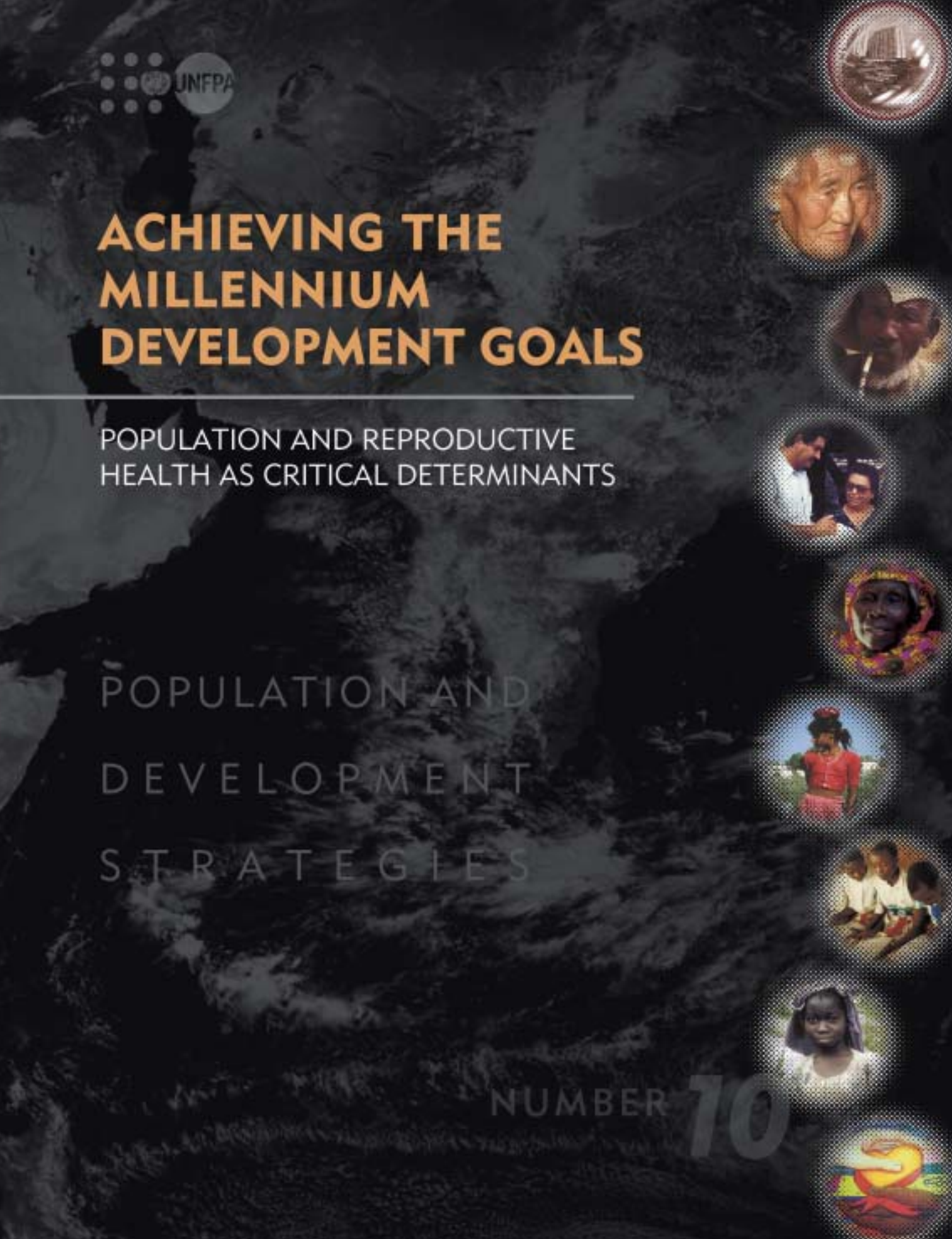
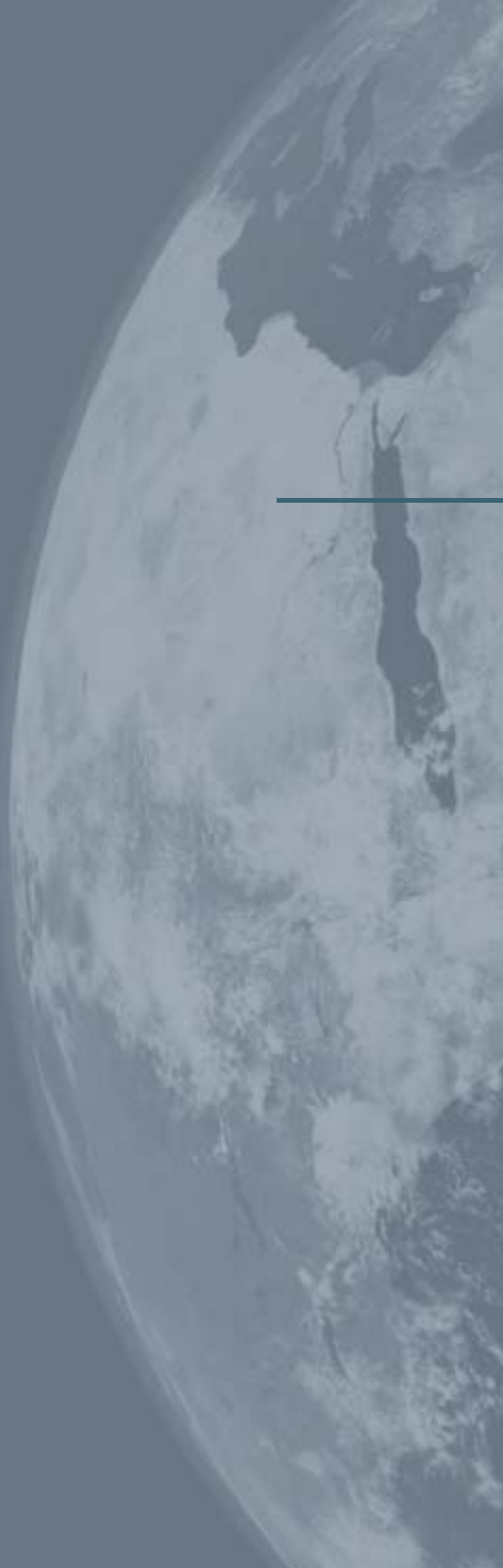


ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS

POPULATION AND REPRODUCTIVE HEALTH AS CRITICAL DETERMINANTS

POPULATION AND DEVELOPMENT STRATEGIES

NUMBER 10



United Nations
Population Fund
220 East 42nd Street
New York, N.Y. 10017

ISBN: 0-89714-686-7
E/1500/2003

ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS

POPULATION AND REPRODUCTIVE HEALTH AS CRITICAL DETERMINANTS

NUMBER 10 | 2003

POPULATION AND DEVELOPMENT STRATEGIES SERIES

First Published September 2003
New York, NY 10017

Other titles in this series:

PDS No.1 ***Population, Environment and Poverty Linkages: Operational Challenges*** August 2001

PDS No.2 ***Situation and Voices: The Older Poor and Excluded in South Africa and India*** April 2002

PDS No.3 ***Population Ageing and Development: Social, Health and Gender Issues*** April 2002

PDS No.4 ***Population and Housing Censuses: Strategies for Reducing Costs*** October 2002

PDS No.5 ***Population Ageing and Development: Operational Challenges in Developing Countries*** October 2002

PDS No.6 ***Global Population and Water: Access and Sustainability*** March 2003

PDS No.7 ***Counting the People: Constraining Census Costs and Assessing Alternative Approaches*** May 2003

PDS No.8 ***Population and Poverty: Achieving Equity, Equality and Sustainability*** June 2003

PDS No.9 ***The Impact of HIV/AIDS: A Population and Development Perspective*** August 2003

NOTES: The views and opinions expressed in this report are those of the Technical Team and do not necessarily reflect those of the United Nations Population Fund (UNFPA).

The designations employed and the presentation of material in this publication do not imply the expression of any opinion whatsoever on the part of the United Nations Population Fund (UNFPA) concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The term 'country' as used in the text of this report refers, as appropriate, to territories or areas. The designations of 'developed' and 'developing' countries are intended for convenience and do not necessarily express a judgment about the stage reached by a particular country or area in the development process.

Graphic Design and Production: Andy Musilli
Cover photos: *right edge*: Johns Hopkins Center for Communications Programs (JHU/CCP), UNFPA Photo Archive, UNESCO Photobank

FOREWORD

"The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning."

United Nations Secretary-General, Kofi A. Annan, Bangkok, December 2002

According to the United Nations *World Population Prospects, The 2002 Revision*, global population will reach 8.9 billion persons in 2050, compared with 6.3 billion in 2003. Growth rates are slowing and the 2050 figure is 0.4 billion lower than projected in *The 2000 Revision*. Part of the slowing of population growth has been due to the effects of the continued ravages of the HIV/AIDS pandemic, which is markedly increasing mortality levels in some countries, especially in sub-Saharan Africa. But an important part of the lower growth rates is due to the success of population programmes, coupled with the empowerment of women.

Yet, even in the shorter time span to 2015, there will be almost 1 billion more people added to the world's less developed countries – from 5.1 billion in 2003 to 6.0 billion in 2015. In many of these countries, the number of people living in poverty is rising and inequalities are widening. And many people are still unable to enjoy basic human rights and human security.

The Millennium Declaration, arising from the Millennium Summit held in September 2000 and building on the outcomes of the international conferences of the 1990s, especially the International Conference on

Population and Development (ICPD), marked a strong recommitment to the right to development, to the eradication of the many dimensions of poverty, and to gender equality and the empowerment of women. The Declaration mainstreams into the global development agenda eight mutually reinforcing goals, to be achieved by 2015, that are driving national development and international cooperation.

The ICPD goal of universal access to quality reproductive health services by 2015 is not one of the Millennium Development Goals (MDGs). Yet, as this publication demonstrates, the attainment of reproductive health and reproductive rights are fundamental for development, for fighting poverty, and for meeting the MDG targets. Conversely, reproductive ill-health undermines development by, *inter alia*, diminishing the quality of women's lives, weakening and, in extreme cases, killing poor women of prime ages, and placing heavy burdens on families and communities.

Women who can plan their families and who are educated are better able to seek health care for themselves and their families - thereby helping to break the cycle of poverty and to enter a virtuous cycle. We will not reduce poverty, child and maternal mortality and the spread of HIV/AIDS unless couples and individuals can plan their families, receive health care during pregnancy and birth, and have the information and services they need to protect their health and prevent HIV infection. Reproductive health is thus crucial, not only to poverty reduction, but to sustainable human development.

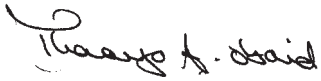
Sustainable economic growth is important for increasing revenues for social sector investments. But it does not guarantee better reproductive health status of the poor. This is especially so for those living in extreme poverty in remote areas with limited access to basic health and basic education, and where there is a large unmet need for reproductive health services, including family planning.

UNFPA, working in multiple partnerships, supports gender sensitive policies and programmes to achieve the MDGs. These should be customised to national and local circumstances, take into account cultural diversity, and the voices of the poor. Civil society organisations have a key role to play to complement government efforts, in meeting the reproductive health needs of the poor, especially of adolescents, and in preventing abortions and HIV/AIDS.

But we cannot accomplish the MDGs and ICPD goals without the financial means to do so. Under the Global Partnership for Development, as agreed in MDG 8, developed countries have committed to the transfer of the necessary resources to ensure meeting these and other development goals. Yet, despite the Monterrey Consensus, external assistance, including that for population and development programmes, has not improved significantly in recent years. While programme countries must make stronger commitments to population programmes, these commitments must be fully supported by increased donor ODA flows and technical assistance. And there should be less politicisation of population issues. Financing and investing in reproductive health and women's empowerment is cost effective and fully supports progress towards the achievement of the MDGs.

In conclusion, I would like to take this opportunity to sincerely thank the members of the Technical Team who prepared this publication (**page vi**), with the encouragement of Ms. Mari Simonen, Director, Technical Support Division of UNFPA, for their professionalism and creativity. I sincerely hope that it serves to heighten awareness of the critical importance of addressing population and reproductive health issues for achieving the MDGs.

