directing council | *regional committee*

PAN AMERICAN HEALTH ORGANIZATION

WORLD HEALTH ORGANIZATION

XXXVII Meeting

XLV Meeting

Washington, D.C.
September-October 1993

Provisional Agenda Item 5.10

CD37/18 (Eng.)
22 July 1993
ORIGINAL: ENGLISH

FAMILY PLANNING, REPRODUCTIVE HEALTH AND POPULATION

The Director's report examines the current situation and recommends modifications in the Organization's action policy on population matters.

The report has been discussed at PAHO's Technical Discussions, the 20th Meeting of the Subcommittee on Planning and Programming (April 1993), and the 111th Meeting of the Executive Committee (June 1993). Revisions have been made throughout this process to include comments and recommendations made by delegates to those meetings.

The document reaffirms, reexamines and expands on the importance of maternal and child health on the overall health of the populations and stresses the role played by fertility regulation as a fundamental element of reproductive health. Within this framework, the document emphasizes the need to view sexuality and reproductive health as essential elements in the process of sustainable and equitable development; and it underscores the significance of granting special attention to the most vulnerable groups, which do not always have access to related services.

The document examines fertility regulation in the Region in terms of policies, programs, coverage and prevalence of contraceptive usage and provides a comparative study of the indicators that better establish the correlation between socioeconomics and health. Drawing attention to future needs and requirements, it recommends moving toward an integrated approach for implementing programs and activities related to reproductive health with special emphasis on fertility regulation. Additionally, the document puts forth working strategies for future strengthening of the Organization's action policy on population matters.

Financially speaking, it recommends that the governments of individual countries make the financial commitments necessary to guarantee services for the most vulnerable sectors. In addition, it states the importance of establishing shared financial responsibility among the public sector, the private sector, and nongovernmental agencies to bear the necessary costs in the future.

Interprogram cooperation among the ministries of public health, the local health systems, and PAHO is important in order to generate proposals and mobilize technical and financial resources, both foreign and domestic, to implement activities related to reproductive health among the population at large.

Once more it was reaffirmed that, population, reproductive health and family planning programs must respect to their fullest extent the human rights of individuals and couples, and the sovereignty of countries to decide how to implement their population policies and family planning programs within their national situation and the recommendations of the international community.

Thus, recommendations are made for the revision of legislative policies related to this issue, the formulation of strategies in order to reach the most vulnerable groups and the need to develop qualitative research, which will provide a broader dimension of reality. Specific requests are made that governments make a special effort to assume responsibility for interagency coordination at the local level in order to avoid duplication of efforts, and that Governing Bodies provide a mandate for the Secretariat to seek, in conjunction with or in representation of PAHO's Member States, new sources of financial cooperation to fund effective actions and measures that will result in enhanced reproductive health for the population of the Americas.

The document is presented to the XXXVII Meeting of the Directing Council with the request to review the current situation in the Americas, to consider the proposed strategies for improving the reproductive health and population programs and the PAHO's technical cooperation program in this field, and to consider and approve, if appropriate, the resolution proposed to it by the Executive Committee in Resolution XIX, which is transcribed below:

RESOLUTION XIX

FAMILY PLANNING, REPRODUCTIVE HEALTH, AND POPULATION

THE 111th MEETING OF THE EXECUTIVE COMMITTEE,

Having seen and analyzed in depth the report of the Director on family planning, reproductive health, and population (Document CE111/18),

RESOLVES:

To recommend to the XXXVII Meeting of the Directing Council the adoption of a resolution along the following lines:

THE XXXVII MEETING OF THE DIRECTING COUNCIL,

Reaffirming and reiterating the concepts and mandates contained in Resolutions CD30.R8, CD31.R18, CD32.R9, CD33.R13, CD35.R19, CSP23.R17, and CD36.R18, on the subjects of population, family planning, maternal and child health, prevention and reduction of maternal mortality, and comprehensive health of adolescents; and

Taking note of the changes that are occurring in the international and national spheres, as well as the obstacles standing in the way of more rapid progress in the actions necessary in order to attain the goals set by the Governing Bodies of the Organization and the World Summit for Children,

RESOLVES:

1. To reaffirm that population and family planning activities are indispensable to health, and that family planning should be integrated into health programs and promoted actively under the principle of respect for the rights of individuals and couples.

2. To urge that the Member Governments:

   a) Participate actively in the World Conference on Population, to be held in Cairo, Egypt, in 1994, endeavoring to ensure that issues relating to population and health, reproductive health and family planning are duly considered and included under the plans of action on matters of population and development;

b) Review, adjust, and reformulate, as necessary, their plans of action and programs on reproductive health and family planning, emphasizing the improvement of the quality of services and the search for financing to reach neglected groups and the population that remains uncovered;

c) Develop projects of technical and financial support in the area of family planning, reproductive health, and population to be submitted to bilateral or multilateral cooperation agencies.

3) To request that the Director:

a) Ensure that the Pan American Health Organization provides the necessary technical support so that the issues of population and health, reproductive health, and family planning are included in the proposed regional and global plans of action on population;

b) Collaborate with the countries in situation studies, policy design, and the development of strategies and programs to provide family planning and reproductive health services to the entire population;

c) Continue to contribute to the search for and mobilization of national and international resources in order to make it possible to expand the Organization's activities in these areas.

(Adopted at the seventh plenary session, 1 July 1993)

Annex

FAMILY PLANNING, REPRODUCTIVE HEALTH AND POPULATION

CONTENTS

FAMILY PLANNING, REPRODUCTIVE HEALTH, AND POPULATION

1. BACKGROUND

Since the early 1970s, the Pan American Health Organization (PAHO) has assumed responsibility and leadership in promoting family planning, because it is an element of utmost importance to maternal and child health. With this objective in mind, and in conjunction with its Member Countries, PAHO strove to develop projects supported by the Agency for International Development (USAID) in order to increase its &own resources and those available at the country level.

After the United Nations Population Fund (UNFPA) was established in 1972 and the United States Government began contributing to this international agency, PAHO continued promoting family planning, and, at the request of the UNFPA and PAHO Member Countries, subsequently assumed responsibility for executing, in a tripartite fashion until 1992, most of the family planning projects financed by UNFPA in the American Region and within the PAHO service area. Between 1985 and 1987 PAHO implemented up to 80% of the support projects aimed at institutionalizing family planning in the Latin American countries and was able to put into effect regional projects which made it possible to face problems common to the countries of the Region. This situation has changed pursuant to UNFPA organizational changes, and funds executed by PAHO have decreased to approximately 30% of those devoted to family planning.

In order to create a framework that would allow the accomplishment of this work in a more sound and organized way, during the XXX Meeting of the Directing Council in 1984, the Members and the Secretariat were given a mandate to execute the Organization's Action Policy in Population Matters through Resolution VIII. Since then three progress reports have been presented to the Directing Councils in 1985, 1988 and 1991, in which the policies, recommendations, lines of action and activities have undergone constant modification to fit the realities imposed by the current situation.

To the extent that these activities relate to health planning and the organization of services, the Action Policy's mandate to the countries and to the Organization made it possible to concentrate efforts on the following priorities:

- Promoting participation of social leaders from all sectors, especially from the health sector in the formulation and application of a population policy suitable to specific national developmental plans;

- Stimulating studies on mortality, fertility, and other demographic variables and introducing measures designed to alleviate the deficiencies revealed by

these studies, not only in the health field but in other developmental areas as well;

- Conducting research and providing assistance to train the human resources needed in order to get effective family-planning projects off the ground;

- Ensuring the use of demographic data for identifying health problems related to population growth and to unprotected groups, and other priority groups; defining service needs; and structuring the services required based upon the needs and demands of the population;

- Inducing active involvement of the health sector in perfecting the quality of demographic data, vital statistics and services to be used as building blocks by the agencies responsible for health planning;

- Ensuring that human reproduction programs and related activities become integral parts of maternal and child health programs and that these reach the whole population with a view to granting parents the right and ability to make sound decisions concerning the number of children to have and the spacing between births. Consequently, the health risks related to the reproductive process will be reduced, and there will be an increased likelihood that demographic growth will not outpace the economic and social policies that further development;

- Extensive and intensive dissemination of information on family planning to the community with the objective of enabling it to participate in the decisions and activities relevant to the human reproductive process;

- Focusing on the problem of adolescent pregnancy, promoting and supporting adequate education on family-life issues for young men and women;

- Intensifying coordination of efforts between the Organization and United Nations agencies, as well as with other governmental and nongovernmental organizations, with a view to activating and redistributing resources in support of maternal and child health programs and family planning.

The Organization's Action Policy in Population Matters was reaffirmed through specific mandates to prevent and reduce maternal death (CSP23.R2 and CSP23.R17, 1990), as well as to promote comprehensive adolescent health (CD36.R9, 1992). Because of their importance, these topics demand additional joint actions to strengthen activities currently under way, and to empower and enhance the health of women, children, and adolescents, all of whom continue to be priority groups for the countries

of the Region. The relevance of these actions to reproductive health is underscored within the context of the topics discussed.

The political and technical consensus attained by PAHO Member Governments, the international community and the agencies providing technical and financial assistance during the World Summit for Children held in New York in 1990, and endorsed by the heads of state of the Americas, cemented lines of action and activities to be established. These lines of action and activities were consistent with those formulated in Alma-Ata in 1973; Mexico, 1984; Nairobi, 1985; and Amsterdam, 1990, and with those proposed by the Region of the Americas. The actions are targeted for 1995 and the year 2000 and will provide a point of reference for an assessment of the progress made. Some of the goals are designed to enhance overall maternal health, reduce maternal mortality by 50% and child mortality by 30%, make fertility-regulation services accessible to all couples and prenatal care accessible to all pregnant women, and eliminate neonatal tetanus. Other goals aim at reducing infant malnutrition and female anemia, as well as at eradicating poliomyelitis.

Global changes are unfolding at all levels, among them: 1) technical and financial cooperation agreements are favoring bilateral over multilateral support; 2) the quantity of technical and financial assistance is diminishing during crises; 3) new action plans are being implemented by UNFPA, which is moving toward technical cooperation and direct implementation with Member Countries; 4) international banking policies that grant credit to countries are broadening to focus on the social sector; 5) new political and economic trends--such as democratization and administrative decentralization are being generated which enable the initiation of economic recovery; 6) changes are also taking place in the conceptualization of sexuality and reproductive health. These changes were in part responsible for the recent decision to assign the Special Program for Maternal and Child Health and Population to the Office of the Director. The Director himself proposed at the 19th Meeting of the Subcommittee on Planning and Programming that family planning be addressed at the 20th Meeting in April 1993; this proposition was affirmed.

Given the importance of this issue to the Organization, this document presents an analysis of the present situation and suggests recommendations to improve the Program's strategy and plans so that the Organization and the countries can overcome obstacles and be better equipped to tackle future problems. Strategies chosen within this plan of action should mobilize national and international resources to enable the Organization and the countries not simply to sustain but also to expand activity in the reproductive health field.

The proposal presented by the Special Program on Maternal and Child Health and Population was thoroughly examined during the Technical Discussions in February 1993 at Headquarters and in the countries. Modifications and revisions have also been made to comply with the recommendations made by the 20th Meeting of the Subcommittee on

Planning and Programming. It is expected that upon further review by PAHO's Executive Committee and Directing Council, guidelines will be issued for the technical cooperation programs of the Organization and the countries.

2. PRESENT SITUATION

The analysis of the current demographic, socioeconomic, and health situation reflects the prevailing approach of maternal and child health and family planning and is based on the available data concerning tendencies, policies, and contraceptive use. (Tables 1-4, Figure 1)

2.1 Trends

Despite the significant progress made in the last 30 years, there still remains much to be accomplished to reach the goal of Health for All by the Year 2000 and to achieve the objectives agreed upon during the United Nations World Summit for Children.

Birth rates at the regional level decreased by 40% between 1950-1955 and 1990-1995, reaching 27 per 1,000 in 1992 (Figure 2). Population growth rates decreased, going from 3.6% to 1.9% in 1992, and the length of time needed for the population to double increased from 20 to 34 years. The population in the Americas will continue to increase until it stabilizes, possibly by the year 2050. The most significant growth will occur in Latin America and the Caribbean. The population is expected to increase by 90.4 million between 1990 and 2000, mainly in urban areas, which will translate into additional needs and demands of the population and a widening of existing gaps.

