In Focus

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Healthy people—in numbers the world can support

The control of population growth, the achieving of sustainable development and the winning of good health are interrelated aspirations whose fulfilment requires political will, the commitment of resources, and, very notably, the participation of women as key players.

The world community appears to have recognized that the population issue is central to questions of general economic and social development (1). Estimates indicate that, by the year 2000, core population activities will require US$ 9000 million annually, including $5000 million for contraceptives (2). A rapid doubling of current resources is needed to achieve the population goals and development objectives set for the year 2000.

The world population, currently about 5500 million, is increasing by 95 million a year; 95% of this growth is occurring in developing countries, where the number of people rose from 2000 million in 1960 to some 4000 million in 1990. The industrialized countries are expected to have less than a fifth of the world’s population by the year 2000. More than 40% of the developing world’s projected population of about 5000 million will then be under the age of 25.

Africa’s population is growing at almost 3.0% annually; those of Asia and Latin America are doing so at 1.8% and 2.1% respectively. By contrast, Europe has an average growth rate of 0.2%, while the corresponding value for both the USSR and USA is 0.8%. The population of the developed countries (Europe, Japan, USSR and USA) has increased from 832 million in 1950 to 1200 million in 1990; it is expected to rise to 1250 million by the year 2000 (3).

Uncontrolled migration and urbanization have been a direct outcome of rapid population growth. The most recent estimates indicate that 45% of the world’s population now lives in urban areas and that by the end of the century this will be true of over 50%. At 70% the proportion of urban

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dwellers is currently highest in Latin America and the Caribbean.

If current trends continue, by the year 2000 Mexico City will have 25 million inhabitants and São Paulo will have 22 million; they will be the largest cities in the world. Asia, which at present has six of the world's most populous cities, will have far more in the year 2000. Of the world's ten largest megacities, each with 13 million people or more, eight will be in the developing world (Fig. 1).

**Effects of population growth**

Accelerated population growth and its corollaries of uneven distribution, migration and rapid urbanization, in combination with poverty, are seriously affecting natural resources, the environment, health, food and water supplies, the global climate and the socioeconomic fabric of nations. Migration exerts severe pressures: urban agglomeration strains the infrastructure of cities and disrupts their services, facilities and supply lines, while rural areas are being depleted of their human resources to such an extent that development is threatened.

Health promotion and disease prevention are seriously jeopardized by population pressure in combination with other factors. The most vulnerable groups in developing countries are the rural and urban poor, women, children and the aged, the vast majority of whom have little or no access to health care. Deficiencies in the availability or accessibility of primary health care

**Fig. 1. Megacities, 1950–2000**

![Diagram showing population growth in megacities from 1950 to 2000]

Source: Population Division, United Nations
including family planning services and maternal and child health care, exacerbated by demographic trends, are major causes of rampant childhood diseases and high rates of infant and maternal mortality.

As cities strain to absorb newcomers their boundaries expand, consuming farmland and forests and increasing the demand for energy, food and water. In rural areas, communities are forced into unsustainable practices: burning or felling trees, overusing or misusing farmland, polluting water and using too much of it. In some cities up to half the population lives in slums or shanty towns, often without running water, toilets or electricity. If the most pessimistic forecasts are borne out, by the year 2000 three out of five city residents in developing countries will be squatters who have fled rural poverty.

Migration and urbanization create enormous difficulties. Three-quarters of the health problems in the developing world could be solved by a simple combination of prevention and cure: enough of the right food, clean water to drink, safe sanitation, access to family planning, immunization, and around 200 basic drugs. But rapid population growth coupled with a lack of resources makes even primary health care an elusive goal for most people in the developing countries. Further complicating the picture is the threat of AIDS. It wastes lives and disrupts efforts to balance population and development.

Corrective strategies

A radical alteration is needed in the socioeconomic conditions that affect population growth. In particular, it is necessary to expand the role and raise the status of women. Sustainable development can be achieved by improving women’s opportunities for education, employment and health care, including their access to family planning services and facilities for the care of mothers and children.

Concerted efforts should also be made to give women the chance to train as health care providers and managers. Since mothers have charge of nutrition, hygiene and sanitation in their homes, and are first-line care-givers in respect of childhood diseases, it would aid development and enhance family health if women received basic training in these areas.

There is a close correlation between women’s status and the achievement of population objectives. Strengthening the role and status of women and increasing their opportunities for education, employment, credit, and decision-making in both private and public life should have a major impact on demographic trends. Since women are at the centre of the development process, the extent to which they are free to make choices and decisions for themselves and their families should strongly influence population growth rates.

Rapid population growth coupled with a lack of resources makes primary health care an elusive goal for most people in the developing countries.