Thoraya Ahmed Obaid



Executive Director
September 2003

TECHNICAL TEAM

Mr Richard Leete
Chief, Population and Development Branch (PDB)
Technical Support Division (TSD), UNFPA

Dr Soraya Azmi Burhani
Research Assistant
PDB, TSD

Ms Mickie Schoch
Research Assistant
PDB, TSD

Additional assistance

Ms Ann Pawliczko
Senior Resource Flows Officer
PDB, TSD

CONTENTS

MILLENNIUM DEVELOPMENT GOALS: TARGETS AND INDICATORS

GOALS AND TARGETS *(FROM THE MILLENNIUM DECLARATION)*	INDICATORS FOR MONITORING PROGRESS
GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER	
TARGET 1: *Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day*	**1a**. Proportion of population below $1 (PPP) per day[a] **1b**. Poverty headcount ratio (% of population below the national poverty line) **2**. Poverty gap ratio [incidence x depth of poverty] **3**. Share of poorest quintile in national consumption
TARGET 2: *Halve, between 1990 and 2015, the proportion of people who suffer from hunger*	**4**. Prevalence of underweight children under-five years of age **5**. Proportion of population below minimum level of dietary energy consumption
GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION	
TARGET 3: *Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling*	**6**. Net enrolment ratio in primary education **7a**. Proportion of pupils starting grade 1 who reach grade 5 **7b**. Primary completion rate **8**. Literacy rate of 15–24 year-olds
GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN	
TARGET 4: *Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015*	**9**. Ratios of girls to boys in primary, secondary and tertiary education **10**. Ratio of literate women to men 15–24 years old **11**. Share of women in wage employment in the non-agricultural sector **12**. Proportion of seats held by women in national parliament
GOAL 4: REDUCE CHILD MORTALITY	
TARGET 5: *Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate*	**13**. Under-five mortality rate **14**. Infant mortality rate **15**. Proportion of 1 year-old children immunised against measles
GOAL 5: IMPROVE MATERNAL HEALTH	
TARGET 6: *Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio*	**16**. Maternal mortality ratio **17**. Proportion of births attended by skilled health personnel
GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES	
TARGET 7: *Have halted by 2015 and begun to reverse the spread of HIV/AIDS*	**18**. HIV prevalence among 15–24 year old pregnant women **19**. Condom use rate of the contraceptive prevalence rate[b] **19a**. Condom use at last high-risk sex **19b**. Percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS[c] **19c**. Contraceptive prevalence rate **20**. Ratio of school attendance of orphans to school attendance of non-orphans aged 10–14
TARGET 8: *Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases*	**21**. Prevalence and death rates associated with malaria **22**. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures[d] **23**. Prevalence and death rates associated with tuberculosis **24**. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY	
TARGET 9: *Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources*	**25**. Proportion of land area covered by forest **26**. Ratio of area protected to maintain biological diversity to surface area **27**. Energy use (kg oil equivalent) per $1 GDP (PPP) **28**. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons) **29**. Proportion of population using solid fuels
TARGET 10: *Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation*	**30**. Proportion of population with sustainable access to an improved water source, urban and rural **31**. Proportion of urban and rural population with access to improved sanitation
TARGET 11: *By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers*	**32**. Proportion of households with access to secure tenure

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing States.

TARGET 12: *Develop further an open, rule-based, predictable, non-discriminatory trading and financial system* *Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally*	**Official development assistance** **33**. Net ODA, total and to LDCs, as percentage of OECD/DAC donors' gross national income **34**. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) **35**. Proportion of bilateral ODA of OECD/DAC donors that is untied **36**. ODA received in landlocked countries as proportion of their GNIs **37**. ODA received in small island developing States as proportion of their GNIs
TARGET 13: *Address the special needs of the least developed countries* *Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction*	**Market access** **38**. Proportion of total developed country imports (by value and excluding arms) from developing countries and LDCs, admitted free of duties **39**. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries **40**. Agricultural support estimate for OECD countries as percentage of their GDP **41**. Proportion of ODA provided to help build trade capacity
TARGET 14: *Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)*	
TARGET 15: *Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term*	**Debt sustainability** **42**. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) **43**. Debt relief committed under HIPC initiative, US$ **44**. Debt service as a percentage of exports of goods and services
TARGET 16: *In co-operation with developing countries, develop and implement strategies for decent and productive work for youth*	**45**. Unemployment rate of 15-24 year-olds, each sex and total[e]
TARGET 17: *In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries*	**46**. Proportion of population with access to affordable, essential drugs on a sustainable basis
TARGET 18: *In co-operation with the private sector, make available the benefits of new technologies, especially information and communications*	**47**. Telephone lines and cellular subscribers per 100 population **48a**. Personal computers in use per 100 population and Internet users per 100 population **48b**. Internet users per 100 population

THE MILLENNIUM DEVELOPMENT GOALS and targets come from the Millennium Declaration signed by 189 countries, including 147 Heads of State, in September 2000 (www.un.org/documents/ga/res/55/a55r002.pdf - A/RES/55/2). The goals and targets are inter-related and should be seen as a whole. They represent a partnership between the developed countries and the developing countries determined, as the Declaration states, "to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty."

a For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

b Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals. Because the condom use rate is only measured amongst women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b).

c This indicator is defined as the percentage of population aged 15-24 who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the following: a) Percentage of women and men 15-24 who know that a person can protect herself from HIV infection by "consistent use of condom". b) Percentage of women and men 15-24 who know a healthy-looking person can transmit HIV. Data for this year's report are only available on women.

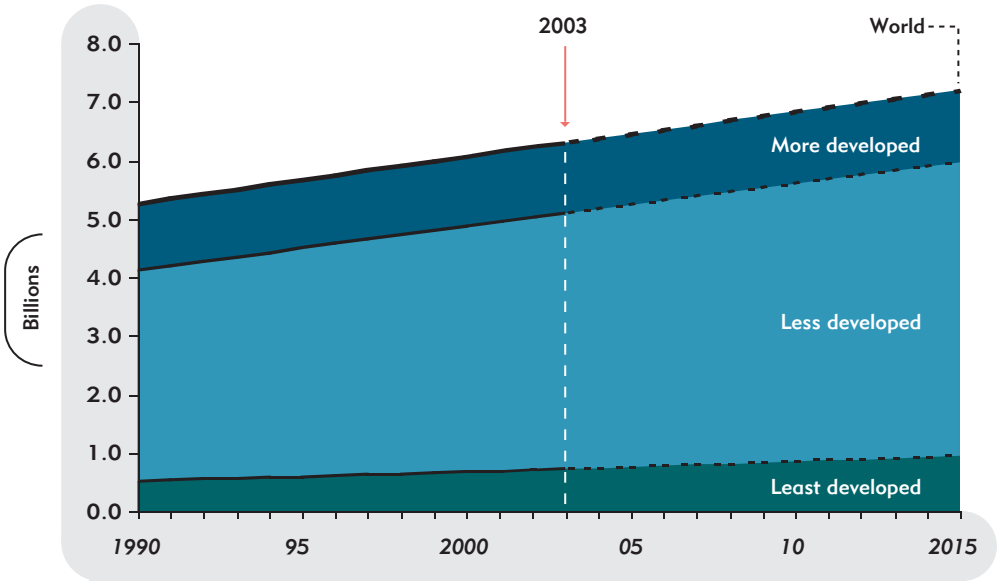
d Prevention to be measured by the percentage of children under 5 sleeping under insecticide-treated bednets; treatment to be measured by percentage of children under 5 who are appropriately treated.

e An improved measure of the target is under development by ILO for future years.

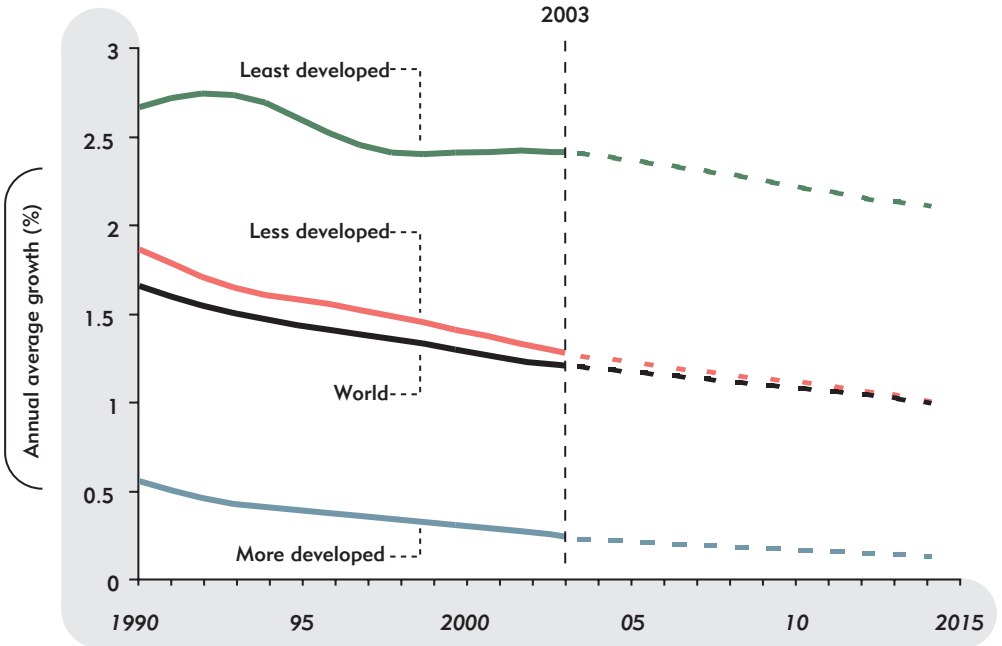
GLOBAL POPULATION

Global population in 2003 is 6.3 billion, of whom 19 per cent live in developed countries and 81 per cent in developing countries. World population growth rates are slowing but remain above the level required for population stabilisation.

Population size continues to grow but mainly in developing countries...

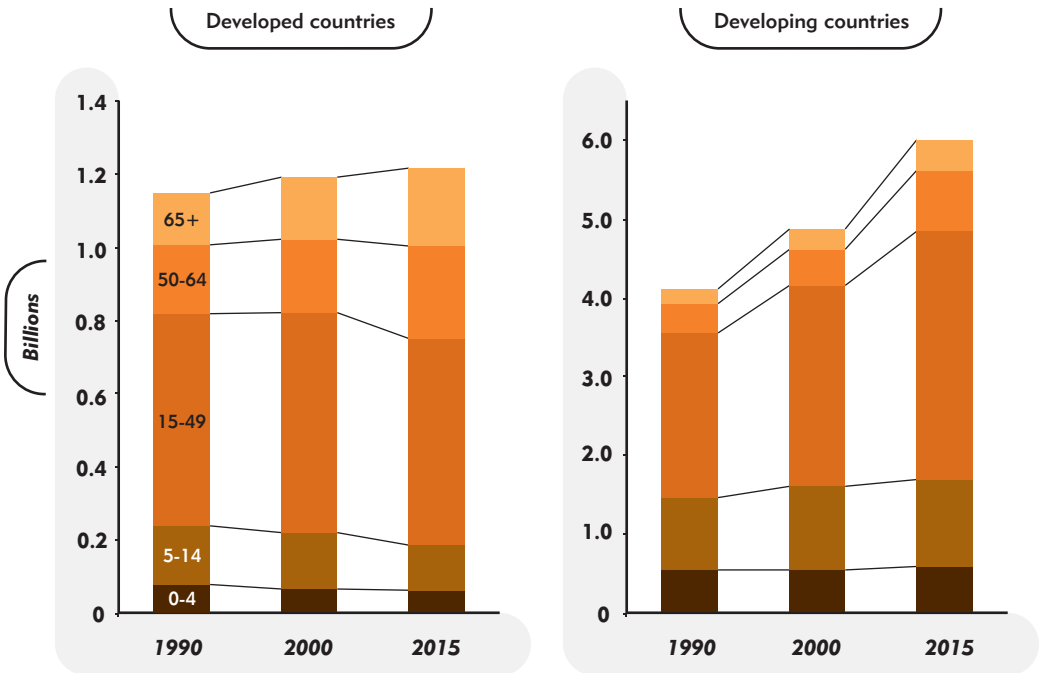


Population growth is most marked in the poorest countries, but everywhere the rate is declining, albeit slowly in the least developed countries...



Most developed countries have completed the demographic transition. And many developing countries are well along the path from high to low fertility – the final stage of the demographic transition – which is the main cause of lower population growth rates. But, especially in poor countries, it cannot be assumed that once fertility transition has begun it will automatically continue and reach population replacement level.

Populations are ageing: in developed countries the older age groups are growing fastest, in developing countries the working age population is also growing rapidly...



