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Monitoring of population programmes: population, gender and development

Report of the Secretary-General

Summary

The present report has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which was endorsed by the Economic and Social Council in its resolution 1995/55. One of the topics for 1999 is gender, population and development.

This report is intended to give a broad overview of the range of activities that have been initiated towards implementation of the outcome of the International Conference on Population and Development in the area of gender, population and development. It presents the strategies and approaches that countries have adopted in response to the recommendations of the Programme of Action of the International Conference on Population and Development concerning gender in population and development. It also provides an analysis of the challenges and constraints encountered by countries in programme implementation and matters pertaining to resource mobilization within the area of gender, population and development.

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Contents

Tables

Introduction

1. The present report on the monitoring of population programmes has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which was endorsed by the Economic and Social Council in its resolution 1995/55. One of the topics for 1999 is gender, population and development.

2. This report reviews progress with respect to population programmes and related development activities at the country level. It focuses on programme experiences and strategies in the area of gender, population and development initiated towards implementation of the outcome of the International Conference on Population and Development. It primarily addresses operational activities to promote gender equality and equity and the empowerment of women in population and development programmes.

3. Over the past decade, profound social, political and economic changes have taken place throughout the world. New objectives and goals on gender, population and development have been established that concern empowerment, equality and equity, human rights, male responsibility and participation, poverty, health, education, employment, violence, migration, the environment and the media.

4. These objectives have led to changes in the strategies used to reach the goals of equality and equity. They have signalled the unfolding of a political process that encourages the involvement of a spectrum of civil society and reflects the emergence of new partnerships. Promotion of gender equality, equity and empowerment of women has increasingly become important concerns for Governments, non-governmental organizations, civil society and, in many instances, the private sector.

5. The focus on gender, population and development has been underscored by the realization that women and men experience all aspects of development in different ways. Taking this into account increases the effectiveness of planning, policy formulation and programme implementation at every level. A gender-integrated approach to population and development aims to ensure that both men and women benefit equally from development efforts and enjoy equal access to, and control over, opportunities and resources. In turn, this supports accountability and participation in processes that impact on people's lives.

6. Gender as a perspective in development work recognizes and responds to the different roles, interests, needs and relations of men and women, which arise from their different responsibilities in society. Such roles and interests intersect with those based on class, ethnicity or age to override assumed homogeneity, which often results from focusing on women or men as a group. The preference for focusing on gender, as opposed to women or men, is also fuelled by widespread evidence showing that development benefits have been accruing in a substantially different manner to both men and women, with women gaining a fraction of what men are gaining. This perspective therefore aims to redress these imbalances.

I. Methodology

7. In preparation for this report, the United Nations Population Fund (UNFPA) analysed reviews of the various United Nations conferences conducted by United Nations organizations, and other documentary evidence as well as data from the 1998 UNFPA Field Inquiry on Progress in the Implementation of the ICPD Programme of Action (PoA) as part of the International Conference on Population and Development plus five review process. A total of 114 developing countries and countries with economies in transition responded.[1]

8. The report focuses on efforts to effectively integrate gender into population and development programmes through strategies and initiatives to ensure access to quality sexual and reproductive health care and services, promotion of women's empowerment and protection of their reproductive rights, reduction of maternal mortality, protection of the girl child, increasing of women's participation in

decision-making, and involvement of men in safeguarding their own as well as their partner's sexual and reproductive health. In addition, the report examines challenges and constraints that exist to date.

II. Gender, population and development in United Nations conferences

9. A series of international United Nations conferences have over the past two decades helped to create a shift from thinking of men or women as targets of development interventions, to a concern with gender relations, which may hinder or facilitate the realization of such interventions. The 1985 World Conference to Review and Appraise the Achievements of the United Nations Decade for Women,[2] held in Nairobi, analysed development efforts from a human rights, and specifically a women's rights, perspective. That conference demonstrated that obstacles to women's advancement have their roots in society and the economy, and that measures to overcome those obstacles must be based on the concepts of equality, integration, participation and cooperation. Subsequent global conferences, including the 1992 United Nations Conference on Environment and Development[3] held in Rio de Janeiro and the 1993 World Conference on Human Rights[4] held in Vienna were profoundly influenced by the Nairobi recommendations.

10. The Vienna Conference advanced the integration of a human rights approach to population and development, advocating for a strong commitment to women's rights, to safe motherhood, to the right to health, and to the availability of affordable quality family planning services and to timely access to information. These emerged as the key linkages between Vienna and Cairo. The adoption of the Programme of Action of the International Conference on Population and Development[5] in Cairo in 1994 established the essential linkage between gender concerns, on the one hand, and population and sustainable development, on the other. The International Conference on Population and Development further underscored the fact that the empowerment of women is an essential goal in itself, a position strongly reinforced at the Fourth World Conference on Women held in Beijing in 1995.[6]

11. The results of these conferences and the consensus they fostered ushered in a new paradigm in the formulation and implementation of population and development policies and programmes. Population issues are now seen in the broader context of reproductive health, human rights and sustainable development, for which the achievement of gender equality and equity and empowerment of women are essential. These goals are global and universal. Their implementation entails changes in attitudes and a focused commitment to internationally accepted norms and standards of gender equality, including the protection and promotion of the human rights of girls and women.

III. Promoting gender equality and empowerment of women

12. Various reviews indicate that considerable advances have been made, in both developed and developing countries, in promoting gender equality, in accordance with International Conference on Population and Development goals. The Field Inquiry carried out in view of the Conference plus five review showed that, in most countries, gender concerns have been integrated in population and development strategies by establishing and/or strengthening national institutional mechanisms dealing with population and/or gender concerns. Of the 114 countries that responded to the survey, 79 had revised their population policies and reported explicit new policy measures that reflected gender concerns in the overall development strategy.

