of the last 20 years with that of the earlier 30 years of the twentieth century's second half shows that there are great differences that need explanation and that might suggest new policies. Table 1 shows that an Asian mortality miracle dominated the world's experience during those first three decades, with a gain in life expectancy of around 19 years (almost two thirds of a year per elapsed year) compared with a global gain of less than 15 years. Excluding Asia, the world gain is less than 10 years. Not only did Asia dominate world mortality change in those first 30 years but Eastern Asia, especially China, dominated change in Asia. Both Asia and the Pacific were heterogeneous in their experience. For example, Micronesia and Polynesia, but not Melanesia, now have life expectancies similar to East Asia.

Table 1. Regional gains in life expectancy, 1950-1955 to 2000-2005
(all measurements in years)

Region	Life expectancies		30-year gain	Life expectancy 2000-2005	20-year gain
	1950-1955	1980-1985			
World	46.5	61.3	14.8	65.4	4.1
More developed countries	66.1	72.9	6.8	75.8	2.9
Less developed countries	41.0	58.5	17.5	63.4	4.9
Asia	41.4	60.3	18.9	65.7	5.4
Eastern Asia	42.9	67.7	24.8	72.1	4.4
Southern Central Asia	39.4	54.6	15.2	63.2	8.6
South-Eastern Asia	41.0	58.1	17.1	66.7	8.6
Western Asia	45.2	62.9	17.5	69.1	6.2
Australasia	69.6	75.0	5.4	79.0	4.0
Melanesia	37.5	52.8	17.3	60.3	7.5
Micronesia	53.3	66.3	13.0	72.0	5.7
Polynesia	48.6	64.1	15.5	71.0	6.9

Source: United Nations, 2003.

The most striking feature in table 1 is the slowdown in mortality reduction in the most recent period, most prominently in Eastern Asia with, a gain in the earlier 30 years of almost 25 years compared with less than five years in the latter 20 years. There are several interrelated explanations. The first is that mortality gains

will be smaller as the slowly rising ceiling of the human life span is approached. The second is that the earlier gains against mortality were relatively easy to secure because high-fertility populations are characterized by a youthful broad-based age structure. In the Asian population of 1950 one third of all deaths were infants, with one half children under the age of five. This mortality was mostly the result of infectious diseases, which were progressively brought under control. By the early twenty-first century, only 10 per cent of deaths were attributed to infants and 15 per cent to children under five years. The ailments of older populations include chronic degenerative diseases, and their conquest is difficult. Australasia (Australia, New Zealand and islands of the South West Pacific) gained less than ten years in half a century.

These reasons do not add up to a full explanation. There has been a slowdown in the decrease in mortality. The advocates of liberal economics have convinced much of the world that growth in government expenditures, including those in health and education, should be restrained to maintain past economic growth. The theory is this will bring future advances in health. Central planning proved to yield faster reductions in mortality but less economic success. Both China and India have witnessed disproportionate growth in the private health sector. As seen in table 3, neither China nor India now record mortality levels significantly better than their real (parity purchasing power) incomes.

Table 2 shows just how varied the ESCAP mortality experience is, in spite of the much vaunted globalization of health. The first group exhibits life expectancies of approximately 80 years while the second group falls short by about 30 years. Afghanistan's life expectancy is equivalent only with some of the poorest countries in Africa. The table's notable figures are the degree to which life expectancy is determined by income.

Further examination of table 2 reveals a more complex mortality picture. Afghanistan, Timor-Leste, Lao People's Democratic Republic, Cambodia and Myanmar have experienced warfare and civil unrest in the last two decades. In every country, either overcoming crisis, or promoting ideology, has tended to displace economic growth as the major policy goal. The lack of peace has directly impacted on health systems. Money has been diverted to what are regarded as more urgent priorities, such as purchasing guns and other military hardware. Health centres have been understaffed, under-supplied with drugs, and even dangerous to reach. Immunization campaigns are disrupted, and planned safe water and faecal and rubbish disposal programmes are abandoned. The main impact of disorder, however, is to limit economic growth and in turn starve development programmes of adequate funding.

Table 2. Winners and losers: top five and bottom five countries by life expectancy, 2004

	Expectation of life at birth	Infant mortality rate	Under 5 mortality rate	GDP per capita (US dollars 2001)
(a) Six ESCAP countries with the highest life expectancies				
Hong Kong, China	82.0	2	4	24,074
Japan	81.5	2	4	32,601
Australia	79.5	5	7	19,019
Macao, China	79.0	4	5	-
Singapore	79.0	3	4	20,733
New Zealand	78.5	6	7	13,101
(b) Six ESCAP countries with the lowest life expectancies				
Afghanistan	44.0	159	274	-
Timor-Leste	50.0	120	177	-
Lao People's Democratic Republic	55.0	86	136	326
Cambodia	57.5	71	103	278
Myanmar	57.5	81	124	162
Papua New Guinea	58.0	60	61	563

Sources: ESCAP, 2004; Maddison, 2003.

These conclusions are tested in table 3, where countries for which Maddison (2003) reports data are ranked by real per capita income (i.e. per capita gross domestic product corrected for purchasing parity and based on standardized 1990 American dollars). Where a country's income ranking is above that of its health ranking (i.e. the figure in the final column is negative), the country does not perform as well in its health status, as it could afford to do; where the figure in the final column is positive, it is doing better than economic strength might predict. This is usually achieved by above-average spending on not only the health system, but also the educational system, and is helped by individualistic cultures where each individual can speedily seek assistance when they, their children or aged dependants are sick.

The most important information in table 3 is that the rankings are extraordinarily close to each other. Differences of two, or even three, rankings are not really significant. The extent to which income determines health is stronger

than it used to be (Caldwell, 1986). One reason is that economic reform in the shape of structural adjustment programmes has led to the widespread introduction of fees for both health services and schooling. Another is that educational differences have narrowed as they reach asymptotic values and as expensive tertiary education levels are attained.

Table 3. Relationship between real per capita income (pci) and life expectancy^a

Country	Ranking order of pci by ppp ^a	Ranking order of life expectancy ^b	Difference (1)-(2)
Japan	1	2	-1
Singapore	2	4	-2
Australia	3	3	0
Hong Kong, China	4	1	3
New Zealand	5	5	0
Republic of Korea	6	6	0
Malaysia	7	8	-1
Thailand	8	12	-4
Turkey	9	12	-3
Kazakhstan	10	20	-10
Armenia	11	10	1
Sri Lanka	12	9	3
Uzbekistan	13	17	-4
China	14	12	2
Georgia	15	7	8
Indonesia	16	19	-3
Azerbaijan	17	10	7
Turkmenistan	18	19	-1
Kyrgyzstan	18	17	2
Philippines	20	15	5
Pakistan	21	24	-3
India	22	21	1
Myanmar	23	25	-2
Tajikistan	24	16	8
Nepal	25	22	3
Bangladesh	26	23	3

Notes: ^a As estimated in gross domestic product per capita in purchasing power parity (ppp) for 2000 in fixed US Dollars by Maddison, 2003.

^b As estimated expectations of life at birth by ESCAP, 2004.

There are, however, some ranking differences deserving comment. Thailand, which has a wide-open economy with only a vestigial welfare state apparatus, does not perform well. It could be argued that its adherence to liberal economic policy has led to faster economic growth and to lower mortality than would have been achieved if it had taken Sri Lanka's welfare state approach. By the authors' measure however, Sri Lanka's system still has health advantages. Health in the Philippines also benefits from relatively high levels of education.

More significant differences are found among the former Soviet Republics. Furthermore, the record of these countries is more complex than many have suspected. They provide the most extreme examples of both countries where the reduction of mortality is better than their economic strength would imply, and where it is worse. This may be a short-term anomaly as the new states develop new market economies and decide how much non-market support can be given to the health system. There may also be weaknesses in the statistical systems that measure both mortality and income. Some Governments have greater access to natural resources and a greater capacity to budget for health services, such as Azerbaijan with its oil industry.

The potential for improving longevity

Examples of poor health performance can actually suggest potential answers for reducing mortality. Several of these opportunities will now be examined.

The first opportunity is when one sex does much better than the other in terms of survival. It is likely that for most of the world's history life expectancy for males and females was similar. Women experienced high reproductive mortality due to uncontrolled conception (with consequent high fertility levels), and primitive conditions for childbirth. Today, however, the life expectancy of females is four years greater than that of males. In the United States of America the gap is five years and in Western Europe six years (United Nations, 2004). The gap widened as fertility fell to very low levels. Males in these societies are also known to be more self-destructive with higher levels of smoking, excess alcohol consumption, drug use and refusal to seek early medical attention when ill.

The male to female gap in longevity is greatest in the countries emerging from the Soviet Union and in the former communist countries of Europe, all recording a gap of 7 or more years, rising to 11 years in Ukraine, 12 years in Belarus and 13 years in Russia (United Nations, 2004; Russia is recorded as 12 years in the ESCAP 2004 Population Data Sheet and hence in table 4). One proposed explanation for the higher levels is substance abuse, particularly male binge-drinking of alcohol.

Table 4. Excessive sex differentials in life expectancy, 2004

Country	Life expectancy at birth		Female excess
	Male	Female	
(a) Female excess seven years and above			
Russia	61	73	12
Kazakhstan	61	72	11
Georgia	70	78	8
Kyrgyzstan	65	73	8
Armenia	69	76	7
Azerbaijan	69	76	7
Thailand	68	75	7
Japan	78	85	7
(b) Female excess less than three years			
Pakistan	62	61	-1
Bangladesh	62	62	0
Afghanistan	44	44	0
India	64	65	1
Nepal	62	63	1
Bhutan	63	65	2
Lao People's Democratic Republic	54	56	2
Timor-Leste	49	51	2
Papua New Guinea	57	59	2

Source: ESCAP, 2004.

Table 4 demonstrates the extreme male to female mortality gaps in the ESCAP region. The high female rates are dominated by the former Soviet Republics. There is a loose correlation with religion, as all countries with Muslim majorities show male to female gaps of eight years or lower (Encyclopaedia Britannica, 2005) Uzbekistan and Tajikistan for example which are 76 and 85 per cent Muslim respectively, are not even included in table 4, as their gender gaps in mortality, at six and five years, are within the expected span.

The other extreme shown by table 4 is a small gender age gap or even a reverse one. This characterizes the South Asian mainland more than any other region in the world. In the past, the life expectancy of males was greater than that of females in every country of the region. Two explanatory factors predominate. The first is that male births are more favoured than female births, especially higher order female births. This is largely explained by a dowry system in which the

marriage of daughters can be expensive – even ruinously so. The second factor is that only a minority of women give birth in health facilities, or with the aid of a trained birth attendant.

Dowry is followed by the majority of South Asia's population. It was originally a North Indian Hindu practice, but also is increasingly a factor in marriages of the region's Muslims and south India's Hindus (Caldwell, Reddy and Caldwell, 1988). Families can flourish economically by having mostly sons to marry off, especially in more than one generation, and can be ruined by successive generations of daughters. Among some Indian castes the traditional response was female infanticide. Its modern equivalent is selective female abortion following the identification of the foetus' sex. In addition, selective infant and child mortality has occurred due to the relative neglect of female babies and young girls. This is often not deliberate, but adherence to cultural practices, such as the belief that boys are more fragile and have a greater need for care and medical attention plays a significant role. Differential feeding, based on the same belief, is also widespread.

The lack of adequate assistance during pregnancy and before and after birth explains the bump in excess female mortality during the main reproductive years, ages 15-35. This lack of provision is partly explained by poverty, including in some Muslim areas a male-oriented way of assigning priorities.

The situation is slowly improving. One area in which effective work has been done is family planning programmes. In the last 50-60 years, the fertility level of the region has almost halved, with the total fertility rate falling from over six to a little above three (United Nations, 2003). This alone has substantially reduced the mortality risks of younger adult women. National family planning programmes have also brought more trained persons and facilities in reproductive health to rural areas. An area of continuing concern, however, is the spread of clinics, especially in northern India and the Republic of Korea, where the sex of the foetus is identified and often followed by the aborting of female foetuses. This serves to reinforce the attitude that females are inferior. A future shortage of available brides may help to improve female status, but this is far from certain.

Tables 3 and 5 examine the dimensions of the mortality crisis in former Soviet Asia. The last 16 years have also witnessed an economic crisis, rather than a purely demographic one. In all the countries GDP per capita fell between 1990 and 2002, including as much as over 50 per cent in Tajikistan and Georgia. Realistic income assessment however, may be attained better in some countries than in others. Thus Tajikistan, Georgia, Azerbaijan, Kyrgyzstan and Armenia are all shown as recording higher life expectancies than their economic ranking would

predict (table 3), but their average per capita GDP is shown as having dropped by 41 per cent between 1990 and 2002 (table 5), while Kazakhstan, Uzbekistan and Turkmenistan are shown as having performed below economic expectations while having dropped an average of only 18 per cent in per capita GDP.

Table 5. Health crisis in former socialist Asia and comparisons

Country	Life expectancy at birth			Increase in life expectancy at birth		Increase in GDP pc (%) 1990-2002
	1950/5	1980/5	2000/5	1950/5-1980/5	1980/5-2000/5	
Armenia	65	73	72	8	-1	-16
Azerbaijan	61	68	72	7	4	-36
Georgia	62	71	74	9	3	-56
Kazakhstan	57	67	66	10	-1	-16
Kyrgyzstan	55	66	69	11	3	-33
Mongolia	42	58	64	16	6	-
Tajikistan	56	66	69	10	3	-62
Turkmenistan	53	63	67	10	4	-24
Uzbekistan	56	67	70	11	3	-16
Comparisons						
Portugal	59	72	78	13	6	37
Greece	66	75	78	9	3	30
Romania	61	70	71	9	1	-1
Bulgaria	64	71	71	7	0	10
Viet Nam	40	59	69	19	10	-
Russia	65	68	67	3	-1	-27
China	41	67	71	26	4	99
India	39	55	64	16	9	68

Sources: United Nations, 2003; Maddison, 2003.