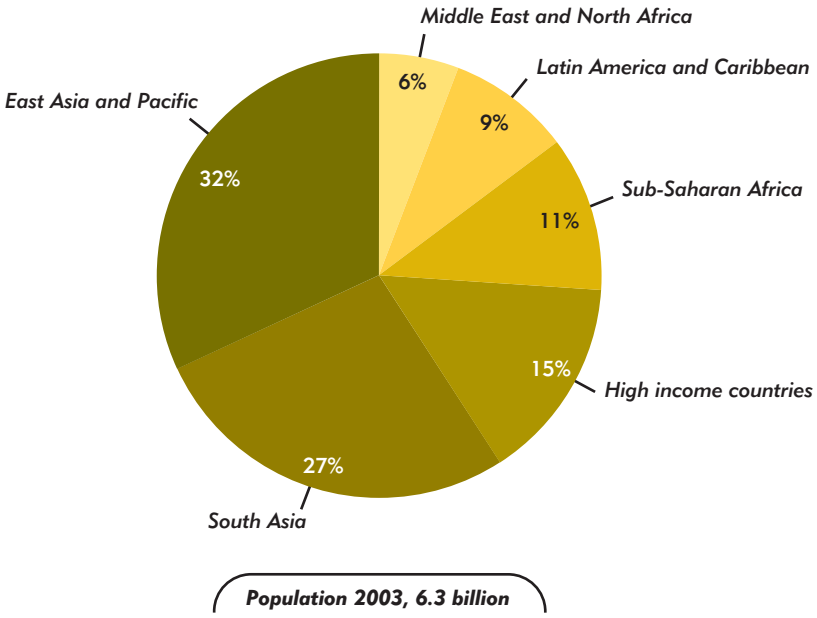
Population stabilisation will be attained only if efforts are maintained to expand and improve the quality of reproductive health programmes to better serve the large unmet needs of poor communities. And these must be accompanied by increased investments in human capital, particularly more widespread education of girls, in line with both the ICPD and the MDGs.

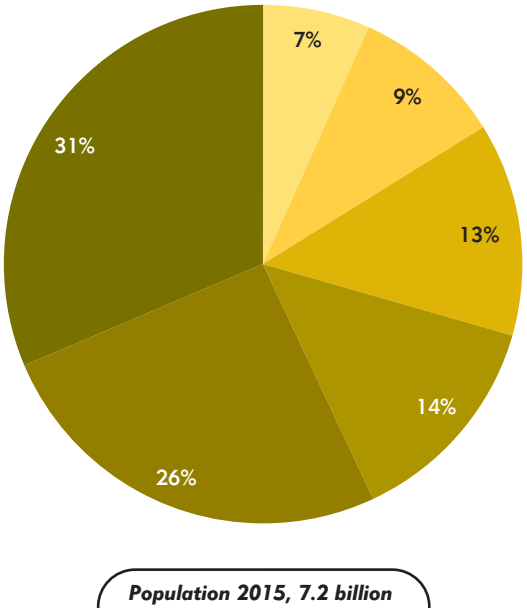
Global population is not only growing larger, but is also becoming older. Population ageing is primarily the result of declines in fertility and, to a lesser extent, improvements in life expectancy. Because fertility (and mortality) declined earlier in developed countries their share of children and young adults is currently much smaller. High and increasing elderly dependency ratios are thus a feature of developed countries, and also some developing countries where the demographic transition has gone furthest. Women are in the majority among the elderly due to their longer life expectancy.

The median age of the population, - the age where half is above and half below – is currently 39 years in developed countries, 25 years in less developed countries and just 18 in the least developed countries. Because of their youthful age composition, child dependency ratios in the poorer countries are much higher. And within poor countries, poverty levels, along many dimensions, are highest in households where family size is largest.

Sub-Saharan Africa, the world's poorest region, is the fastest growing, despite the increasing population losses from AIDS mortality. By 2015 its share of global population will rise from 11 per cent to 13 per cent. With the share of the population living in developing countries expected to rise in the decade ahead the imperative of achieving the MDGs and ICPD goals becomes even greater.

More than half of global population is concentrated in Asia...



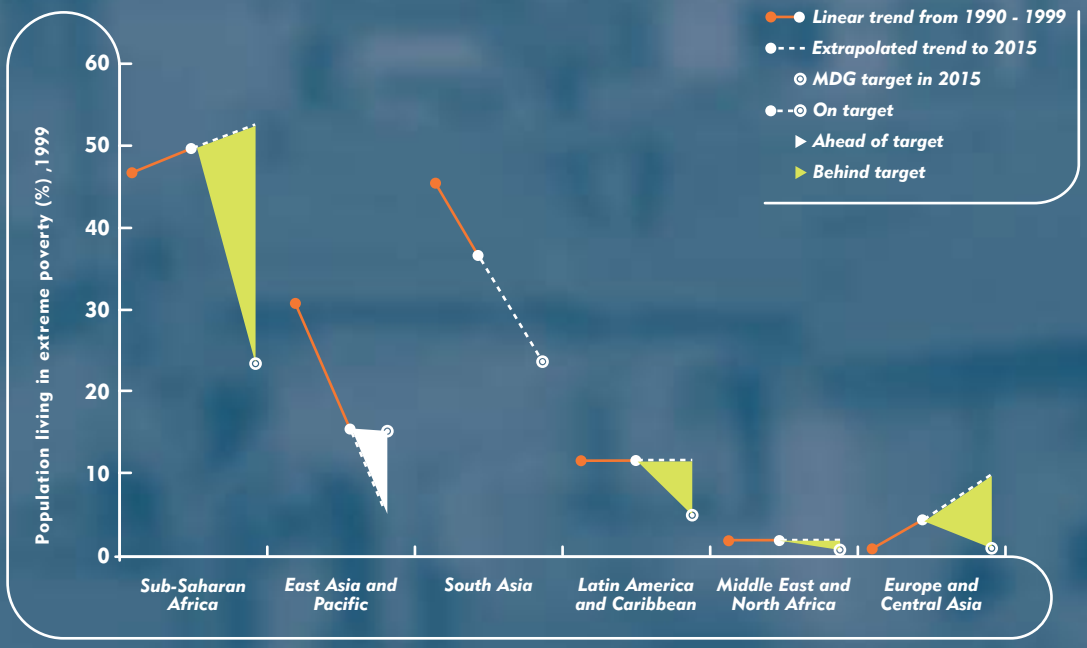


For country classification within groups see page 22

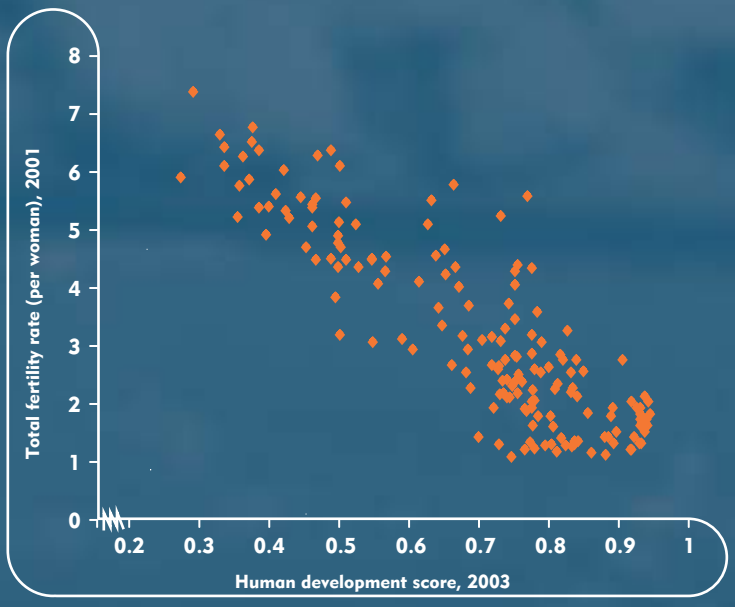
ERADICATE EXTREME POVERTY AND HUNGER

Population dynamics and structure, reproductive health, including adolescent reproductive health and HIV/AIDS prevention, the empowerment of women and gender equality are fundamental for halving the proportion of people in extreme poverty by 2015.

Some regions are reducing extreme poverty: in others poverty is on the rise...



As investments in human development rise, family size falls...



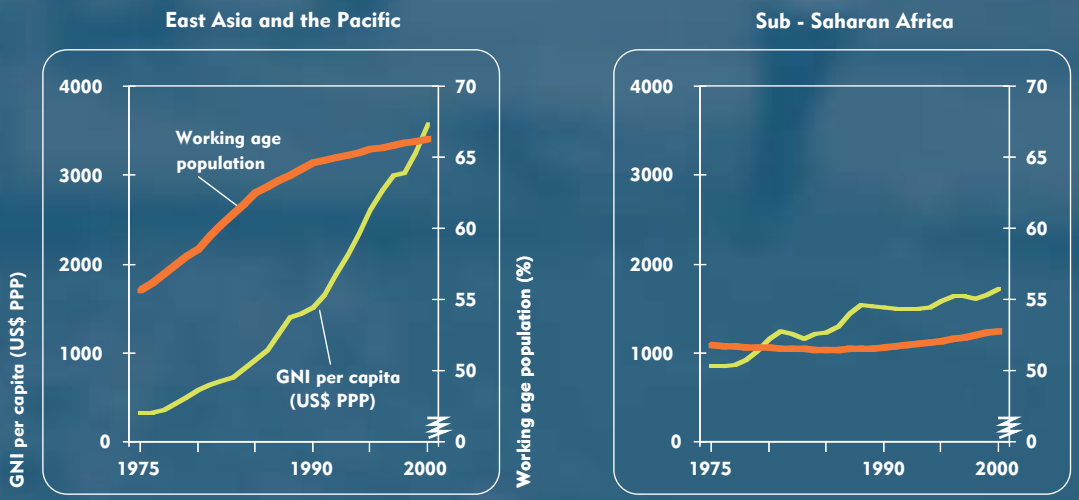
Human development, as well as human security, tend to be highest where fertility levels are lowest. In such settings, saving rates tend to be higher and governments have more resources to invest in people's health and education. The many positive feedbacks from pro-poor targeting in population, reproductive health, and gender, linked to other human development inputs, both reduce poverty in the short-term and play a vital role, especially for young women and their families, in enhancing the ability to escape or avoid poverty over the life-course.

Fertility transition has progressed faster in countries that provide women with choices to space and time their births, provide services for healthy pregnancies, advance gender equality, increase coverage of schooling and adopt pro-poor population policies within a human rights framework. High fertility is concentrated in sub-Saharan Africa and several south Asian countries, where access to services and information remains out of reach for many, especially the rural poor.

Fertility transition is spreading but women in poor countries continue to have many children...

A growing share of the population of working ages has the potential for raising incomes and decreasing poverty. Reaping the benefits of declining dependency burdens depend on increased employment opportunities, improvements in public health, gender equality and investments in human capital.

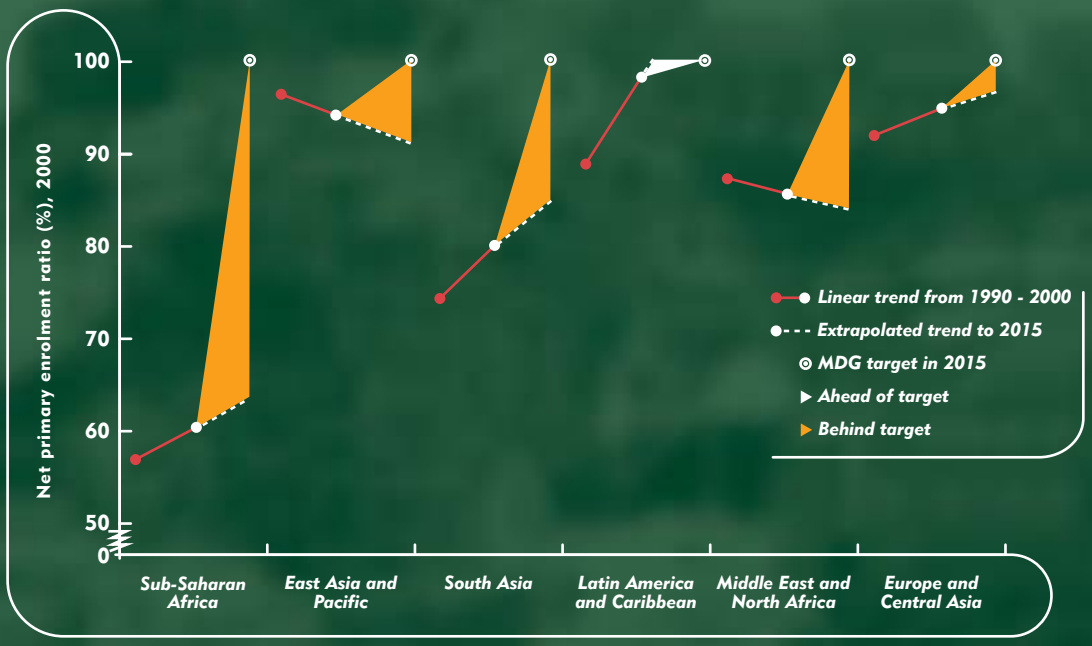
Demographic dividend? Growing share of population of working ages may lead to rising per capita incomes...