Life expectancy increased from approximately 55 to 68 years between 1960 and 1992 (Table 5, Figure 3); 71.9% of the population of the Americas, approximately 520 million people, have reached a life expectancy of 67 years or more which represents 80% of the goal set 20 years ago. Unfortunately, seven countries, accounting for 26% of the population, will have a life expectancy of 65 to 66 years, and only two, with 2% of the population will not have reached a life expectancy of 60 at birth.

Similarly, overall fertility decreased by 46% from 1965 to 1969 and from 1990 to 1995, declining from 6.0 to 3.2 children per woman. (Figures 4, 5) Fertility by age group continued to decrease, especially in women in the over-20 years age group and declined to a much lower rate in the younger-than-20 group, indicating variations from 10 to 35% in the last 15 years (1). Adolescent fertility increased in Brazil and Peru.

Infant mortality continued to decrease from 100 to 48 per 1,000 live births between 1960- 1965 and between 1990-1995, which represents a decrease of 54% (Table 6, Figures 6, 7). Nevertheless, the rate of decrease has slowed in recent years so that it would be wise to follow the development of this indicator closely; living conditions

could continue to deteriorate and children might not survive due to the delayed effects of adjustment policies resulting from the economic crisis. In effect, those policies have been characterized by reduced investment in the social sector and have resulted in rendering the very poor--the women and children--even more vulnerable (2).

Conditions that originate in the perinatal period are the leading causes of infant mortality; diarrhea and acute respiratory conditions follow as the second and third causes of death.

Maternal mortality rates have been slow to decline. This is an alarming fact given that the initiative for Safe Motherhood in Nairobi was approved seven years ago, and the Action Plan for Prevention and Reduction of Maternal Mortality in the Americas Region was established three years ago. The most optimistic estimates made by the WHO (Figure 8) indicate a 17% decrease between 1986 and 1989; however, there are still 11 countries in the Region with mortality rates exceeding 100 (Figure 9). Some correlations are not new: a direct correlation between maternal mortality and high fertility and between induced abortion and maternal mortality, and an inverse correlation between maternal mortality and the availability of professional medical care during labor (Figure 10). Infectious diseases, the occurrence of AIDS in mothers, children and adolescents, and the need to adequately manage invasive procedures make it imperative to train and support medical staff in order to prevent their accidental infection as well as the patients. The increased rate of sexually transmitted diseases, especially congenital syphilis, is unacceptable.

Likewise, the results of analyses of indicators associated with maternal and child health for countries outside the Region (the Netherlands, Sweden and Japan) (3, 4), within the Region (the United States, Canada, Chile, Costa Rica, and Cuba) and within a country (northeast Brazil, Huancavelica in Peru, Oaxaca in Mexico, northeast Argentina, etc.) are equally alarming. Efforts to provide health care to the most underprivileged social groups have not been sufficiently equitable nor effectively planned. There is no other course of action left if this alarming situation is to be remedied than to formulate unequivocally effective and innovative strategies and to target those countries which have the most serious needs. That is, there is no other choice if the concept of sustainable development is to be kept alive, and if the goals set during the United Nations World Summit for Children are to be achieved.

2.2 Policies

At present, the national constitutions of seven countries of the Region cover specific aspects concerning population matters or fertility regulation. Thirty-three out of 36 countries in the Region reported to the United Nations about fertility levels. Of these, 18 countries consider it high; 11 claim to be implementing programs toward reducing it; 14 consider it satisfactory; and only one considers its level to be too low. Furthermore, all countries of the Region support family-planning programs and all

related activities, and regard their application as ethically and medically valuable. In addition, most of these activities are included in the mother-and-child health programs (4, 5).

In spite of the fact that some countries have restrictions on the use of specific contraceptive methods, in practice the population has access to most of the ones that exist, particularly those sectors of the population that have the means to pay for the services. The same applies to the practice of induced abortion. This is not considered a family-planning method, nor is it legal for this purpose in most countries. Unfortunately it is practiced illegally by individuals who generally are not qualified, and the method is used by a significant number of women to interrupt unwanted pregnancies with concomitant risks to their health and life (6-10).

Abortion rates in Latin America are the highest in the developing world, and this is reflected by the fact that induced abortion, as a percentage of causes of maternal mortality, ranks first in eight countries: Trinidad and Tobago, 55%; Argentina and Chile, 35%; and second in three countries (Table 7). The cost of medical care for high-risk abortion must be added to the already strained health resources. If maternal mortality is to be reduced, abortion issues must be addressed at length at the country level and appropriate preventive measures such as family planning and appropriate treatment for those complicated cases must be available on demand.

The prevention of unwanted pregnancies through access to high quality family planning services, as well as insuring early medical care for initiated, incomplete, or complicated abortion, offers the most effective and least costly choices for the reduction of morbidity and mortality both from abortion and maternal deaths. Several countries are now exploring the possibility of making abortion unpunishable because the far-reaching and adverse consequences of unsafe abortions affect individuals, families, and the entire society. Attempts to legalize abortion have given rise to intense controversy. Similarly, a large number of countries have tax policies that benefit large families, some that limit or prohibit access to contraceptive methods and some that support marriage at a young age. An in-depth analysis of maternal and child health policies is now necessary as well as timely (5).

2.3 Programs and Access to Reproductive Health Services

Activities relating to reproductive health are neither unified nor well coordinated in the Region. They fall under the Maternal and Child Health, Sexually Transmitted Diseases, Comprehensive Care for Women, Care of Adolescents, and Genital Cancer Prevention programs. The Alternative Health for Women Programs also offer some services. It is of the utmost importance to coordinate all interprogram activities to prevent duplication and to increase efficiency.

Data on the accessibility of family planning were published in 1992 (7). The survey includes 124 countries where 95% of the world population lives as well as 19 countries of the Americas covering approximately the same percentage of the population for the Region. The evaluative model looks at 10 indicators, which yield a maximum of 100 points when added. Three indicators are used to evaluate different aspects of access to family planning: available options, technical competence of care providers, and availability of information and services. As Table 8 shows, most of the countries are considered to have good and fair programs. Those demanding more attention for further development are: Bolivia, Guatemala, Guyana, Haiti, Nicaragua, and Paraguay.

Between 1987 and 1992 some countries of the Region improved their programs: Honduras, Peru and Trinidad and Tobago. Conversely, three countries deteriorated: Brazil, Jamaica and Panama. Seven countries were regarded as having good access, obtaining 75 points or greater. Nine countries got between 50 and 74 points, which categorizes them as having acceptable programs (Table 8).

Access in four countries was deemed poor, inasmuch as they received 25 to 49 points. Guyana, French Guyana, Nicaragua, and Suriname were not studied. The Netherlands and Sweden obtained 95 points each.

Coverage for contraceptive services has improved greatly at the country level in recent years as a result of an increase and strengthening of complementary activities supported by private, governmental, and nongovernmental agencies. Groups working on the Alternative Health for Women Program have been extremely valuable in their contributions to education and reproductive health. In recognition of the health needs of women, they have worked creatively and with few resources and have been able to generate enriching experiences which should be emulated in other programs. It is estimated that 50% of all contraceptive users are covered by governmental agencies and 50% by the private sector, which includes both free and for-profit services. It should be recognized that governmental agencies have penetrated more deeply into scattered rural areas, while there still is some duplication of effort and competition in areas surrounding urban population centers. It is therefore very important that governments take a decisive step to coordinate their activities with other sectors and that they revise their policies for expanding the outreach for community distribution and social marketing especially in highly underserved areas. Evidence supporting the benefits attainable through this practical scheme already exists within the Region. Community distribution of contraceptives is already practiced successfully in 17 countries and social marketing exists in 13 countries (5, 11-13, 39, 45).

Only a few countries have well-defined goals for contraceptive coverage at the national level or plans as to how to achieve objectives through active participation of the various local institutions. It is difficult to obtain reliable data on the available resources

and expenses incurred by programs for family planning, maternal and child health and reproductive health. There is no doubt that the proportion of the investment contributed by the individual countries is considerably higher than that provided through external cooperation. Many countries remain dependent on external resources, which are used largely for the acquisition of contraceptives. These items are not included on the basic medication lists of many countries. Thus, the ability to carry out future reproductive health programs is problematic. It is therefore advisable to implement the available practical alternatives and to devise new ones.

Furthermore, few programs have information systems for continued monitoring and evaluation. The nongovernmental sector has made greater advances in this area. As a result, at least 17 countries have opted to carry out periodic surveys on population and health. They have been successful thus far because they included recent, timely and good-quality data, and have allowed not simply the documentation of the advances made but also the comparison of data between countries. Although these surveys are costly, the cost incurred is still smaller than that needed to support bureaucratic information systems, which, by producing inaccurate and outdated information, are not conducive to timely and rational decision-making. Argentina, Chile, Panama, Uruguay, and Venezuela are priority countries for having a population and health survey conducted in the future. PAHO will work together with these countries to seek possible funding sources for conducting health and demographic surveys.

2.4 Coverage of Contraceptive Methods

No significant progress has been made since the Directing Council's report (CD 35/17) in terms of reproductive health coverage since 1991. Sixty percent of the 13 million births reported benefit from prenatal care; 72% of all labors take place in a medical institution; and 28% are still assisted by traditional midwives or relatives. Growth monitoring is either limited or unreported, and it is estimated that no more than 60% of all children receive follow-up care.

The focus on adolescent health has been improved over the past two years as a result of the approval of new policies specific to this purpose. Data on sexual education programs and the ability of programs to combat sexually transmitted diseases are unavailable, and the availability of data on perinatal AIDS is minimal.

In terms of family planning services, the prevalence of contraceptive use for women of fertile age, 15-49 years, married or in union, has undergone a dramatic increase from 11% in 1960 to 60% in 1992 (Figure 11). For usage exclusively of effective methods, the prevalence drops to 48%, with a maximum prevalence of 67% and a minimum of 10%. In Japan, Holland, and Norway, the average percentages are 60, 72 and 65, respectively (Tables 8, 9).

2.4.1 *Distribution of Contraceptive Methods*

With regard to different contraceptive methods used by women of fertile age, married or in union, the most frequently used method is female sterilization with 20% usage, followed by oral contraceptives, 16%; intrauterine, devices, 5%; and condoms and natural methods, 5%. Approximately 40% do not use any contraceptive method at all (Figure 5) (14).

In the 20 countries for which data are available, female sterilization is the leading contraceptive method, with variations from 30% usage in Puerto Rico to 18% in Ecuador. Oral contraceptives constitute the leading method in nine countries, with a range of percentages from 20% usage in Jamaica to 4% in Haiti. Traditional methods are still the primary contraceptives used in Bolivia and Peru--19% and 24%, respectively.

It should be stressed that male sterilization is practiced by less than 1% of the population, with the exception of Puerto Rico where it reaches 4%. Total male use of condoms barely reaches 1% or less, with the highest percentages reported by Trinidad and Tobago and Costa Rica--12%--and Jamaica, 9%. This is a clear indication of the extremely low participation by men in the practice of family planning. The rate of contraceptive use in recent years, with a view to family planning, especially the use of condoms, does not appear to be correlated with the efforts being made to increase utilization.

The use of injectable contraceptives is only 2% or less in the Region, with the exception of Jamaica, 8%; Paraguay, 5%; and Mexico, 3%. The use of vaginal barriers is 1% or less, except in Colombia, which reported 2%, and Trinidad and Tobago, which reported 5%. Therefore, users resort mainly to sterilization and oral contraceptives for protection. It is necessary to collect information on both the availability of contraceptive methods and the importance placed on the dissemination of information, the promotion of related practices, and the monitoring of contraceptive users. An examination of the psychosocial and cultural elements which determine contraceptive use within the population remains to be done (5).

The prevalence of contraceptive use indicates different patterns among the various groups. For instance, adolescents make minimal use of contraceptives. There are also variations according to location, as prevalence is higher in urban areas than in rural ones. Sterilization, oral contraceptives, and intrauterine devices are more widely used in urban areas, while oral contraceptives, barrier methods, and conventional methods which are ineffective are more widely used in rural areas.

Women and couples also report differences based on length of use, type of method, and individual preference. Some of the reasons they give for choosing contraceptives are: protection against sexually transmitted diseases; the desire to prevent unwanted pregnancy, especially in the absence of a permanent relationship with a partner; spacing between pregnancies; the desire to delay the first pregnancy; and blocking fertility for prolonged periods of time.