For this assessment, additional observations can be made. The first is that this health crisis has not emerged in the major socialist countries, China and Viet Nam, or in the former socialist country outside the Soviet Union, Mongolia. The second, and more important, point is that the crisis in the former Soviet Republics and

former socialist Eastern Europe is not a recent phenomenon. In the early 1950s Russia, Romania, Bulgaria, Armenia, Azerbaijan and Georgia recorded life expectancies similar to those of Greece and Portugal. Fifty years later the Asian countries were 4-6 years behind European Union countries, Romania and Bulgaria seven years behind, and the Russian Federation 12 years behind. Indeed, Russia had fallen behind both China and Viet Nam and was only three years higher than India. These changes clearly reflect the early emphasis in centrally planned economies on educational and universal health services, much of the latter through the workplace, and the subsequent disappearance of free health services.

A fair assessment of health status might be that the former Soviet Asian countries have weathered the change to market economies better than former communist Europe. A reasonable explanation for some having greater life expectancies than their economic levels would predict is that older higher levels of education have largely persisted. Their earlier experiences with state welfare systems may well again move them towards some kind of public health scheme or insurance.

In the authors' previous paper (Caldwell and Caldwell, 2002) attention was drawn to the fact that in Asia and elsewhere Asian slum dwellers usually had no lower mortality rates than the rural areas from which many of them had migrated, and far higher levels than the rest of the urban population. After examining the broader transition in Asia and the Pacific, the authors then focused on the situation in Dhaka, Bangladesh. This appraisal will be repeated with new data. The justification for this emphasis on urban population is that 40 per cent of Asia's population is already urban and in 20 years' time over half will be (United Nations, 2004). Dhaka's population was under half a million in 1950 and is now over 12 million. The city is one of the few in the developing world that still owes the majority of its growth to rural-urban migration.

The treatment of Dhaka this time will contrast with the previous analysis in two ways. The first is that it will focus on recent changes. The central questions studied are why populations living so close to modern medical facilities in the city benefit so little from them, and whether there has been any success. The second change is a concentration on the "real" slums, the shanty towns or *bostie* that are formed usually by squatting illegally on vacant land. The authors previously examined both *bosties* (or slums) and other poor areas. The latter were in areas where poor populations lived in mixed neighbourhoods with higher income residents. All the housing was permanent and the land legally built on. There were permanent streets and usually access to municipal services such as water, electricity, gas and garbage and sewage disposal.

Since then, a relevant published paper by Montgomery and Hewett (2005) has drawn on Demographic and Health Survey (DHS) findings for the developing world. The authors noted that 10 per cent of households in poor areas were not poor. This was also the case in the 1999-2000 Access to Health and Reproductive Health Services Study (AHRHS) conducted in Dhaka when data on slums and poor neighbourhoods were merged. It was not true, however, in the *bosti* or squatter settlements. Due to the lack of tenure rights and services, squatters were not willing to build substantial houses in their neighbourhoods, investing only in old corrugated iron, hessian bagging and earth for construction. This kept out the higher income individuals and families as well as pharmacies, doctors' offices and health centres. Nevertheless, the central finding of the Montgomery and Hewett (2005) study remains relevant. The authors found that the level of births being attended by trained personnel was 60 per cent among poor households in poor neighbourhoods, 70 per cent among both the wealthier in poor neighbourhoods and the poor in the wealthier neighbourhoods, and 80 per cent among the wealthier in wealthier neighbourhoods. This demonstrates the dual impact of the family economic situation and the neighbourhood. The same is true in Dhaka, though at a lower level because Bangladesh is among the poorer countries in which DHSs have been conducted.

Changing access to health services in the Dhaka slums, 1999 - 2006

This section examines the impact of changes in access to health services on health behaviour and health outcomes in Dhaka, and in particular its slums, in recent years. The focus will be on infant and child mortality, and maternal mortality as these are the areas where mortality is most preventable. In recent years there has been a substantial decrease in infant and child mortality in Bangladesh, but the decline has been much more impressive in rural areas – in part because mortality was previously highest there. Retrospective data from the Bangladesh Demographic and Health Survey (BDHS) (Mitra and others, 1994; Al-Sabir and others, 2005) for the ten years preceding the 1993-1994 and 2004 surveys on Under-Five Mortality (U5M) show a slow decline in urban areas from 114 (1983/1984 - 1993/1994) to 92 (1994-2004). In rural areas there was a much steeper decline from 153 to 98.

The reduction in mortality seems to be largely attributable to improved public health measures, especially immunization. The proportion of eligible children with no vaccinations fell between 1993-1994 and 2004¹ from 8.7 to 2.8 per cent in urban areas and from 14.6 to 3.5 per cent in rural areas. The proportion of children who had received the full government-approved course of immunization (BCG,

measles, three polio doses, three DPT shots) rose from 70.4 to 80.9 per cent in urban areas and from 57.5 to 71.1 per cent in rural areas. The Government has also provided vitamin A, oral rehydration salts (ORS) for the treatment of diarrhoea, and has heavily promoted family planning.

The public health measures have been reflected in sharp declines in child mortality (deaths to children aged one to four years) from 36 to 21 per 1,000 in urban areas and 56 to 27 per 1,000 in rural areas. Similar but smaller declines were recorded for post neonatal deaths (28 days to one year), which are also strongly affected by many of the infectious diseases for which immunization is effective.

Although the data indicate the cities, including Dhaka have benefitted, their initial advantage over rural areas has largely disappeared while urban slums now appear to suffer from worse infant and child mortality; worse not only than the wealthier urban population but also the rural population. Part of the explanation lies in the government's investment, with international donor support, in primary health-care services, which have until recently focused on previously underserved rural areas. With the recent growth in the urban poor population, and increasing concern about its continuing high rates of infant and child mortality, new programmes have been developed to address this problem, including the Urban Primary Health Care Project (UPHCP) funded by the Asian Development Bank and implemented by the four main city corporations, including that of Dhaka.

Nevertheless it is clear that many preventable deaths continue to occur to both children and adults. Further improvements in preventative health, especially in immunization and ORS, will help, but major improvement probably requires a more effective curative health system. The surprising conclusion is that the more developed health system of the urban areas, especially that of Dhaka, have had very little apparent additional benefit for the inhabitants there. This is especially revelatory, as on average the urban population, and particularly the urban elite, is much wealthier and better educated, both factors normally associated with better health. Dhaka is the centre of Bangladesh's health services, with a concentration of large public hospitals and clinics. These institutions give, at least in theory, access to health services far superior to those available in rural areas. However, this access has not led to the health advantage that might be expected, with the exception of the urban elite.

A possible explanation for this conundrum is that the urban population suffers from a particularly unhealthy environment, especially in the *bosti*. The *bosti* are illegal settlements built on land either owned by the Government or simply not designated for development. This is often because the land is subject to flooding. As illegal settlements, the slums are generally ineligible for government services

such as water, sewage and rubbish collection. They also are not paved, which is a necessity in the monsoon season to prevent flooding and in the dry season to avoid pollution from open sewers. As occupants are always under the shadow of eviction, there is no incentive to improve latrines, which are generally open, or to provide clean water supplies. The housing is generally crowded and of very poor standard.

Nevertheless, it is also true that the more advanced health system in urban areas is not benefitting its inhabitants' health to the extent that it should. The reason for this is a combination of short falls in service provision, especially for the poor, and a failure to address basic sociocultural issues. The AHRHS study conducted extensive interviews on the factors affecting early child mortality and the failure to use health services effectively. With the exception of limited non-governmental organizations' services and the new urban primary health-care clinics, urban health services are mainly provided by a restricted public health sector comprised primarily of large specialist hospitals and the private sector. The large public hospitals perform an important role in providing more advanced treatment, but they are notoriously overcrowded and under-resourced. The private sector is more complex, consisting of expensive clinics catering to the wealthier, private doctors catering to a more mixed clientele and private dispensaries (or pharmacies) providing drugs to a broad cross-section of the population. For most conditions the needs of the poor are largely met by the dispensaries – more difficult conditions are handled by public hospitals. An issue here is that dispensaries often provide drugs for which their staff have little knowledge (there are few trained pharmacists) while hospitals are generally seen as a place of last resort, as they can be expensive for the poor, who usually have to pay out of pocket for medicines, and are often hit with unofficial charges simply for getting treatment. Moreover, hospitals are notorious for long waiting times and generally “disrespectful” treatment. The poor find it difficult to raise the necessary money to pay for medical emergencies and many are unconvinced that they are getting the best possible treatment. The situation is particularly difficult for rural-urban migrants, who often lack the resources needed to help manage the system.

A recent major change is a growing number of private doctors competing to provide health services, this has forced many to rely on poorer patients. These doctors provide better treatment than dispensaries, and are much more convenient than public hospitals, though they are not a substitute for the large hospitals when more complicated treatment is required.

The difficulties in using the health system are particularly clear in the case of maternity services. Neonatal mortality is now a major challenge, as it accounts for nearly half of all deaths in children under five years, while a major cause of adult

female death is maternal mortality. These high rates can be reduced with the provision of antenatal check-ups. However, real progress will require access to effective obstetric services, particularly in cases of emergency. Ideally, all births, including normal deliveries, should be attended by skilled health workers, preferably in a hospital or clinic with appropriate hygiene and access to health services.

These observations should conclude that urban areas have a major advantage over rural areas, but when compared, neonatal mortality rates are similar, and in fact are worse among the urban poor. Moreover, neonatal mortality rates in the cities show no signs of improvement. For the ten-year periods preceding the 1993-1994 BDHS and the 2004 BDHS, urban neonatal mortality remained unchanged at 44 per 1,000, though in rural areas it fell from 65 to 47. The decline in rural areas probably reflects the greater provision of maternal health services, such as antenatal care, but most importantly the provision of a tetanus toxoid for pregnant women to protect their unborn children. The proportion of rural women with one or more tetanus vaccinations rose from 64.4 per cent in 1993-1994 to 84.2 per cent in 2004, while in urban areas it rose more modestly from 80.9 to 88.1 per cent. Nevertheless, neonatal mortality in both urban and rural areas remains high, presumably due to the limited availability and use of obstetric services.

More developed obstetric services should give the urban population a major advantage in terms of neonatal and maternal health. However, only a minority of the urban population, and a very small proportion of the urban poor, make effective use of the available services. The 2004 BDHS recorded only 29.6 per cent of urban women were receiving assistance from medically trained personnel (medical doctor, nurse, trained midwife or paramedic). This figure is lower than the one from 1993, and although possibly affected by definitional issues, it is nevertheless indicative of a lack of change. The 2004 urban figure is well above the rural one of 9.2 per cent. It is nevertheless remarkably low by international standards. The low urban and rural figures are largely due to the lack of medically trained personnel attending deliveries taking place outside hospitals or clinics, the difficulties of patients to get to and use hospitals or clinics to give birth, and a preference for giving birth at home.

The preference for giving birth at home reflects a view that the hospital is an alien environment where little provision is made for the needs of expecting mothers, and the home is the most supportive environment, as a woman can get care from family and friends. It is also in keeping with the institution of *purdah*

the practice of maintaining female modesty by screening them from men or strangers. Male relatives often oppose the change from the private home to a more public hospital.

A major problem with women giving birth at home is that in cases of emergency, such as obstructed labour or eclampsia, women are less likely to get timely medical assistance. This is particularly predominant in slums, where the husband is often away from home during the birth, in part because the family cannot afford him taking time off work, and in part because birth is seen as a woman's concern, and he would be in the way. This is a problem in case the woman needs her husband to accompany her for an urgent hospital visit. In Bangladesh, it is regarded as socially unacceptable for a woman to leave home unattended, particularly, without the husband's explicit permission. In the slums, many women feel it would not be safe to leave home unaccompanied. Moreover, household expenditures are controlled by the husband and hospital treatment is often expensive. Patients generally have to pay unofficial fees, especially for medicines, because hospitals often lack essential supplies. In the AHRHS survey, women expressed great concern that if they visited a hospital they would be given a caesarean section which they knew to be expensive – (for a poor family often ruinously so), and which they believed to be dangerous.

In general, those who provide assistance during birth – female family members, neighbours and especially traditional birth attendants – discourage official medical treatment. One well-respected female traditional birth attendant commented in a AHRHS interview that while a woman could seek medical treatment, there was no need as she could handle any emergency situation. All that was required was patience.

A major issue for neonatal and maternal deaths among slum populations is the high proportion of women returning to rural areas to give birth. In this area of high rural-urban migration, a few women gave birth before migrating but the majority were migrants already living in the city who chose to return to either the wife's parents' household or her husband's parents' household for the birth. By doing so, the woman could obtain care and assistance for herself and her children – something she would not have been able to get in Dhaka. However, a woman does not have access to Dhaka's health services. Moreover, the husband often remains in Dhaka (as he cannot afford to stop working) and therefore is unable to assist her when in need.

Conclusion

Asia is doing well in regards to mortality improvement. In the 20 years of the *Asia-Pacific Population Journal's* existence the life expectancy of its population has risen by 5.4 years. Gains have been greater outside East Asia, where mortality rates were already low, and are now at the level reached by the developed world around 1980. This paper has focused on potential gains against mortality, and has identified mortality differentials, discussing how the least privileged may be able to decrease mortality and attain the standards of higher income societies.