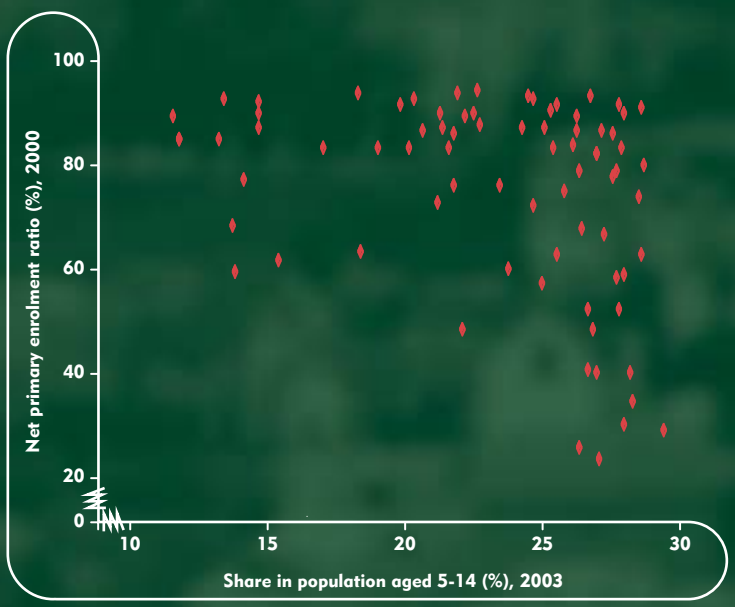
ACHIEVE UNIVERSAL PRIMARY EDUCATION

Education, for girls and boys, is fundamental for reducing poverty and opening up choices and opportunities throughout life. Where the right to education is guaranteed, people's access to and enjoyment of other rights is enhanced.

Primary school enrolment is rising, yet many children never attend school and the 2015 target is unlikely to be met...



Primary enrolment rises as the share of children in the population decreases...

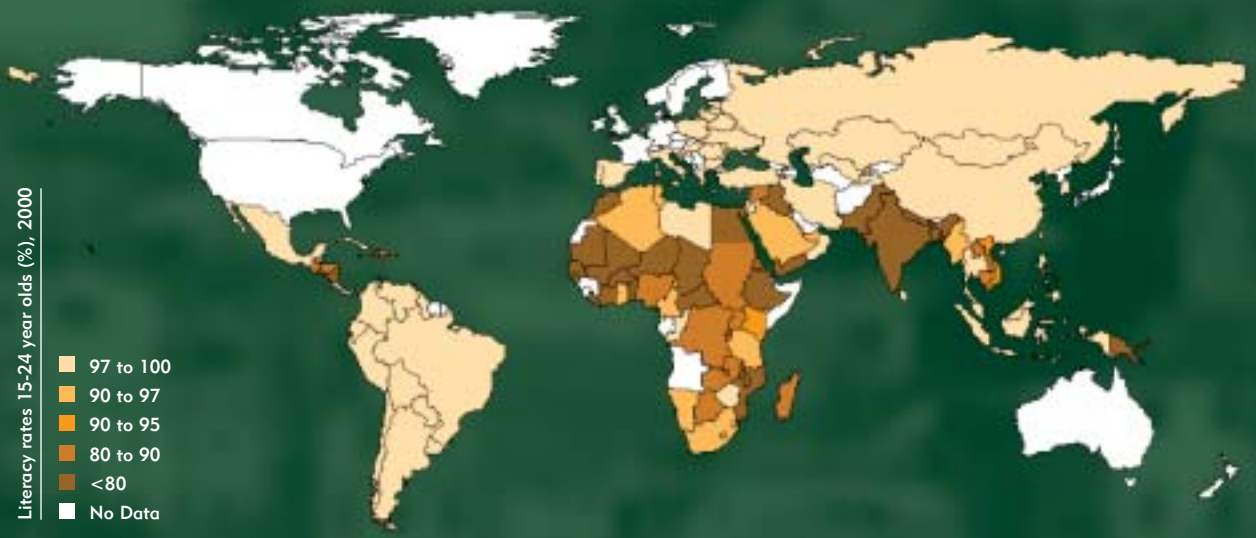


School enrolment is rising in several regions of the world, benefiting both boys and girls, but more needs to be done to meet the target of universal primary education. Children living in conditions of poverty, particularly girls, have the lowest education participation rates.

Education of girls positively impacts on population and health outcomes, and is strongly associated with lower levels of fertility. In turn, smaller family size enables more resources to be spent on each child and leads to higher school enrolment.

Primary education is the main driver for the eradication of illiteracy. Secular gains in school enrolments have led to lower illiteracy rates among young adults. While currently the highest proportions of young adults unable to read and write are located in sub-Saharan Africa (23 per cent), Asia contains the largest number (approximately 87 million). Reducing illiteracy further requires increasing access to education as well as overcoming barriers that constrain demand.

Where children do not go to school, illiteracy of young people is high...



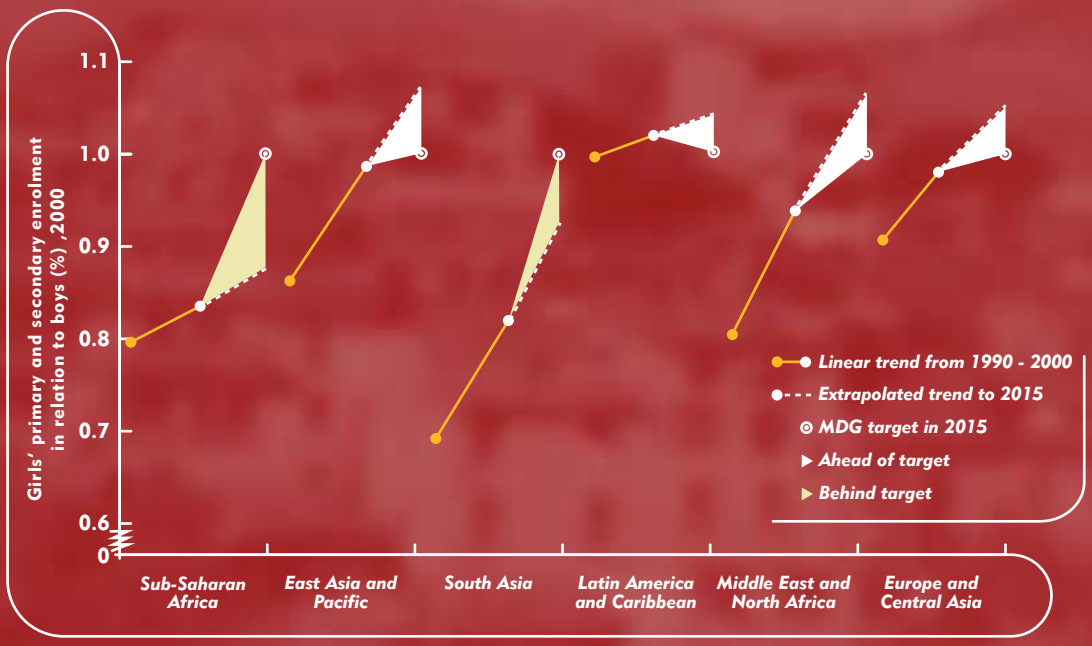
Across many countries, the evidence shows that better educated women are more likely to use contraception, have smaller family size and lower maternal mortality. Further, their children are less likely to die during infancy and they are less likely to live in poverty.

Better schooling of girls leads to improvement in population and reproductive health outcomes...

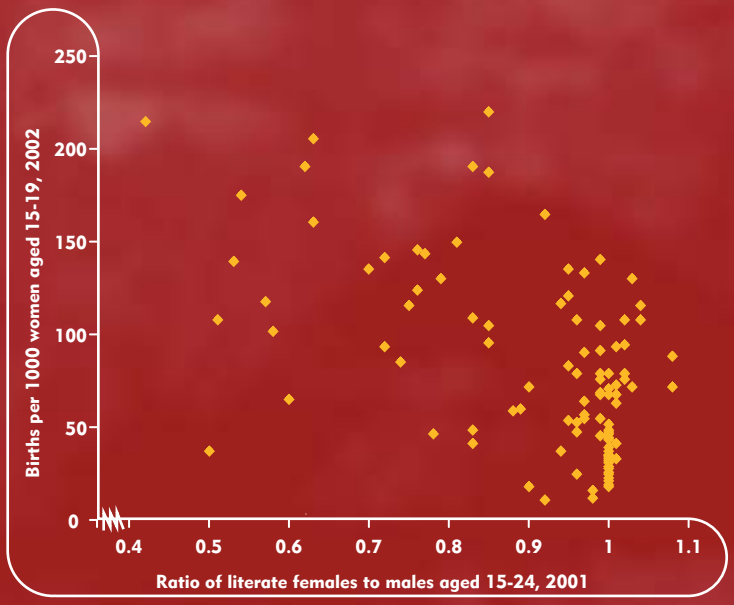
PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Empowering women is an important end in itself: as a basic human right and it contributes to human well-being. Gender equality, equity and women's empowerment are essential to achieve economic, political and social development for all.

Gender differentials in schooling are declining sharply, yet discrimination against girls going to school still persists...



As disparities in literacy between young females and males decrease so too does adolescent fertility...



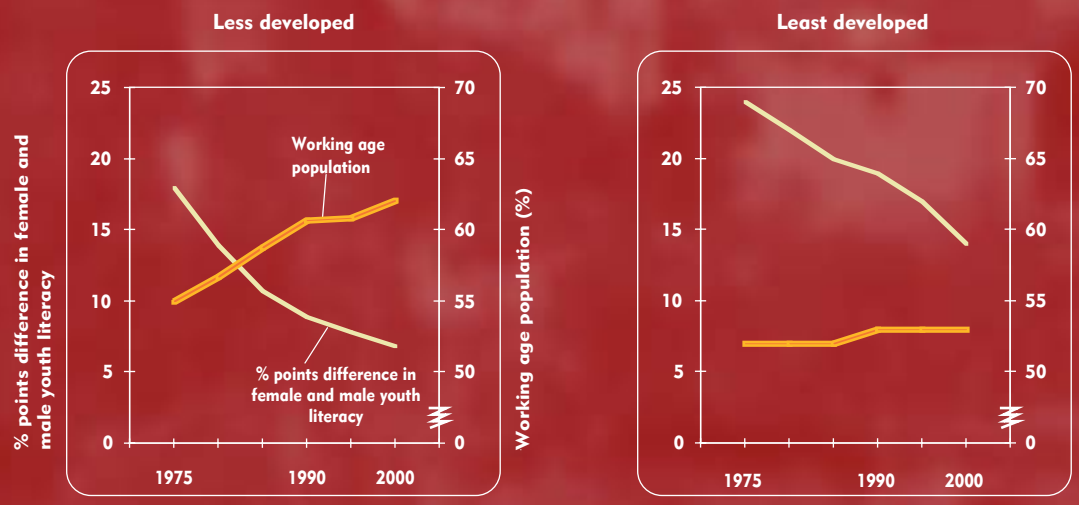
Girls who are literate are more likely to marry and start childbearing later and have smaller and healthier families. Conversely, young illiterate women tend to marry early, start families soon after marriage, or even before, with many and frequent pregnancies – factors that perpetuate the cycle of poverty. Among other ways that poverty affects gender relations is in intensified inter-generational violence, including rape and incest within families, as well as in increases in prostitution and trafficking of girls.

Girls' access to education is more limited than for boys because of traditional and cultural attitudes and practices, lack of adequate school facilities, and gender discrimination. Because of such factors the gender gap in schooling still persists. Closing the gap is an important challenge to policymakers, particularly in sub-Saharan Africa and South Asia where gender differentials in primary enrolment are largest.

Fewer girls than boys receive primary schooling in most countries...

Women, particularly rural women, tend to be the poorest of the world's poor. They constitute more than half of all persons living in extreme poverty. Women are under-represented in formal sector employment, as well as in policy and political decision making positions.