However, users do not always have the option to make free and rational decisions according to their preferences and health conditions. The choice generally depends on the availability of various services and the skill, information, and attitudes of the care providers who have access to the contraceptives.

2.4.2 *Continuity of Use*

Continuity of use also shows marked variation among countries, programs, health units and the fluctuating needs of the users at various stages of life. This does not exclude other factors, such as the availability of contraceptives; the relationship that the user has with the providers; the time the provider devotes to assessing the real needs of the user to determine the most appropriate method; the cost in time and money, and the determining cultural factors on which the selection is based.

Frequently, the providers of contraceptives lack the time and skills to offer sound information and guidance on the various contraceptive methods available, the possible options, and the timely identification of side effects and the serious complications that may arise. As a result of this information gap, the users develop doubts and fears and ultimately interrupt or discontinue use of the method. Many other individuals who wish to practice contraception refrain from doing so from the onset due to reservations and fear. The availability of services that offer different contraceptive options and a constellation of services have a positive influence on the continued use of contraceptives.

Population and health surveys provide convincing evidence that a large number of women of child-bearing age do not wish to have children but, despite this fact, do not use contraceptives. Some of the reasons given are: lack of services, few transportation options, the price of contraceptives, and fear of their use. These women often live in isolated rural and marginal urban areas.

Countries where high needs for contraceptive use remain unmet are Bolivia, Guatemala and Peru, where 36, 29 and 28% of women, respectively, do not have access to reproductive health or contraceptive-related services (14). A correlation exists between the level of education and that of unmet needs, with the exception of Guatemala, where all age groups share similar needs, and Mexico, where information is unavailable.

The percentage of unmet needs is high for the age group 24-29 years and greater still for the one 15-19 years.

Global fertility trends, usage patterns, effectiveness of the method and continuity of use influence the correlation between total fertility and the prevalence of contraceptive usage. The influence exerted by breast feeding during six months after childbirth, induced abortion and age of marriage is also recognized; in some countries the legal age for marriage is 16 or below. Thus, not all countries with similar contraceptive coverage exhibit similar fertility rates (Table 9).

The Organization's assessment on conditions of efficiency for over 3,000 maternal and child health services in 22 countries reveals that family planning services have been inadequate, some are poorly managed, and others limit their services to the distribution of contraceptives but lack an educational component. This results in obstructed access to contraceptives and difficulty in the continuity of use.

3. CONTEXT AND FRAMEWORK

The great diversity of issues associated with sexuality, reproductive health, and fertility regulation and their relationship to the comprehensive health of the population are outside the scope of this paper. In fact, this document is intended to focus on the health sector's participation in carrying out population policies. Thus, the following description is provided primarily to establish a conceptual framework for a proposal for refining the strategies and plans of the Organization in regard to this area.

3.1 Population and Sustainable Development

The concept of "sustainable development" as an objective, internationally envisioned for the 21st century, is defined as "improvement of the quality of life without overburdening the carrying capacity of the ecosystems on which it depends. Sustainable development maintains its natural-resources baseline and is able to continue evolving by adapting and perfecting its knowledge, organization and technical competence." (15-18)

Sustainable development is attainable through economic strengthening and enhancement of the population's well-being, which are, in turn, functions of technical progress, productive employment and investment in human resources. This is the central working assumption of the proposal for a productive and equitable transformation made by ECLAC during its 1991 and 1992 sessions. The following goals are thereby deemed possible: 1) guaranteed access to education and health services, drinking water, and sanitation; 2) assertion that health is the foundation for the economic and social development of human potential and that its improvement increases an individual's

capacity to lead a productive life and reap economic benefits; and 3) guaranteed respect for political and judicial rights, as well as equal opportunities for all without discrimination based on social class or gender (15, 19).

Sustainable development goes beyond the elimination of extreme poverty, since development must also focus on the aspirations of the population at the intermediate economic strata. Similarly, sustainable development presupposes reducing environmental costs, lowering excessive consumption patterns and preventing environmental deterioration, which endangers human well-being.

In terms of the environment, consideration must also be given to the wide spectrum of environmental factors that can alter complex and delicate reproductive cycles. The price of this damage is frequently very high and leads to decreased fertility, spontaneous abortion, delayed intrauterine development, fetal mortality, and some congenital defects. Infectious diseases, malnutrition, and inadequate living conditions are important causes of reproductive health problems typical of developing countries. Chemical contamination, radiation, and stress have become the major threats in the industrialized world. Numerous and well-known surveys attest to the adverse effect that these factors have on the ovarian cycle and ovogenesis, as well as on conception and gestation. The decreased quality of human sperm in the last 50 years--characterized by a decline in spermatic count and increased testicular deficiencies--has prompted scientists to call attention to the countless risks to human existence (20).

Sustainable development does not only call for increased productivity but also, fundamentally, for the impartial distribution of socially generated wealth and respect for the principle of equity among countries and within each one of them. It entails equitable development irrespective of social class, gender or ethnicity, without endangering the future, and ensuring a legacy for future generations that is at least equivalent to that inherited by the present one. Reasonably, it is necessary to obtain a new temporal perspective with projections which go beyond a few decades. Sustainable development similarly implies respect for human rights in its most profound sense. It lays the groundwork for the right to life, equality, social justice, education and work, among others; and underscores the need for deep respect for the culture and values that characterize each human group and which are ingrained in its identity. Within the context of human rights are those decisions concerning the exercise of sexuality, as well as those related to the number of children to have and the timing of their birth.

To achieve this development, high priority must be accorded to improving the quantitative and qualitative aspects linked to the characteristics of the population, as well as insuring that there is no harmful impact on the equilibrium of the ecosystems that support it. The size, growth rate, structure and distribution of the population are regarded as being among the important quantitative factors.

There are many unknown factors that have yet to be identified and that will need to be overcome. It is presently accepted, however, that the population--subject, object and backbone of development--the environment and health are closely interrelated (15, 16).

Protection of the environment, attainment of health and the promotion of economic and social development are not isolated goals, since they are linked to many political and social factors. Accelerated population growth, for instance, can have profound effects on the environment and economic development. However, it must be made clear that other factors must be met simultaneously; among those worth mentioning are internal and international mechanisms for equitable distribution of wealth.

3.2 Sexuality, Reproductive Health, and Fertility Regulation

3.2.1 *Health and Sexuality*

It is important to point out that a new concept of sexuality and reproductive health has been developed over the last few decades; this new approach now forms an integral part of the framework for discussing the health of the population, transcending the conventional mother-and-child concept. In this new perspective, health promotion and lifestyle choices frequently constitute determining factors of health. Increasing attention is being given to the gender factor in epidemiological interpretation, as gender and sexual stereotypes may pose an additional element of risk to health. The analysis of maternal, perinatal and infant mortality, and sexually transmitted diseases, particularly AIDS, emphasizes the relevance of human sexuality. Other causal factors are undoubtedly linked to significant socioeconomic, cultural and demographic changes; for instance, the rapid scientific and technical progress being made with respect to birth control methods.

Within this new approach, human sexuality is closely linked to the health of the population; because of its effects on people and their lifestyles, its impact cannot be overlooked when considering comprehensive health. Yet, it is important to emphasize that the health sector has only partial responsibility for the promotion of healthy sexuality; ultimate responsibility is shared with other sectors and social entities.

3.2.2 *Reproductive Health*

Reproductive health takes great importance and is a subject in which the health sector has made enormous progress. The great contributions made in the past in this area by maternal and child health programs helped to lower maternal and infant mortality rates in the Region, although the prevailing precarious conditions of unprotected social groups are still to be remedied.

During recent years, the emphasis of reproductive health has been placed on the mother-child pair, the care of pregnant women, prenatal monitoring, adequate nutrition, labor in medically equipped facilities or assisted by trained staff, nursing under hygienic and nutritionally adequate conditions, and immunization of the newborn.

Nevertheless, it is desirable to point out that the burden of these problems is unevenly distributed between the sexes. The woman is at a great disadvantage, as she must face the unfolding of pregnancy and labor and all of the resulting physical, emotional, and social consequences. Maternal and child care has failed to stress the importance of male participation in the procreation process.

When a couple faces a decision concerning the use of birth-control methods, the responsibility for the choice, acquisition, and use of the selected method usually falls on the woman. With regard to infertility, although it is the couple's concern and one in whose etiology men and women participate with equal regularity, it is women who endure most of the testing and treatment and who show greater psychological and social consequences. Similarly, sexually transmitted diseases, in general, have more serious consequences for women than for men. Furthermore, abortion continues to be a very serious problem for women's health and for society in general. It is the leading cause of maternal death in eight countries of the Region and the second most important cause in four (Table 7) (21).

The concept of reproductive health is becoming broader and, within the context of WHO's definition of health, it means not simply an absence of illness or disorders in the reproductive process, but a situation in which this process evolves to a state of physical, social and mental well-being.

The implication of this is that people have or can easily attain the capacity to reproduce whenever they deem it timely, that couples or women who so decide can have a pregnancy, that the peri-partum and postpartum periods are healthy, and that children can survive and develop in a healthy environment. By extension, this concept asserts people's right to embrace wholesome and enriching sexuality as an element conducive to the welfare of the person and family. It also implies that when they choose freely and responsibly to engage in sexual relations, these can be mutually gratifying and not be distorted through fear of unwanted pregnancy or sexually transmitted disease (22, 23).

Departing from this conceptualization of reproductive health, a place of prominence is given to all relevant measures that can offer people adequate methods to exercise options concerning their fertility. This is tantamount to providing them with the necessary educational elements and specific procedures to regulate their fertility; it also means that they will have access to treatment in case of infertility.

The term *Family Planning* has been frequently used in this Region to label these concepts. Presently, the term *Fertility Regulation* is being considered, since it is more encompassing and embraces all people at different stages of their reproductive life and under various circumstances. Throughout the decades, the objectives of reproductive health have been modified to include demographic considerations and improvement in the quality of life of the population, without losing sight of individual needs (24). Some of these aspects are dealt with elsewhere in this document, but what must be stressed is the role that fertility regulation plays in the reproductive health of the population.

3.2.3 *Fertility Regulation*

Fertility regulation is regarded as a human right, an important lifestyle choice that is socially acceptable to a large percentage of the population, both individuals and couples. It is a very important health intervention, with ramifications that go beyond health benefits and contraception, since it has the advantage of being cost efficient. For these and other reasons, fertility regulation should be made available to the entire population without exception. It contributes to a woman's ability to make decisions about her body; it also allows her to transfer this experience of autonomy to other areas of life, enabling her to choose among different opportunities for future development. Fertility regulation assists her in achieving her desired sexual realization, and to prevent unwanted and high-risk pregnancies and abortion. It allows her to decide at what age she wishes to have her children and their spacing and number (21, 22, 25-30).

It is important to point out that improved status and education of women promote greater social mobility for women, improve their fertility and the health of their children, all of which ultimately benefits the nuclear family and society at large. It is essentially an attempt to give women their basic human right to health, which they are frequently denied (15, 16, 25, 28, 31).

There is still no ideal contraceptive and one must keep in mind the beneficial effects as well as the potential side effects of each of them. The protective effects of some hormonal contraceptives must be considered, as in some malignancies such as cervical and ovarian cancer, as well as the preventive effects against ectopic pregnancy that some intrauterine devices may have (32). Some contraceptives, such as male and female condoms, also prevent sexually transmitted diseases, and AIDS in particular. Fertility regulation can prevent conceiving children who, given a risk situation, could fall ill or die. Simply spacing pregnancies by two years can reduce child mortality by 50% in those groups characterized by high fertility and high infant mortality. Naturally, spacing children's births also benefits the children that parents already have (26, 32-37).

It is important to remember that fertility regulation encompasses the prevention, diagnosis and treatment of infertility, as well as the provision of medically assisted conception. All this undoubtedly contributes to the modification of family formation patterns, since it provides greater opportunities for family members to attain greater development (21, 29, 38).

Fertility regulation also concerns men and allows them to assume their responsibility in the reproductive process. Men must assume a more receptive and participatory attitude, not just by deciding to have children and how to have them, but also through ample fulfillment of the responsibilities that child rearing entails, which transcends his role as family provider (39-41).