The major determinant of health and mortality levels is real per capita income. The situation is almost as simple as that bald statement, but not quite. China enjoyed lower mortality in the 1950s and 1960s than predicted by its per capita income, but today, with a substantially privatized health sector, no longer has such a lead. The highest mortality is found not only in the poorest countries, but also those that have experienced war and civil disorder. Here, an eventual peace dividend may take the form of both economic growth and health improvement. A generation ago, higher levels of parental education were a major determinant in the survival of a country's children, but improvements in educational access for all has weakened this advantage.

A more likely area for health gains could be the reduction of male-female mortality differentials. If good health has been achieved for one sex, it should be possible for the other. The countries most afflicted by high male mortality are the former Soviet Republics, but it should be noted that mortality in Asia is lower than the Russian Federation and other former communist countries in Eastern Europe. This is possibly due to Muslims being a higher proportion of the population, which reduces the numbers of those affected by alcohol. To the extent that the male-female mortality imbalance arises from drinking or smoking, the problem can be tackled by both education and regulation. South Asian female mortality is still high compared to male mortality. Advances have been made, through the majority of improvement can be explained as a by-product of falling fertility. Education is likely the most effective path. Successful legislation outlawing the dowry system may also have an impact. An easier target may be the socio-economic mortality differentials found in urban areas, especially larger cities, as the poor have migrated to the vicinity of the largest concentration of health facilities and providers in the country. The poor, however, need access to the providers, and the providers need access to the poor. Above all, the poor need secure land tenure, and access to roads, government services and health centres needed even in illegal slums.

Finally, what has been the impact of an increase of 25 years in life expectancy over the last half century? Potentially detrimental population growth has been largely held in check by a considerable drop in fertility (see table 6).

Table 6. Continuing population growth, Asia

	1950-1955	1980-1985	2000-2005	2045-2050 projection ^a
Birth rate (per 1,000)	43.0	28.3	20.5	12.5
Death rate (per 1,000)	23.6	9.7	7.7	10.5
Annual increase (per cent)	1.94	1.86	1.28	0.2
Annual population growth ('000)	28,692	51,043	44,554	9,349
Percentage of world growth	60	64	53	32

Source: United Nations, 2003.

Note: ^a United Nations Medium Projection

Nevertheless, Asia's annual population growth is still approximately 1.3 per cent per year, down from 1.9 per cent 20 years ago, but only about 0.3 per cent lower than 50 years ago. However, falls in the mortality rate will continue to decrease as life expectancies increase. The full benefits of the decline in fertility will be captured, as the era of exceedingly high population growth rates draws to a close.

Endnote

1. These figures cannot be compared directly with the mortality figures quoted above as they refer to different reference periods.

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Age-Structure Transition and Development in Asia and the Pacific: Opportunities and Challenges

Fertility and population growth have declined significantly in much of Asia during the past half century. Consequently, the age structure of populations is in the midst of a major transition. Countries are at different stages in this process, which is having a significant impact on their development.

By K. S. Seetharam*

Patterns of production and consumption vary with age. Therefore, the age structure of the population should influence the development process through the

* Specialist on Population and Development, former staff member of the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP), e-mail: kseetharam@hotmail.com.

supply of, and demand for, labour and goods and services. However, much of the debate and discussion on population and development during the past several decades has centred on the size and growth of the population. This is because the high rate of population growth that resulted from unprecedented declines in mortality leading to larger population vis-à-vis resources – after the Second World War was seen as impeding economic growth in developing countries, including those in Asia and the Pacific.

Some studies on the experience of selected countries and areas in East and South-East Asia that have recorded high rates of economic growth during the past few decades reveal that changes in age structure, occurring as a result of their demographic transition, have contributed significantly to the economic growth of these countries and areas (Bloom and Williamson, 1998; Mason, 2001). These studies also indicate that benefits afforded due to age structure change, called the “demographic dividend”, are not automatic. They will be realized only if appropriate policies and enabling conditions are in place.

Since the end of the Second World War, and with the emergence of newly independent States during the middle of the twentieth century, most countries in Asia and the Pacific have undergone an unprecedented transition in demographic behaviour, from high fertility and high mortality to low fertility and low mortality. This process has run its course in many countries, while in others it is still under way. This transition has resulted in rapid shifts in the age structure of these populations. In some countries and areas, it has led to rapid population ageing, which will have significant implications in the future for countries in Asia and the Pacific.

This paper reviews trends in population growth and the dynamics of age structure in Asia and the Pacific. It also examines likely future trends by broad subregion, as well as in selected countries. This is followed by a review of the findings of recent studies on the contribution of age structure dynamics to economic growth, and on the types of policies and enabling environment that have proved essential for benefits of the age structure transition to accrue. This paper also examines ageing, and how the benefits of a changing age structure can be harnessed to sustain economic growth and meet the inevitable increase in the resources required to fulfill the needs of older persons. It concludes with a discussion on the relevance of the findings for planning and the implications for policy so that a country can effectively utilize the opportunities afforded by the changing age structure for economic growth and sustainable development.

Population growth, age-structure transition and labour supply

Population growth and age-structure transition

The population of Asia and the Pacific was approximately 1.5 billion in 1950, according to recent estimates by the United Nations (2005).¹ By 2000 that population had increased 2.5 times to 3.7 billion. The region's population is projected to increase to 5.1 billion, or an increase of 40 per cent over the current level, by 2050 (see table 1).

Table 1. Population size, growth rate and age structure: 1950-2050

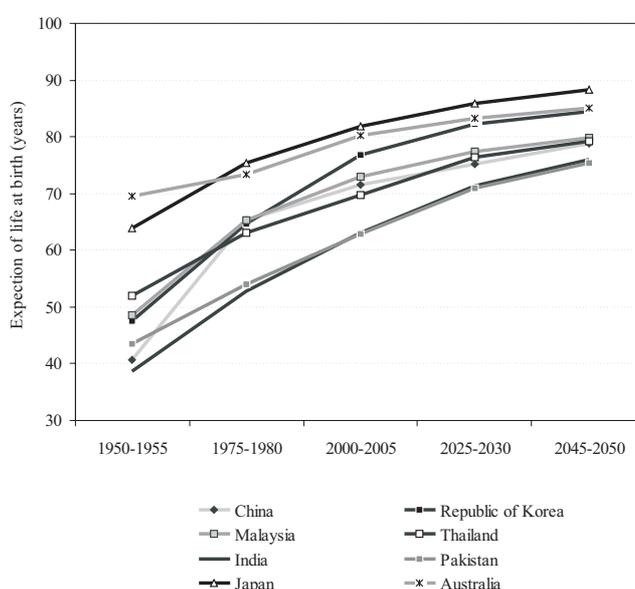
Age group (years)	1950	1975	2000	2025	2050
Population (millions)					
<15	533.8	965.7	1,103.0	1,037.5	920.4
16-64	891.9	1,425.7	2,407.3	3,168.1	3,271.9
>65	63.8	112.7	233.8	500.0	916.7
Total	1,489.6	2,504.1	3,744.1	4,705.5	5,109.0
Percentage					
<15	35.8	38.6	29.5	22.0	18.0
16-64	59.9	56.9	64.3	67.3	64.0
>65	4.3	4.5	6.2	10.6	17.9
Total	100.0	100.0	100.0	100.0	100.0
Rate of growth					
	1950-1975	1975-2000	2000-2025	2025-2050	
<15	2.4	0.5	-0.2	0.5	
16-64	1.9	2.1	1.1	0.1	
>65	2.3	2.9	3.0	2.4	
Total	2.1	1.6	0.9	0.3	

Source: United Nations (2005). *World Population Prospects: the 2004 Revision*, (United Nations publication, Sales No. E.05.XIII.5).

During this five-decade period, the population growth rate, which was very high at first, began to steadily decline – a trend that is projected to continue. For example, during the period from 1950 to 1975 the rate of population growth averaged 2.1 per cent annually for the region, as mortality rapidly declined (see figure 1), while fertility remained high in most countries. With the introduction of

national family planning programmes during the 1960s and early 1970s, fertility also registered significant declines in many countries (see figure 2), resulting in reductions in the population growth rate to 1.6 per cent per year during the period 1975-2000. With the decline in fertility expected to continue, the rate of population growth is projected to decline to almost zero by 2050.

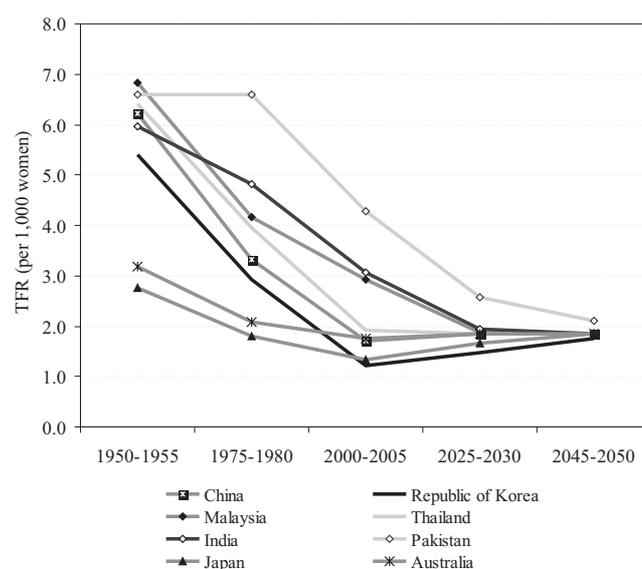
Figure 1. Trends in life expectancy at birth, selected countries



Source: United Nations (2005). *World Population Prospects: The 2004 Revision*. ST/ESA/SER.A/245, New York.

These trends are manifested in the age structure of the population and its transition from “young” to “old” in a relatively short span of time, as seen in table 1. For example, the percentage of the population younger than 15 years of age declined from around 38.6 per cent of total population in 1975 to 29.5 per cent in 2000. By 2050, this portion of the population is projected to decline to only 18 per cent of the total, while the percentage of the population aged 65 and above is expected to increase threefold, from 6 per cent of the total to 18 per cent. During this period, the percentage of the population of working age (15-64 years) will also undergo significant change, increasing rapidly at first and moderately thereafter, before beginning to decline.

Figure 2. Trends in total fertility rates, selected countries



Source: United Nations (2005), *World Population Prospects: the 2004 Revision*, ST/ESA/SER.A/245, New York.

The timing and pace of the transition, however, differed among subregions, and even more importantly, among countries. Figures 3 and 4 and table 2 illustrate the overall trends in population growth and differences among the subregions.

In general, all ESCAP subregions have experienced a decline in the rate of population growth, a trend that will continue well into the future. The two subregions that have experienced the highest rate of population growth are South and South-West Asia and South-East Asia. These subregions have recorded a threefold increase in their populations during the period 1950-2000. By 2050, the increase will be fivefold. East and North-East Asia recorded a twofold increase in its population during the same fifty-year period, and the population is projected to increase moderately for a couple of decades before declining to its 2000 level by 2050. The North and Central Asian subregion has had the lowest rates of population growth much lower than in other ESCAP subregions since the 1960s. In recent periods the rate of population growth has become negative, a trend that is expected to continue due to declining fertility and migration. The Pacific subregion

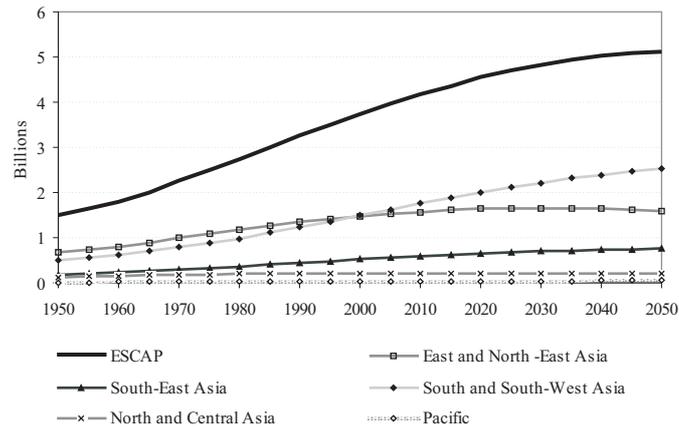
experienced moderately high rates of population growth though they have been steadily declining. This trend is expected to continue partly as a result of migration to Australia and New Zealand, and also due to consistently high fertility rates in some of the Pacific island economies. Consequently, the timing and pace of the age structure transition has been different among the subregions, as shown in table 2.