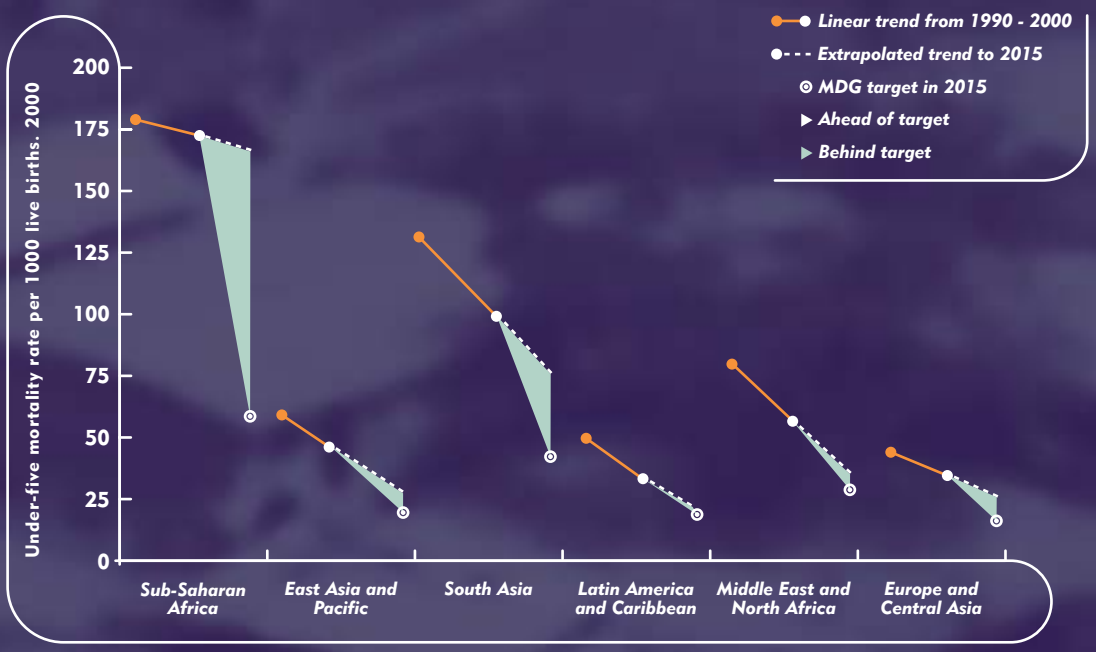
Growth of working age population is beneficial to reducing the gender gap in youth literacy...



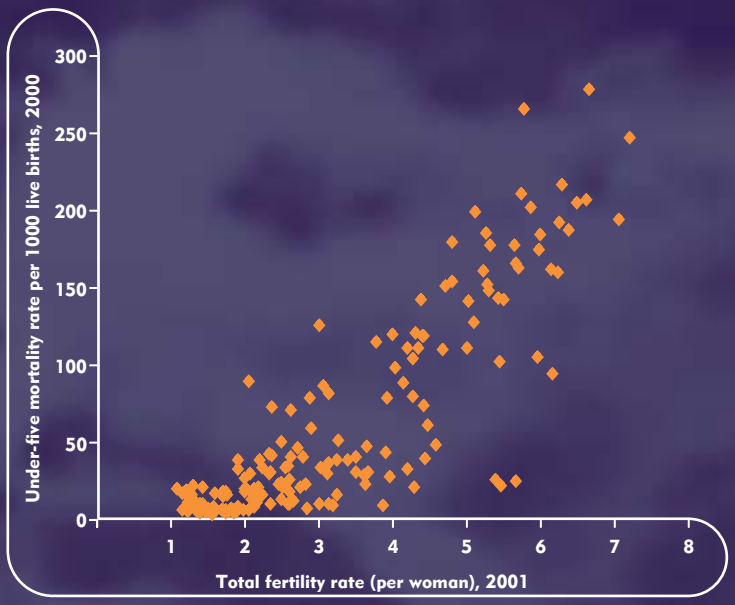
REDUCE CHILD MORTALITY

Impressive reductions in child mortality have been seriously set back, especially in sub-Saharan Africa, by preventable illnesses, especially HIV/AIDS, making it improbable that the target of reducing child mortality by two thirds by 2015 will be reached.

Progress on meeting child mortality reduction targets faltering in the poorest regions...



Child mortality declines with smaller family size...



Child mortality, which accounts for some 11 million deaths annually, is highest among families with large numbers of children. Education and access to resources, such as land and credit, empowers women to have smaller families and provide better care for their children. Reductions in child mortality require, *inter alia*, attention to neonatal health including nutrition and immunization, as well as avoidance of high-risk pregnancy and attention to the care and well-being of mothers during pregnancy, delivery and the post-partum period. Other challenges to be overcome include unsafe water and poor sanitation.

Not surprisingly, child mortality is shown to be sharply higher in the poorest countries where primary health care systems tend to be inaccessible or unavailable. Complex humanitarian crisis situations, prevalent in several poor countries, tend to further degrade already weak health systems exacerbating the risk of infant and child mortality. A major challenge is to provide basic social services, especially for rural communities.

Child mortality is highest in the poorest countries...

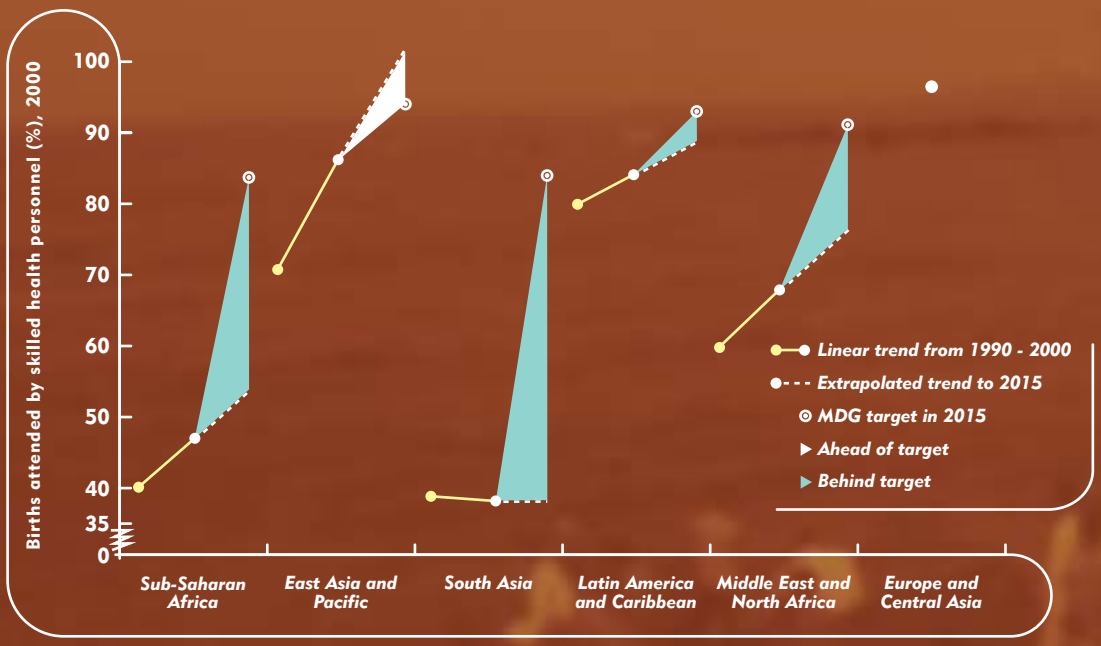
Wealth is a powerful determinant of population and health outcomes. Across all regions and countries the poor have more children than the rich, and they also have higher child and infant mortality.

Within countries the poor have more children than the rich and higher child mortality...

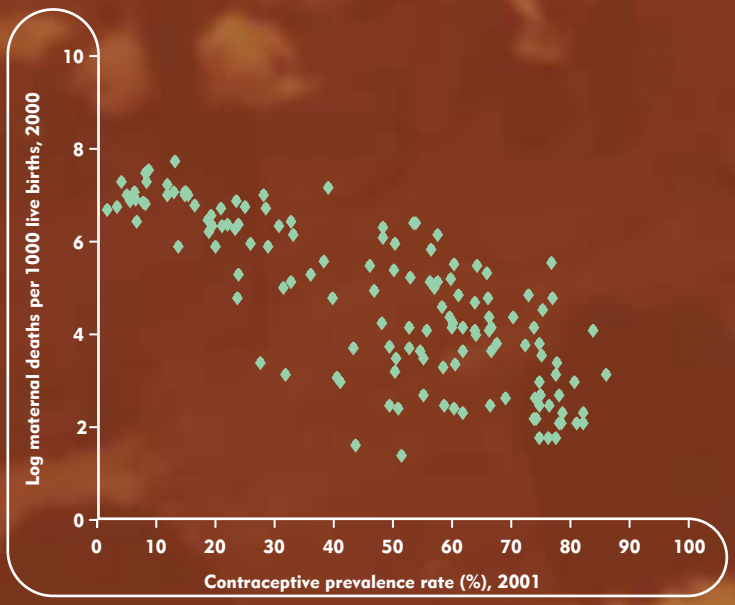
IMPROVE MATERNAL HEALTH

Some half a million women die and many millions more suffer ill-health during pregnancy or childbirth each year. Most live in the poorest countries where reproductive health services are out of their reach.

Too many births not attended by skilled health personnel putting at risk mothers' lives ...



As use of family planning rises fewer mothers die at childbirth...



Reducing maternal mortality depends on many factors, including the availability of contraception and quality health care. Especially important are skilled birth attendants for dealing with complications arising during pregnancy and at childbirth. Globally, skilled attendants assist less than 60 per cent of births. Pro-poor investments in prenatal, EOC and post-natal care support poverty reduction.

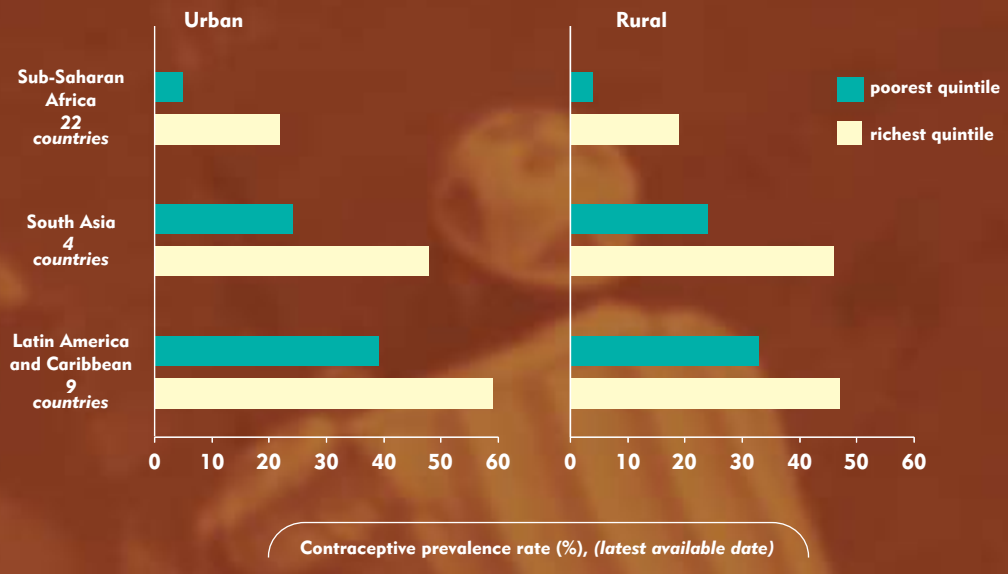
Adolescent motherhood presents a high pregnancy risk as does closely spaced numerous pregnancies. Adolescent girls often lack decision-making power and access to reproductive health services. And adolescents are also at high risk of contracting sexually transmitted diseases (STDs) including HIV/AIDS.

There has been progress towards the ICPD goal of providing access for all who need reproductive health services by 2015. Yet there is still considerable unmet need, especially among countries in sub-Saharan Africa and South Asia. Globally, there are 80 million unplanned pregnancies annually, and 120 million women wanting to use contraception for spacing and limiting births but not doing so. Much remains to be done to improve reproductive health and realise reproductive rights.

Many couples still lack access to family planning...

The use of contraception is influenced by many factors, especially access to quality reproductive health services – social and cultural factors often constrain women from accessing services. Those living in rural areas and having low income are least likely to be using contraception.

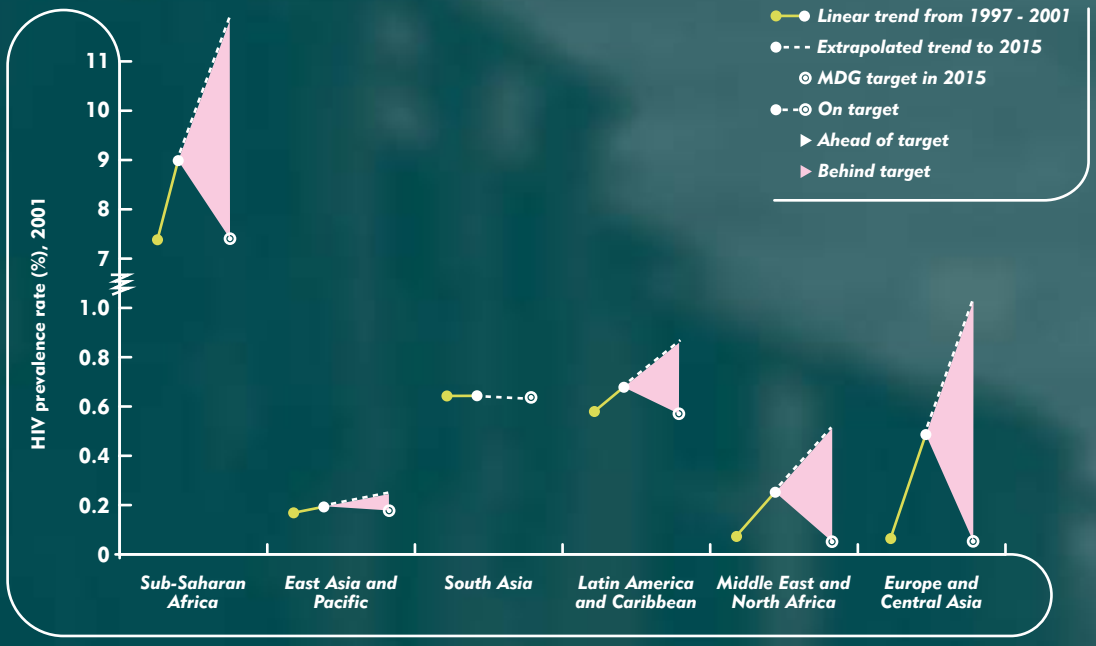
Contraceptives continue to be less accessible to the poor and those living in rural areas...