Educational and health interventions have direct effects on the demographic variables of mortality and fertility, as well as on family-formation patterns, family size and population growth. Scientific evidence reveals the role played by family planning in the demographic changes of the Region over the last 30 years, and indicates that it is an excellent indicator for evaluating the level of development and the impact that activities related to reproductive health have on the population.

It is important to recall the positions adopted at international conferences on population in Bucharest, 1974; Mexico, 1984; Amsterdam, 1990; Earth Summit on the Environment, Rio de Janeiro, 1992; Saint Lucia, 1992; and Mexico, 1993. Also important to recall are positions adopted at regional and national fora in which countries of Latin America and the Caribbean rejected programs dealing with "population or birth control;" and supported those in which governments and national delegations affirmed and supported the humanistic policies of respect for human rights, health benefits and the enhancement of the role played by women and the family in society.

3.3 Adolescence

Adolescents have special needs associated with reproductive health that deserve particular attention and consideration, even at developmental stages prior to adolescence. At the crucial time of identity integration, it is imperative to support the development of their self-esteem, communication skills with peers and adults, as well as their ability to manage the pressure and messages conveyed by society. Promoting the development of a critical mind makes it feasible for adolescents to adopt lifestyles and sexual behavior rooted in a value system that allows the practice of wholesome, healthy, and responsible sexuality. It also helps them to protect themselves from sexual abuse and exploitation (40, 42-46). A beneficial result would be the reduction in the rates of adolescent pregnancy.

It should not be overlooked that adolescents constitute a high-risk group for contracting sexually transmitted diseases, of which HIV-AIDS infection bears dramatic health and social consequences, particularly during this developmental stage, including the heavy burden imposed on newborn and older children affected by and infected with their parents' diseases.

3.4 Ethics, Sexuality, and Reproductive Health

All health activities must be treated within a bioethical framework. This approach should be a determinant in all activities related to sexuality and reproductive health of the population.

Health workers must be highly skilled in order to understand the precise possibilities and limitations of their role. They should refrain from making value judgments that may prove detrimental to the people with whom they deal and from trying to force their values and beliefs on others by means of their decisions and instructions. Only through deep respect for the culture and group values of their clients can educational and formative work be conducive to promoting the adoption of healthy and self-directing behavior (47).

4. THE FUTURE SITUATION

When reproductive health is placed within the framework of sustainable development, there are a multiplicity of demands which exceed the capacity of the health sector.

It is estimated that by the year 2000, the Region will have a population of 538 million, 65% of whom will be participating in the programs in maternal, child, and adolescent care. There will be approximately 13 million births.

The challenges presented by reproductive health under the terms being defined will demand greater efforts and resources from public, private, governmental, nongovernmental, and international support agencies. To attain this goal, it is imperative that services be distributed effectively, based on adequate and accurate information. It will also become necessary to increase the technical and financial resources to facilitate redirecting programs in order to make them consistent with the concept of comprehensive health.

In terms of fertility regulation, an enormous effort will have to be made to achieve the goal of 70% of women of fertile age, married or in union (15-49 years old), or who have a partner using contraceptives. To achieve 65 million users of fertility

regulation services by the year 2000, the annual increase will have to be 3%--twice the annual growth percentage in recent years. This objective is feasible only if the benefits of fertility regulation and other reproductive health services can reach those groups which are presently deprived of them for cultural, economic, and geographical reasons. Adolescents and the poor from marginal and isolated areas are considered priority groups. It is necessary to increase the coverage of the age group 20-24 years and, above all, the age group 19 years and under. It is also necessary to increase the participation of men of all ages in activities associated with contraception, giving priority to the younger age group. The effort must be directed toward optimal planning of health services to promote improvement in the quality of care in four areas: access, opportunity, continuity of health care received, and user satisfaction. The objective would then be attainable.

4.1 Strategies and Lines of Action

The strategies approved in 1984, 1985, 1988, and 1991 remain valid and include the following:

- Improvement in collecting demographic and statistical data to allow better identification of groups showing the most serious problems, especially those within the local health systems.
- Promotion of research and training in order to make reproductive health care viable.
- Support of activities that promote participation of the community.
- Integration of fertility regulation services into services of comprehensive care for the population and the family.
- Coordination among agencies and sectors for optimal use of resources.
- Technical assistance to the countries with a view toward increasing competency in the skills necessary to design, execute, monitor and evaluate plans, programs and projects for the development of reproductive health services that achieve increased coverage and quality of care.

With the objective of making these strategies operational within the updated reproductive health context, some necessary modifications are recommended for PAHO's Member Countries and the Organization.

4.1.1 *Costs and Financial Strategy*

All estimates of the necessary costs to implement activities associated with reproductive health and fertility regulation are merely speculative since future economic conditions remain uncertain. Nevertheless, whatever the amount of the investment, it

will have to be defrayed by both the governmental and nongovernmental sectors. Potential user fees to finance the investment may also be needed.

Because the present economic circumstances of the Region are erratic and yield unstable costs, it is recommended that shared financial schemes be devised to make the programs sustainable in order to avoid neglecting, at any given time, those with the greatest needs. Thus, the state must assume a protective role and guarantee reproductive health services by subsidizing them for the poor (11, 13, 15, 39).

Giving priority to fertility-regulation activities will be essential, as they are at the core of reproductive health. Devising adjustments in the policies, strategies, programs, and services of PAHO's technical cooperation will also be essential in order to maximize coverage and quality in order to attract more users and retain them.

Efforts will have to be continued to ascertain the real costs of reproductive health because these data are minimal in the Region. Sound information can lead to more effective alternatives.

It is advisable that countries bear the necessary costs for the procurement of contraceptives as this will relieve them from the dependency they now have on external donations. This would reaffirm their political and financial commitment and, without a doubt, lessen their vulnerability, especially if external sources of assistance to Latin America continue to diminish.

The joint efforts of the health sector and PAHO, especially those that originate locally, have great importance for the generation of operational proposals. These cooperative efforts will facilitate access to funds designed for social development available from the Inter American Development Bank (IDB), the World Bank and PAHO/WHO. Bolivia, Ecuador, Mexico, Peru, and Venezuela are presently using this resource, and other countries can resort to this financial avenue in the future. Proposals for obtaining bilateral or multilateral assistance must be generated and presented at fund-raising meetings.

4.1.2 *Political Support*

Future strategies should aim at obtaining the highest level of political support.

With respect to external political support, three goals should be:

- Fulfillment of the goals set forth at the 1990 United Nations Summit for Children in New York;

- Participation of the health sector in the Third International Conference on Population in September 1994 in Cairo;

- Participation of the health sector in the Conference on Women and Development in 1995.

Delegates to these Conferences and representatives from governmental agencies, the social security system, the private sector, and non-profit health organizations should take part in national discussions to define the role of the state, and to agree upon the policies and programs that are necessary for progress in reproductive health to occur. The coming together of the various institutions that provide services and that are involved in reproductive health will foster and reinforce a spirit of cooperation in devising innovative and effective strategies.

Similarly, the activities of the health sector during the International Year of the Family in 1994 will be important to evaluate needs and generate proposals based on them, so that governments can later present them during the Conference on Women and Development to be held in 1995. Efforts made on these interrelated aspects will give the countries the opportunity to revise their plans to further national development in the 21st century.

At the national level, the health sector should initiate an open dialogue with the national agencies responsible for social and economic planning to achieve greater influence in the formulation of developmental plans, population policies, and resource allocation. It is necessary that the health sector disseminate information on the progress being made in reproductive health and the still unmet needs. Scientific findings and updated information can be instrumental for negotiating policies and accentuating the potential gains of improved health and decreased fertility rates. Combining forces with governmental agencies responsible for population and health matters has proved to be an effective avenue in several countries.

4.1.3 *Legislative Strategies*

Governments could make reproductive health and fertility regulation services more accessible to the population by eliminating restrictions on the acquisition of contraceptives and added production as well as eliminating import taxes on contraceptives. It is also important that properly trained staff distribute contraceptives to the community.

Legislative revisions concerning the minimal age to marry are also advisable in order to make it compatible with social trends and adequate health practices. Sex and family life education must be incorporated into the educational system. Sex education

should begin early to develop permanent roots in individuals, families, and society. Given that current laws foster the existence of illegal abortion clinics where abortion is performed under precarious conditions, laws must encompass appropriate treatment for induced abortion in the beginning stages and for complicated cases as well, if so decided by the countries, without making criminal charges against the physicians and/or women involved.

It is also important for countries to increase accessibility to contraceptives by making necessary revisions in the laws that prohibit the acquisition and use of contraceptives. Ensuring lactation amenorrhea through the promotion of exclusive breast-feeding until the newborn is six months of age and revising laws which give tax exemptions to large families would also constitute substantive efforts.

4.1.4 *Participation by the Least-Protected Groups*

The programs in the Americas have reached a coverage level that demands that the populations for whom the services are intended be clearly identified, and that the plan of action be equally well delineated for each group. Specific objectives and indicators should be established for all intended activities. By doing so, monitoring and continued assessment of the actual outreach of services to the targeted groups can be improved. All members of marginal urban areas, isolated rural groups, and adolescent and adult males should receive special care which is consistent with the economic and social conditions of the country. Governments and communities should determine the priorities to be followed, although it is recommended that adolescents be given highest priority, as they are exposed to innumerable risks and they hold the key to the future.

Mechanisms should also be developed to urge and guarantee active participation from the community and specific target groups to define the kinds and constellation of reproductive health care services needed. Program objectives must be revised to focus more on quality control of the services provided than on expansion of conventional coverage.

4.1.5 *New Sources for the Delivery of Services*

Opening new channels of outreach and distribution, such as community-based distribution and social marketing, in response to the needs for fertility regulation must be promoted and continuously assessed. This is a particularly important proposal given the limited ability of government services to reach all scattered rural areas, the information already available on the practicality of programs, and the acceptance by the community of all related activities. Sufficient experience with these strategies is available in our Region and elsewhere; and experience with technical cooperation within countries is expected in the future. In addition, the experience gained in men's reproductive health clinics in Brazil and Colombia is worth being replicated.

4.1.6 *Quality of Care*

The quality of services offered is considered a key element. Therefore, it will be necessary to train health care staff to focus on sexuality and reproductive health as components of the comprehensive health of the population. In addition to technical education, training should teach health care workers to be aware of their potential as well as their limitations and instill respect for the population's reproductive health needs. The issue of values should also be a substantive element of training, by imparting the fundamental notion that value judgements and disregard for the opinions of others are a great disservice to health care patients. A bioethical approach is crucial to all levels of sexuality and reproductive health care.

New contraceptive technologies and alternatives developed in recent years will probably help to influence and eventually reshape contraceptive use patterns. Recent developments include: the expansion of the postpartum, post-abortion programs; extension of the use of oral contraceptives for women up to the age of 45 years and the use of intrauterine devices for as long as nine years; the approval of Depoprovera as a contraceptive method; the introduction of Norplant, Cyclofen and RU486; post-coital emergency contraception; and new vasectomy and salpingectomy techniques. These changes should be considered when program guidelines undergo revisions. Nevertheless, these changes will also be subject to the flexibility that social attitudes, programs, and services exhibit in adopting available technologies (47-53). Revising standards that pose unnecessary visits and laboratory tests will increase efficiency and decrease medical barriers to contraception.

Contraceptives should be included in the medical procurement list of the individual countries, and the appropriate resources should be guaranteed to ensure easy access to a wide array of services. Standards should reflect the latest information on contraceptive prescription and, on this basis, decisions should be made concerning what available methods will be included in the programs. It would be ideal to offer a reasonable number of alternatives so that men and women can have the opportunity to choose among them according to their own needs.

The need for programs to include all methods is not envisioned. However, it is essential that each program offer adequate and timely information concerning all the available methods and a series of options from which users can choose. Referral to other institutions when necessary must be included in the norms.

The foregoing considerations indicate the urgent need to introduce and develop the concept of quality care with a view to eliminating existing gaps. To this end the following measures are recommended: provision of complete and accurate information on the various methods; availability of a variety of methods in sufficient quantities to

allow users to select the desired method; assurance that personnel have the necessary technical competence and skills to discuss the risks associated with each method; assurance that personnel have the social and verbal skills necessary to communicate effectively geared toward the user's education level; monitoring services that promote continuity of contraceptive use; an operational logistics system to ensure permanent availability of methods; provision of a wide array of services; extension of the hours during which services are offered; and continued inquiries on the perception of the users to ascertain if their needs are being met in a satisfactory way.