A. Protecting rights and promoting women's empowerment

13. International recognition of the need to promote and protect women's right to reproductive and sexual health has continued to increase. Human rights treaty bodies have strengthened their commitment to the application of human rights standards to securing women's health, including their sexual and reproductive health. In January-February 1999, at its twentiethsession, the Committee on the Elimination of Discrimination against Women (CEDAW) adopted general recommendation 24 on article 12 of the Convention on the Elimination of All Forms of Discrimination against Women — women and health,[7] expanding substantively on article 12 of the Convention[8] which focuses on women and health. At around the same time, the Commission on the Status of Women, at its forty-third session, recommended to the Economic and Social Council the approval of a draft resolution containing the Optional Protocol to the Convention,[9] which would give complainants due judicial process, for adoption by the General Assembly. The Council adopted the draft resolution (Council resolution 1999/13) and the Assembly, at its fifty-fourth session, noted the adoption of general recommendation 24 (Assembly resolution 54/137 of 17 December 1999) and adopted the Optional Protocol (Assembly resolution 54/4 of 6 October 1999). Both instruments are landmarks in protecting women's rights as human rights, including freedom from violence and coercion, and gender-based discrimination, and promoting their right to have control over, and decide freely and responsibly on matters related to, their own sexuality.

14. Propelled by the need to harmonize rights-based approaches within the United Nations system as well as among bilateral donors, the Inter-Agency Committee on Women and Gender Equality, established by the Administrative Committee on Coordination (ACC), jointly with the Division for the Advancement of Women of the United Nations Secretariat, organized a workshop in 1998 on a rights-based approach to the empowerment and advancement of women and gender equality. In 1999, another workshop for the same group was held, focusing on women's economic security issues. Both workshops reviewed various strategies to accelerate progress towards gender equality in different contexts, and assessed policy and operational implications, as well as collaborative approaches.

15. Countries have adopted a variety of national strategies to promote gender equality and equity through policy reform and legislative action which include: legislation to protect women's rights; family law modification; tougher legislation on violence against women; and establishment of women's affairs offices to protect women's rights and promote their empowerment. Courts in several jurisdictions have drawn on the Convention on the Elimination of All Forms of Discrimination against Women to assist in the interpretation of domestic legal provisions. Countries have also intensified policy discussion and opened dialogue in new areas.

16. Nearly half of all countries surveyed reviewed their policies in light of a new understanding of the role of population in development. More than one third have recently updated their population policies or have integrated factors relating to quality of health care, gender equality and equity, and improvement of information systems, into long-term development plans. Furthermore, two thirds of all countries have introduced policy or legislative measures in areas such as inheritance, property rights and employment, and protection from gender-based violence.

17. Some of the most important initiatives Governments have taken involve the strengthening of national laws, policies and mechanisms promoting human rights, including reproductive rights. This has entailed the development of comprehensive women's health policies that assist countries in moving from a target-based family planning approach to a client-centred approach where a range of services, including expanded choices of contraceptive methods, are offered. Countries are also liftingregulations and policies, for example, on marital status and spousal permission, that limit wider access to reproductive health and family planning services.

18. Developed countries have also had to make new adjustments. For example, social security systems have been based on the traditional concept of a woman as dependent spouse. However, a number of countries have taken steps to adapt their social security legislation to the new realities created by women's participation in paid employment.[10] This recognizes that women in paid employment have acquired independent rights to social security coverage.

19. A major obstacle to the realization of women's rights is their inability to own and control access to land. Although women's right to land is a critical factor for food production, they continue to be largely prohibited by sociocultural norms and practices from owning and controlling access to land. This impacts negatively on their access to other natural resources, such as water, fuelwood, fish and forest products, which are crucial for food security, on income and, ultimately, on health.

20. While many national plans highlight efforts to achieve de facto equality of women, they also emphasize the continuing need for legislative and administrative reform to eliminate the inequality and discrimination that continue to exist.

B. Promoting women's participation in decision-making

21. Both the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action[11] underscored that the empowerment and autonomy of women and the improvement of their political, social, economic and health status are highly important ends in themselves. The promotion of women's participation in decision-making is an important strategy towards this end. In this regard, many countries have established mechanisms for women's equal participation and equitable representation at all levels of the political process and public life. These include minimum quotas for women in electoral bodies and public institutions. Governments are involving women-related institutions, primarily non-governmental organizations, in government policy and oversight groups.

22. However women continue to be grossly under-represented in positions of power and decision-making, because of obstacles such as poverty, illiteracy, limited access to education, inadequate financial resources, a patriarchal mentality and the dual burden of women's domestic tasks and occupational obligations.

C. Globalization and its impact on women's health

23. Past development policies and economic strategies have contributed to an improvement in the health status of both men and women, particularly in those instances where there has been a simultaneous emphasis on social policies. These have invariably improved quality-of-life indicators, including life expectancy, and reduced infant, child and maternal mortality rates. Most countries have witnessed progressive development of health infrastructure, including secondary and tertiary care, as well as a wide primary health care system aimed at bringing health services to the community level.

24. More recent developments, however, have undermined some of these gains. The impact of certain trends in the global and national economies poses significant threats to attaining and sustaining health in general, and women's health in particular. Among the most important of these trends are privatization and the increasing role of the market mechanism; global recession; structural adjustment policies; and global trade.[12] In each case, women's health has borne the brunt owing to gender roles that restrict their access to income, thereby making them unable to exercise leverage in accessing health under these new circumstances.

25. For people in many developing countries, privatization of the health sector has been associated with lessening access to health services, as the cost of services has risen. At the same time, privatization in some instances has lowered the quality of health services, as the role of the State in establishing norms and standards and enforcing supervisory mechanisms has weakened. The private sector's capacity to deliver health services equitably has, in many cases, been overestimated, and the impact on women has been considerably different from that on men. In many countries in Asia and Africa, the provision of health care, especially reproductive health care, has been shifted out of the hospitals and other health-care

centres, and on to the shoulders of women and, increasingly, young girls. This is particularly the case for long-term care that families can no longer afford to purchase.

26. Global recession has had a profound impact in some parts of the world. In Africa, for example, many countries have been left with a heavy and ever-increasing debt burden. The servicing of this debt drains financial resources that could otherwise be invested in health services and infrastructure. The results are evident. At the community level, poverty is on the rise, and a greater proportion of families are unable to meet their basic needs. In the health sector, hospitals and clinics are crowded and basic drugs are missing. Health personnel are overworked and underpaid, and lack training and necessary skills. Many seek alternative employment, thereby further depriving the sector of needed personnel. Consequently, health indicators, such as maternal mortality rates, have stagnated and, in a few instances, taken a downward trend.