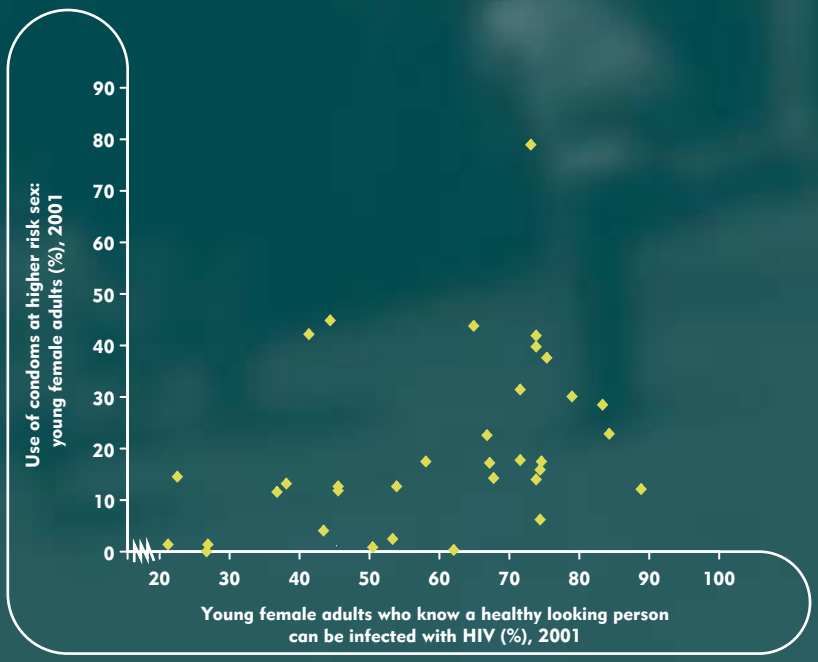
COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

More than 40 million people are currently living with HIV/AIDS. By far the largest proportion are concentrated in low income countries where knowledge about, and access to, reproductive health information and services is lowest.

HIV/AIDS continues to spread: at alarming proportions in sub-Saharan Africa...



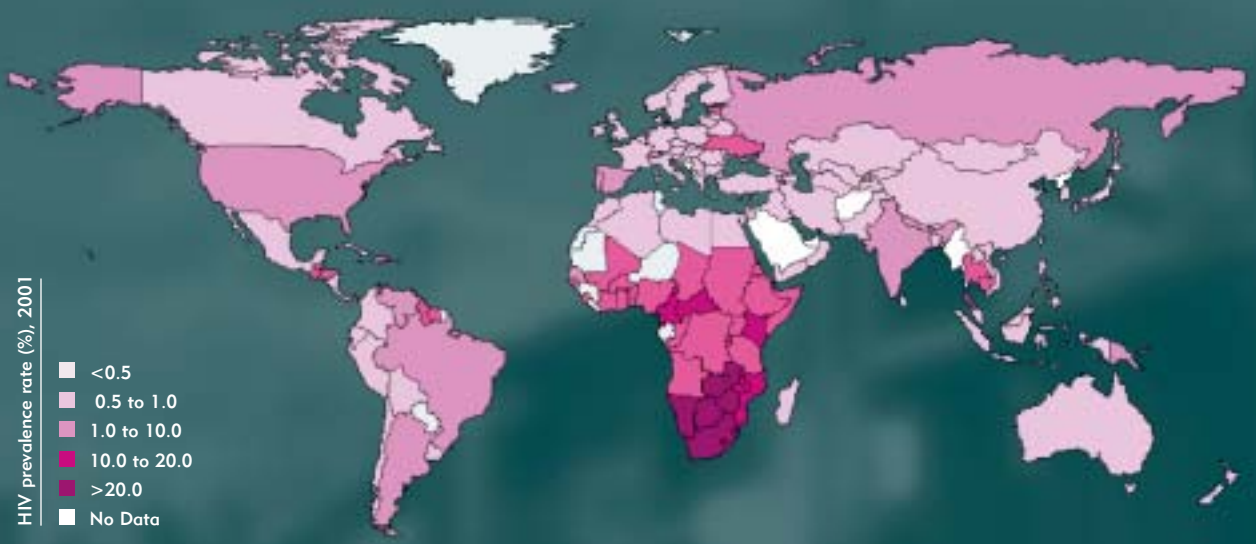
As knowledge of HIV/AIDS increases so too does the use of condoms among young persons...



HIV/AIDS is having a major impact on illness and death. In high prevalence settings it has led to major declines in life expectancy and population. The pandemic is threatening development progress and advances made towards the other MDGs. The MDG targets are all closely inter-related and reversals in any one of them tend to have implications for the others. Effective responses to HIV/AIDS require multi-sectoral strategies that will increase knowledge of the causes of the infection at all levels of society.

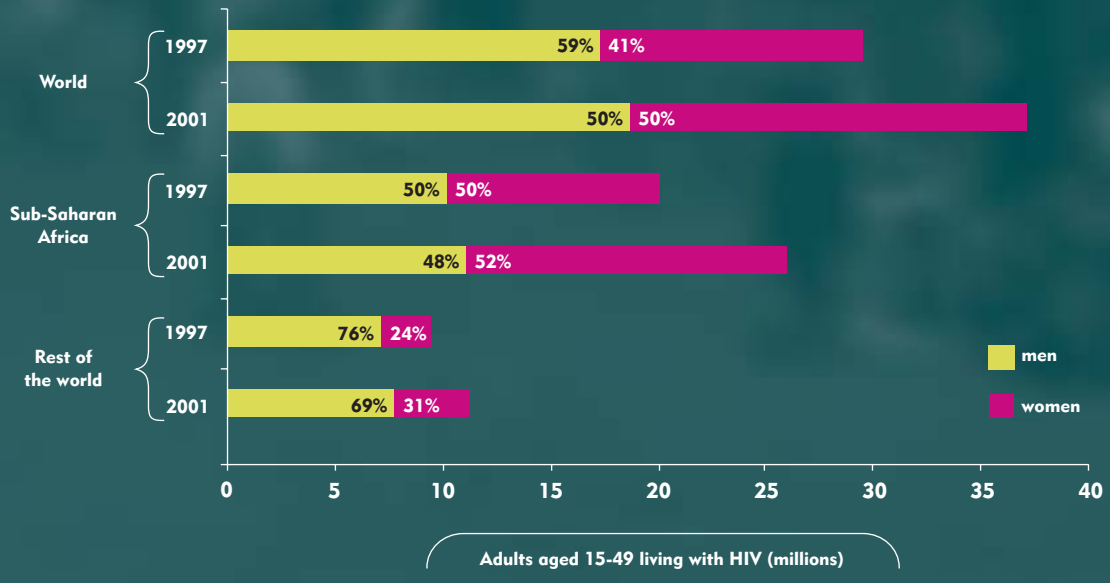
In most countries there is evidence of the invasive presence of the HIV/AIDS pandemic. In some countries it is concentrated in high-risk groups. But in many others it has moved beyond the boundaries of high-risk groups and into the general population. In several countries in sub-Saharan Africa, rates of infection among the population are greater than 20 per cent. This impact is catastrophic, undermining development progress in all sectors.

Staggering variation in HIV/AIDS prevalence...



Globally, more men are infected with HIV/AIDS than women. But female infection rates are rising: in sub-Saharan Africa more women are infected. This may reflect gender imbalances in power relations, including about decisions to use condoms – a means of preventing HIV transmission.

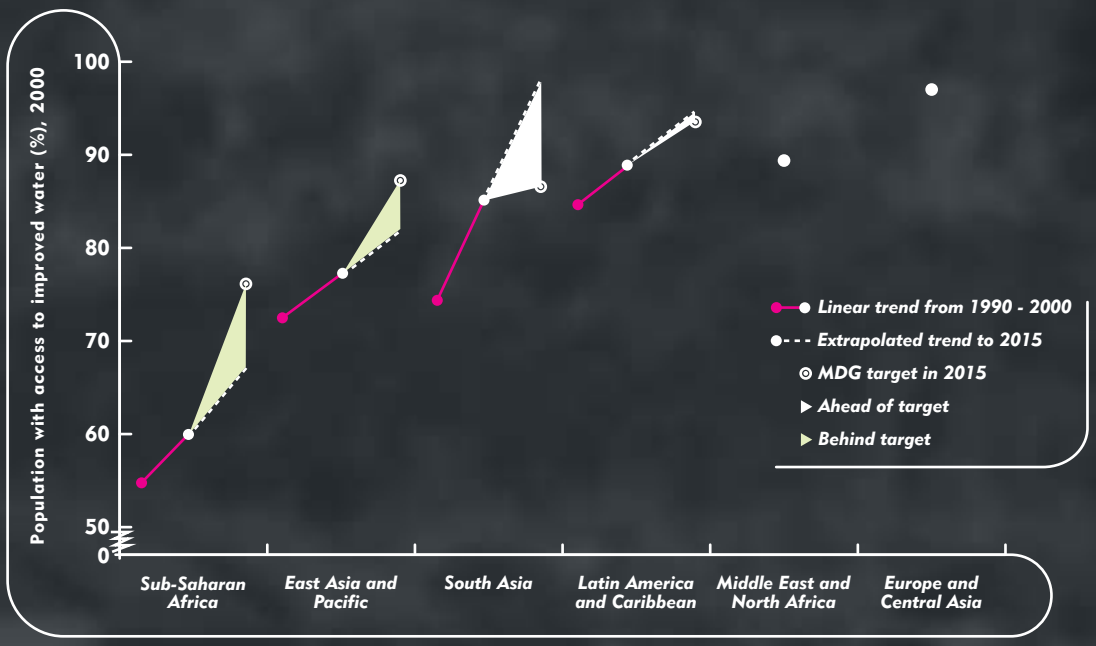
Increasing proportions of women are living with HIV/AIDS as the pandemic spreads...



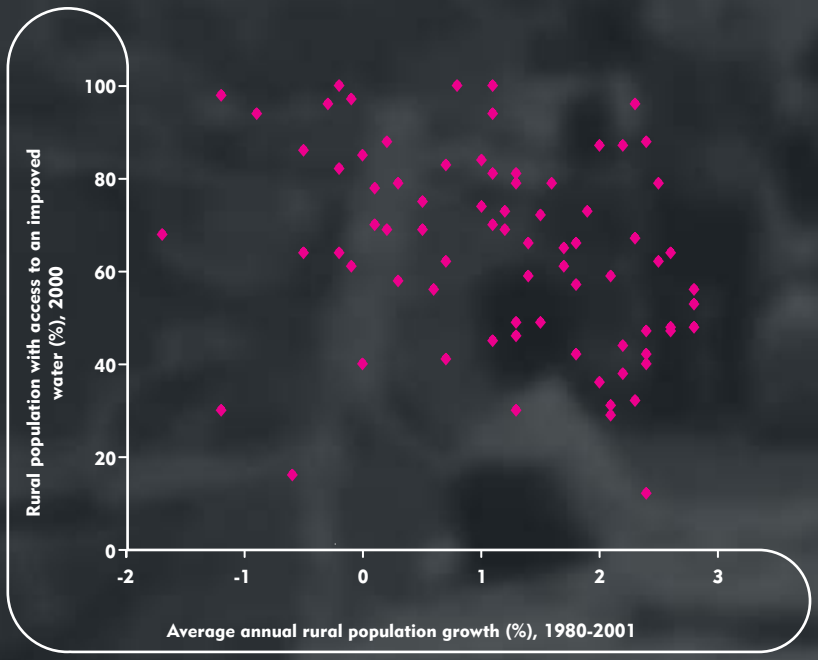
ENSURE ENVIRONMENTAL SUSTAINABILITY

The relationship between population (size, growth and distribution) and sustainable development is complex. Many current patterns of consumption and production, both over-consumption among the rich and under-consumption among the poor, are unsustainable.