It must be remembered that interrupted and discontinued use, as well as the use of unreliable methods, contribute to the inability of some countries with high coverage to achieve the expected positive results. Finally, by creating a situation of easy access to various contraceptive options, the likelihood that a large percentage of couples will resort to contraceptives is highly increased.

4.1.7 *Research Strategies*

Given the important role of WHO's Special Program on Human Reproduction and Training on Reproductive Research, it is recommended that its research policies and priorities be widely disseminated.

It is necessary to have a broad spectrum of information from basic information to new evidence on the development of new contraceptive methods, include these methods in the programs, and evaluate their effectiveness and safety. It is also essential to have knowledge on the psychosocial and cultural aspects that influence the use of these methods.

The decentralization of the program to the Region of the Americas should be strengthened by developing and magnifying the existing networks of 13 collaborating centers and 74 institutions that participate in the program. The further support and development of the Latin American Society for Research on Human Reproduction is equally important.

PAHO and its Member Countries will need to complement resources for their investment in operational research which will enlighten and bring us closer to uncovering the factors that determine whether or not priority groups can be reached by reproductive health services. Other valuable information will be ascertaining the level of satisfaction that people express concerning the services, and the reasons that they have for using or discontinuing the use of contraceptives.

In recognition of the rich experience developed by women's groups delivering services in the Region, their approach should be considered and incorporated into this research. It is necessary to examine what kinds of services women want and how they can become actively involved in the process of organizing and evaluating these services.

4.1.8 *Managerial Strategies*

The achievement of the above proposals will require special efforts to improve the management of operational programs, projects, and services. The current circumstances demand strategic programming and administration which guarantee a high degree of flexibility in adjusting to local situations and programs, the level of development of the services, and the actual conditions of each country (54).

Decentralization of decisions and resources to local health systems will be encouraged, seeking ways in which programming can be conducted in accordance with the particular needs of the individuals and the population, and inviting greater participation and shared responsibility at the local level.

Training and supervision of technical and administrative personnel will constitute the main focus of the programs. The trainees will be in a position to bridge the system's gaps through provision of competent and quality care and the identification of people's needs and wishes associated with the promotion of health.

Furthering the development of systems of information on management and monitoring of reproductive health care will be of marked importance. The process should guarantee that data collected are essential to facilitate the decision-making process at the different levels of work within one sector or among sectors. To this end, greater analytical capability will be necessary as will widespread dissemination of the results of the analyses.

The inclusion of questions related to reproductive health in periodic household surveys needs to be promoted. Also, population and health surveys need to be conducted in the countries that lack current information. Argentina, Chile, Panama, Uruguay and Venezuela should be considered for this need. Research and data collection should be integral parts of the monitoring and evaluation processes, resulting in upgraded integration and revision of the program's objectives and work plans to reflect current needs and trends. It is recommended that countries produce a yearly report on reproductive health, both for national decision-making on program adjustments and international reporting.

The systems of logistics will place emphasis on timely procurement and distribution of contraceptive methods in adequate numbers to prevent both under provision and overstocking, which would lead to additional costs.

The great need for good collaboration strategies is reiterated. These must be coherent and should complement managerial and technical strategies to produce activities that are designed for effective planning, implementation, and evaluation of the programs.

The fundamental aspects of the approach presented in this document are supported by the experience gained from various reproductive health services in different countries of the world and the Region. Nevertheless, the aim is to bring about a serious debate and assessment of the reproductive health practices of the population at the country level. The outcome of the process should be the revision and formulation of policies and programs associated with reproductive health which promote comprehensive health for individuals and groups, who, in turn, will contribute to the sustainable development of the population. PAHO must advocate and participate for this to happen.

4.2 Summary of Technical Cooperation Program Modifications

Based on the proposals made throughout this report, the main modifications proposed in PAHO's program of technical cooperation are:

a) To promote extensive use of census data, demographic health survey results and service statistics for reproductive health programming, monitoring and evaluation, especially at the level of local health systems. These must be complemented by an increase in information syntheses and dissemination of scientific and technical information on successful case studies and recent advances in the field of reproductive health and fertility regulation. Special emphasis must be placed on the aspects of new or improved contraceptive technology feasible for inclusion in the programs.

b) Technical support for the development of a comprehensive review of policies, programs and norms related to reproductive health and fertility regulation to allow a more rational use and coordination with intersectoral institutions such as the Ministries of Education, Labor, Finance and Planning, and a better partnership within governmental, private, for-profit and nongovernmental organizations. Proposals to update standards will be developed to improve the use of the scarce available resources. National and regional meetings will be held to discuss how diverse reproductive health activities can be integrated. Standards for contraceptives available to programs, prescription standards, and especially counselling in reproductive health will be reviewed and further developed.

c) PAHO will ensure that regional courses supported by the Organization include updated knowledge on reproductive health. At all levels of human resources development, counselling skills will be included in the training of service delivery personnel. Updated standards and norms will be used as teaching tools in order to pursue skill-oriented training.

d) Operational research will be a priority, especially research oriented toward understanding qualitative aspects of fertility regulation and reproductive health such as non-user perceptions of fertility regulation messages and services and the decision-making processes for accepting the use of methods.

e) Mobilization of international resources to allow the implementation of PAHO's technical program and national reproductive health program development will be a priority. Projects specifically geared to reproductive health teaching at the school level will be developed and supported. Male participation in reproductive health and fertility regulation activities and projects will be presented to international donors and promoted within the national programs. The development of services for males and adolescent populations is the greatest challenge to the development of PAHO's projects.

f) The Special Program on Maternal and Child Health and Population must continue to lead and advocate coordination on reproductive health and population issues promoting activities jointly with other programs, especially sexually transmitted diseases, AIDS prevention programs, and women's health and development programs.

g) PAHO must participate and ensure health sector participation both in preparatory meetings and in the International Conference on Population in 1994, International Year of the Family in 1994, and the International Conference on Women in 1995. Also, wide dissemination of material and documents produced around these events is recommended.

h) Technical cooperation among countries must be promoted in the field of population and reproductive health.

Resources to develop national and regional projects will be available at the country level. Special consideration will be given to explore the possibility of including some reproductive health projects financed by PAHO's Investment Plan on Health and Environment.

PAHO will continue to strengthen population, reproductive health and fertility regulation activities, where appropriate, through the Organization's new structure and programs. Coordination of the activities and programs will be more vigorous, with programs on women's health and development, disease control, health systems development and health policies programs.

PAHO's attitude and practice towards interagency coordination will continue to be a top priority and, in every possible way, will try to avoid the duplication of activities. However, an aggressive search for extrabudgetary funds will be pursued in order to increase the feasibility of the proposed activities and the future development of these approaches both at the regional and country level and to ensure that Ministries of Health lead and continue to support and expand, in partnership with NGOs and the private sector, the availability of reproductive health and fertility regulation services to the entire population.

TABLE 1
LATIN AMERICA AND THE CARIBBEAN: GROWTH OF INCOME PER CAPITA
GROSS NATIONAL PRODUCT PER HABITANT
(Percentages based on values at 1980 prices)

	Median Annual Rates								Variación acumulada
	1985	1986	1987	1988	1989	1990	1991	1992[a]	1981-1992[a]
Latin American and the Caribbean[b]	0.6	1.6	1.2	-1.2	-1.1	-1.6	1.6	0.5	-7.3
Oil exporting countries	-0.2	-2.0	0.4	-0.2	-2.0	1.9	2.4	1.3	-5.2
Bolivia	-3.4	-4.9	0.1	0.5	0.4	0.2	1.7	1.1	-21.1
Colombia	1.7	4.9	3.7	2.3	1.7	1.9	0.5	1.4	19.9
Ecuador	1.2	0.2	-7.2	6.1	-2.3	-1.0	1.7	1.1	-5.2
Mexico	0.2	-5.9	-0.5	-1.0	1.0	2.2	1.4	0.6	-4.8
Peru	0.0	6.4	5.8	-10.3	-13.3	-7.0	-0.1	-4.5	-31.8
Trinidad and Tobago	-5.6	-3.5	-5.9	-4.5	-1.8	1.0	0.6	-1.2	-30.0
Venezuela	-2.5	4.0	1.3	3.4	-9.9	4.4	7.8	5.0	-8.3
Non oil exporting countries[b]	1.3	4.3	1.7	-1.8	-0.4	-4.1	1.0	0.0	-9.0
South America	1.6	4.7	1.8	-1.7	-0.5	-4.3	1.3	-0.1	-8.4
Argentina	-6.4	3.8	1.8	-3.0	-7.5	-1.0	6.0	4.8	-11.2
Brazil	5.7	5.5	1.6	-2.0	1.4	-6.1	-0.8	-3.1	-9.3
Chile	0.5	4.0	3.9	5.7	8.0	0.3	4.1	7.8	25.4
Guyana	0.5	0.0	-0.8	-2.6	-5.0	-3.4	5.3	2.1	-23.4
Paraguay	0.9	-3.3	1.4	3.6	2.9	0.2	-0.5	-1.3	-1.3
Suriname	0.0	-1.1	-8.0	6.1	2.2	-3.5	-4.3	-1.9	19.0
Uruguay	1.0	7.7	7.3	-0.7	0.9	0.2	1.0	6.4	2.6
Central America and the Caribbean[b]	-1.8	-0.1	2.0	-2.3	0.9	-1.5	-1.4	1.7	-8.7
Bahamas	11.3	1.7	3.0	0.5	0.2	-0.7	-3.7	-0.7	16.8
Barbados	0.6	4.8	2.3	3.2	3.3	-3.6	-3.6	-3.0	-1.0
Belize	-2.3	1.7	9.9	7.1	11.3	5.0	2.5	...	...
Cuba[c]	3.6	0.2	-4.8	1.1	0.0	...	...	...	...
Haiti	-1.5	-1.9	-2.6	-1.1	-1.0	-2.2	-2.3	-6.9	-27.8
Jamaica	-6.7	1.1	5.7	0.3	5.4	2.9	0.9	0.5	6.6
Panama	2.6	1.2	0.1	-17.6	-2.2	3.1	7.0	5.4	-3.0
Dominican Republic	-4.1	0.7	6.0	-0.7	1.8	-7.5	-3.1	5.5	-1.4
Central American Common Market	-2.4	-1.2	0.7	-0.8	0.5	-0.5	-0.5	1.0	-15.0
Costa Rica	-2.1	2.3	1.6	0.4	2.6	0.8	-1.4	1.5	-5.7
El Salvador	0.6	-1.0	1.0	-0.3	-0.8	1.4	1.2	2.4	-10.4
Guatemala	-3.4	-2.6	0.7	1.0	0.8	0.0	0.3	1.2	-16.9
Honduras	-0.7	-1.1	1.6	1.6	1.5	-3.5	-0.9	1.2	-10.3
Nicaragua	-6.7	-3.5	-3.0	-14.2	-4.5	-3.7	-4.0	-3.4	-38.6
OECS countries[d]	6.5	5.9	4.0	7.4	4.4	4.3	2.5	3.9	71.5
Antigua and Barbuda	7.9	9.1	8.4	7.1	4.5	2.0	...	...	...
Dominica	2.2	7.2	7.1	8.2	-0.9	6.9	2.4	2.4	69.1
Granada	4.7	5.2	5.8	5.0	5.4	5.0	2.8	0.4	59.3
Saint Kitts and Nevis	6.2	6.6	7.9	10.3	7.2	3.6	7.3	...	...
Santa Lucía	7.5	3.5	-0.9	7.7	3.9	4.1	0.5	...	...
Saint Vincent and the Grenadines	6.3	4.9	4.7	6.4	6.1	6.0	3.6	8.9	91.5

Source: ECLAC, based on official figures. Population figures correspond to estimates made by the Centro Latinoamericano de Demografía.