D. Improving access to, and availability of, reproductive health services

27. The integration of family planning and maternal and child health under a common institutional umbrella has been the most common change in respect of providing effective health-care delivery services. Gender-sensitive reproductive health services that ensure universal access to quality health care have become priorities in health sector reform and sector-wide approaches.

28. Many countries are testing ways of integrating reproductive health services, while others are establishing linkages among the components of reproductive health, particularly family planning, maternal and child health and sexually transmitted diseases/human immunodeficiency virus/acquired immunodeficiency syndrome (STDs/HIV/AIDS) services, through development of referral systems. This has contributed to improved access to services and to better-trained service providers. As a result, essential health services packages are becoming increasingly available at delivery points, and better referral systems are ensuring increased availability of, *inter alia*, STD treatment and emergency obstetric care.

29. Health ministries and family planning agencies in developing countries are focusing increasingly on the quality of the services they provide. Many are seeking new strategies to improve counselling so as to respond to the needs of clients. Programmes are increasingly offering a wider choice of methods to take into account users' widely varying reproductive choices, health status, age and life circumstances. Social or subsidized marketing strategies have been successful in increasing access to contraceptives, including male and female condoms. Advocacy campaigns targeting men have been particularly helpful in increasing the use of condoms and vasectomy.

30. Of the 114 countries that responded to the Field Inquiry, 36 stated that they were offering all the components of reproductive health as stated in the Programme of Action of the International Conference on Population and Development. In the last five years, 54 countries have taken some measures to add new components to their existing reproductive health programmes. Progress was most evident in Asia, where 45 per cent of the countries have taken some measures, followed by Africa, with 44 per cent of countries having done so.

31. The most common measures taken by countries in adding new components to reproductive health programmes encompass the provision of services for the prevention and treatment of STDs, including HIV/AIDS. Forty-five countries reported adding services for the prevention and treatment of infertility and the treatment of reproductive tract infections, and providing safe delivery and post-natal care including prenatal care (table 1).

32. The Field Inquiry results also suggested that more progress had been made in improving universal access to, than in the expanding of, reproductive health services. Among the developing countries, a total of 59 countries (76 per cent) are taking measures to improve universal access. More than half of the

countries in Africa, Asia and Latin America and the Caribbean reported progress in improving universal access to reproductive health care services.

33. The most common measures taken by countries to improve access to reproductive health services were (a) increased training of service providers; (b) expanding and/or constructing more health service delivery points; and (c) allocating more equipment and resources and/or increased provision of equipment (table 2).

Table 1.
Measures taken by countries to add new components of reproductive health

Measures	*Countries*
Prevention and treatment of STDs/HIV/AIDS	Burundi, Democratic People's Republic of Korea, Dominican Republic, Kenya, Latvia, Lesotho, Marshall Islands, Mexico, Micronesia, Niger, Pakistan, Paraguay, Poland, Tajikistan, Tuvalu, United Republic of Tanzania, Uruguay
Prevention and treatment of infertility	Algeria, Bangladesh, Bhutan, Bolivia, China, El Salvador, Honduras, Islamic Republic of Iran, Kenya, Madagascar, Mali, Mongolia, Niger, Nigeria, Philippines, Senegal, Yemen
Provision of safe delivery and post-natal care	Azerbaijan, Botswana, Burundi, Costa Rica, Democratic People's Republic of Korea, Dominican Republic, Ecuador, Gambia, Guinea-Bissau, India, Islamic Republic of Iran, Jordan, Nigeria, Latvia, Maldives, Marshall Islands, Mexico, Micronesia, Nepal, Pakistan, Poland, Paraguay, Tajikistan, Tuvalu, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu
Provision of prenatal care	Botswana, Burundi, Costa Rica, Dominican Republic, Ecuador, Gambia, Guinea-Bissau, India, Islamic Republic of Iran, Jordan, Lesotho, Maldives, Mali, Marshall Islands, Mexico, Micronesia, Mozambique, Nepal, Niger, Nigeria, Pakistan, Paraguay, Poland, Tajikistan, Tuvalu, United Republic of Tanzania, Uruguay, Vanuatu

Table 2.
Measures taken by countries to improve universal access to reproductive health

Measures	*Countries*
Training of service providers	Azerbaijan, Bhutan, Cambodia, Central African Republic, Cook Islands, Ghana, El Salvador, Honduras, Islamic Republic of Iran, Jordan, Kenya, Marshall Islands, Micronesia, Papua New Guinea, Samoa, Swaziland, Turkey, Uganda, Uzbekistan
Expansion/construction of more health centres	Albania, Bangladesh, Belize, Burundi, Cambodia, Central African Republic, Cuba, Dominican Republic, El Salvador, Ethiopia, Ghana, Guinea, Honduras, India, Islamic Republic of Iran, Jordan, Kenya, Latvia, Lesotho, Madagascar, Marshall Islands, Micronesia, Mongolia, Morocco, Nepal, Pakistan, Papua New Guinea, Philippines, Samoa, Tunisia, Turkey, Uganda, Ukraine, Zambia, Zimbabwe
Allocating more resources and/or increased provision of equipment	Azerbaijan, Bolivia, Central African Republic, Dominican Republic, Egypt, Ghana, Madagascar, Mali, Micronesia, Nigeria, Papua New Guinea, Peru, Syrian Arab Republic, South Africa

E. Reducing maternal mortality

34. The Programme of Action of the International Conference on Population and Development calls for the reduction of the 1990 level of maternal mortality by half by the year 2000 and by a further one half by 2015 (para. 8.21). Towards this end, some progress is evident. Maternal health has improved in a number of developing countries as a result of the expansion of midwifery skills, the existence of a general health infrastructure and the accessibility of health care. That safe motherhood has been identified as being both a development issue and a human rights imperative has resulted in a greater awareness of the issues of maternal mortality and morbidity. Most countries are strengthening efforts to prevent unwanted pregnancies, whiles others are working more systematically to reduce the health impact of unsafe abortion.

35. A large number of countries now allow abortion in order to save the lives of pregnant women. Only a few, however, have made progress in ensuring that, in all circumstances where it is not against the law, there are sufficiently trained and skilled personnel and facilities to ensure that the procedure is safe and

accessible. Services to treat women suffering from life- and health-threatening complications of unsafe abortion are often not available.