Table 2. Percentage distribution of population by broad age groups, ESCAP subregions: 1950-2050

Region/Age group	1950	1975	2000	2025	2050
East and North-East Asia					
<15	34.1	37.8	23.8	17.4	15.4
16-64	61.4	57.4	68.5	67.6	59.8
>65	4.5	4.7	7.7	15.0	24.7
Total population (millions)	671.0	1,096.7	1,479.2	1,652.0	1,586.7
South-East Asia					
<15	38.9	42.1	31.9	22.5	18.0
16-64	57.3	54.3	63.3	68.7	64.9
>65	3.8	3.6	4.8	8.8	17.1
Total population (millions)	178.1	321.3	518.9	678.3	752.3
South and South-West Asia					
<15	38.9	40.7	35.2	25.9	19.7
16-64	57.5	55.6	60.2	66.7	66.6
>65	3.6	3.8	4.6	7.4	13.7
Total population (millions)	500.1	879.9	1,497.5	2,119.3	2,520.6
North and Central Asia					
<15	29.5	27.5	23.1	18.7	17.2
16-64	64.2	64.5	66.7	67.2	63.0
>65	6.3	8.0	10.2	14.0	19.8
Total population (millions)	128.0	185.0	217.9	215.6	202.5
Pacific					
<15	28.4	31.2	26.1	21.0	17.9
16-64	64.1	61.4	64.2	64.1	62.6
>65	7.5	7.4	9.8	14.9	19.4
Total population (millions)	12.5	21.1	30.6	40.3	46.9

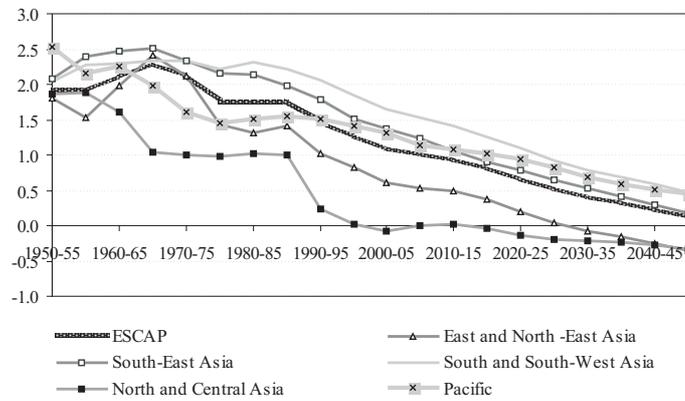
Source: United Nations (2005), *World Population Prospects: The 2004 Revision*, ST/ESA/SER.A/245, New York.

Figure 3. Trends in population growth by subregion



Source: United Nations (2005), *World Population Prospects: The 2004 Revision*, ST/ESA/SER.A/245, New York.

Figure 4. Trends in population growth rate by subregion

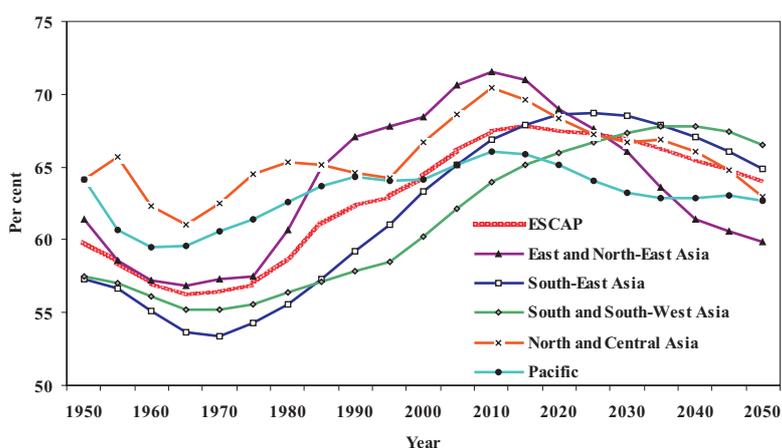


Source: United Nations (2005), *World Population Prospects: The 2004 Revision*, ST/ESA/SER.A/24, New York.

Implications for labour supply

The impact of the changes in population growth rate and the age-structure transition on the working-age population, a proxy for labour supply, can be seen in figure 5. In general since the period 1960-1970, all subregions have experienced significant increases in the percentage of the population 15-64 years of age. This increase will peak at different times in different subregions during the next three to four decades. For example, the transition has been most rapid and pronounced in East and North-East Asia, where the percentage of the population 15-64 years of age increased from about 57 per cent in 1970 to 68 per cent in 2000. It is expected to increase further, and peak at approximately 72 per cent by 2010, before declining rapidly to about 60 per cent by 2050. The transition in South-East Asia has also been rapid and pronounced, but took longer to occur. The percentage of the population 15-64 years of age increased from about 53 per cent in 1970 to 63 per cent in 2000, and is projected to increase to 69 per cent by the period 2025-2030.

Figure 5. Percentage share of population aged 15-64 by subregion



Source: United Nations (2005), *World Population Prospects: The 2004 Revision*, ST/ESA/SER.A/245, New York.

In South and South-West Asia, the percentage of the working-age population started to rise in 1970, from a low of 53 per cent. This increase remained modest until 2000, when it reached 60 per cent. The pace of this increase will accelerate up to 2025, when it is projected to reach 67 per cent. It is predicted to remain at that level until 2040, after which it will begin to decline, albeit slowly.

North and Central Asia and the Pacific subregions present a different scenario, owing to specific contextual factors that influenced the demographic trends in the countries of these subregions. In both subregions the demographic transition was under way well before 1950. As a result of lower fertility, they consequently had a higher percentage (64 per cent) of population in the working age group. However, the percentage of the population 15-64 years of age declined to about 60 per cent by 1965. This phenomenon was associated with an increase in fertility during the years immediately after the Second World War. Since then, the percentage of the population in this age group has increased steadily in both subregions; it is expected to reach its peak in 2010, before beginning to decline.

Thus, the increase in the percentage of working-age population, from its lowest level to its highest, has been greatest (15-16 points) in East and North-East Asia and in South-East Asia, where it took 45 and 55 years to occur. In South and South-West Asia, the increase is expected to be about 13 points in approximately 70 years. The increase since 1950 is more modest (9 and 7 points) in North and Central Asia and in the Pacific, where it is expected to take place during a span of 45 years. The patterns in the subregions of North and Central Asia and the Pacific, which got an earlier start in their demographic transition, also reflect the impacts of their swings in fertility and migration.

Ageing

An increase in the percentage of the old age population, defined here as 65 years and older, is the final stage in the age-structure transition. Ageing is an inevitable consequence of this demographic transition. For Asia and the Pacific, the number of older persons increased nearly 3.5 times during the period from 1950 to 2000, from 64 million to 234 million. This number is projected to reach 918 million, a nearly fourfold increase, by 2050. As a result of the decline in mortality among the older age population, its rates of growth have been high, at over 2 per cent annually during the period 1950-1975. That rate is expected to peak at 3 per cent annually during the period 2000-2025. Thus, ageing, which has been taking place at a modest rate until now, will accelerate in the coming decades. Older persons increased from 4.2 per cent of the total Asian and Pacific population in 1950 to 6.2 per cent in 2000. They are expected to increase to 17.9 per cent of the population in 2050 (see table 1).

Among the subregions, there are substantial differences in the timing and pace of the ageing process, as indicated in table 2. East and North-East Asia, where the demographic transition has been most rapid, will experience equally rapid ageing of the population, with the percentage of older persons increasing from a

modest 8 per cent of total population in 2000 to 25 per cent by 2050. Though less rapid, there will be a significant acceleration in the ageing process in South-East Asia during the period 2025-2050. In South and South-West Asia, where the population is still young, the process of population ageing will be slower, and it will therefore take longer to reach the levels attained in East and North-East Asia. The process will also be slower in the Pacific and in North and Central Asia, due to migration to Australia and New Zealand, as well as the slower pace of demographic transition and the effects of the previously mentioned age- structure fluctuations.

In general, however, population ageing in most countries in Asia and the Pacific will take place at a more rapid pace than in developed countries. Countries in the ESCAP region will have less time to address the consequences. Moreover, ageing will occur when countries in the ESCAP region are not as advanced as the developed countries had been when they reached comparable levels in the ageing process. The proportion of children born to the ageing population of Asia and the Pacific will be smaller, and these children will be more mobile and better educated, presenting significant challenges for the future (see United Nations, 2005a). However, the inherent potential in a transitional age structure, if harnessed through the timely interventions discussed below, could help maximize benefits and enable countries to manage the challenges associated with ageing.

Age-structure transition in selected countries

The broad regional differences discussed above can be further illustrated in the experience of selected countries, as shown in figure 6. However, differences exist among the countries in terms of the timing and pace of age-structure transition, which is related to the timing and pace of the demographic transition. In general, every country will go through a period of 40 to 70 years during which the supply of labour will expand and overall dependency significantly decline. At later stages every country will inevitably experience population ageing, moderately at first and rapidly thereafter.

In countries such as Japan and the Republic of Korea, periods of labour-supply expansion are near their end. These countries are entering an era of labour-supply contraction, barring significant changes in the labour force participation of women. Their workforce is ageing along with the ageing of their populations. China, Thailand, Viet Nam and the Islamic Republic of Iran, where a precipitous decline in fertility began during the early 1990s, will experience the same phenomenon in the not too distant future. The Russian Federation has very low fertility coupled with high mortality among young adult males, due to behavioural factors. The Russian Federation also faces rapid ageing and an

impending decline in population size and the supply of labour. By contrast, countries such as India, Malaysia, Pakistan, Papua New Guinea, the Philippines and Uzbekistan will experience an expansion in the supply of labour for a few more decades, lasting in some, until the middle of this century. During this time ageing will occur at a moderate pace. Australia and New Zealand, due to their managed migration policy, are projected to slow the pace of decline in their supply of labour and in the ageing process.

Figure 6. Percentage of population by selected age groups in selected countries

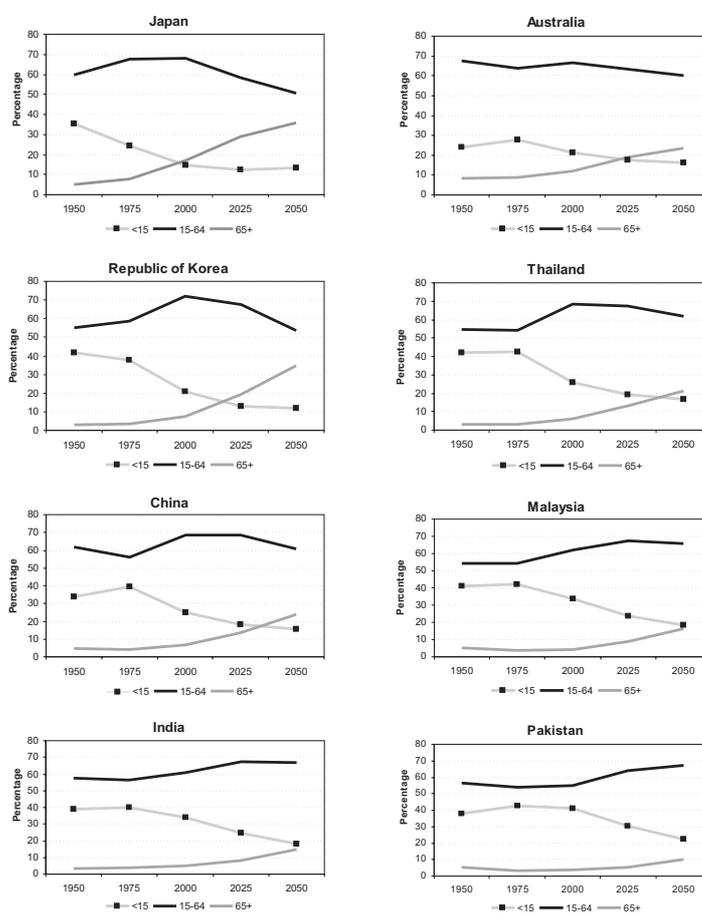
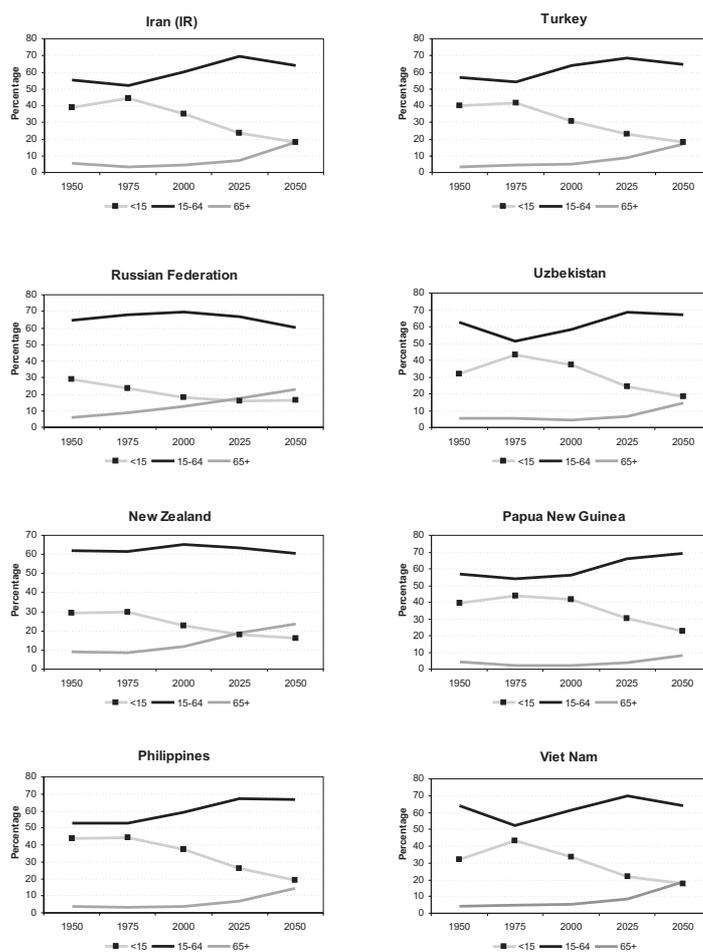


Figure 6. (Continued)



Source: United Nations (2005), *World Population Prospects: The 2004 Revision*, ST/ESA/SER.A/245, New York.

