state of world population 2002

people, poverty and possibilities

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To reduce poverty in developing countries, urgent action is needed to combat poor reproductive health, help women avoid unwanted pregnancies, and eliminate illiteracy and gender discrimination, warns *The State of World Population 2002* report from UNFPA, the United Nations Population Fund.

The report argues that addressing population concerns is critical to meeting the Millennium Development Goals of cutting global poverty and hunger in half by 2015, reducing maternal and child deaths, curbing HIV/AIDS, advancing gender equality, and promoting environmentally sustainable development.

Pointing to a "population effect" on economic growth, the report cites new data showing that since 1970, developing countries with lower fertility and slower population growth have seen higher productivity, more savings and more productive investment. They have registered faster economic growth.

Investments in health and education, and gender equality are vital to this effect. Family planning programmes and population assistance were responsible for almost one third of the global decline in fertility from 1972 to 1994. These social investments attack poverty directly and empower individuals, especially women. They enable choice.

Given a real choice, poor people in developing countries have smaller families than their parents did. This downturn in fertility at the "micro" level translates within a generation into potential economic growth at the "macro" level, in the form of a large group of working-age people supporting relatively fewer older and younger dependents.

This "demographic window" opens only once and will close as populations age and older dependents increase. When other policies are supportive, the opportunity can allow dramatic progress. Several countries in East Asia, as well as Mexico and Brazil, have taken advantage of it. The effect of declining fertility in Brazil has been equal to economic growth of 0.7 per cent of GDP per capita each year.

However, the gap between rich and poor continues to widen and the poorest countries continue to lag behind. Poverty, poor health and fertility remain highest in the least developed countries where population has tripled since 1955 and is expected to nearly triple again over the next 50 years.

More social investment is required to promote better health, allow parents to have the number of children they wish, encourage further declines in fertility and enable better education and life choices. The process will hasten the accumulation of "human capital" needed for accelerated and sustainable development. Far more attention from policy makers and greater international support is needed for population and reproductive health if countries are to halve poverty by 2015 and make effective progress towards the Millennium Development Goals.

Multiple Dimensions of Poverty

Income is not the only measurement of poverty, and economic growth alone will not end poverty. Escaping poverty depends on improving personal capacities and increasing access to resources, institutions and support.

The overall gap between rich and poor, globally and within countries, has been growing. The difference in per capita income between the world's wealthiest 20 per cent and the poorest 20 per cent grew from 30 to 1 in 1960, to 78 to 1 in 1994. It fell slightly to 74 to 1 in 1999.

Poor health, illiteracy, inadequate schooling, social exclusion, powerlessness and gender discrimination contribute to poverty. Poor health diminishes personal capacity, lowers productivity and reduces earnings. A high prevalence of disease and poor health in a country harms economic performance while higher life expectancy, a key indicator of health status, stimulates economic growth. An analysis of 53 countries between 1953 and 1990 found that higher adult survival rates were responsible for about 8 per cent of total economic growth.

Progress has been achieved easier and faster in countries that have provided reproductive health services, including family planning, increased the coverage and quality of education, advanced gender equality, and developed responsible and accountable systems of governance and social participation.

A judicious combination of income-based, indicator-based, and participatory-based information should be used to assess poverty and derive policy implications. Institutions should have incentives to use this information for planning purposes.

Macroeconomics, Poverty, Population and Development

Long-term demographic and economic data from 45 developing countries show that high fertility increases poverty by slowing economic growth and by skewing the distribution of consumption against the poor.

Enabling women to have smaller families—by reducing mortality, increasing education and improving access to reproductive health and family planning—counters both of these effects. The national effects on poverty reduction are clear from both average gross domestic product (GDP) increase and consumption figures.

The average poverty incidence in 1980 was 18.9 per cent, about one in every five people. Had all countries reduced net fertility by 5 per thousand during the 1980s, as many Asian countries did, poverty incidence would have been reduced to 12.6 per cent, or one in eight.

Smaller families have fewer expenses and more opportunities to increase their income and savings, leading to increased consumption. Half of the improvement in population-related economic growth has come from taking advantage of the "demographic window", the other half from shifting economic consumption towards the poor. The impacts can be considerable. A fall of 4 per thousand in the net birth rate, for example, would translate into a 2.4 per cent decline in those living in absolute poverty in the next decade.

Poverty and Gender

More women than men live in poverty and the disparity has increased over the past decade, particularly in developing countries. Reducing the "gender gap" in health and education reduces individual poverty and encourages economic growth.

While economic growth and rising incomes reduce gender inequality, they do not break down all barriers to women's social participation and development. There must be specific action to ensure that social and legal institutions guarantee women's equality in basic legal and human rights. Women need access to or control of land and other resources, equitable employment and earnings, as well as social and political participation.

The most obvious and brutal impact of gender bias is in sexual violence. One woman in three will experience violence at some time in her life.