36. In recent years, substantial declines in levels of abortion have been documented in Central and Eastern Europe/newly independent States and in the Central Asian republics, as a result of increased availability and use of modern contraceptives. Some progress has been made in training health-care providers and equipping hospitals in the management of complications arising from abortion, and several developing countries have developed special approaches to improve post-abortion services and care.

37. Despite these achievements, overall progress in reducing maternal mortality has been slow. The major factors contributing to high levels of maternal mortality and morbidity in developing countries still persist. These include the low status of women, their lifelong poor nutritional status and high levels of anaemia. Reducing maternal mortality is constrained not so much by lack of technology as by insufficient political commitment and resources, and by the failure to prioritize effective interventions.

F. The acquired immunodeficiency syndrome (AIDS) pandemic

38. The most recent Joint United Nations Programme on Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) (UNAIDS)/World Health Organization (WHO) report, of December 1998, estimates that more than 95 per cent of all HIV-infected people live in developing countries. Globally, 33.4 million people are living with HIV infection or AIDS. Of these, 32.2 million are adults and 1.2 million are children under age 15. Almost 3 million young people aged 15-24 were infected with HIV in 1998. Women now account for the highest proportional increase in new infections, as they constituted 43 per cent of newly infected adults in 1998, compared with 41 per cent just one year earlier. Infection rates among married women with only one partner are also very high in developing countries.

39. Sub-Sahara Africa has been particularly hard hit. Although it has only 10 per cent of the world's population, 70 per cent of all new infections since 1998 have occurred in that region, and now more than two thirds of people living with AIDS are in the region. Of the 2.5 million deaths from AIDS in 1998, 2 million occurred in Sub-Sahara Africa. Ninety-five per cent of all AIDS orphans in this region have lost their mother or both parents to AIDS. In Africa, HIV-positive women now outnumber infected men by 2 million.[13]

40. The gender dimensions of HIV/AIDS, which give rise to these trends, pose a special threat to women. The UNAIDS/WHO report notes that women are generally at greater risk of HIV infection than men. Women have a higher biologically determined susceptibility to STDs/HIV. Their culturally determined roles leave them with little control over their own sexuality and low, if any, negotiating power regarding sexual practices. New studies also indicate a clear linkage between HIV transmission and acts of sexual violence, affecting, in particular, women in the commercial sex industry.[14]

41. Another aspect of women's vulnerability to HIV/AIDS is linked to age and economic status. AIDS is commonest among young and poor women. This is the section of the population that often lacks basic education, decent housing, adequate food and access to quality medical care. While the drugs used to treat HIV/AIDS are unavailable to most people, they are even farther out of the reach of women. They often lack the means to seek medical help or are unable to do so because their unemployment status precludes them from participating in medical insurance schemes through which such assistance is usually given. Adolescent girls are particularly vulnerable — studies in several countries have found that African girls aged 15-19 are five to six times more likely to be HIV-positive than boys the same age.[15]

42. At present rates of infection, it is estimated that maternal deaths due to AIDS in Africa, Asia and Latin America will leave nearly 42 million children orphans by the year 2010. Mother-to-child

transmission of HIV affects approximately 300,000 newborns each year, most of them from developing nations.

43. The scope of the pandemic and its gender dimensions create the need to develop multiple strategies to address its complexities. This includes analysing the effects of the health sector reforms that have been put in place in many developing countries at a time when imperatives for public investment in health are increasing. This state of affairs has impeded the capacity of health systems to respond effectively to the AIDS pandemic, especially in the worst-hit countries in Africa. As a result, many health systems are on the verge of collapse, and significant gains in reducing maternal and infant mortality have been reversed.

G. Addressing the needs of adolescents

44. Adolescent reproductive health is now clearly part of the public-health agenda in the majority of countries. A large number of countries have adopted policies, standards and mechanisms to address the needs of adolescents. They have incorporated adolescent reproductive health components into youth programmes and national health plans, or have established youth offices within ministries. Progress has been achieved in providing information and services for adolescents. Early marriage and some harmful practices against girls are on the decline. The need to listen to and consult young people themselves is being increasingly regarded as a vital input to the design, planning and implementation of programmes offering information and services to adolescents.

45. A total of 91 countries that responded to the Field Inquiry took action to improve adolescent reproductive health. Countries in the Latin American and Caribbean region have shown the greatest progress in meeting adolescent reproductive health needs, followed by those in Africa. Of the countries that have taken measures to address these needs, several have provided outreach efforts/advocacy and school-based programmes; developed youth-related policies; and established new institutions for providing reproductive health services to adolescents (table 3).

46. Despite considerable progress in collaborative work between non-governmental organizations, the private sector and Governments, particularly in Africa, adolescents continue to be one of the most under-served groups, especially considering their large numbers. As a result, unplanned parenthood for both girls and boys often curtail their potentialities very early in their lives, and uninformed decision-making about sexual behaviour exposes them to STDs including HIV/AIDS. Greater political commitment that demonstrates a willingness to devise acceptable and effective strategies is therefore imperative.

Table 3.
Measures taken by countries to address the needs of adolescent reproductive health

Measures	*Countries*
Outreach efforts/advocacy	Albania, Azerbaijan, Barbados, Bhutan, Bolivia, Cameroon, Cape Verde, Comoros, Costa Rica, Cuba, Ecuador, El Salvador, Ethiopia, Haiti, Kenya, Lao People's Democratic Republic, Madagascar, Malawi, Maldives, Mauritius, Mexico, Micronesia, Mongolia, Morocco, Mozambique, Namibia, Nepal, Papua New Guinea, Saint Lucia, Seychelles, Sierra Leone, Sri Lanka, Syrian Arab Republic, Trinidad and Tobago, Turkey, United Republic of Tanzania, Uruguay, Uzbekistan, Venezuela, Viet Nam, Zambia
School-based programmes	Azerbaijan, Bhutan, Cape Verde, Central African Republic, Comoros, Côte d'Ivoire, Democratic People's Republic of Korea, Ecuador, Egypt, Estonia, Fiji, Gambia, Haiti, Jordan, Kiribati, Lesotho, Madagascar, Mali, Micronesia, Mongolia, Morocco, Panama, Papua New Guinea, Peru, Poland, Romania, Russian Federation, South Africa, Turkey, Turkmenistan, Uzbekistan, Viet Nam