Age-structure transition, ageing and development

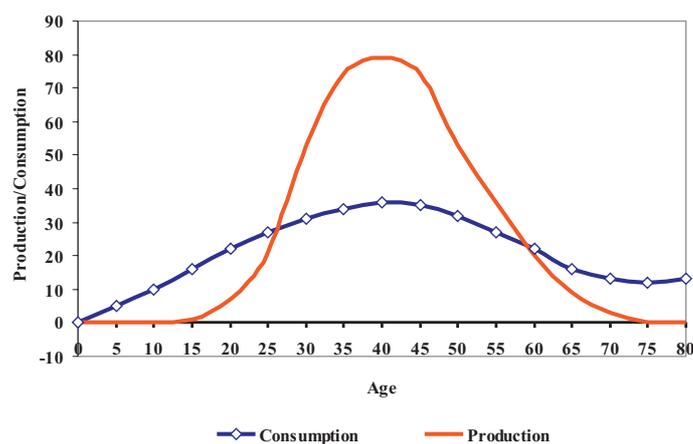
Age structure and development

As noted previously, the discussion about population and development during the 1960s to 1980s focused on the adverse implications for economic growth with high rates of population growth resulting from rapidly declining mortality and high fertility. Consequently, during the past several decades, population policies and programmes in most countries of Asia and the Pacific focused primarily on reducing fertility and population growth through government-supported family planning programmes.

The seminal work done by Coale and Hoover (1958) analysing the prospects of population change and economic development in Mexico and India – two of the countries experiencing rapid population growth at the time – played an important role in shaping the neo-Malthusian thinking of the 1960s: rapid population growth adversely affected economic growth. Two factors were central to their argument. The first was the impact on household savings of increasing household size. The impact was largely due to children, who would increase household consumption, and consequently reduce savings for investment, as well as investment in education and the health of children in the household. The second was the impact on government spending due to a very young population age structure. Increasing demand for investment in the social sector, particularly in education and health, would constrain investment in other sectors of production aimed at increasing the growth rate of gross domestic product (GDP) and generating employment for a growing labour force, albeit with a time lag. The impact of a young population age structure on economic growth, mediated through savings, capital formation and investment (and consequently on the quality and utilization of labour), therefore, has been at the core of the argument. However, the relationship is interpreted by many as an issue of a high population growth rate – and high population density – vis-à-vis resources.

Because population growth and fertility levels have declined significantly in the past few decades, many in policy and planning circles have the perception that population is no longer a major concern for development. This thinking is based on the old paradigm that it is mainly population growth that has an adverse impact on development. It reflects a lack of understanding that the relationship between population and development is mediated through the age structure of the population, as production, consumption, and hence savings and investment, are dependant on age – as shown in figure 7.

Figure 7. Age pattern of consumption and production



Therefore, it is important to understand how the age structure has an impact on development as it undergoes the transition from “young” to “old”. In this regard, the experience of Asian and Pacific countries provides some valuable lessons. The analysis in the preceding sections has indicated that age-structure transition provides a window of opportunity for economic growth through its favourable impact on dependency and labour-supply dynamics. However, as the experience of Asia and the Pacific reveals, such a transition alone even as it reduces dependency and increases labour supply is not sufficient. Benefits will accrue only if an enabling environment and supportive policies are in place for the development and utilization of human resources, economic growth and the creation of wealth.

Asian experience and lessons

Half a century ago, countries in Asia and the Pacific shared similar demographic features high but rapidly declining mortality, high fertility, and consequently, an increasing population growth rate and very young age structure but they differed in terms of their economic policies, governance and planning systems. Such systems were open or closed, centrally planned or market oriented, or a combination of both. They were also heterogeneous in their sociocultural and religious composition and related norms and practices. Geopolitical factors and ideological underpinnings also influenced the shaping of policies and programmes during that era.

Since the 1950s, as discussed in the preceding sections, countries in Asia and the Pacific have been undergoing a rapid demographic transition. By 2000, the process had been completed in many of these countries – in the remaining it is still under way (for details, see also Gubhaju and Moriki-Durand, 2003; Seetharam, 2002). Consequently, countries are at different stages of an equally rapid transition in their age structures, which has important implications for economic and social development. During this period, countries have also been undergoing other transitions – economically, socially and technologically – and a slow, but gradual, transition is occurring in political, governance and planning systems as well: from one-party to multiparty democracy, from the central to the local level, and to a free-market orientation, due to the increasing openness of their economies. As a result, countries in Asia and the Pacific today represent a mosaic, characterized by a high degree of diversity in economic growth and social progress.

What has been the role and importance of demographic factors, specifically the age-structure transition, in economic growth? A number of studies (e.g., Bloom and Williamson, 1998; Mason, 2001) indicate that the East-Asian demographic transition has been a major factor in the region's rapid economic growth, contributing from one fourth to two fifths of East-Asia's miracle. The evidence that emerges has been summarized as follows:

Between 1965 and 1990, per capita income rose annually by more than 6 percent. One explanation for this phenomenal growth is that in the late 1960s when the baby-boom generation started work, their entry into the workforce changed the ratio of workers to dependents in the population. With the benefits of a good education and a liberalized trade environment, this generation was absorbed into the job market and into gainful employment, thereby increasing the region's capacity for economic production. The region's working age population grew four times faster (an average of 2.4 per cent a year) than its dependent population... (Bloom, Canning and Sevilla, 2003, p. 45).

The studies also reveal that the benefit afforded by the changing age structure, called the “first demographic dividend”, is transitory, and the length of time the benefit can accrue, called the “window of opportunity”, will last for a few decades, typically between four and seven, in most countries. The studies also reveal that policies to stimulate economic growth and human capital formation are essential if the benefits afforded by the changing age structure are to be realized.

Highlighting the importance of supportive and synergistic policies in the East-Asian miracle, Mason (2005, pp. 2-3) states:

Although age structure variables have predictive power and can “explain” (in the statistical sense) a significant portion of economic growth, the relationship between demographic variables and the economy is not deterministic. Rather, the economic outcome from demographic change is policy dependent. The experience of the Asian Tigers provides very clear evidence in support of this view. A successful export-oriented growth strategy produced more than enough jobs to absorb the rapidly expanding workforce. A stable macroeconomic environment – until the late 1990s financial crisis struck – was attractive to investment. Large-scale-pay-as-you-go pension programmes that undermine saving and work incentives were avoided. These and other policies worked in concert with demographic change to produce high rates of saving and investment, rapid growth in employment, and spectacular economic growth. In the absence of complementary economic policies, the demographic dividend cannot be counted on to produce favourable economic results.

Thus, economic and social policies that promoted economic growth and created human capital, aided significantly by a changing age structure that is characterized by an increasing proportion of the population of working age and its effective utilization, have been an essential component of success in the economies responsible for the East-Asian miracle.

Policies and programmes to improve health and education can be facilitated by the transition in age structure. In analysing human capital aspects of economic development in Asia, Jones (2005, p. 42) states:

Declining dependency ratios and strong investment in human capital are inter-related; reduced dependency ratios have facilitated human capital deepening, particularly through an increase in public spending per secondary school student.

Together with an integrated health and voluntary family planning programme, these developments, in turn, led to a rapid decline in fertility and a shift in the age structures towards lower dependency ratios, thus reinforcing higher savings, investment and rapid economic growth.

In Japan, the most advanced country in Asia and the Pacific, the demographic transition began early in the twentieth century. The country's total fertility rate had declined to less than 3 children per woman by 1950 and it dropped well below the replacement level of 2.1 children per woman by 1975. The high proportion (more than 60 per cent) of people of working ages, as well as Japan's well-educated and healthy workforce, together with policies that focused on rebuilding the war-ravaged country, contributed to the rapid economic growth Japan experienced after the Second World War.

Examining the policy lessons from the East Asian demographic transition, McNicoll (2006) highlights the role of public administration and local institutions in contributing to the "miracle", as follows:

...the more significant lessons of East Asia have to do with the effectiveness of public administration and the local opportunity structures that it fosters. Getting those local institutions right not only directly promotes demographic transition but has an important, if ordinarily less-than-miraculous, economic payoff as well.

Australia and New Zealand, two of the other developed countries in the Asian and Pacific region, present a contrasting picture with that of Japan. Although the demographic transition was also well under way in these countries before 1950, their populations are projected to increase, albeit slowly, due to immigration. Also, the age-structure transition has been slower in these countries because managed immigration has played an important role in keeping the proportion of population of working age high (above 60 per cent) and fertility approximately at the replacement level due to high fertility among migrants and their preponderance in younger age groups. Along with other favourable factors, such as the openness of their economies and better human capital, lower dependency and the increased labour supply generated by migration have played a part in the economic growth of these countries.

Countries that lag behind, and those in which rapid economic growth is relatively recent, usually had policies and planning systems that stymied economic growth and/or human capital formation. This occurred even when they had been able to reduce mortality and moderate fertility and population growth through State-run family planning programmes. Consequently, they experienced increased proportions of their population being of working age. For example, in many countries in Asia and the Pacific centralized control and planning was once the norm. Production sectors were State-owned, and the role of the market was negligible. Thus, in countries such as the Russian Federation and those in Central Asia when they were part of the former Union of Soviet Socialist Republics

(USSR), the rate of GDP growth remained low. It still remains low (except in countries such as Kazakhstan and Turkmenistan during recent years as a result of revenues from oil and natural gas), even though their populations had achieved high levels of human capital development due to investments in health and education, as well as the promotion of equality between men and women. Furthermore, their dependency ratios have been declining and their supply of labour has been increasing.

Writing on the experience of the Russian Federation and the former USSR, Bloom, Canning and Sevilla (2003, p. 67) state:

Relative to other parts of the world, Russia has had a high working age share since at least 1950. From 1950 on... the high working-age share should have given the Soviet Union a significant economic boost. Instead...the country fell behind the capitalist world economically, to a greater degree than virtually anyone had anticipated. Although it is difficult to sort out causality, it is clear that the higher working-age share was not translated into robust economic growth, presumably the result, at least partly, of a state-driven economy insulated from market forces.

Countries experiencing high rates of economic growth in recent years (e.g., India and Viet Nam) also illustrate the contribution that age structure can make to economic growth, given a favourable policy environment. Until recently, a number of factors in these countries, such as poor health and education and State controls on production, have inhibited economic growth in spite of the increase in labour supply. Notwithstanding the differences between them, the opening up of their economies through trade liberalization, removal of capital controls etc., has provided the stimulus for entrepreneurship and rapid economic growth. It should be mentioned that Viet Nam is a centrally planned economy that had been engaged in a prolonged war and India is a mixed economy with democratic traditions, but is ideologically tilted towards a socialist approach. Given that the two countries continue to experience labour-force expansion brought about by age-structure transition, both can benefit significantly from the “first demographic dividend”. Reaping those benefits, however, would imply that the potential inherent in their human resources is further developed through improved education and health. It would also imply utilization of economic policies that promote savings and create conditions for private-sector investment domestic and foreign and generate employment and economic growth. In India, where the age-structure transition will take longer, the window of opportunity to benefit from this dividend will be open for few more decades.

In other countries, such as the Philippines and Sri Lanka, the beneficial effects of age-structure transition have not contributed to economic growth due to unfavourable political factors, among others. Herrin and Pernia (2003) conclude: “The Philippines experience is one where the advantages of a reasonable human capital endowment were frittered away through an inappropriate macroeconomic policy and adverse political factors”. Although Sri Lanka has also undergone rapid demographic and age-structure transition, and has been endowed with human capital, it could not benefit from the favourable effects of its changing age structure due to inward-looking and protectionist policies, as well as continuing civil strife and conflicts which began nearly three decades ago.

While the opportunity initially afforded by an increasing proportion of the population in the working-age groups, i.e., the first demographic dividend, is transitory in nature, a more sustained opportunity, i.e., the second demographic dividend, presents itself when the large number of young people who enter the workforce begin to save. These savings are partly a response aimed at protecting future consumption, as well as an investment in the education and health of their children. This in turn contributes to the growth of labour productivity, capital and income.

Realization of the second demographic dividend, i.e., the pro-growth effect of capital accumulation, depends on how accumulation of wealth is related to population ageing. Information about wealth accumulation, through various forms of financing for consumption during retirement years, and its contribution to the second demographic dividend, is beginning to emerge (for details, see Mason, 2005). An understanding of how this potential can be realized is important for sustaining economic growth into the future, as well as for effectively managing the social and financial security needs of a rapidly ageing Asian population.

Looking towards the future

Fertility and population growth have declined significantly in much of Asia during the past half century. Consequently, the age structure of populations is in the midst of a major transition. Countries are at different stages in this process. This transition is predictable, barring any shocks. It presents both opportunities and challenges for sustainable development of Asian and Pacific economies for the next half century and beyond.

A number of countries in the region have completed the demographic transition. Their populations and labour supply will begin to decline and the dependency burden, caused by the rising proportion of older persons in the population, will increase. At one end of the spectrum is Japan, where the

favourable demographic window of opportunity has already closed. Japan's closed-door policy on immigration has led to the beginning of a contraction in its labour force. This situation, which together with an ageing population and workforce and the "pay-as-you-go" pension system as it is applied today, will significantly strain the country's economy (see Bongaarts, 2004). There are other countries and areas in the region that are not far behind Japan. A key to deal with this issue is the provision of social and financial security for older persons. Thus, a review of existing pension systems is needed. Existing pay-as-you-go pension schemes can be effective in a rapidly growing economy, as well as in one where new labour-force entrants outnumber retirees. However, in situations where pension disbursements increase rapidly due to increases in the number of older persons and the longevity of retirees relative to workers who contribute to the scheme, the scheme will become unsustainable (see also Asian Development Bank, 1997; Ogawa, 2003). It would thus be equally important for such countries to review their policies on migration, the employment of women etc. This could help both meet the demands of the labour market and the needs of an ageing population.