When the status of women is raised, voluntary family planning increases. Reciprocally, family planning helps to raise the status of women by giving them a degree of freedom from which other freedoms flow. The ability of women to control their fertility gives them opportunities for good health, education,
gainful employment, self-awareness, self-respect, and self-realization (4). Data on women's fertility in the mid-twentieth century, together with projected values, are indicated in the table.

Education and employment are critical elements in improving the lot of women. Priority should therefore be given to ensuring access for girls and women to good education and literacy programmes. Girls should have the same opportunities as boys in education. Traditional constraints, prejudices, and structural obstacles that hamper the participation of women in education should be eradicated. Employment opportunities for women, particularly in the modern sector, should be enhanced. Research has indicated that the fastest way to lower fertility is to employ women in this sector.

In Sri Lanka and the Indian State of Kerala the attention given to women’s development and maternal and child health alongside family planning services has produced impressive results. In Sri Lanka contraceptive usage is approaching 70%; the general fertility rate declined by 18% between the periods 1965–70 and 1975–80.

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<tr>
<th>Region</th>
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<td>World</td>
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<td>Africa</td>
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<td>Asia</td>
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The situation in Sri Lanka, where the female literacy rate is 81%, is similar. A strong primary health care approach, encouraging rural women’s involvement, has been adopted in both Kerala and Sri Lanka (5).

Maternal and child health care and family planning

Family planning is a demographic necessity and a global responsibility. An essential component of the mechanism of development, it is pivotal to population policy and programmes. It is highly effective when integrated with maternal and child health care in a primary health care setting. Both the health and development infrastructures are strengthened through such integration.

The evidence indicates that high rates of population growth are fuelled by high fertility rates, high infant and child mortality rates, and a lack of family planning services. By bringing family planning services under the umbrella of maternal and child health care as part of primary health care, service and delivery can be expanded.

In Kerala the birth rate was 24.9 per 1000 population in 1983, the lowest of any Indian state; the comparatively high mean age of marriage and the relatively low infant mortality rate in Kerala have been attributed to a literacy rate of 75% as well as to efficient health and family planning services.

If there is to be a better life for future generations, rhetoric will have to be translated into resources.
Improvements in maternal and child health lead to a decline in mortality and fertility rates. The integration of services also facilitates community-based initiatives in disease control, safe sanitation, health education and related activities. An impressive example of this is the Orangi Project in Karachi, Pakistan (6): family planning education and services have been successfully integrated into a self-help, environmental programme that aims to reduce population pressure on fragile ecosystems.

Significant declines in fertility require widespread voluntary family planning. Family planning policy has been largely driven by demographic, human rights and health considerations, of which the latter have tended to transcend religious and political differences and to unite governments, organizations and individuals.

The correct spacing of births through family planning favours child survival, protects mothers, enhances family life, moderates population growth and is a key to sustainable development. Family planning should be provided as a component of maternal and child health care. Child survival and family planning are interactive: family planning improves child survival; child survival increases the demand for family planning. By combining both under the maternal and child health care infrastructure, services and delivery can be improved and strengthened in a cost-effective way.

Maternal and infant deaths are closely correlated with pregnancies that are too early, too late, too many or too close. Dramatic reductions in infant and maternal mortality rates can be achieved through family planning. Simply stated, family planning saves lives. About 500 000 women die unnecessarily each year because of complications relating to pregnancy and childbirth. Most developing countries have maternal mortality rates ranging from 300 to 800 per 100 000 live births. In some parts of Africa there are more than 1000 maternal deaths for every 100 000 live births. The lifetime risk of dying because of a pregnancy-related condition ranges from 1 in 25 to 1 in 40 for women in developing countries, whereas in northern Europe there are only between two and nine maternal deaths for every 100 000 live births (2).

Similarly, infant mortality rates are ten times higher in the developing world than in the developed countries. Approximately 10 million infant deaths (before the age of one year) and another 4 million children’s deaths (between one and five years) occur annually in developing countries. Current international targets require a 50% reduction in maternal mortality between 1990 and the year 2000, and a one-third reduction in infant and under-five child mortality rates.

To achieve these goals a substantial extension and improvement of family planning services is required. Also, it will be necessary to bring family planning information and services closer to the people requiring them. A particular effort should be made to provide high-quality services to people in rural areas and in the poorest underserved urban areas. At the same time, neglected groups such as adult men, newlyweds, and adolescents should also be
Family planning services should be integrated into all health services, especially the first levels of care, and community-based programmes should be strongly encouraged.

In Mexico the Centro de Orientación para Adolescentes offers recreational activities, counselling, job training, sex education and health services to young people. Research indicated that trained young volunteer outreach workers, supervised by a community counsellor and working through informal networks, were highly effective in reaching people, particularly young single men. In the Matlab project in Bangladesh, family planning services were carefully adapted to community needs, and as a result the use of contraceptives rose from under 10% in 1977 to 33% in 1979; a pattern of rapid increase not recorded elsewhere in the country (7).