Access to water increasing but still inaccessible to many of the poor...



Access to improved water increases as rural population growth diminishes...

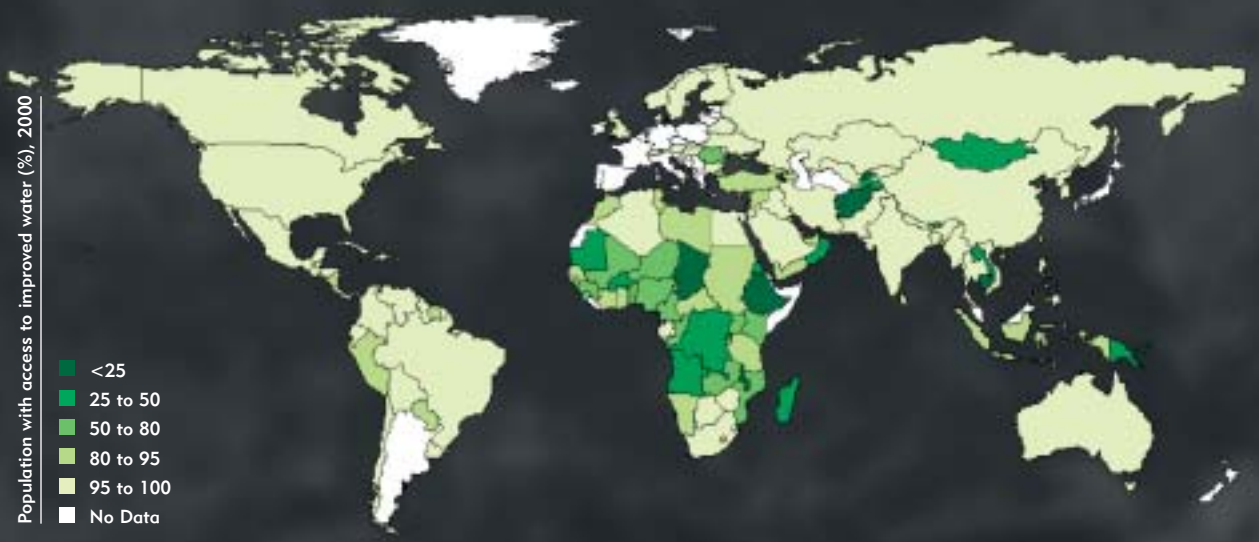


The long-term growth of global population, which currently adds almost 80 million to the world's population annually and is heavily concentrated in developing countries, affects the world's consumption growth. Combined with increased economic activity, it leads to exponential growth in the use of scarce natural resources.

The global consumption of water doubles within a generation, and it is estimated that in 2025, if present rates of water consumption continue, 5 billion of the world's 8 billion will be living in areas where it will be difficult to meet basic water requirements.

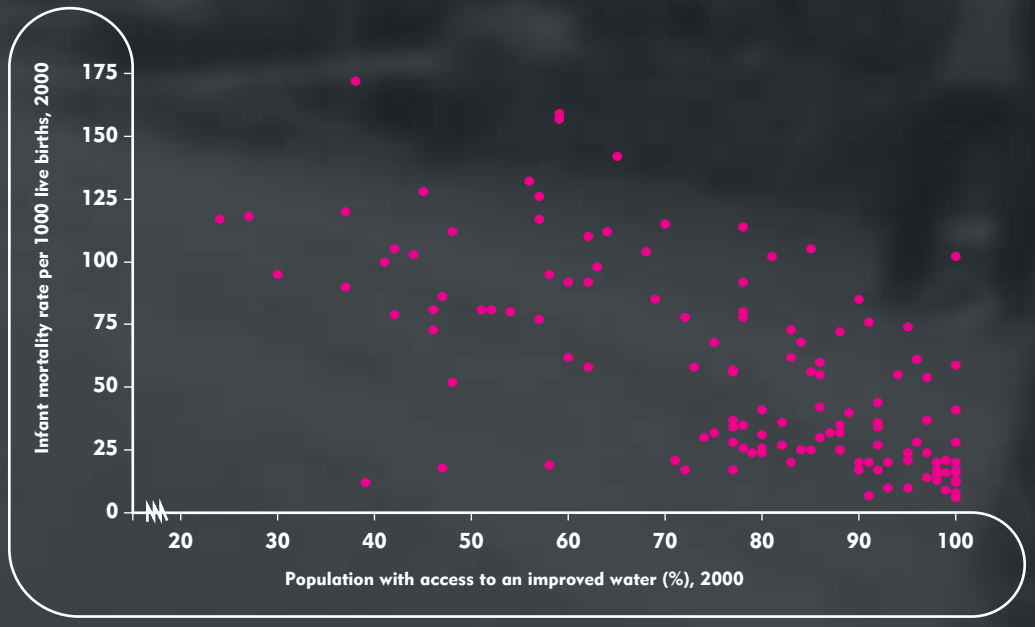
Many low-income countries facing water scarcity have fast growing populations. They are generally least able to make costly investments in water saving technologies. And it is women and children who tend to carry the burden - often having to walk long distances to collect heavy water loads. This tends to impact adversely on the health of women and the schooling of their children.

Access to water remains a problem for many even at the beginning of the new Millennium...



Some 60 per cent of all infant mortality is linked to infectious and parasitic diseases, most of them water-related, such as diarrhoea and cholera. Currently about 1 billion people lack access to safe drinking water, and more than twice this number lack adequate sanitation.

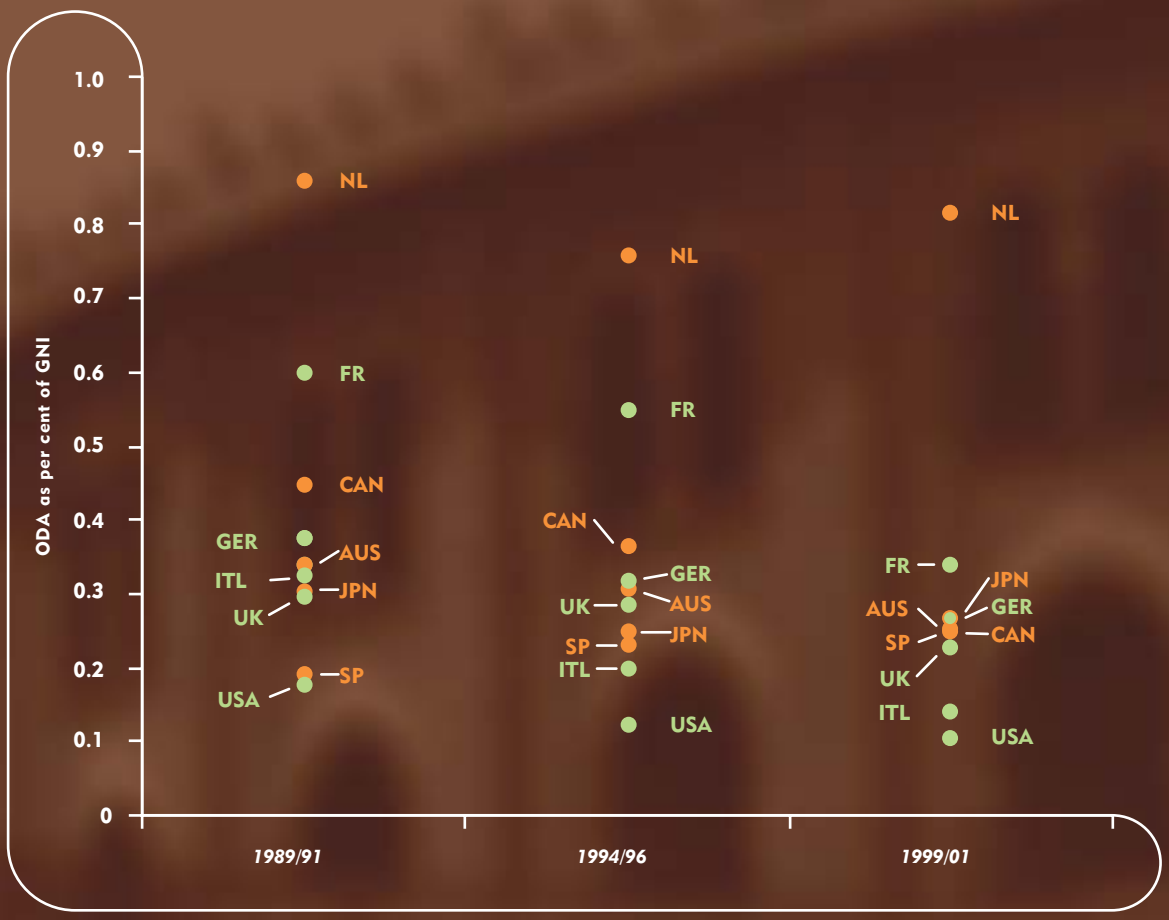
As access to clean water improves infant mortality declines...



DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

The 2002 Monterrey Consensus called for a new partnership for development and outlined an agenda for resource mobilisation, technology transfer and capacity building. But trade barriers and agricultural subsidies persist, as do debt burdens, while ODA flows are below target.

Most of the 10 largest OECD economies well below 0.7% ODA target...



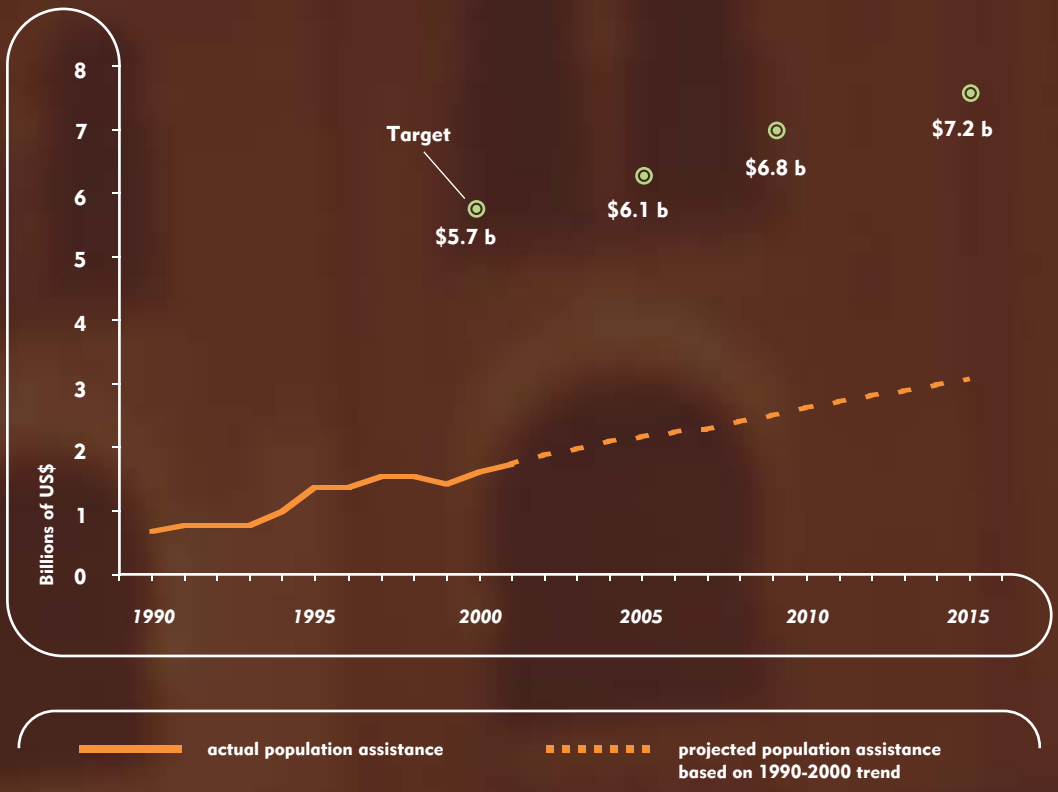
ICPD specified the magnitude of resources necessary to achieve Cairo goals in the period to 2015: starting at $US 17 billion a year and rising to $21.7 billion, with approximately two-thirds expected from domestic sources and one-third from international donors.

The immediate post-ICPD period saw an increasing flow of resources, both external and domestic, for population programmes. But the momentum generated by the ICPD has plateaued, with the current level of resource mobilisation falling far short of the Cairo targets. Instead of increasing steadily to meet the target of $5.7 billion by 2000, international assistance hovered around the $2 billion level for several years and was $2.5 billion in 2001, that is 44 per cent of the target level.