Most of Asia's population is in countries where the demographic transition, that is, the shift from high to low mortality and fertility, is still under way. In these countries, population continues to grow as a result of fertility, which remains higher than the replacement level, and "population momentum". At the same time, the age structure is also undergoing rapid change owing to rapid declines in fertility, providing countries with the window of opportunity afforded by a rapidly expanding working-age population. Recent trends in globalization, characterized by increased trade, flow of capital and infusion of new technologies, could help many of these countries benefit from the "demographic dividend" afforded by the changing age structure.

In many of these countries, particularly those in South Asia, access to education and health services remains inadequate, and women remain considerably disadvantaged. Fertility levels also remain high due to a lack of access to reproductive health services, high unmet need for family planning and the relatively lower status of women. Access to services is severely limited for adolescents and young adults who constitute a large share of the population, and in many countries, an increasing share. Thus, policy priorities for these countries should be to continue improving access to education and health, including reproductive health services, as well as promoting gender equality and women's empowerment. This will sustain the momentum of fertility decline, which in turn will facilitate greater investments in improving access to, and the quality of, education and health services.

At the same time, these countries can benefit from favourable age structure (increased labour supply and reduced dependency) through the first demographic dividend, which is of varying magnitude and duration. They would benefit from supportive economic and social policies that promote economic growth and human capital formation and its effective utilization, as well as be able to create efficient public administration and local structures. They could also initiate steps to establish mechanisms for benefiting from the second demographic dividend by improving facilities and institutions that would foster wealth accumulation. In the long run, this would contribute to better management of the finances needed by an ageing population.

Endnote

1. The population estimates used in this paper are derived from United Nations (2005). Estimates for future years assume a convergence of total fertility rates towards the replacement level by 2050 (see figure 2), although this might be unrealistic for countries in which fertility has reached, or will decline to, levels well below the replacement level, thus having greater impacts on age-structure transition and the ageing of those populations.

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Progress and Prospects in Reproductive Health in the Asian and Pacific Region

Central to improving reproductive and sexual health is a greater focus on promoting reproductive and sexual health rights. Women and men of all ages, and of all social positions, must be aware of their rights to information and quality services.

By Philip Guest*

In regards to the demographic-oriented indicators traditionally used to measure the progress made by population programmes, the Asian and Pacific region is viewed as a much heralded success. The current total fertility rate (TFR) of the region is 2.3 and the annual population growth rate is just 1.1 (ESCAP, 2005). There has also been progress in indicators that reflect the more inclusive concept of reproductive health based on supporting individuals to achieve their

* Country Director, Population Council, Bangkok, e-mail: philip@popcouncil.th.com.

reproductive health goals. The quality of reproductive health care and services has improved, and reproductive rights, rather than demographic targets, now underlie most reproductive health programmes in the region.

With the progress that has been made in reproductive health over the last two decades in Asia and the Pacific, and with much of the international community now focused on meeting the Millennium Development Goals (MDGs), there has been a reduction in efforts aimed at developing and monitoring reproductive health programmes. However, new challenges have emerged over the last decade that require a strengthening of existing reproductive programmes and, in some cases, a change in their direction. There is also increasing recognition that in order to achieve the MDGs, it is necessary for reproductive health to be placed at the forefront of the international agenda (UNFPA, 2005).

The primary objective of this paper is to assist in identifying how reproductive health programmes in the Asian and Pacific region can more effectively meet the challenges of improving the lives of women and men in the rapidly changing development context that characterizes the region. In order to achieve this objective, this paper will document progress in selected areas of reproductive health that have occurred in the Asian and Pacific region and identify new challenges that programmes need to address over the next decade.

Fertility and family planning

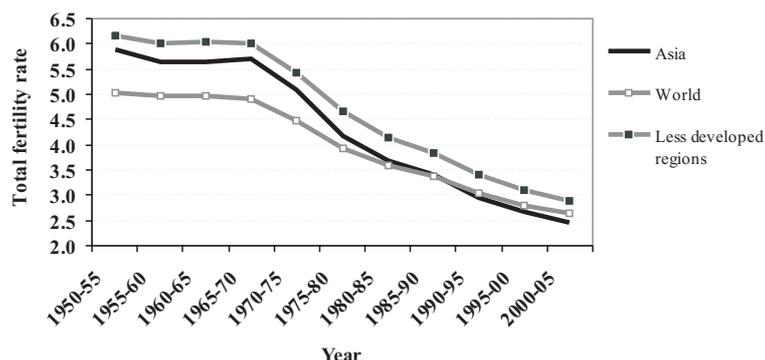
Although there is tremendous diversity in the reproductive health status of different countries in Asia and the Pacific, overall there has been marked progress on a variety of indicators over the last two decades (ESCAP, 2004). Progress is best documented in change in demographic indicators, but can also be observed in a variety of other reproductive health indicators.

Fertility reduction

Fertility in Asia has declined much more rapidly than in other regions of the world. Five decades ago the total fertility rate (TFR) of women in Asia was almost one child higher than the TFR for all women in the world. Currently Asia has a TFR that is below that estimated for the world, and which is almost 0.5 births less than for all less developed regions combined (see figure 1).

Fertility reductions have been primarily a result of the adoption of modern contraceptives by women throughout the region. At the start of the 1960s, less than 10 per cent of women were using modern contraception to control their fertility. Currently, almost two thirds of women in Asia are using a contraceptive method, with almost all of these using a modern method (see table 1).

Figure 1. Total fertility rate for selected areas, 1950-1955 to 2000-2005



Source: United Nations (2005).

This rapid adoption of contraception was facilitated by national family planning programmes that were established in most Asian and Pacific countries in the 1960s and 1970s (Jones and Leete, 2002). Both national and international support for family planning programmes was strong, and a declining desired number of children fuelled a demand for contraceptives (Harbison and Robinson, 2002). Family planning programmes exhibited a diversity of institutional structures, varying from programmes completely separate from the public health system to some fully integrated into the public health system.

Progress in family planning and fertility has not been uniform throughout the Asian and Pacific region. High levels of contraceptive use, particularly of modern methods, and below replacement levels of fertility, are most evident in East Asia, while in South Central and Western Asia, TFR remains above three and less than one half of women are using contraception. There is also a significant gap between the percentage of women using contraception and the percentage using modern methods (table 1). Guest (2003) notes that this diversity in experience is also evident within subregions of Asia and the Pacific. In South-East Asia, for example, Thailand had reached replacement level fertility by the end of the 1980s primarily as a result of the rapid adoption of contraception, supplied by both the Government and private sectors. In the neighbouring country of the Lao People's Democratic Republic, however, government support for family planning has been muted and fertility remains high.

Table 1. Selected indicators of fertility and contraceptive use in Asia and the Pacific by subregion, 2005

Region	Total fertility rate	Contraceptive prevalence rate	
		All methods	Modern methods
Eastern Asia	1.68	82	81
South-East Asia	2.42	60	51
South Central Asia	3.04	48	41
Western Asia	3.23	47	28
Oceania	2.27	62	57
All Asia	2.41	64	59
Less developed regions	2.82	59	54
World	2.60	61	54

Source: UNFPA, *State of the World Population 2005*.

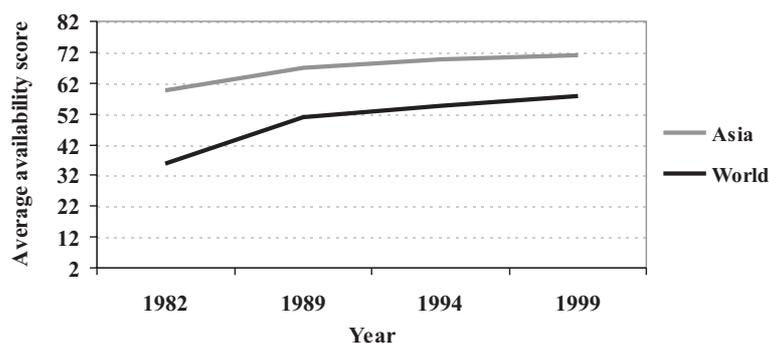
Note: Oceania in this table includes: Australia, Melanesia, New Zealand and Papua New Guinea.

Quality of care

The Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo in 1994, stressed a rights-based approach to reproductive health programmes, focusing on meeting the reproductive and sexual health needs of all members of the population. Although there are many dimensions to this approach, one area that has been stressed is improving the quality of care in reproductive health programmes. The quality of care framework (see Bruce, 1990), provides a set of guidelines that programme managers can use to reorganize their activities to make them more consistent with the recommendations on reproductive rights of the Programme of Action of the ICPD.

A central component of the Bruce framework is clients having a choice of methods. Ross, Stover and Adelaja (2005) have attempted to measure the overall availability of modern methods. Although globally their conclusions reveal a bleak picture, with less than two thirds of national programmes providing at least one long-term and one short-term method, the situation in Asia is better, with almost 80 per cent of programmes providing at least one short-term and one long-term method. Furthermore, as measured by the average availability of methods indicator, there have been consistent increases in Asia in availability over the last two decades (see figure 2).

Figure 2. Average availability of contraceptives score: Asia and all regions, 1982 - 1999



Source: Ross, Stover and Adelaia (2005).

Among countries in Asia and the Pacific, there is substantial variation in the extent to which there is full access to a range of modern contraceptive methods. For example, in the Philippines there have been legal restrictions on the sale and distribution of contraceptives. These restrictions, in addition to the decentralization of health care, have severely limited access to affordable contraception (Center for Reproductive Rights, 2005), and have likely contributed to the high levels of reported unplanned pregnancies and unsafe abortion (Center for Reproductive Rights, 2005).

Other aspects of the quality of care in reproductive health programmes in the Asian and Pacific region also appear to be improving, although data to support this conclusion is sparse, and there is an urgent need to collect data that measures the quality of care in the programmes. In a recent review of reproductive health-care programmes in Asia and the Pacific, ESCAP (2004: 34) concluded that access to, and the quality of, reproductive health programmes was “gradually improving”. This assessment, based on responses to a questionnaire sent to national reproductive health programmes, noted improvements in a range of areas, including strengthening logistics systems, setting quality standards, increased staff training and more service delivery points. The ESCAP assessment cited a number of barriers to improving quality of care that had also been cited in a previous assessment in 1998 (see Walker, 1998). These include: a lack of understanding of quality of care, insufficient progress in integration of services, and weak management structures.

There are compelling reasons to integrate family planning services, as well as other reproductive health services, into the primary health-care system. According to the ESCAP review (ESCAP, 2004), approximately one half of countries had integrated reproductive health services into their primary health-care system, but there were significant organizational and resource barriers to integration in many of the remaining countries.

The mechanisms through which reproductive health services are provided have important, but often poorly understood, impacts on access to (and quality of), reproductive health services. In 1997, in response to the ICPD Programme of Action, the Government of Bangladesh introduced a new strategy to provide family planning and other reproductive health services as part of an essential package of health services. This strategy, which focused on the establishment of community clinics, was designed to increase local community involvement in health care and entailed a reduction in outreach services (see Bates, Islam, Al-Kabir and Schuler, 2003). However, these changes under the new strategy were widely criticized, both because what was perceived to be stagnation in fertility decline and the view they were making it more difficult for poorer women to access services. For example, Arends-Kuenning (2002), argued that field workers have been most effective at meeting the family planning needs of poor and uneducated women, and that removing these workers completely from family planning programmes affected these women's contraceptive choices. While Bates, Islam, Al-Kabir and Schuler (2003) dispute these claims, arguing that the changes were not adequately implemented, the Government of Bangladesh did reverse the strategy and again began to focus on fieldworkers visiting households as the central component of the programme.

There have been pilot projects implemented in countries in Asia and the Pacific that focus on improving quality of care. For example, Jain and others (2002) report on a pilot project in the Philippines that used information about the needs of clients, expressed by clients, to design provider work plans and direct service efforts. This new approach replaced an existing system that was based primarily on demographic and medical criteria. An evaluation of this project found that improved quality of care was associated with improved continuation of use of contraception (Ramarao and others, 2003).

Maternal and child health

Maternal mortality and morbidity

Among all reproductive health indicators, perhaps the least progress has been made in reducing levels of maternal mortality. Improving maternal health is one of

the MDGs, and a reduction of maternal mortality is the key indicator for achieving that Goal, with the objective of reducing the maternal mortality ratio by three quarters by 2015. Accurate measurement of maternal mortality remains an enduring problem which makes it difficult to make conclusions about the extent to which levels have declined over the last two decades.

Even in countries such as Malaysia, which is recognized as having a reliable vital registration system, maternal deaths have been shown to be under-reported by a large amount. An analysis of revised estimates of maternal mortality show little change in levels through the 1990s (Leng, 2005). Utomo (2005), based on an analysis of survey data in Indonesia over the past 15 years, states that although the trend in maternal mortality appears to be declining, large sampling errors associated with the estimates make it impossible to conclude this, and other evidence even suggests that maternal mortality levels have stagnated through the 1990s.

Current levels of maternal mortality in Asia and the Pacific remain high in several countries, particularly in South Asia (Devasahayam, 2005). Data shown in table 2, illustrates the disparities in maternal mortality among regions. In Eastern Asia, it has declined to a moderate level of 55. However, in South-Central Asia, the ratio is a very high 520, and approximately 40 per cent of the maternal deaths that occur in the world are found in this subregion of Asia and the Pacific.