Measures	*Countries*
Youth-related policies	Bangladesh, Bolivia, Botswana, Cameroon, Costa Rica, Cote d'Ivoire, Ecuador, El Salvador, Estonia, Honduras, Lesotho, Malawi, Mali, Mexico, Morocco, Nepal, Niger, Nigeria, Panama, Paraguay, Peru, Poland, Romania, Sierra Leone, South Africa, Uganda, United Republic of Tanzania, Viet Nam, Zambia
New institutions	Albania, Bhutan, Burkina Faso, Cape Verde, Costa Rica, Dominican Republic, Ecuador, Fiji, Ghana, Kazakhstan, Mongolia, Mozambique, Nicaragua, Sri Lanka, Turkmenistan
Youth counselling	Angola, Cook Islands, Costa Rica, Côte d'Ivoire, Cuba, Egypt, Estonia, Gambia, Honduras, Madagascar, Mali, Mexico, Micronesia, Mongolia, Morocco, Nicaragua, Tonga, Uruguay
Non-governmental organization participation	Azerbaijan, Barbados, Bolivia, Botswana, Cape Verde, Comoros, Costa Rica, Ecuador, Egypt, Estonia, Ethiopia, Fiji, Gambia, Ghana, India Jamaica, Kenya, Maldives, Mali, Marshall Islands, Nepal, Nicaragua, Panama, Romania, Senegal, Sierra Leone, Syrian Arab Republic, Tonga, Turkey, Tuvalu, Uzbekistan, Vanuatu, Venezuela, Zambia

H. Elimination of violence against women

47. Violence against women is a serious obstacle to the achievement of women's human rights. Governments in collaboration with the United Nations system, international and local non-governmental organizations have become active partners in promoting zero-tolerance of violence against women. The strategies adopted have varied widely. The Convention on the Elimination of All Forms of Discrimination against Women is increasingly being used as a monitoring instrument on, *inter alia*, gender violence. Other related United Nations institutional mechanisms for protecting human rights offer powerful support for legal, political and social actions to protect women from violence, and countries are beginning to use them effectively at the national level.

48. As a result, gender-based violence, once taboo, is now being openly acknowledged. Laws have been enacted in a number of countries to protect women from violence, and codes of family law have been revised to include issues of domestic violence. Other strategies adopted include establishment of family counselling and support centres, telephone hotlines to report incidence of domestic violence, programmes to train police to deal with such violence, training about sexual harassment especially in work environments, and development of financial schemes for rural women to enhance their economic options.

49. To ensure the success of these strategies implementers are establishing linkages among government agencies, law enforcement bodies, non-governmental organizations, and women's groups. Non-governmental organizations, for example, have been effective in creating centres for victims of rape, incest and other forms of violence, while Governments are strengthening their data-collection systems on marriage and divorce and training judges and religious leaders to develop and use monitoring mechanisms to track violence against women. However, given the pervasiveness of violence against women, these efforts need to be reinforced considerably.

I. Taking action against harmful practices

50. Abolishing harmful practices requires a long-term commitment. Interventions need to be focused, specific and based on a thorough understanding of the cultural environment. Harmful practices constitute a form of gender-based violence and are now explicitly addressed in the Convention on the Elimination of All Forms of Discrimination against Women.

51. Progress has been made in outlawing harmful practices that compromise the well-being of women and girls. Nine African countries — Burkina Faso, the Central African Republic, Côte d'Ivoire, Djibouti,

Ghana, Guinea, Senegal, Togo and the United Republic of Tanzania — have taken steps towards criminalizing the practice of female genital mutilation. The penalties range from a minimum of six months to a maximum of life in prison. In Egypt, the Ministry of Health issued a decree declaring female genital mutilation unlawful.

52. Countries have thus demonstrated that successful initiatives can be undertaken to eliminate harmful practices without compromising sound cultural values. Various country-specific strategies are used. These include providing new information and skills supportive of women's health to adherents of harmful practices; undertaking campaigns on women's rights so as to sensitize lawmakers and the public alike on the health dangers and the human rights violations posed by some cultural practices; establishing monitoring mechanisms, entailing research and advocacy, to document and disseminate information on the prevalence and nature of harmful practices; and using intersectoral approaches that involve community leaders, church organizations, parent-teacher associations and the government to eradicate such practices.

53. Countries have recognized the need to adopt integrated approaches that address the social, cultural and economic context within which harmful practices thrive. Governments are therefore supporting the role of family members, especially parents and other legal guardians, in strengthening the self-image, self-esteem and status of young girls and protecting their health and well-being.

54. Nonetheless, harmful practices continue to persist and endanger the health and lives of large numbers of women and girls. Honour killings, widow-cleansing rites, forced marriages and bride burning are still common. Reasons for their persistence include the absence of laws to combat them, gender biases in enforcing existing laws, and lack of autonomy for women.

J. Advocacy for the education of the girl child

55. Educating girls is a key factor in building their self-esteem and confidence. Moreover, evidence continues to accumulate that girls' education is one of the strongest correlates of women's reproductive health status. Many studies demonstrate that education of girls leads to fewer and healthier children, informed health-seeking behaviour for self and family, and timely recourse to health care.[16]

56. The Field Inquiry results show that 57 countries (50 per cent) considered their level of access to primary education of the girl child already adequate. Sixty-one per cent and 59 per cent of African and Asian countries, respectively, reported taking some measures to improve access to primary education, particularly for the girl child.

57. Governments are moving closer to achieving universal access to primary education. Developing countries have now placed greater emphasis on providing free education or scholarships, increasing the number and location of schools, and revising curricula to make them more gender-sensitive. Some have introduced legal measures to support the right of girls to education. These initiatives have contributed to an increase in the primary school enrolment ratios of girls in numerous countries. In most regions of the world, the female primary enrolment ratio as a proportion of male enrolment now exceeds 80 per cent.

58. However, universal access to basic education and the closing of the gender gap in education are yet to be achieved, especially in sub-Saharan Africa and South Asia. Children living in conditions of poverty, particularly girls, have the lowest educational attainment rates. School drop-out rates are high at all levels, particularly during the transition between primary and secondary school. Low-income families are often unable to meet the costs of school uniforms, fees, books and transport. Retention rates, especially among girls, are often poor. Moreover, high pupil-teacher ratios, inadequate or gender-inappropriate curricula, insufficiently trained teachers and inadequately equipped schools all lower the quality of education in these regions. Declining investments in educational infrastructure as a function of poor economies are also a major contributing factor.