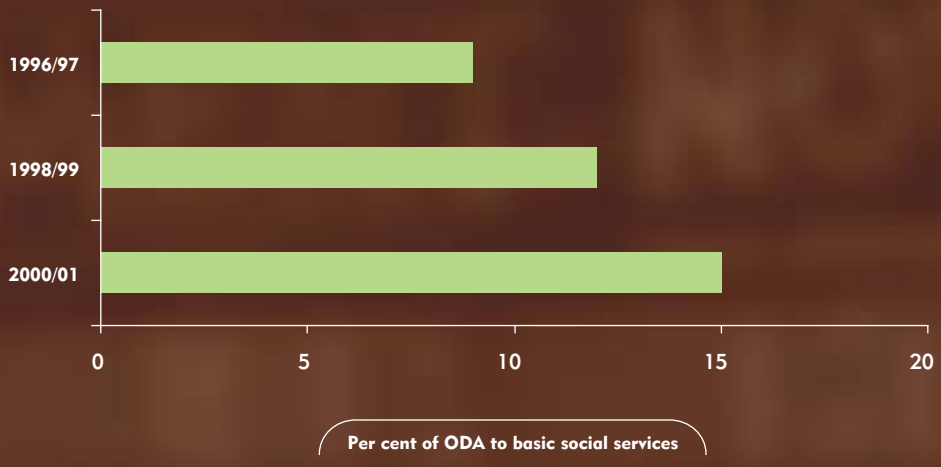
Lack of adequate resources is one of the chief constraints derailing progress towards ICPD goals. It is denying poor women access to reproductive health services, contributing to high levels of maternal morbidity and mortality, constraining progress in the fight against HIV/AIDS which in turn is reversing developmental gains.

Investments in health and education of poor people, especially females, contribute to economic growth, poverty reduction and improved equity. The 1995 Social Summit called for 20 per cent of domestic expenditures and 20 per cent of ODA for basic social services. Despite some progress, the 20/20 target remains elusive, and many of the poorest are still denied access to these services. Yet access to basic social services for all is fundamental to development and the realisation of human rights.

Donor country assistance to population programmes well below ICPD targets...



Increasing share of ODA going to basic social services...



POPULATION, REPRODUCTIVE HEALTH, POVERTY AND THE MDGS

with access to RH

without access to RH

MDG 1 — Eradicate extreme poverty and hunger

- Lower fertility, slower population growth, favourable age composition, increased economic growth, reduction in poverty
- Smaller families so higher female labor force participation
- Income distribution less skewed so less extreme poverty and more scope for growth

- Higher population growth, insecure livelihoods, higher risk of food insecurity
- Teenage births and short birth intervals, some unplanned, larger than desired families
- Intergenerational poverty cycle more likely

MDG 2 — Achieve universal primary education

- Fewer children, more educational resources per child, better school performance
- Reduction in child labor
- Enlarges opportunities throughout adolescence and adulthood

- Low retention rates, especially for girls
- Girls burdened with sibling care and thus less scope of success at school
- Higher pupil-teacher ratios and lower expenditures per child

MDG 3 — Promote gender equality and empower women

- Later marriage and increased life opportunities
- Male participation in RH results in better understanding among spouses so less domestic violence
- Increases bargaining power of women in sexual behaviour and child bearing decisions

- Harmful practices and endemic violence
- Low status and power of girls and women
- Large families more hierarchical with respect to age and gender

MDG 4 — Reduce child mortality

- Lower risk of infant and child morbidity and mortality
- Improved knowledge about hygiene, baby-feeding and childrearing practices
- Better parenting skills

- Children in large families, more likely to be deprived in terms of nutrition and affection
- Lack of exposure to baby-friendly health initiative and baby-care practices
- Higher malnutrition, stunting and lower birthweight

MDG 5 — Improve maternal health

- Reduction of maternal morbidity and mortality
- Availability of emergency obstetric care and antenatal care
- Fewer and well-spaced births

- Lack of contraceptive access and choice
- Births delivered by unskilled persons
- Consequences of complications of pregnancies are more serious

MDG 6 — Combat HIV/AIDS, malaria and other diseases

- Better information on contraction and prevention of HIV/AIDS and other STDs
- Increased negotiating skills for safe sex reduces risk
- Wider and deeper public knowledge about sexual health

- Lack of antenatal care and medicines increases risk of mother to child infection
- Lack of STD examinations and care leads to increased possibility of HIV/AIDS infection
- Early sexual debut and lack of contraceptives increase risk of HIV/AIDS

MDG 7 — Ensure environmental sustainability

- Improved sustainable use of space and land
- Less pressure of existing infrastructure and basic social services
- Enhanced role of women as resource managers

- Migration to crowded urban slums deteriorates local environmental resource base
- Pressures on food and water security
- Expansion into forested areas, marginal lands and fragile eco-systems

MDG 8 — Develop a global partnership for development

North-South Transfers are Essential for Progressing Towards the MDGs

- Developing open trading and financial system
- Addressing special needs of LDCs, landlocked and small island developing countries
- Managing debt relief and Increasing ODA
- Creating productive youth employment
- Providing affordable medicine
- Spreading benefits of new technologies

NOTES AND SOURCES
COUNTRY CLASSIFICATION WITHIN GROUPS

SUB-SAHARAN AFRICA: Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Réunion, Rwanda, São Tomé and Principe, Senegal, Seychelles, Sierra Leone, Somalia, South Africa, Sudan, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia, Zimbabwe.

EAST ASIA AND PACIFIC: Cambodia, China, Democratic People's Republic of Korea, Fiji, Indonesia, Kiribati, Lao People's Democratic Republic, Malaysia, Marshall Islands, Micronesia Fed. Sts, Mongolia, Myanmar, Palau, Papua New Guinea, Philippines, Samoa, Solomon Islands, Thailand, Timor-Leste, Tonga, Tuvalu, Vanuatu, Viet Nam.

SOUTH ASIA: Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka.

LATIN AMERICA AND CARIBBEAN: Antigua and Barbuda, Argentina, Barbados, Belize, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Dominica, Dominican Republic, Ecuador, El Salvador, French Guiana, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Puerto Rico, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, Suriname, Trinidad and Tobago, Uruguay, Venezuela.

MIDDLE EAST AND NORTH AFRICA: Algeria, Djibouti, Egypt, Iran (Islamic Republic of), Iraq, Jordan, Lebanon, Libyan Arab Jamahiriya, Morocco, Occupied Palestinian Territory, Oman, Saudi Arabia, Syria Tunisia, Yemen Rep.

EUROPE AND CENTRAL ASIA: Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Georgia, Hungary, Isle of Man, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Macedonia (Former Yugoslav Republic), Poland, Republic of Moldova, Romania, Russian Federation, Slovakia, Tajikistan, Turkey, Turkmenistan, Ukraine, Uzbekistan, Yugoslavia, Fed Rep.

HIGH INCOME: Andorra, Aruba, Australia, Austria, Bahamas The, Bahrain, Belgium, Bermuda, Brunei Darussalam, Canada, Cayman Islands, Channel Islands, China Hong Kong (SAR), China Macao (SAR), Cyprus, Denmark, Faeroe Islands, Finland, France, French Polynesia, Germany, Greece, Greenland, Guam, Iceland, Ireland, Israel, Italy, Japan, Korea Rep., Kuwait, Liechtenstein, Luxembourg, Monaco, Netherlands, Netherlands Antilles, New Caledonia, New Zealand, Northern Mariana Islands, Norway, Portugal, Qatar, San Marino, Singapore, Slovenia, Spain, Sweden, Switzerland, United Arab Emirates, United Kingdom, United States, Virgin Islands (US).

MORE DEVELOPED COUNTRIES: all regions of Europe, Northern America, Australia, New Zealand and Japan.

LESS DEVELOPED COUNTRIES: all regions of Africa, Asia (excl. Japan), Latin America and Caribbean, Melanesia, Micronesia and Polynesia

LEAST DEVELOPED COUNTRIES: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, Central African Republic, Chad, Comoros, Democratic Republic of Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, Niger, Rwanda, Samoa, São Tomé and Principe, Senegal, Sierra Leone, Solomon Islands, Somalia, Sudan, Togo, Tuvalu, Uganda, United Republic of Tanzania, Vanuatu, Yemen, Zambia.

SOURCES OF DATA

GLOBAL POPULATION source of data for ***all population charts:*** United Nations (2003) *World Population Prospects: The 2002 Revision*, United Nations Publications, New York.

MDG 1 source of data for: ***goal chart*** World Bank (2003) *World Development Indicators 2003*, Washington DC; ***scatterplot*** United Nations (ibid); UNDP (2003) *Human Development Report 2003: Millennium Development Goals: A Compact among Nations to end Human Poverty*, New York: Oxford University Press; ***World Map*** United Nations (ibid); ***'4th chart'*** United Nations (ibid), World Bank (ibid).

MDG 2 source of data for: ***goal chart*** World Bank (ibid); ***scatterplot*** World Bank (ibid); UNDP (ibid); ***World Map*** World Bank (ibid); ***'4th chart'*** Demographic Health Surveys, latest year available on **www.measuredhs.com**.

MDG 3 source of data for: ***goal chart*** World Bank (ibid); ***scatterplot*** World Bank (ibid), UNDP (ibid); ***World Map*** United Nations (ibid); ***'4th chart'*** World Bank (ibid), United Nations (ibid).

MDG 4 source of data for: ***goal chart*** World Bank (ibid); ***scatterplot*** World Bank (ibid), United Nations (ibid); ***World Map*** United Nations (ibid); ***'4th chart'*** Demographic Health Surveys (ibid).

MDG 5 source of data for: ***goal chart*** UNFPA (2002) *State of the World Population: People, Poverty and Possibilities*, New York, UNICEF, data available on www.unicef.org, WHO, data available on www.who.int; ***scatterplot*** UNFPA (ibid); ***World Map*** United Nations Population Division (2002) *World Contraceptive Use 2001*, United Nations Publications, New York; ***'4th chart'*** Demographic Health Surveys (ibid).

MDG 6 source of data for: ***goal chart*** UNAIDS (1998) *Report on the Global HIV/AIDS Epidemic,* Geneva, UNAIDS (2002) *Report on the Global HIV/AIDS Epidemic*, Geneva; ***scatterplot*** UNAIDS (ibid); ***World Map*** UNAIDS (ibid); ***'4th chart'*** UNAIDS (ibid).

MDG 7 source of data for: ***goal chart*** World Bank (ibid); ***scatterplot*** World Bank (ibid), United Nations (ibid); ***World Map*** World Bank (ibid); ***'4th chart'*** United Nations (ibid), World Bank (ibid).

MDG 8 source of data for: ***1st chart*** World Bank (ibid), OECD-DAC data available on **www.oecd/dac**; ***'2nd chart'*** UNFPA (2002) *Financial Resource Flows for Population Activities in 2000*, New York, UNFPA (forthcoming) *Financial Resource Flows for Population Activities in 2001*, New York; ***'3rd chart'*** OECD-DAC (ibid).

Population and Development Strategies (PDS) series

Population and Development Strategies (PDS) is one of two major substantive thematic areas guiding the operational activities of UNFPA – the other being reproductive health – with advocacy and gender as important cross-cutting dimensions. The focus of PDS is on integrating population issues into sustainable human development processes and on examining the impact of development processes on population variables.

The goal of the Fund's work in this area, guided by the ICPD Programme of Action, the recommendations of ICPD + 5 and the Millennium Declaration, is to help countries achieve an improved balance between population dynamics and economic and social development. The Fund's PDS work follows a people-centred approach to sustainable development, putting the well-being of individual women and men at the centre of sustained economic growth and sustainable development.

Within the PDS programmatic area, UNFPA seeks to enhance countries' capacity to develop and implement integrated and multisectoral population and development policies, mainstreaming gender and human rights approaches. The Fund helps support country efforts to articulate population and development policies and programmes; strengthen national capacity in the area of data collection and analysis; and deepen the knowledge base of the linkages between population variables and economic and social phenomena. These linkages occur among poverty, environment, migration, urbanisation, population ageing and intergenerational solidarity. In carrying out its programmatic interventions, the Fund attempts to ensure maximum impact on the lives of the poor, and especially women.

This series, *Population and Development Strategies*, seeks to contribute to an improved understanding of population and development, and to the adoption of a more integrated approach to their analysis and management. The series will have a special focus on the conditions that generate and perpetuate poverty, inequality and inequity – the operational challenges arising from these conditions, and how UNFPA is responding to these at the global, regional and country levels.

Reports in this series will be issued periodically and will also be available through the UNFPA website http://www.unfpa.org. Comments or suggestions relating to this series should be addressed to the Director, Technical Support Division.

PDS | NO. 10

ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS: POPULATION AND REPRODUCTIVE HEALTH AS CRITICAL DETERMINANTS

United Nations Population Fund
220 East 42nd Street
New York, N.Y. 10017

ISBN: 0-89714-686-7
E/1500/2003