Power, nutrition, health and time allocation may be more important than income in determining the differences in well-being between men and women. Surveys show that women work longer hours than men in nearly every country and that at least one half of women's total work time is spent on unpaid work. Much of this work is not included in national accounting systems. This invisibility translates into incapacity: what countries do not count, they do not support.

Programmes that reduce gender inequality can significantly improve individual and household welfare and national economic growth. If sub-Saharan Africa, South and West Asia had had the same female-male ratio in years of schooling that East Asia did in 1960, and had closed the education gender gap at the rate achieved by East Asia from 1960 to 1992, their per capita income could have grown by an additional 0.5 to 0.9 percentage points per year in sub-Saharan Africa, 1.7 per cent in South Asia and 2.2 per cent in West Asia.

Improving women's education helps reduce fertility and child malnutrition and improve maternal and child survival. One study found that an additional year of female education reduced total fertility by 0.23 births, another that the reduction was 0.32 births. In countries where girls are only half as likely to go to school as boys, there are on average 21 more infant deaths per 1,000 live births than in countries with no gender gap.

Empowering women is also key to halting the AIDS epidemic. Today, women represent nearly one half of all infected adults and 58 per cent of adults infected in hard-hit sub-Saharan Africa. A study in Zambia revealed that only 11 per cent of the women interviewed believed that a married woman could ask her husband to use a condom, even if she knew that he had been visiting sex workers and was possibly infected.

The global community has developed a serious set of blueprints for addressing inequality. Their recommendations are laid out in the Convention on the Elimination of All Forms of Discrimination Against Women, the Programme of Action of the 1994 International Conference on Population and Development, and the Platform for Action of the 1995 Fourth World Conference on Women.

Poor Health and Poverty

Poor health is both a cause and consequence of poverty. In the least developed countries, life expectancy is just 49 years and one in 10 children do not reach their first birthday. Poor people in a 41-country survey cited illness most frequently as the cause of their slide into poverty.

For women in developing countries, poor reproductive health is responsible for one fifth of the burden of disease and 40 per cent for women in sub-Saharan Africa.

Reproductive health has some of the largest gaps between rich and poor. This translates into less opportunity for poor women and families to break out of poverty.

Poor women face a risk of dying during pregnancy and birth that is up to 600 times higher than for women in developed nations. One woman dies every minute, over half a million women a year. A woman's lifetime risk of dying due to maternal causes is one in 19 in Africa, one in 132 in Asia, one in 188 in Latin America, compared to one in 2,976 in developed countries. Skilled birth attendants could reduce these risks. Yet, in South Asia, the poor are only one tenth as likely as the rich to use them; in the Middle East and North Africa, they are less than one sixth as likely.

The poorest women start their childbearing youngest. In many developing countries, women marry and start bearing children between the ages of 15 and 19. In Latin America and the Caribbean, as well as in East Asia and the Pacific, the young in poor households have children at more than five times the rate of the young rich. In communities where family planning has not been fully accepted and opportunities are limited, people view births and family size as unchangeable conditions, within which they make other choices.

Investment in basic health services in developing countries is only a fraction of what is needed. Low-income countries are spending only $21 per capita per year on health care, much of it for expensive curative services rather than basic prevention and care. The World Health Organization (WHO)/World Bank Commission on Macro-economics and Health estimated that an additional $30 billion per year is needed. Reproductive health must be a priority.

Regardless of income, countries can design their health systems to improve access to services for the poor. Viet Nam has reduced the differences between the richest and poorest on most health measures, including those related to reproductive health, to less than 2 to 1.

Better health, including reproductive health, and education contribute to economic growth. Better education helps women to protect their own and their children's health and widens economic choices. Higher incomes improve living environments, reduce malnutrition and provide a buffer against the costs of poor health.

HIV/AIDS and Poverty

HIV/AIDS poses a great threat to development in poor countries and the impact is hardest among the poor. Striking 14,000 men, women and children daily, AIDS is the leading cause of death in sub-Saharan Africa and the world's fourth biggest killer. By 2010, about 40 million children will have been orphaned by the pandemic.

Women are more vulnerable to infection and sex workers are far more likely than the population at large to be infected. But the sexual behaviour of men is largely responsible for spreading the disease.

One half of new HIV infections are among young people aged 15-24, many of whom have no information or prevention services and are still ignorant about the epidemic and how to protect themselves. Studies in seven African countries show that at least 40 per cent of 15-19 year olds did not believe they were at risk.

The health-care system in Africa is overwhelmed and health workers are being struck down, leaving a decimated staff to confront an exploding crisis. Education systems are also collapsing. A recent forum in Cameroon suggested that 10 per cent of teachers and 20 per cent of students could be infected with HIV in the next five years.

HIV/AIDS is already slowing economic growth and activity in the worst-affected countries. In the 1990s, AIDS reduced Africa's per capita annual growth by about 0.8 per cent. Models suggest that in the worst-affected countries 1-2 percentage points will be sliced off per capita growth in coming years. This means that after two decades, many economies will be about 20-40 per cent smaller than they would have been without AIDS.