K. Enhancing men's roles in the family and in reproductive health

59. In the last few years, more attention has been focused on male involvement in sexual and reproductive health, through sex education, counselling and health outreach services. This has been driven by the premise that such involvement leads to healthier reproductive health outcomes for both men and their partners. A large majority of countries that responded to the Field Survey have acted to increase men's responsibility for their sexual and reproductive behaviour and their social and family roles, through measures such as employment legislation and child-support laws.

60. Among countries that have special reproductive health activities for men, advocacy campaigns have been the most common. These have used approaches that address the effects of sociocultural attitudes and practices, including gender-based violence, on the sexual health and reproductive rights of women and girls. Countries are also increasingly expanding their family laws to respond to the needs of men with respect to single fatherhood, child custody and adoption and related issues.

61. According to the Field Inquiry results, 37 countries have taken measures to promote male involvement in sexual and reproductive health (table 4).

Table 4.
Measures taken by selected countries to promote male involvement in sexual and reproductive health

Measures taken	*Countries*
Education; information, education and communication (IEC); and advocacy activities, including multimedia campaigns	Angola, Barbados, Belize, Botswana, Brazil, Burkina Faso, Burundi, Cape Verde, Central African Republic, Comoros, Democratic People's Republic of Korea, Democratic Republic of the Congo, Dominican Republic, Egypt, Ethiopia, Islamic Republic of Iran, Jamaica, Jordan, Fiji, Lao People's Democratic Republic, Malawi, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Micronesia, Mozambique, Nepal, Pakistan, Papua New Guinea, Paraguay, Peru, Philippines, Saint Lucia, Samoa, Seychelles, Swaziland, Syrian Arab Republic, Thailand, Trinidad and Tobago, Tunisia, Turkey, United Republic of Tanzania, Uruguay, Vanuatu, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe
Family law modification, including revised and expanded laws on child support and paternity	Belize, Bhutan, Botswana, Brazil, Cape Verde, Colombia, Costa Rica, Dominican Republic, El Salvador, Ghana, Guinea, Jamaica, Jordan, Marshall Islands, Mongolia, Mozambique, Nicaragua, Niger, Peru, Poland, Romania, Saint Lucia, South Africa, Viet Nam, Zambia
Promotion of male contraceptive methods, including condom distribution and male vasectomy	Bhutan, Botswana, China, Democratic People's Republic of Korea, Fiji, India, Kiribati, Peru, Samoa, Viet Nam

62. Some countries are conducting research and surveys to understand the needs in respect of, and obstacles to, male participation in reproductive health.[17] Other initiatives include: national policies and plans to promote male involvement; activities that involve men in community-based distribution and promotion of condoms; and advocacy workshops conducted at central and provincial levels.

L. Responding to emergency situations

63. The growing need for reproductive health care in emergency situations has been clearly acknowledged, and several United Nations organizations and international non-governmental organizations are now working to meet these needs. Ensuring the reproductive health of refugees and displaced persons, and protecting refugee women from sexual violence, are priority concerns wherever conflict or natural disaster takes place.

64. In Africa's Great Lakes region, there are programmes to train staff and provide equipment and supplies to women in emergency situations in order to address their needs in: family planning, including contraception; assisted childbirth; complications of unsafe abortion; sexual violence and rape, including post-coital emergency contraception; and prevention of STDs, including HIV/AIDS.

65. United Nations organizations in partnership with international non-governmental organizations have provided emergency reproductive health assistance to thousands of people fleeing the conflict in Kosovo, as well as to camps in Albania and East Timor. An investigation of sexual violence against Kosovar women uncovered accounts of abduction, rape and torture. The United Nations and its partners are providing training for counsellors in offering support to refugees who have been subjected to sexual violence. Emergency assistance has also been provided to the victims of earthquakes in several developing countries.

66. In Asia, United Nations organizations in collaboration with national Governments have provided, *inter alia*, dietary supplements, as an emergency measure, to populations most at risk. International institutions are strengthening the capacity of local branches of government and civil societies, including non-governmental organizations, to respond to emergency situations. This type of capacity-building is likely to be strategic for many other countries.

67. Although reproductive health services are provided in emergencies, these efforts are often hampered by a lack of personnel knowledgeable in reproductive health or skilled in the management of reproductive health services.

IV. Gender concerns in population and development programmes: challenges and constraints

A. Trafficking in women and girls

68. Sexual exploitation and trafficking in children are now growing as a global problem. Each year, it is estimated that more than 2 million girls between ages 5 and 15 are introduced to the commercial sex market.[18] Commercialization of sex is closely tied to poverty in developing countries. Rural poverty, high unemployment and expanding inequalities between the rich and poor are factors that underpin this trade. In some developing countries, young women from poor rural families are taken to cities where a thriving sex industry caters to a wealthy local and tourist clientele. The sex trade, including pornography, has also become a high-tech trade supported by, *inter alia*, the Internet and increasingly linked to organized crime.

69. Women working in the commercial sex industry are much more exposed to STD/HIV infection than most other women. They suffer disproportionately from reproductive tract infections. In some studies, up to 80 per cent have been found to be HIV-positive. Studies of patterns of HIV infection in some countries show a clear linkage between commercial sex and HIV transmission. HIV infection also spreads fastest along trucking routes, where truck drivers have frequent recourse to commercial and unprotected sex.

B. Sex selection

70. According to UNFPA's *The State of World Population, 1997*, at least 60 million girls who would otherwise be expected to be alive are "missing" from various populations as a result of sex-selective abortions or neglect.[19] Through the use of modern technology, parents can determine the sex of the foetus and subsequently choose to abort the foetus when it would turn out to be a girl: over 90 per cent of foetuses aborted are girls.