In order to ensure widespread acceptance and continuation of family planning, contraceptives should be made easily available in culturally appropriate ways. Potential and actual users should be provided with accurate information encouraging sustained use. Recent studies indicate that if family planning services are comprehensive and integrated their use is enhanced: clients who come in for one service frequently utilize others and make repeated visits.

Since most actual and potential users are women, clinics should reflect their concerns. Women want clinics to be welcoming and easily accessible; they also want to be respected and to feel secure. They seek confidentiality and facilities meeting as many of their needs as possible (8). High standards can be achieved in family planning clinics at modest cost, even in less developed or low-income countries. Successful family planning programmes depend on the availability of safe, affordable and effective means of contraception.

Programmes in the fields of population and development should be mutually supportive.

Information, education and communication

People must be aware of what is involved if demographic goals are to be achieved. Information, education and communication programmes provide the knowledge and motivation that people need in order to make choices affecting population growth and socioeconomic development. Information campaigns help to build understanding and awareness about demographic issues, trends and developments. Educational activities in schools and through non-formal channels create an understanding of the nature, causes and implications of population processes; they also aim at inculcating in people a sense of responsibility in these matters. Communication is geared to mobilizing support for population-related activities and creating demand for family planning services. The targeting of specific groups is always a prerequisite for successful intervention.

The mass media are the prime carriers of information, while the traditional channels such as music, dance, theatre and puppetry have proved very effective in conveying family planning information to diverse audiences. In Brazil, the first vasectomy promotion on television helped to increase
the number of operations at advertised clinics by nearly 80%. In Ibadan, Nigeria, almost 25% of new clients at family planning clinics cited television as their source of referral (5).

Targeting young people, especially adolescents, is essential to achieve population goals and to prevent the spread of AIDS and other sexually transmitted diseases. In 1988-89 the Population Centre Foundation of the Philippines launched a highly successful campaign aimed at adolescents in the Manila area (9). Sexual responsibility was advocated with the help of two hit songs and accompanying videos. The message was subsequently reinforced through print, television and radio; a telephone counselling hotline was set up and essay-writing and art competitions were held. A high percentage of people aged between 15 and 25 sought family planning information after seeing the videos.

In Turkey between October and December 1988, more than five hours of family planning programmes, in the form of short dramas and documentaries, were repeated regularly on television during prime viewing hours. Baseline and post-campaign surveys involving more than 2000 women aged 15 to 44 showed significant increases in awareness and approval of family planning; the use of modern contraceptive methods increased from 39% to 42%. The campaign had its greatest impact on women who had had only one to five years of education, among whom contraceptive use increased from 16% to 22% over a six-month period.

Interpersonal communication is vital in improving family planning and health care services. Service-providers, particularly at the grass-roots level, should be given special training in counselling and effective communication.

![Fig. 2. Projected costs of contraception in developing countries, 1991–2000](image)

**Contraceptives**

Although contraception is responsible for much of the decline in fertility that has occurred, further efforts are needed to ensure universal access to a wide choice of contraceptive methods. Family planning services should be culturally acceptable and of adequate quality. If the United Nations medium-fertility variant giving a population projection of 6200 million is to be achieved by the year 2000, the use of contraception in developing countries will have to reach 59% by that date. In other words, some 567 million couples will have to be using some form of contraception at the end of the century. This projection means that 151 million surgical procedures for female and male sterilization, 8760 million cycles of oral pills, 663 million doses of injectables, 310 million intrauterine devices and 44 000 million condoms will be needed in developing countries by the year 2000. The cost of contraceptives, if purchased on the international market, would be about US$5000 million, excluding services delivery.
costs. The expected costs over the decade for the different methods are indicated in Fig. 2 (10).

The cost would be $3700 million for Asia and the Pacific, $224 million for Africa, $701 million for Latin America and the Caribbean, and $340 million for the Arab states and Europe. The volume and cost of contraceptive requirements call for a coordinated international system of procurement, storage, distribution and logistical support.

Centralized purchasing or production in bulk can give economies of scale, help to avoid duplication and waste, and provide a quick, flexible response to worldwide demand.

Population and development policy

In order to curb the explosion in numbers of people, population policy will have to become central to development planning, both nationally and internationally. The ultimate goal of such policy is to improve the quality of life. Population policy addresses fertility, mortality and migration, as well as the interrelationship between population and overall socioeconomic development.