Table 2. Maternal mortality ratio and number of maternal deaths in selected regions

Region	Maternal mortality indicators	
	Maternal deaths	Maternal mortality ratio
Eastern Asia	11,000	55
South-East Asia	25,000	210
South Central Asia	207,000	520
Western Asia	9,800	190
Oceania	530	240
All Asia	253,000	330
Developing regions	527,000	440
World	529,000	400

Source: WHO (2004).

While a focus on maternal mortality is clearly warranted, it is important not to forget that many more women suffer from maternal morbidities than die from causes related to pregnancy or birth. UNFPA (2004) concludes that maternal morbidity is one of the major sources of morbidities for reproductive age women. Utomo (2005) reports that over 10 per cent of Indonesian women suffer from maternal morbidity. Programme interventions designed to reduce maternal mortality will also reduce the incidence of maternal morbidity. However, because many women who experience maternal morbidity do not seek health care, campaigns that communicate to women the importance of accessing appropriate services are vitally important.

Improving maternal health services

The major declines in maternal mortality called for in the MDGs can only be achieved through progress in a variety of areas. The two major areas where improvements can be made are in increasing access to contraceptives and improving maternal health services (Maine and Rosenfield, 1999). Family planning programmes can reduce maternal mortality in some very obvious ways. Reducing the number of births results in reductions in the number of times women face the risk of dying. Furthermore, change in the timing of births, and ages at which women give birth, can contribute to fewer births occurring in high-risk categories.

There are also less obvious, and not well documented, ways in which access to family planning can reduce maternal mortality. For example, use of contraception could lead to an improvement in family income and provide more resources for health. Family planning programmes can also provide women with access to the health system. Phillips and Hossain (2003) found in a longitudinal study in Bangladesh that access to family planning programmes was associated with increased status of women.

In addition to improving access to contraception, more effort needs to be directed at improving maternal health services, including emergency obstetric care. Priority interventions are now well understood (Berer and Ravindran, 1999), though there has been uneven progress in implementing these. One critical intervention is providing skilled attendants for a woman during her pregnancy, at birth and during the immediate postnatal period. WHO (2004a) has recently issued a statement reiterating the crucial role of skilled attendants and calling for a “continuum of care” for women in order to reduce both maternal and child mortality.

Overall, there have been improvements in indicators of access to services for pregnant women. Using survey data from multiple periods of time, but predominantly from the 1990s, AbouZhar and Wardlaw (2004) found that the percentage of women accessing antenatal care increased globally throughout the 1990s, with the increase being greatest in Asian countries. Ross, Stover and Adelaja (2005), report that among countries in Asia for which data is available, 69.4 per cent of women received skilled care through at least one antenatal visit, 59.6 per cent had a trained attendant at birth and 77 per cent had received tetanus immunization. The percentage receiving care was the lowest in countries in South Asia.

Clearly more effort is required to ensure that women receive access to quality medical care that will improve the chances that they and their children survive. This continuum of care approach is being widely advocated at the international level through the Maternal-Newborn-Child Health Continuum of Care (see Sines, Tinger and Ruben, 2006). This approach acknowledges the centrality of providing women with access to quality health care from pregnancy through birth and after birth. Some national reproductive health programmes, such as the Indian programme, have recently implemented this approach. Such programmes are unlikely to achieve their targeted goals unless underlying systems of gender inequality that constrain women's use of services are addressed. For example, in Nepal, Furuta and Salway (2006) documented how women's lack of decision-making power in the household severely constrained their use of maternal health services.

Reducing abortion

A significant contributor to maternal mortality is unsafe abortion. WHO regional estimates of the proportion of maternal deaths that are the result of unsafe abortion is 15 per cent in countries covered by the South-East Asian Regional Office and five per cent in countries covered by the Western Pacific Regional Office. Overall, it is estimated that 13 per cent of maternal deaths are a result of unsafe abortion (WHO, 2004b). Of the total estimated number of unsafe abortions (10.5 million in Asia estimated for 2000), over seven million occurred in South-Central Asia primarily a result of higher levels of fertility in this subregion compared to other subregions in Asia. The highest incidence of unsafe abortion, at 23 per 1,000 women aged 15-44 was reported in the South-East Asian subregion (WHO, 2004b). This indicates that while increased access to contraception, leading to lower fertility, can contribute to drastically reducing the number of maternal deaths resulting from unsafe abortion, also required are changes in policies and programmes that reduce the risk of unsafe abortion.

There is a clear negative association between good access to quality family planning services and use of abortion services. Unfortunately, this link has often been clouded by increased demand for abortion services that occurs as demand for fertility regulation increases. Even with increased contraceptive use, abortion rates may still rise because of the greater motivation couples have to limit their fertility. However, a study by Rahman, DaVanzo and Razzaque (2001), which compared abortion levels over the two decades of the 1980s and 1990s in two areas of Bangladesh (one an area with good access to family planning and one with poor access to family planning) clearly found that while abortion rates stayed relatively constant for the area with good access to family planning, abortion rates more than quadrupled in the area with poor access to family planning. Active family planning programmes, providing broad-based access to contraception, in combination with post-abortion programmes that integrate contraceptive provision into services (Bensen, 2004), remain the main strategy for preventing abortions.

As Munding (2006) and many others have stressed, the major impediment to reducing levels of unsafe abortion for women with unplanned pregnancies are laws that restrict access to abortion. In Asia and the Pacific, there has been a liberalization of laws related to abortion. Though the majority of countries have restrictive laws, there was liberalization in the legal provisions on abortion in Cambodia, Malaysia and Pakistan, while Nepal has effectively legalized abortion (Ganatra, 2006; ESCAP, 2004). In Thailand, a broader interpretation of health under newly authorized Ministry of Public Health regulations also promises to broaden access to abortion. Furthermore, Ganatra (2006) argues that no country in the Asian region has placed greater restrictions on abortion in recent years. However, existing restrictions in many countries mean that many women do undergo unsafe abortion, placing their lives at risk.

Unsafe abortions do not only occur in countries with laws that restrict access to abortion. India is a well cited example of a country where there are liberal abortion laws, but where the majority of women do not have access to safe abortions because of the relatively small number of centres licensed to perform them and the concentration of licensed centres in urban areas (Ganatra, 2006). Even where abortion services are provided, risks to women's health may be exacerbated by poorly trained providers and inadequate equipment. Finally, abortion services are rarely integrated into other reproductive health services. Of most importance is the integration of abortion services with family planning services and services that diagnose and treat reproductive tract infections. Warriner and Shah (2006) provide a number of recommendations for programmes designed to improve abortion services.

There is also a need to make post-abortion care more widely available. In India, where complications from unsafe abortion are common, there is also poor quality post abortion care. Johnston, Ved, Lyall and Agarwal (2003), in a study in Uttar Pradesh, found that most women accessed post-abortion care through generally untrained village-level providers. Standards of care were poor, often exacerbating the conditions, and contraceptive counseling was generally lacking. Even in a country such as Viet Nam, where abortion providers are well-trained, Xinh, Binh, Phuong and Goto (2004) found that among the 30 repeat aborters that they interviewed, only five were practicing contraception and less than one half had been counseled about contraception at the time of their last abortion.

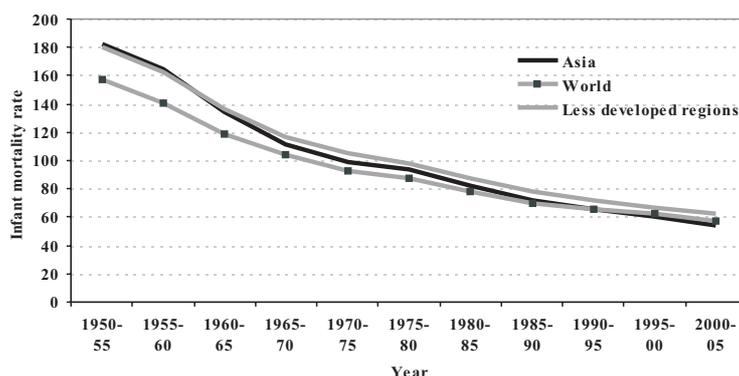
Women in many parts of Asia are also at risk of death as a result of abortion through sex selection (East-West, 2002). The preference for boys over girls has resulted in high levels of abortion of girl fetuses in countries such as Bangladesh, China, India and the Republic of Korea. Foetal sex-identification is a major factor contributing to sex-selective abortion, and even though many countries have banned this practice, it still continues. Bairagi (2001) argues that if foetal sex-identification becomes more widely available in Bangladesh, it may increase the number of abortions of female fetuses. Sex-selective abortion is a reflection of deep-rooted gender inequities, but also contributes to ongoing discrimination through trafficking of women for marriage in societies where sex ratios at young adult ages have become highly unbalance due to a history of sex-selective abortion.

Child health

Many issues related to maternal health are also related to child health, as the health of children is inextricably linked to that of their mothers. A reduction in child mortality is also one of the eight MDGs. In Asia and the Pacific, there have been well-documented decreases in child mortality over the last several decades. In figure 3, infant mortality rates are shown for Asia, less developed regions and the world. Rates of decline in infant mortality have overall been more rapid in Asia than in the world and less developed regions.

Within the Asian and Pacific region child mortality is highest in South-Central Asia and lowest in East Asia. Devasahayam (2005) shows that there have been reductions in child mortality in almost all countries in Asia and the Pacific over the last two decades (an exception is the Democratic People's Republic of Korea). However, she notes that even with the reductions, only the Republic of Korea is likely to achieve the targets set by the MDGs for the year 2015.

Figure 3. Infant mortality rates for selected areas, 1950-1955 to 2000-2005



Source: United Nations (2005).

As with maternal mortality, greater access to modern contraception contributes to a reduction in child mortality through both direct and indirect mechanisms (East-West Center, 1999). Also, as with maternal mortality, reductions in levels of child mortality require interventions in the health system to ensure that pregnant women and their new-born babies receive good quality health care. The continuum of care approach to improving the health of mothers and children is supported by evidence from a number of studies. For example, in India, Choi and Lee (2006) found that access to prenatal care increased access to other subsequent health-care services, such as immunization.

Sexual health

There has been a reluctance to address issues of sexual health in reproductive health programmes in Asia and the Pacific, as in other regions of the world. This reluctance is in part due to the sensitivity of addressing issues related to sexuality, but also derives from a lack of understanding of sexuality and a dearth of applicable programme models. The continued threat of HIV, however, has prompted Governments in the region to pay more attention to sexual health.

Most of this attention has been directed towards strengthening HIV programmes. ESCAP (2004) reports that most countries have taken several steps towards preventing and managing STIs, including HIV. The most common interventions have been improving access to condoms, providing IEC, targeting

what are considered to be “high-risk” groups and providing access to voluntary counseling and testing. However, the review also notes that many of those programmes seem to have had limited impact on changing behaviours. Changing behaviours will require programmes that support interventions which target the social processes and cultural beliefs supporting behaviours that put people at risk of infection.

Reproductive tract infections

The great majority of reproductive tract infections (RTIs) are not sexually transmitted. However, diagnosis and treatment of non-sexually transmitted RTIs is usually undertaken in conjunction with sexually transmitted infections, and it is often difficult to distinguish between the symptoms of the infections that are transmitted sexually and those that are not (Lien and others, 2002).

Although understanding of the large burden that RTIs place on both women, and to a lesser extent men, and the health system has increased over the last decade, responses at the programme level have been limited. It was only in the late 1980s and early 1990s that a series of small-scale studies indicated high levels of prevalence of RTIs in Asian populations. Since then, several countries in the Asian and Pacific region, most notably China, have begun to integrate RTI diagnosis and treatment more systematically into their reproductive health programmes. However, much work remains to be done in order to both develop RTI services and also help women and men understand the importance of seeking treatment for RTIs.

Most programmes’ attention has been directed to sexually transmitted infections, particularly HIV. Although the prevalence of HIV in the adult population in Asia and the Pacific has not reached levels in some other regions of the world, HIV still affects large numbers of people in the region. From table 3 it can be seen that adult prevalence is highest in South and South-East Asia and much lower in East Asia and Oceania. Also, the proportion of those infected who are women is closely related to the prevalence levels: where prevalence is low the proportion of those infected who are women tends to be low. There is evidence that the sex ratio of infected persons is changing in Asia, with higher proportions of women becoming infected (UNAIDS, 2004a) as more women are infected by their husbands.

Although levels of HIV infection in Asia are low compared to other regions, this is not the case for other sexually transmitted infections. WHO (2001) estimates that almost one half of the new cases of curable sexually transmitted

infections in the age group 15-49 occur in South and South-East Asia. The estimated incidence of 158 per 1,000 persons aged 15-49 is only exceeded by Sub-Saharan Africa (257). The rate for East Asia and the Pacific is estimated at only 22 per 1,000.

Table 3. Adult HIV prevalence and percentage infected with HIV who are women, selected regions, 2003.

Region	HIV prevalence indicators	
	Adult (15-49) prevalence (%) end of 2003	Proportion of adults (15-49) living with HIV who are women
East Asia	0.1	22.2
South and South-East Asia	0.6	28.5
Oceania	0.2	19.7
World	1.1	47.6

Source: UNAIDS (2004).

Note: Oceania in this table includes only Australia, Fiji, New Zealand and Papua New Guinea.

Gender relations and sexual health

For those persons who are sexually active, the main means of protection against STIs is mutual monogamy or condom use. Consistent condom use has been shown to be effective against a wide range of sexually transmitted infections, most recently the human papillomavirus (HPV) (Winer and others, 2006). ESCAP (2004) notes that although countries in Asia and the Pacific report expanding access to condoms, surveys in several countries show limited improvements in levels of condom use.