71. Legal measures are just one aspect of overcoming gender discrimination. Public education, action to increase the status of women and girls, appropriate legislative frameworks, and continued monitoring and enforcement of prohibitions are other important steps to stop such practices and enhance the value attached to girl children.[20]

C. Feminization of poverty

72. Despite the progress made in improving the status of women in many countries, a larger proportion of women than ever before now live in poverty. Whereas in the developed countries women have made considerable progress, indicated by their increased life expectancy, literacy rates, educational attainment and political participation, the situation in developing countries is different. The absolute number of women living in poverty has grown and certain human development indicators suggest that poverty has increasingly become a female problem.[21]

73. This situation is a function of the intersection between macrolevel factors such as the persistence of debt, global trade and global recession, which hold particular consequences for women, and microlevel crises within the family itself. Owing to the death of usually older husbands, migration of working spouses, and high rates of desertion and divorce, many women now maintain households virtually on their own. As a result, in parts of Africa, a woman heads one out of every three households. Women now bear a disproportionate share of poverty worldwide and shoulder an unequal burden of coping with poverty at the household level.[22] These two interrelated facts reinforce the vulnerability of women, including their inability to exercise their right to health and to development in general.

74. Attacking poverty by providing economic opportunities improves reproductive health, and realizing sexual and reproductive rights will help to end poverty. In this regard, the poor are multiply disadvantaged. Lacking political influence and social visibility, they are under-served by public services and cannot afford private services to meet their fundamental needs. Their days are often caught up in a struggle for survival. Their basic social and economic rights, including the right to reproductive and sexual health, are often restricted, and they lack information and knowledge regarding these rights.

75. In societies where tradition insists on the social isolation of women, self-employment programmes can have considerable impact simply by involving women in informal social interaction with other women, including those who practice family planning. Along with increased availability of information and access to credit, the result can be changes in social norms concerning fertility and contraception. Experiences of this kind to date confirm that the benefits of individual control over reproductive life and those of individual control over economic life reinforce each other.[23] Improving livelihoods, while also ensuring access to reproductive health services and information, enhances women's self-esteem, their confidence, their participation in political and community life, their decision-making power and their position in the family. They benefit, their families benefit and their communities prosper.

D. Constraints on implementation

76. According to the UNFPA Field Inquiry, the most frequent constraints affecting policy implementation in population and development were as follows: (a) insufficient institutional commitment; (b) lack of financial resources; and (c) lack of institutional capacity, including trained/qualified staff, lack of awareness and understanding of the issues, lack of data, and insufficient coordination among institutions and ministries.

77. Major constraints on the development of sexual and reproductive health policies, and related legislation, exist in many countries. Adverse economic conditions may limit access to reproductive health, sexual health and family planning services. Many social, cultural and religious attitudes and beliefs still put women's childbearing functions before other roles and restrict women's decision-making in the private and public domain. Restrictive attitudes also limit women's economic and political participation as well

as their access to information and knowledge, and exclude their views as important stakeholders in policy formulation, planning and implementation.

1. Persistence of negative cultural attitudes and practices

78. Traditional practices dangerous to the health of women and the girl child have been denounced at several global conferences, including the World Conference on Human Rights, the International Conference on Population and Development and the Fourth World Conference on Women. Governments are increasingly urged to take steps to combat harmful traditional or customary practices. Such practices are sustained by people's attitudes towards women. They perpetuate gender gaps, hinder efforts to empower women, thwart strategies to integrate a human rights perspective and nullify legal and related interventions to promote gender equality.

79. In order to meet commitments made in various international and national forums, many countries identify legislative and policy actions as being imperative. Similarly, they emphasize the need for increased advocacy and information, education and communication (IEC) campaigns to combat harmful practices. While a large number of countries have passed laws, made institutional changes and formulated policies that promote gender equality, the biggest challenge encompasses the implementation of these measures and the assurance that they are fully implemented.

2. Absence of strong institutional mechanisms

80. Governments need to take affirmative action in developing policies and institutions supportive of women's concerns. Partnership should be further promoted among cross-cutting sectors of society, particularly women's groups, community-based organizations, the private sector and non-governmental organizations. Many Governments have recognized their limits and are encouraging non-governmental organizations, the private sector and community groups to increase their participation in population, gender and development programmes.

3. Low technical capacities

81. Less than half of the mothers in developing countries deliver their babies under the supervision of a skilled birth attendant or health professional, a key factor in ensuring survival of both babies and mothers. Countries with the lowest rates of professionally attended births also share some of the world's highest rates of maternal mortality.

82. Capacity-building programmes need to be designed for both female and male workers. They need to focus not only on women's issues but also on the wider topic of gender concerns and human rights. Medical and nursing curricula should be carefully shaped so that gender issues are properly defined in the future planning and delivery of health services.

83. The attitude of many doctors and nurses often presents particular obstacles to women seeking to make informed decisions concerning their own health. It is essential for all health workers to respect the dignity and human rights of all clients, including the formal right to full information about their condition and the available treatment options. This requires a strategy for educating health workers at all levels to understand the significance and impact of applying a gender perspective in their own work.

4. Insufficient resource mobilization and allocation

84. While a number of developed countries have mobilized resources and contributed significantly to the flow of international assistance for population and development programmes, there are constraints that inhibit countries from mobilizing additional resources required for the full implementation of the Programme of Action of the International Conference on Population and Development. Among the constraints encountered by donor countries are: (a) declining official development assistance (ODA); (b) weakening economies and budget cuts; (c) lack of interest in supporting international population projects

on the part of many foundations and philanthropists; (d) lack of understanding of the interdependence of population and development and of the importance of integrating population into development planning; and (e) the perception that there is no need to mobilize resources for population activities because population concerns are adequately addressed by the health and/or social sector.

85. At the same time, however, donor countries recognize the need to intensify efforts to mobilize resources for the continued implementation of the Programme of Action of the International Conference on Population and Development, and suggest the need to (a) explore new modalities, such as increased involvement of the private sector, including private foundations, in financing reproductive health services, including family planning; (b) increase donor support for inputs essential to the core International Conference on Population and Development activities, such as commodities, specialized training and data collection for monitoring and evaluation, where countries are not in a position to provide these inputs themselves; (c) increase international population and reproductive health assistance in the context of health sector reform and decentralization; and (d) encourage developing countries to increase domestic allocation for national population programmes and, in particular, to promote social sector programmes within the 20/20 initiative discussed at the International Conference on Population and Development and endorsed by the 1995 World Summit for Social Development held in Copenhagen.