Health, population and development are closely interwoven. Health largely depends on the provision of clean water, good housing, safe sanitation, adequate nutrition, immunization and other products of the development process. However, accelerated population growth retards development and overburdens health infrastructures. The fruits of development quickly dwindle in the face of rapid population increase; health services and facilities become overwhelmed and unable to meet all the needs of the poor and rural sections of society.

Reducions in mortality rates require health and population policy to be integrated into development planning. The whole range of demographic data should be used to make sectoral planning more accurate; and the impact of development policies and programmes on demographic processes and trends should be assessed. Programmes in the fields of population and development should be mutually supportive.

Family planning is, of course, a key element in population policy. Currently, 123 countries directly support family planning while only seven oppose it. Strong family planning programmes are most effective in areas where socioeconomic development is highest. In countries where women have benefited from development, population programmes have made impressive strides.

Population policies work best in countries with a national population council and a population planning unit, preferably in the national planning ministry. The policies vary from country to country, reflecting differing socioeconomic conditions and infrastructures, cultural values, and traditional beliefs. To be effective, policies have to be flexible and responsive to varying national needs and conditions. However, there is a key common denominator: in order to slow down the population explosion, balance the distribution between rural and urban areas, provide adequate health care and avert an environmental crisis, population policy has to play a central role in all development planning.

* * *

Population, development and health are closely interrelated. Population levels affect both health and development. Development creates opportunities to improve health status and living standards. At the same
time, development is affected by health in that people must be healthy if they are to contribute to socioeconomic progress. If rapid population growth is not curbed, sustainable development will be stalled.

In order to halt the acceleration in population growth, address other unfavourable demographic trends, and achieve sustainable development, there will need to be a substantial increase in funding for core population activities. The required increase to US$9000 million annually by the year 2000 represents an investment in the future. If there is to be a better life for future generations, rhetoric will have to be translated into resources.

By expanding women’s roles, raising their status and ensuring their participation in population and development activities, population growth can be significantly reduced. A critical prerequisite is to increase their opportunities for education, employment and health care.

To advance development, health issues need to be integrated into all aspects of planning. Health care services and facilities of good quality should be accessible to all sections of populations. It is particularly important to ensure that vulnerable groups such as the rural and urban poor, women, the aged and the very young are not neglected. Good health should be regarded as a democratic right. By integrating family planning programmes with systems of maternal and child health care in the context of primary health care, the scope of services and delivery can be expanded and strengthened.

References

Maternal Mortality
A Global Factbook

This book sets out the facts and figures needed to understand why so many women continue to die as a result of pregnancy and childbirth despite the fact that the technical means to prevent such deaths have long been available. Drawing upon a vast database of some 3,000 reports and studies, the factbook shows, in the form of country profiles, where women are dying, what they are dying of and what other aspects of their lives contribute to their deaths. Noting that maternal death is most often the tragic end to a life-long chain of events and disadvantages, the book tracks down the underlying factors, often rooted in sex discrimination present since infancy, as well as the more immediate factors, such as lack of access to life-saving care, that reveal the true complexity of the forces at work. Information such as that contained in this factbook provides the key for effective action, making the best use of limited resources despite the often difficult circumstances.

The main body of the factbook, which runs to some 600 pages, consists of country profiles which, for the first time ever, bring together and analyse the results of all available surveys and studies on maternal mortality, women’s reproductive health and allied subjects, as well as indicators of the coverage of maternity care, family planning and other background factors. Profiles are given for each of 117 developing countries in Africa, Latin America, Asia and Oceania. Data on developed countries are also tabulated for comparison. In compiling the profiles the authors have drawn upon the unique WHO women’s health data base which, in addition to the more readily available government reports and articles from scientific journals, contains information from a large variety of disparate sources, including unpublished articles, doctoral theses and consultant briefings.

To make it easier to compare countries, each profile follows a common format, starting with a section containing demographic and socioeconomic indicators that shed light on women’s lives in each country: their chances of going to school, eating well, and receiving health care, the age at which they are likely to marry, their chances of planning their families, and the number of children they are likely to bear. These data provide a backdrop for the detailed statistics on coverage of care and maternal mortality which follow, and which detail the numbers of deaths, the mortality rates and ratios, the causes and circumstances surrounding each case, the groups of women most at risk of dying, and the kinds of preventive and curative actions that might have averted death.

The interpretation of this vast amount of information is facilitated through the inclusion of four background chapters. The first provides an overview of the dimensions and causes of maternal mortality and morbidity in the world today as well as of the extent of the coverage of care. The different ways of measuring maternal mortality are described in the second chapter, which discusses the strengths and weaknesses of each method. The third explains how the results of surveys should be interpreted and analyses the information that can, or cannot, be obtained from hospital studies, community surveys or registration data. The book also features a comprehensive listing of general resource materials for readers who wish to expand their knowledge on this complex issue.

Maternal Mortality: A Global Factbook
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