[a] Preliminary estimates subject to revision

[b] Does not include Cuba

[c] This refers to the global social product

[d] OECO = Organization of Eastern Caribbean States

TABLE 2
DEMOGRAPHIC INDICATORS: LATIN AMERICA AND THE CARIBBEAN

Region	Population by millions		Median growth rate (%)	Governmental evaluation of the growth of the population	Birth rate per 1000 inhabitants	Death rate per 1000 live births	Life expectancy at birth	Infant mortality rate per 1000 live births	Percentage urban population	Fertility rate per woman
	1990	2025	1990-95	1990	1990-95	1990-95	1990-95	1990-95	1990	1990-95
Latin America	448.1	757.4	1.9	–	27	7	68	48	72	3.2
Caribbean	33.7	50.5	1.4	--	24	8	70	46	60	2.9
Cuba	10.6	13.0	0.9	S	17	7	76	13	75	1.9
Dominican Rep.	7.2	11.4	2.0	H	28	6	68	57	60	3.3
Haiti	6.5	13.2	2.0	H	35	12	57	86	28	4.8
Jamaica	2.5	3.5	1.2	H	22	6	74	14	52	2.4
Puerto Rico	3.5	4.6	1.0	...	18	8	76	13	74	2.1
Trinidad & Tobago	1.3	2.0	1.4	H	23	6	72	14	69	2.7
Central America	117.7	213.2	2.2		29	6	69	39	66	3.5
Costa Rica	3.0	5.3	2.3	H	26	4	75	17	47	3.0
El Salvador	5.3	11.3	2.5	H	36	7	67	53	44	4.5
Guatemala	9.2	21.7	2.9	S	39	8	65	48	39	5.4
Honduras	5.1	11.5	3.0	H	37	7	66	57	44	4.9
Mexico	88.6	150.1	2.0	H	27	5	70	36	73	3.7
Nicaragua	3.9	9.2	3.2	H	39	7	66	50	60	4.6*
Panama	2.4	3.9	1.9	S	25	5	73	21	53	2.9
South America	296.7	493.7	1.9		26	7	68	52	75	3.2
Argentina	32.3	45.5	1.2	L	20	9	71	29	86	2.8
Bolivia	7.3	18.3	2.8	L	41	12	56	93	51	5.8
Brazil	150.4	245.8	1.9	S	26	7	66	57	75	3.2
Chile	13.2	19.8	1.6	S	23	6	72	19	86	2.7
Colombia	33.0	54.2	1.9	S	26	6	69	37	70	2.9
Ecuador	10.6	19.9	2.4	H	31	7	67	57	56	3.9
Guyana	0.8	1.2	0.8	S	24	7	65	48	35	2.4
Paraguay	4.3	9.2	2.7	S	33	6	67	39	47	4.3
Peru	21.6	37.4	2.0	H	29	8	65	76	70	3.6
Uruguay	3.1	3.7	0.6	L	17	10	72	20	85	2.3
Venezuela	19.7	38.0	2.4	S	28	5	70	33	90	3.5

Source: UNFPA 1992. The state of world population 1992. New York: UNFPA

S = satisfactory H = high L = low

* 1992 Reproductive Health Survey (RHS).

TABLE 3
DEMOGRAPHIC INDICATORS: THE CARIBBEAN

	Population by millions		Median growth rate (%)	Governmental evaluation of the growth of the population	Birth rate per 1000 inhabitants	Death rate per 1000 live births	Life expectancy at birth	Infant mortality rate per 1000 live births	Percentage urban population	Fertility rate per woman
Region	1992	2025	1990-95	1990	1990-95	1990-95	1990-95	1990-95	1990	1990-95
Caribbean	35	49	1.8	--	26	8	67/71	54	58	3.1
Antigua & Barbuda	0.1	0.1	0.8	S	14	6	70/74	24.4	58	1.7
Bahamas	0.3	0.4	1.5	S	19	5	69/76	26.3	75	2.2
Barbados	0.3	0.3	0.7	S	16	9	70/76	9.0	32	1.8
Belice*	0.2	0.2	3.3	S	38	5	67/65	42.0	48	4.5
Dominica	0.1	0.1	1.2	H	20	7	73/79	18.4	--	2.5
Grenada	0.1	0.1	2.5	H	33	8	69/74	15.9	--	4.9
Guadeloupe	0.4	0.4	1.4	--	20	6	71/78	9.9	48	2.4
Jamaica	2.5	3.6	2.0	H	25	5	71/75	17	51	2.4
Martinique	0.4	0.5	1.2	--	18	6	74/81	9	82	2.0
Netherlands Antilles	0.2	0.2	1.2	--	19	6	72/76	6.3	53	2.1
Puerto Rico	3.7	4.2	1.2	--	19	7	70/78	14.3	72	2.2
St. Kitts-Nevis	0.04	0.1	1.2	H	23	11	63/69	22.2	45	2.5
Saint Lucia	0.2	0.3	1.7	H	23	6	69/74	20.8	46	3.3
Saint Vincent & the Grenadines	0.1	0.2	1.6	H	23	6	70/73	21.7	21	2.6
Trinidad and Tobago	1.3	1.7	1.4	H	21	7	67/73	10.2	64	2.5

Source: UNFPA 1992. The state of world population 1992 New York: UNFPA

S = satisfactory H = high L = low

* 1991 Family Health Survey and 1993 World Population data sheet

TABLE 4
SOCIAL INDICATORS LATIN AMERICA AND THE CARIBBEAN

	Contraceptive users (%)	Governmental support to Family Planning	Adult literacy men/women	Secondary school enrollment boys/girls	% of births attended by trained health care personnel	% of the population with access to health services	% of the population with access to drinking water	Food production per capita	Agric. Pop. per hectare of arable land	GNP per capita (dollars)	Public Spending Health & Education as a % of the GNP
Region	1980		1990	1986-89	1983-90	1985-90	1985-88	1987-89	1987	1989	1987
Latin America											
Caribbean											
Cuba	70	Y	95/93	85/96	99	...	...	106	0.6	...	9.2
Dominican Rep.	50	Y	85/82	.../...	90	80	63	94	1.8	790	3.1
Haiti	10	Y	59/47	20/17	40	50	36	93	4.2	360	3.2
Jamaica	55	Y	98/99	62/68	90	90	71	92	2.8	1260	8.0
Puerto Rico	70	...	.../...	.../...	...	...	...	...	...	...	...
Trinidad and Tobago	53	Y	.../...	80/85	98	98	98	86	0.8	3230	8.9
Central America											
Costa Rica	70	Y	93/93	40/43	97	80	92	89	1.4	1780	9.5
El Salvador	47	Y	76/70	27/31	50	56	48	90	2.6	1070	3.0
Guatemala	23	Y	63/47	21/19	34	34	61	103	2.4	910	3.4
Honduras	41	Y	76/71	28/36	66	66	73	88	1.5	900	8.2
Mexico	53	Y	90/85	54/53	94	78	71	98	1.1	2010	4.4
Nicaragua	49*	Y	.../...	29/58	41	83	54	63	1.1	...	11.2
Panama	58**	Y	88/88	56/63	89	80	84	92	1.0	1760	11.1
South America											
Argentina	...	Y	96/95	69/78	...	71	65	91	0.1	2160	3.4
Bolivia	30	N	85/71	40/35	42	63	53	102	0.9	620	3.3
Brazil	66	Y	83/80	32/42	95	...	97	115	0.5	2540	5.1
Chile	...	Y	94/93	72/78	98	97	89	107	0.3	1770	6.8
Colombia	65	Y	88/86	55/56	71	60	88	102	1.7	1200	3.4
Ecuador	53	Y	88/84	55/57	56	75	58	106	1.2	1020	5.4
Guyana	31	Y	.../...	.../...	...	...	...	70	0.5	340	14.0
Paraguay	45	Y	92/88	30/29	30	61	34	115	0.9	1030	1.6
Peru	46	Y	92/79	68/61	78	75	61	101	2.1	1010	4.2
Uruguay	...	Y	97/96	68/76	97	82	73	106	0.3	2620	4.0
Venezuela	49	Y	87/90	48/59	69	...	90	88	0.6	2450	7.4

Source: UNFPA 1992. The state of world population 1992. New York: UNFPA

Y = yes N = no *1992 Nicaragua Reproductive Health Survey. ** 1984 Panamá Reproductive Health Survey.

TABLE 5
LIFE EXPECTANCY AT BIRTH IN THE AMERICAS
1990 - 1995

	Years 56		57		65		66		67		68		69		70+	
% goal**					66%		73%		80%		86%		93%		100% *	
	ctry.	pop.	ctry.	pop.	ctry.	pop.	ctry.	pop.	ctry.	pop.	ctry.	pop.	ctry.	pop.	ctry.	pop.
	BOL	7.3	HAI	6.5									BAH	0.3	ARG	32.3
					GUT	9.2	HON	5.1	ELS	5.3	DOR	7.2	COL	33.0	CUB	10.6
					GUY	0.8	NIC	3.9	COR	10.6			GRE	0.1	CAN	27.4*
					PER	21.6	BRA	150.4	PAR	4.3					CHI	13.2
					BLZ	0.2									JAM	2.5
															PUR	3.5
															TRT	1.3
															COR	3.0
															MEX	88.6
															PAN	2.4
															URU	3.1
															VEN	19.7
															USA	255.5
															ANI	0.1
															BAH	0.3
															BAR	0.3
															DOM	0.1
															GUA	0.4
															MAR	0.4
															SUR	0.2
															SCN	0.04
															SAV	0.1
Total Pop. Mil.		7.3		6.5		31.8		159.4		20.2		7.2		33.4		465.04
% Pob.		1.0		0.9		4.3		21.7		2.8		1		4.6		63.5

Source: Statistical Charts pg:41. / State of the World Population 1992
UNFPA / New York, N.Y., United States of America
* In millions

** Percentage of achieved goals compared to Almatta goals (70 years life expectancy).

TABLE 6
LATIN AMERICAN
INFANT MORTALITY*
1960 - 1990

Country	1960	1990	% Decrease
Argentina	61	31	49
Bolivia	167	102	39
Brazil	116	60	48
Canada	28	7	75
Chile	114	20	82
Colombia	99	39	61
Costa Rica	84	18	79
Cuba	62	11	82
Dominican Republic	125	61	51
Ecuador	124	60	52
El Salvador	143	59	59
Guatemala	125	54	57
Haiti	182	92	49
Honduras	144	63	56
Jamaica	63	16	75
Mexico	92	40	57
Nicaragua	140	56	60
Panama	69	22	68
Paraguay	86	41	52
Peru	142	82	42
Trinidad and Tobago	54	15	72
Uruguay	51	22	57
United States	26	9	64
Venezuela	81	35	57

Source: UNICEF 1992. The state of the world children 1992. New York: UNICEF
* per 1.000 live births

TABLE 7
MATERNAL MORTALITY
LATIN AMERICA AND THE CARIBBEAN
CIRCA 1985

		ABORTION (630-639)		HEMORRHAGE (640, 641, 666)		TOXEMIAS (642.4-642.9, 643)		COMPLICATIONS OF THE PUERPERIUM (670-676)		OTHER DIRECT OBSTETRICAL CAUSES (642.0-642.3, 644-646, 651-665, 650)		OTHER INDIRECT OBSTETRICAL CAUSES (647-648)	
Countries	Year	RATE*	%**	RATE	%	RATE	%	RATE	%	RATE	%	RATE	%
Argentina	1986	19.8	35.0	7.8	13.3	8.9	15.8	8.1	14.3	11.0	19.5	0.9	1.6
Brazil	1986	6.2	13.2	7.5	16.0	13.5	28.9	7.5	16.0	8.6	18.4	3.5	7.5
Canada	1988	0.3	6.0	0.8	16.0	1.4	28.0	2.2	44.0	0.3	6.0	-	0.0
Colombia	1986	17.7	10.3	34.0	17.8	40.0	23.3	18.0	10.5	60.0	34.9	2.0	0.2
Costa Rica	1988	1.3	6.7	5.3	26.7	5.3	26.7	2.6	13.2	5.3	26.7	-	0.0
Cuba	1988	9.0	21.8	1.1	2.7	3.4	8.2	6.8	16.5	7.4	17.9	13.6	32.9
Chile	1987	16.2	34.9	3.8	8.1	5.5	11.8	11.4	24.5	7.2	15.9	2.4	5.2
Ecuador	1988	8.0	7.3	26.9	24.6	27.2	25.0	8.0	7.3	37.2	34.0	2.0	1.8
El Salvador	1984	4.2	7.9	4.2	7.1	3.0	5.1	4.7	8.0	42.2	71.7	0.6	1.0
United States	1987	1.2	17.6	0.9	13.2	0.9	13.2	2.3	33.9	1.1	16.2	0.4	5.9
Guatemala	1984	12.4	17.0	1.2	1.6	7.4	10.1	11.1	15.2	38.24	52.7	2.5	3.4
Guyana	1984	61.5	30.8	80.6	40.5	34.6	17.3	11.5	5.7	11.5	5.7	-	0.0
Jamaica	1984	73.8	65.8	7.7	6.9	24.6	21.5	-	0.0	6.1	5.4	-	0
Mexico	1986	6.8	8.9	19..0	24.8	15.0	19.7	6.8	8.9	27.7	36.2	1.2	1.6
Panama	1987	8.8	22.9	1.7	4.4	7.0	18.2	-	0.0	19.3	50.1	1.7	4.4
Paraguay	1986	14.8	13.5	33.6	30.7	19.5	17.8	18.7	17.2	18.0	16.5	4.7	4.3
Peru	1983	10.2	11.2	30.3	33.2	7.7	8.4	13.2	14.4	29.6	32.4	0.4	0.4
Puerto Rico	1987	-	0.0	1.3	6.8	3.8	19.8	9.0	46.8	5.1	26.6	-	0.0
Dominican Repub.	1985	9.1	17.0	8.6	16.1	13.6	25.5	-	0.0	17.6	33.0	4.5	8.4
Suriname	1985	9.5	14.2	47.7	71.6	9.5	14.2	-	0.0	-	0.0	-	0.0
Tr. Tobago	1986	54.8	51.7	6.4	6.0	29.0	27.3	6.9	6.1	3.2	3.0	6.4	6.0
Uruguay	1988	1.9	5.0	3.8	10.0	3.8	10.0	15.3	38.0	15.3	38.0	-	0.0
Venezuela	1987	10.4	19.4	9.2	17.2	13.7	25.7	6.6	12.3	9.6	17.9	4.0	7.5

Source: TIS-PAHO 1992.