The poor have little access to prevention services, condoms, or any form of treatment. Only about one in five people at risk for HIV have access to prevention information and services. Fewer than 5 per cent of people in need get anti-retroviral drugs. Action against the epidemic has been impeded by the slowness of leadership, at all levels, to recognize and admit the nature of the advancing crisis. The universal culture of silence that surrounds sexual behaviour has kept eyes averted and voices silenced.

Effective strategies to turn back the epidemic involve a combination of treatment, education and prevention. Such strategies must go beyond medicine and health care and reach into the community. Strong and committed leadership is also necessary.

Poverty and Education

Investments in education bring substantial returns. Female education, apart from empowering the woman herself and widening her choices, is particularly cost-effective because benefits pass on to her children. Educated women value education and are more likely to send their children to school.

Although overall access to basic education has risen substantially over the last decade in many developing countries, the poor are still less likely to attend school. In many countries, most children from the poorest households have no schooling. A recent study of 35 countries in West and Central Africa as well as in South Asia showed that in 10 countries, one half or more 15-19 year olds from poor households never completed grade one.

Education patterns among the poor differ distinctly by region. In South Asia and West and Central Africa, a large minority of poor children never enrol in school. In Latin America, in contrast, virtually all children complete the first grade, but subsequent dropout rates are high. In Brazil, for example, 92 per cent of 15 to 19 year olds from poor households complete first grade, but only one half complete grade five.

In almost all countries, children aged 6-14 from the wealthiest 20 per cent of households are substantially more likely to be enrolled in school than children from the poorest 40 per cent of households.

The evidence from a range of developing countries suggests that a larger percentage of public spending on education goes to government actions that benefit the wealthy. Many countries would reach the goal of universal primary education just by raising enrolment among the poor.

While the "gender gap" in education has narrowed over the last decade, their relative disadvantage still deprives girls of secondary education in most of South Asia, sub-Saharan Africa and several other developing regions. About 31 per cent of women were without any formal education in 2000, compared to 18 per cent of men.

Investing in education is critical for the future.

Population, Poverty and Global Development Goals: The Way Ahead

Achieving many of the Millennium Development Goals depends in part on the universal availability of family planning and other reproductive and sexual health services.

RECOMMENDATIONS FOR ACTION The essential requirements are to target assistance directly to the poor, to reduce their costs, and to give them a voice in the policies and programmes that affect them. Governments, communities, the private sector and the international community must cooperate more closely. Donors should encourage partnerships among governments and non-governmental organizations (NGOs). Particular attention should be paid to incorporating the views of the poor in the design, implementation and monitoring of programmes.

Reproductive health—family planning, prevention of sexually transmitted infections and HIV/AIDS, care during pregnancy and birth and safe delivery—is most effective as part of an integrated package. Effective health sector reform depends on guaranteed funding, by providing more resources and better use of available funds, and central support for services that cannot be supplied locally. Specific action is needed to protect preventive services like reproductive health. The poor cannot afford to pay user fees, which have deprived millions of poor people, particularly women and children, of the care they need.

In 1994, at the International Conference on Population and Development (ICPD), nations committed themselves to the goal of universal access to reproductive health by the year 2015. The goal remains a priority for the international community. Meeting the goal requires safety net systems—free services, subsidized care, insurance schemes and sliding-scale fees—to ensure that poor clients receive reproductive health care.

The ICPD agenda helps frame the issue of health financing in terms of client needs and empowerment. The question that needs to be asked by any policy initiative is, will it hurt the poor and will it discriminate against women?

Closer attention to poverty alleviation demands that programme benefits reach poor people directly. Underserved groups include the rural and urban poor, migrants, refugees and displaced persons, as well as adolescents.

Integrated approaches, covering different needs, empower people to set their own course out of poverty. Microcredit schemes are among the most effective and often include other services such as literacy and family planning.

Countries need to improve data systems for monitoring progress towards the Millennium Development Goals, and the poorest need external assistance. UNFPA is working with partner institutions of the United Nations, the international financial institutions, bilateral donors and foundations to strengthen national monitoring capacity.

Since 1969, UNFPA has been the largest multilateral source of population assistance, providing nearly $6 billion for population and reproductive health programmes.

At ICPD, countries agreed that one third of the $17 billion annual requirement for basic reproductive health and population programmes in 2000, or $5.7 billion, was to come from the international community; two thirds, or $11.4 billion, was to be provided by developing and other countries needing assistance.

In the year 2000, total expenditure was $10.9 billion, $6.1 billion short. Donor countries contributed $2.6 billion, less than a quarter (24 per cent) of total expenditure, and less than half (46 per cent) of their commitment. Developing countries contributed $8.3 billion, 76 per cent of the total spent and about 73 per cent of their commitment.

The international goals for poverty reduction and improvement of life quality offer a noble vision. Achieving and protecting them will require both a focus on the goals themselves and sensitivity to the context. Universal access to reproductive health care, universal education and women's empowerment are goals in their own right, but they are also conditions for ending poverty.

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