This may be because few programmes have addressed underlying issues of gender power relations that hamper the ability to communicate regarding the desire to use a condom (Blanc, 2001). Where communication does occur, consistent condom use is more likely. In a meta-analysis of over 50 studies of the relationship between communication about safe sex and condom use, Noar, Carlyle and Cole (2006) found that communication about condom use and sexual history, as well as communication about safer sex, were all significantly related to greater use of condoms.

A lack of communication between partners, especially as it relates to issues of sexuality or reproduction, has been documented in a number of Asian countries and has been shown to affect health-seeking care and behaviours in areas such as RTIs (Santhya and Dasvarma, 2002) and maternal health (Furata and Salway, 2006).

Lack of communication between partners is also related to gender-based violence. Gender-based violence, particularly violence against women, has been shown to be common in many countries. Kishor and Johnson (2004), in a multi-country study that included Cambodia and India, found that 18 per cent of women in Cambodia and 19 per cent of women in India reported having been abused by their partners. Better educated women were more likely to disagree with the practice of abuse, and women who made decisions jointly with their spouses were far less likely to suffer abuse.

The study by Kishor and Johnson (2004), also found evidence to suggest that violence against women has serious health consequences for women and their children. They report that abused women were more likely to report unwanted births and sexually transmitted infections. They were also less likely to receive antenatal care when they were pregnant. Im-em, Kanchanachitra and Archavanitkul (2005), found that women in Thailand who experienced sexual coercion from an intimate partner, compared to those women who had not experienced it, were more likely to have experienced their first sexual intercourse at an early age, more likely to have been sexually coerced by other men, more likely to have a partner who visited sex workers, and more likely to have a partner who had sexual relationships with other women.

UNFPA (2005:69) argues that reproductive health programmes provide “a strategic venue for offering support for women who have suffered violence”, and also provides a number of examples, including Malaysia, of programmes that have integrated services related with gender-based violence into reproductive health services. While such approaches are needed, they are inadequate, as they fail to address the needs and concerns of men involved in gender-based violence, both as perpetrators, and in some cases, victims.

The needs of men are often ignored in programming for sexual and reproductive health. As a recent report by The Alan Guttmacher Institute (2003) persuasively argues, sexual and reproductive health issues involve both men and women and the needs of both should be addressed. This requires research to identify the reasons why men (and women) engage in behaviours that lead to unhealthy outcomes, as well as interventions that attempt to assist men (and women) to change their behaviours.

Adolescent reproductive health

The Plan of Action of the ICPD was very clear in recommending that the reproductive needs of adolescents, including access to information and services, be met. However, the recent regional review undertaken by ESCAP on progress in

meeting the ICPD goals concludes that although adolescent reproductive health is on the national agenda, “when information on specific actions is examined in detail, it becomes clear that far fewer countries have taken actions that go beyond the formulation of plans or policies and/or IEC/advocacy in support of adolescent reproductive health information and service provision” (ESCAP, 2004:45).

The progress is limited despite a strong regional consensus on the need to address the sexual and reproductive health needs of adolescents. For example, the proposed “Pattaya Programme of Action on Adolescent Reproductive Health” made recommendations to improve adolescent reproductive health that were aimed at individual, provider and societal levels (UNFPA, 2000). However, the sensitivity of addressing issues related to sexual behaviour in young people has hindered the development of policies and the implementation of programmes.

It is becoming increasingly clear that substantive action directed at providing young people with access to services and skills to develop healthy and responsible sexual lives is required. Such action is also necessary for addressing the MDGs. Although there is no specific MDG directed at young people, failure to serve the sexual and reproductive health needs of young people will result in reduced social and economic opportunities and poorer health for this age group, making it more difficult to achieve goals related to reducing poverty, maternal and child mortality and prevalence of HIV.

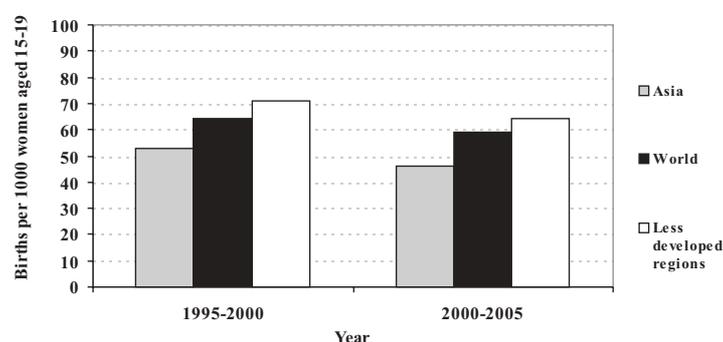
Early entry into sexual relations and child-bearing

There have been a number of regional reviews that document the early entry into sexual relations of significant proportions of young persons in countries in the Asia and Pacific region (Gubhaju, 2002; Jejeebhoy and Bott, 2003). This body of evidence continues to accumulate. Not only is sexual behaviour among youth widespread, for young men it often involves transactional sex and sporadic use of condoms. In one of the most recently published studies on these issues, Douthwaite and Sareoun (2006), based on an analysis of survey data from 665 male Cambodian youth, found that approximately one half were sexually active and one third of these reported transaction sex. Similar results have also been recently reported for youth in Sri Lanka (Perera and Reece, 2006).

There are many factors that appear to be associated with the increased sexual activity of young people before marriage. Rising ages of marriage result in longer periods during which adolescents remain unmarried. Furthermore, social changes that are weakening social norms against premarital sex are occurring within a context where young people have more economic resources and where they have a greater opportunity to interact with each other outside the home environment.

Although ages at marriage are rising in almost all countries of the region (Gubhaju, 2002), for many adolescents their first sexual intercourse experience occurs within marriage. Fertility rates for ages 15-19 are lower in Asia than in all less developed regions overall, but still remain over 40 (see figure 4) and have declined at a slower rate than overall fertility rates over the last two decades.

Figure 4. Fertility rates for age-group 15-19 for selected areas, 1995-2000, 2000-2005



Source: United Nations (2005).

Within Asia and the Pacific there is considerable variation in adolescent fertility rates (table 4). Rates are highest in South and South-West Asia, where mean ages at marriage tend to be low, and are lowest in East and North-East Asia where the mean age at marriage for women are well into their twenties. Overall, in the Asian and Pacific region approximately four per cent of women aged 15-19 give birth each year. In Afghanistan, Bangladesh and Nepal, over 10 per cent of women aged 15-19 give birth annually.

Table 4. Age-specific fertility rates for women aged 15-19 in selected regions

Region	Fertility rate aged 15-19
East and North-East Asia	5
South-East Asia	42
South and South-West Asia	72
North and Central Asia	30
Pacific	30
Asian and Pacific region	42

Source: ESCAP (2005).

Consequences of early sex and pregnancy for young people

Globally, the main cause of death of women aged 15-19 is maternal mortality. As noted above, levels of adolescent child-bearing remain high in many parts of Asia, thus many young women are exposed to the risk of dying or experiencing reproductive morbidities. In addition to the biological factors that lead to elevated risk of dying in childbirth for young pregnant women, use of maternal and child health services also tends to be lower for young women. In a cross-national study on the use of maternal and child health services, Reynolds and others (2006) found that younger women, especially those in several of the Asian countries in their sample, were significantly less likely to use maternal and child health-care services than were older women. The highest incidences were in South Asian countries, and they speculate that the results reflect a combination of age and gender-based discrimination that provides women with little decision-making power in reproductive health decisions. They argue that maternal and child health programmes need to target pregnant youth in their communities.

Many young women who become pregnant never reach the stage where they need to access maternal and child health services. These women, particularly those who are unmarried, often resort to abortion to end an unwanted pregnancy. Ahman and Shah (2002) note increases in levels of unsafe abortion among the unmarried. There is also evidence from a number of Asian countries such as Thailand and Viet Nam that the unmarried now constitute a higher proportion of women who seek abortions (Center for Reproductive Rights, 2005).

Young people are also at higher risk, both for biological and behavioural reasons, of contracting sexually transmitted infections, including HIV. A lack of information about protection, insufficient skills to protect themselves, and a lack of power in sexual relationships all combine to make young people especially vulnerable to contracting sexually transmitted infections (UNFPA, 2005).

This vulnerability is in large part a result of the dynamics of sexual relations involving young people. As noted by Jejeebhoy and Bott (2003), studies typically show that the sexual behaviour of young men and women vary markedly. While young women who engage in premarital sex normally have sex with only one partner with whom they are in a committed relationship, significant proportions of young men engage in sexual relations with multiple partners, often sex workers. In a qualitative study of young college students in Malaysia, Ng and Kamal (2006) found that gender was a major determinant of how young men and women perceived relationships and the risk of STI infection. Concerns about pregnancy outweighed concerns about STIs and affected their prevention behaviour. The

importance of trust in relationships was, especially for young females, a major limiting factor in the use of condoms.

For many young people, early sexual experiences may occur within a coercive context. Coerced sex is more likely to be experienced by women, and occurs both inside and outside of marriage. Jejeebhoy and Bott (2005: 38) argue that some of the factors that place young people, particularly young women, at risk of coercive sex range from “unbalanced gender norms to unequal power relationships and inability to negotiate or communicate on sexual matters, unsupportive family relationships, inadequate health and education sector responsiveness and inappropriate law enforcement”.

The outcomes of coerced sex can be both physical and psychological. Unwanted pregnancies are one of the most obvious outcomes of coercive sex. Evidence from a study in rural India indicated that a high proportion of abortions among unmarried women resulted from decisions to end unwanted pregnancies that were outcomes of non-consensual sex (Ganatra and Hirve, 2002). Coercive sex can also increase exposure to sexually transmitted infections, including HIV (Koenig and others, 2005). Damage to mental health resulting from sexual coercion may also occur. Patel and Andrew (2005), in a study of secondary school students in Goa, India, found that students who reported having experienced coercive sex were significantly more likely than those who had not experienced it to report a range of adverse socio-psychological outcomes.

Unintended pregnancy, or pregnancy at an early age, has important implications for poverty. Young women who become pregnant may be forced to discontinue their education (Center for Reproductive Rights, 2005) and are hampered in pursuing economic opportunities. Limiting educational and economic opportunities for young women increases the likelihood that they and their children will spend the rest of their life in poverty.

Sexual and reproductive health programmes for young people

There is increasing emphasis on promoting abstinence to contribute to the sexual health of young persons. Although there has been a lack of research in Asia and the Pacific on the impact of abstinence-based programmes on the sexual behaviour of young people, evidence from other regions suggests that such programmes have a limited impact. Therefore, an abstinence approach should not be undertaken in the absence of programmes that support prevention for sexually active young persons.

In addition to messages related to abstinence, interventions aimed at persons who are, or are planning to become, sexually active are necessary. At their most basic

level, such programmes should supply information about prevention and, where appropriate, provide the means of prevention. For example, providing information about condoms is one way to promote condom use among sexually active youth. In a study of Cambodian youth, Douthwaite and Sareoun (2006) found that condom use was highest among those who were more knowledgeable about condoms and had more positive attitudes towards condoms.

One area where considerable progress has been made is in introducing sexuality/life skills programmes into schools. UNFPA (2005) notes that 32 countries in the region stated that they had such programmes, while UNAIDS (2005) reports that 64 per cent of secondary school students in South and South-East Asia and 33 per cent in the Western Pacific receive basic AIDS education (UNAIDS, 2005). While such efforts are laudable and need to be expanded both in terms of coverage and depth of information provided, many young people in Asia and the Pacific never attend secondary school. Programmes need to focus more on out-of-school adolescents.

The problem of reaching subgroups of adolescents with information and services has resulted in the call for greater integration in the provision of services. FHI (2006) suggests that counseling on HIV, including counseling associated with Voluntary Testing and Counseling (VCT), provides an ideal opportunity to also discuss issues related to sexuality and contraception. Such an approach has a number of advantages – it provides an opportunity to access sexually active youth, many of whom may feel themselves to be at risk of contracting an STI, and also opens an entry point to male youth, a group not often accessed by more traditional reproductive health programmes.

Aggleton, Chase and Rivers (2004), in a review of research related to HIV prevention approaches for young people, conclude that assisting young people reduce their vulnerability requires greater attention be placed on the underlying social vulnerability faced by this age group, including their lack of access to “youth friendly” health services. They also stress the need to both promote and support the sexual and reproductive rights of young people in order to help them make informed decisions.

Conclusion

Addressing the core issues of reproductive health is essential for meeting the MDGs (UNFPA, 2005). Providing couples with the choices that will enable them to plan the number of children they want will contribute to improving maternal and child health, as well as reduce poverty and provide children with prospects for a much better life. At a global level, Singh, Darroch, Vlassoff and Nadeau (2003)

document both the direct and indirect impacts of reproductive health interventions on reducing health burdens in households and societies and improving opportunities for men and women to become more productive.

Underlying much of the action that needs to be undertaken is confronting the deeply rooted gender-based inequities that exist throughout the region. Increasing access to reproductive and sexual programmes, especially for the most vulnerable groups such as youth, improving the quality of care and services of programmes, integrating services that address gender-based violence, addressing issues of sexual health, including sexuality, and actively reaching out to men, can play a major role in promoting gender equity. Improved sexual and reproductive health contributes to reducing poverty, promoting positive change in gender relations, and empowering women.

Central to improving reproductive and sexual health is a greater focus on promoting reproductive and sexual health rights. Women and men of all ages, and of all social positions, must be aware of their rights to information and quality services. Service providers must understand the rights of clients to make informed decisions about their reproductive health, and national and international communities need to act to provide the necessary resources for women and men to exercise their rights.

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Fax: (66 2) 288-1009
Web site: <http://www.unescap.org>
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