* Per 100,000 registered live births

** Of all maternal deaths in the country

TABLE 8
CONTRACEPTIVE PREVALENCE* AND ACCESS IN THE AMERICAS - CIRCA 1990

Program Points	Good 75 +		Regular 50-74		Poor 25-49		Not studied **	
70	Canada USA Cuba	74/69 73/69 70/67					Puerto Rico	70/62
60	Colombia	66/55	Costa Rica	68/56	Brazil	66/57	Chile Uruguay Argentina	- - -
50	Mexico Trinidad & Tobago	53/45 53/44	Domin.Rep. Ecuador Jamaica Panama	50/47 53/41 55/51 58/54			Bahamas St. Vin. & Gr. Ant.&Bar. Barbados Dominica Martinique	- 53/55 53/51 55/53 50/48 51/37
40	El Salvador Venezuela	47/45 49/38	Honduras Peru	41/33 46/23			Nicaragua Guadaloupe Belize St.Lucia St. Kitts Grenada	49/-** 44/31 47/42 47/46 41/37 31/27
30			Bolivia	30/12				
20			Guatemala Paraguay	23/18 26/10			Guyana	21/23
10					Haiti	10/10		

Sources: Population Reference Bureau 1992**, Population Wall Chart, World Access to Birth Control 1992, Population Crisis Committee.
*TM/*MM = Total methods/Modern methods
** Personal communication Leo Morris CDC.

TABLE 9
THE AMERICAS
ACCESS TO FAMILY PLANNING RELATION OF MODERN AND TOTAL METHODS
TOTAL FERTILITY AND DECLINE IN FERTILITY
CIRCA 1990

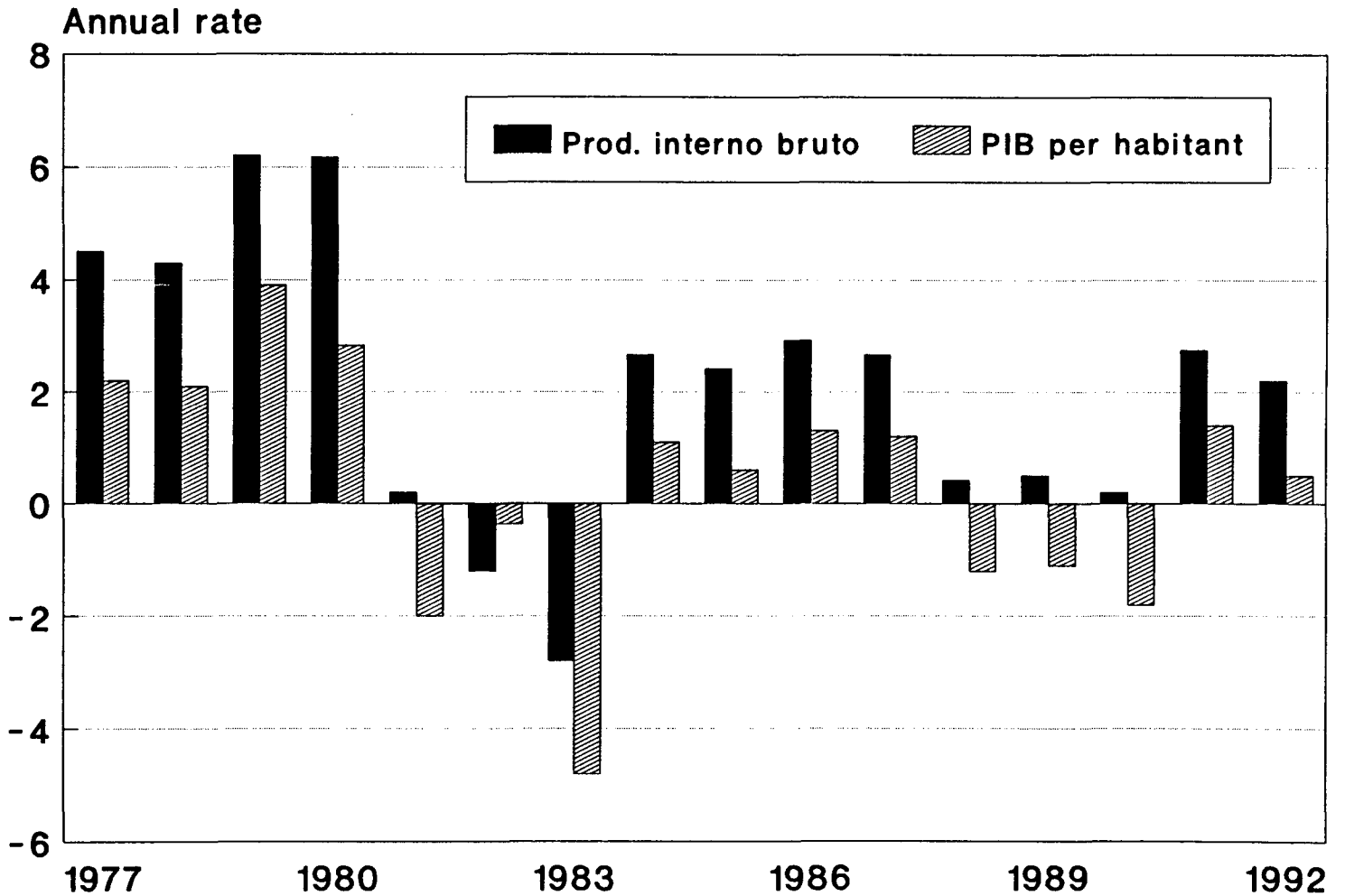
Countries in descending order	Score** Mx 100 Pts.	Rel Met/Mod	Total Fertility	Decline in total fertility 1965-1970 to 1990-1995 (1)
*The Netherlands	95	76/72	1.6	-
*Sweden	95	78/71	2.1	-
Mexico	88	53/45	3.1	54
Trinidad & Tobago	88	53/44	2.7	29
Cuba	86	70/67	1.9	56
El Salvador	78	47/45	4.5	32
Colombia	77	66/55	2.9	54
*United States	77	74/69	2.0	-
Honduras	74	43/41	4.9	33
Dominican Republic	74	50/47	3.3	50
Costa Rica	73	68/56	3.0	48
Canada	71	74/69	1.8	-
Ecuador	68	53/41	3.9	42
Chile	64	-	2.7	40
Guatemala	63	23/18	5.4	19
Panama	62	58/54	2.9	49
Peru	60	43/26	3.6	46
Jamaica	60	55/51	2.4	49
Venezuela	53	-	3.5	41
Uruguay	52	-	2.3	17
Brazil	46	66/57	3.2	40
Haiti	46	10/10	4.8	20
Paraguay	46	46/23	4.3	32
Argentina	38	-	2.8	9
Bolivia	34	30/12	5.8	11

* The grading methodology may vary
** Maximum score
(1) Suriname, Guyana, French Guyana, Nicaragua and Uruguay were not studied.

Source Population Reference Bureau 1992, Population Wall Chart, World Access to Birth Control 1992, Population Crisis Committee.