V. Conclusions

A. Strengthening the incorporation of a gender perspective into policies, programmes and activities

86. Over the last five years, many countries have successfully implemented various elements of the Programme of Action of the International Conference on Population and Development to promote the advancement of women. Important lessons have been learned and good practices have been documented. Gender equality is increasingly being used as a fundamental guiding principle in population and development programmes, notwithstanding different social, cultural, economic and political contexts. Nonetheless, there is need to reinforce action in a number of areas, as identified during the special session of the General Assembly (June-July 1999) for the overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development (International Conference on Population and Development plus five).

87. Some of the actions needed to incorporate a gender perspective into policy, programmes and activities are described below:

1. The rights-based approach to population and development policies and programmes needs to be further developed and strengthened and human rights education should be incorporated into both formal and informal education processes.

2. Action should be taken to eliminate existing negative traditional, religious and cultural attitudes and practices that subjugate women and reinforce gender inequalities.

3. A gender perspective should be strengthened in policy formulation and programme implementation processes and in the delivery of services.

4. Mitigating measures should be adopted against the gender-differentiated impact of globalization of the economy and of the privatization of social and health sectors, especially on the poor.

5. All data and information systems should ensure availability of sex-disaggregated data for translating policy into strategies that address gender concerns and developing relevant gender impact indicators for monitoring progress.

6. The reproductive health needs of the aged should be addressed through the development of special programmes, services and institutional mechanisms that serve both men and women equally. The needs of other groups, such as the handicapped, immigrant communities, refugees and displaced persons, should also be addressed.

7. Every action should be taken both by Governments and by the private sector to remove all gender gaps and inequalities pertaining to women's participation in the labour market. Policies or legislation for equal pay for work of equal value must be instituted and enforced.

B. Recommended actions on gender, population and development

88. Actions recommended at the special session of the General Assembly (International Conference on Population and Development plus five) to promote gender equality include those described below:

1. The institutional capacity and technical expertise of staff in Government, and civil society, especially non-governmental organizations, should be strengthened in order to promote gender mainstreaming.

2. Education of children in gender awareness should be promoted as a crucial step in eliminating discrimination against women. Enrolment in school for girls must be enforced to ensure empowerment of women in future generations.

3. The participation of women at political and at all policy- and decision-making levels, including those for financial reforms and conflict prevention and resolution, should be accelerated.

4. The family is a powerful force in shaping women's lives. Strategies must be developed to promote gender equality at family level. It is also important to focus on the family as a unit of analysis for monitoring progress.

5. All countries should ratify the Convention on the Elimination of All Forms of Discrimination against Women, as well as the Optional Protocol thereto, and remove reservations where they exist. Legal frameworks need to be established to protect the human rights of women.

6. The media, parliamentarians and other similar entities should adopt and strengthen strategies to tackle negative attitudes about women and assist in enhancing the value that society places on women.

7. Zero-tolerance for all forms of violence against women and children, including rape, incest, sexual violence and sex trafficking, should be promoted.

8. The girl child should be protected, particularly from harmful practices, and her access to health, education and life opportunities should be promoted. The role of the family in safeguarding the well-being of girls should be enhanced and supported.

9. Action should be taken to promote a positive self-image and self-esteem among girls and women through information, education and communication strategies. Curricula reform should be undertaken to ensure that gender stereotypes are removed from all educational and training materials, and to promote male responsibility and partnership with women instead.

10. Men's own needs for reproductive and sexual health should be addressed, and they should be supported in taking responsibility for their own sexual behaviour.

11. All leaders at the highest levels of policy- and decision-making should speak out in support of gender equality, the empowerment of women and the protection of the girl child.

Notes

[1] *Report of the 1998 UNFPA Field Survey: Progress in the Implementation of the ICPD Programme of Action* (UNFPA, New York, January 1999).

[2] See *Report of the World Conference to Review and Appraise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, Nairobi 15-26 July 1985* (United Nations publication, Sales No. E.85.IV.10), chap. I, sect. A.

[3] See *Report of the United Nations Conference on Environment and Development, Rio de Janeiro, 3-14 June 1992*, vol. I, *Resolutions Adopted by the Conference* (United Nations publication, Sales No. E.93.I.8 and corrigendum), resolution 1, annexes I and II.

[4] See A/CONF.157/24 (Part I), chap. III.

[5] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[6] See *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annexes I and II.

[7] *Official Records of the General Assembly, Fifty-fourth Session, Supplement No. 38* (A/54/38/Rev.1), part one, chap. I, sect A.

[8] General Assembly resolution 34/180, annex.

[9] See *Official Records of the Economic and Social Council, 1999, Supplement No. 7* (E/1999/27), chap. I, sect. A.

[10] See *1999 World Survey on the Role of Women in Development: Globalization, Gender and Work* (United Nations publication, Sales No. E.99.IV.8).

[11] *Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995* (United Nations publication, Sales No. E.96.IV.13), chap. I, resolution 1, annex II.

[12] *Women's Health: Towards a Better World*, Report of the First Meeting of the Global Commission on Women's Health (Geneva, WHO, 1994).

[13] UNAIDS, "AIDS epidemic update", December 1999.

[14] R. Petchesky and K. Judd, eds., *Negotiating Reproductive Rights: Women's Perspectives across Countries and Cultures* (London, Zed Books, 1998).

[15] UNAIDS, press release, 23 November 1999.

[16] United Nations Children's Fund, *UNICEF Annual Report 1999* (New York, UNICEF, 1999).

[17] International Union for the Scientific Study of Population (IUSSP), Committee on Gender and Population, *Men, Family Formation and Reproduction* (Liège, Belgium, IUSSP, May 1998).

[18] United Nations Population Fund, *The State of World Population, 1997: The Right to Choose: Reproductive Rights and Reproductive Health* (New York, UNFPA, 1997).

[19] Ibid., chap. 3.

[20] See Deborah Meacham, "Go girls! young women claim their health rights and needs", *Women's Health Journal*, July 1998, pp. 29-36.

[21] United Nations Development Fund for Women (UNIFEM), *A Commitment to the World's Women: Perspectives on Development for Beijing and Beyond* (UNIFEM, 1995).

[22] *Risks, Rights and Reforms: A 50-Country Survey Assessing Government Actions Five Years after the International Conference on Population and Development* (New York, Women's Environment and Development Organization (WEDO), March 1999).

[23] Ibid.