FIGURE 1

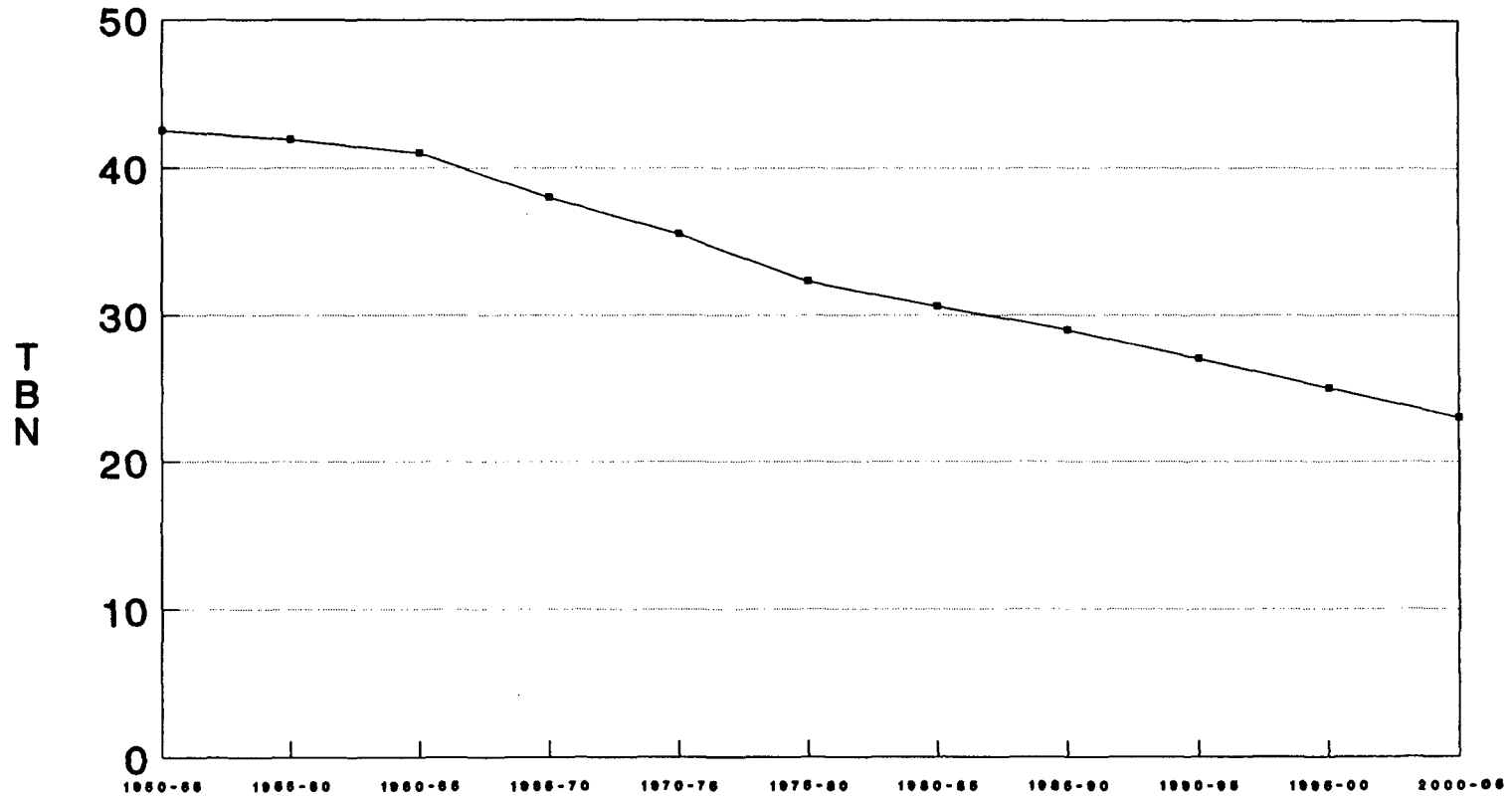
LATIN AMERICA: MAIN ECONOMIC INDICATORS



Source: Informe CEPAL 1992, provisional

FIGURE 2

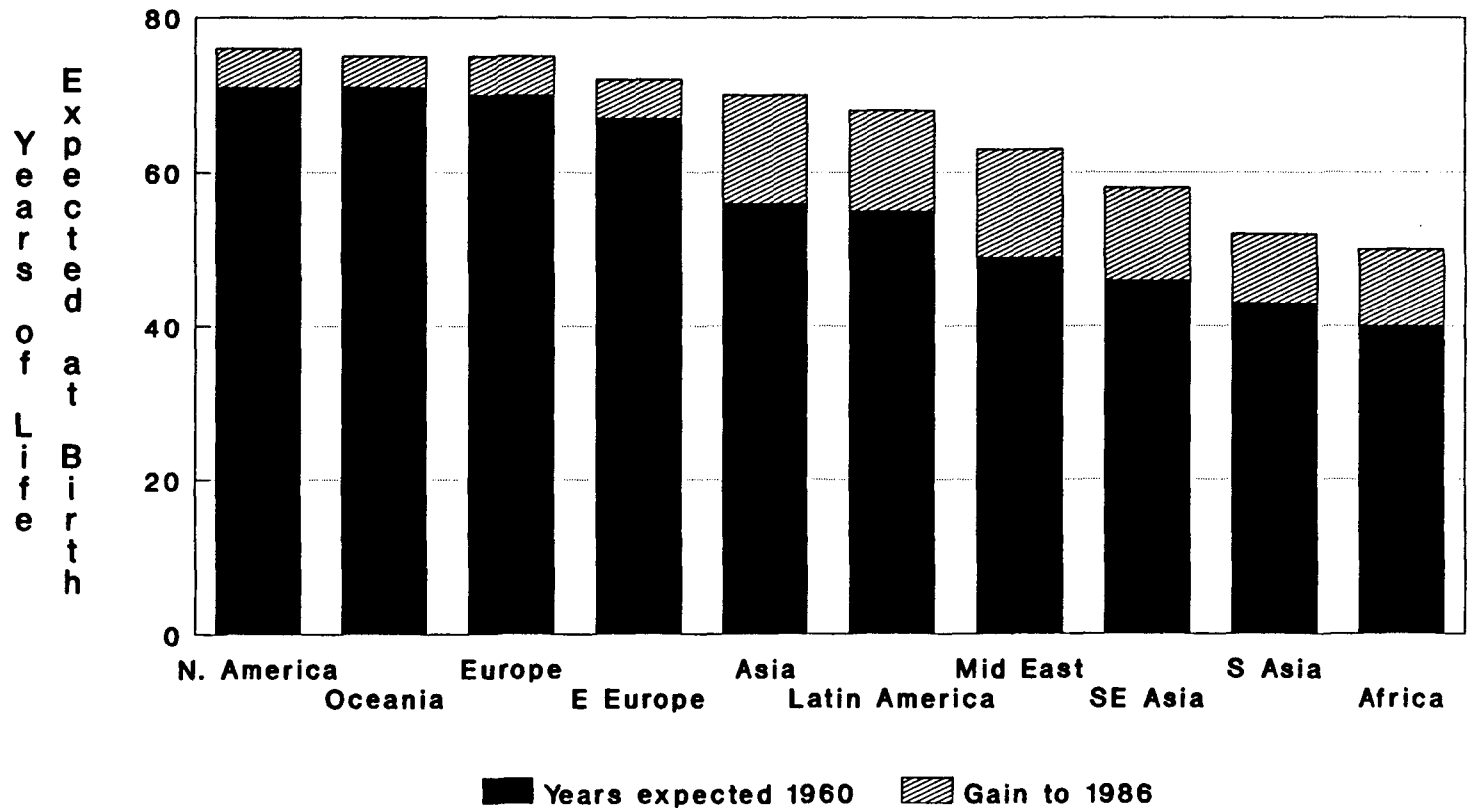
BIRTH RATE* - LATIN AMERICA 1950-2005



* Per 1000 population
Source: United Nations 1991, World Population Prospects 1990, New York: UN

FIGURE 3

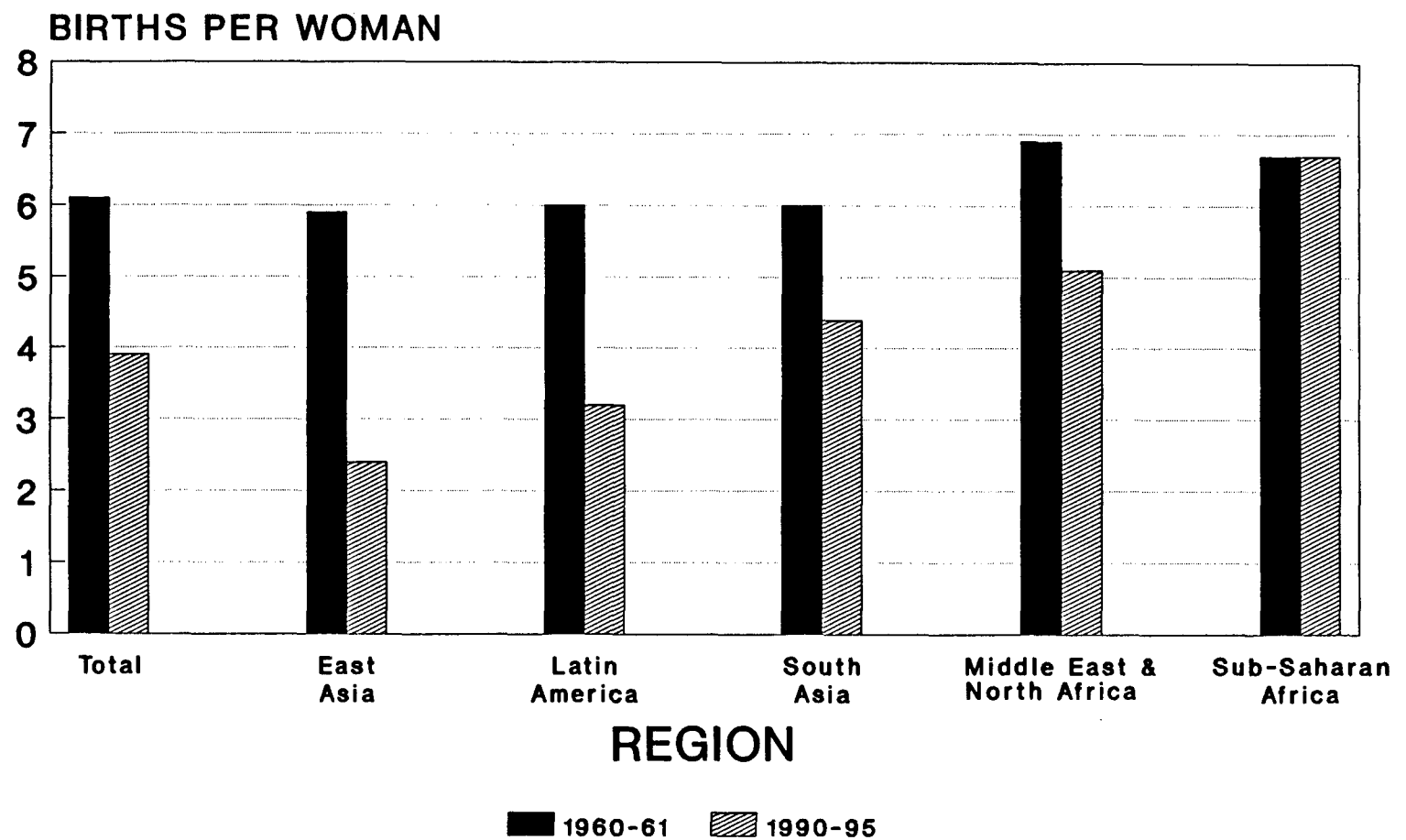
LIFE EXPECTANCY BY REGION
1960-1986



Source: The Task Force for Child Survival, updated by PAHO

FIGURE 4

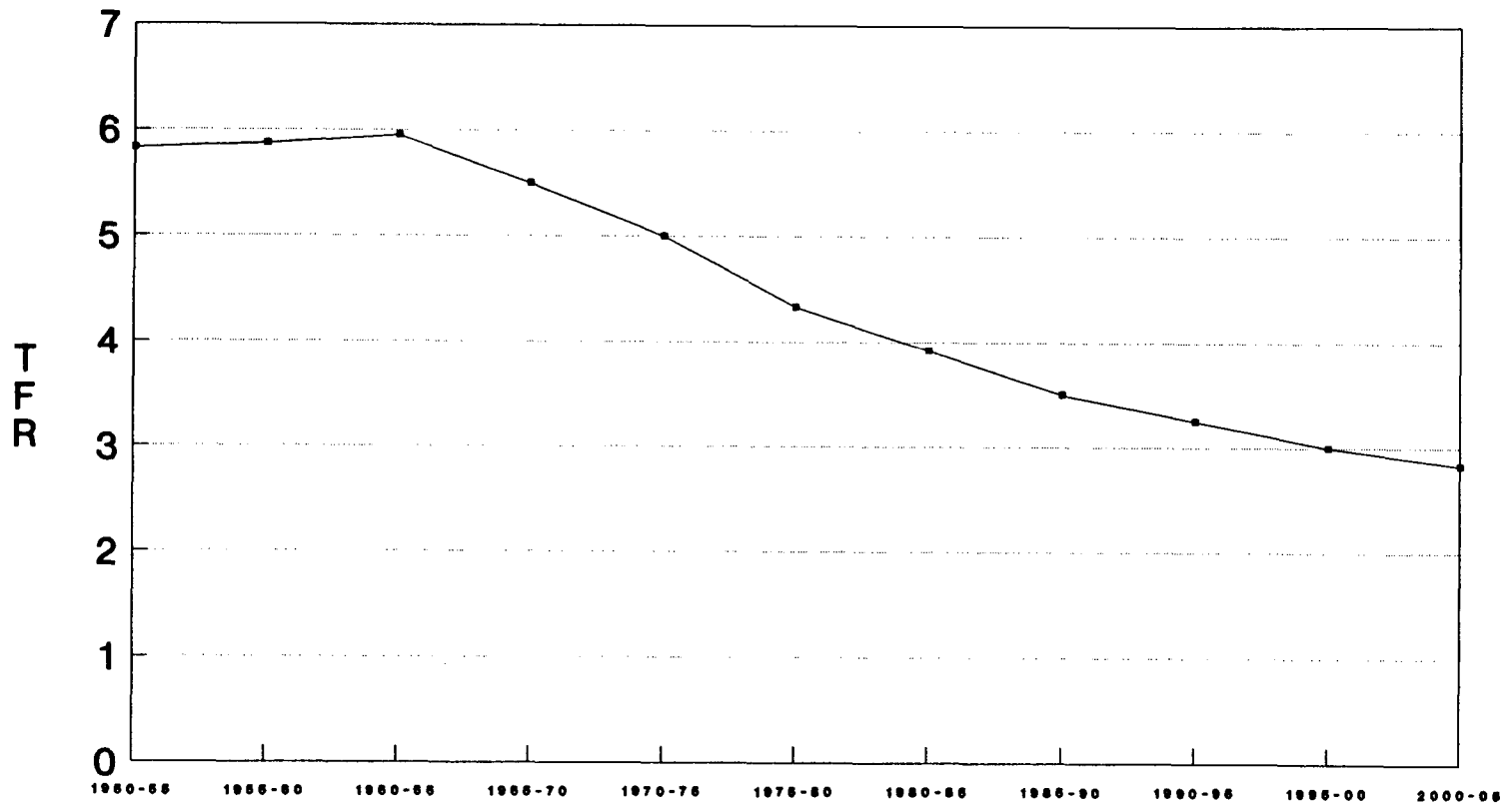
TRENDS IN FERTILITY IN THE DEVELOPING WORLD, BY REGION



Source: Family Planning & Child Survival Programs as Assessed in 1991
John A. Ross, Mauldin Parker Page 2, Modified for the Americas, PAHO

FIGURE 5

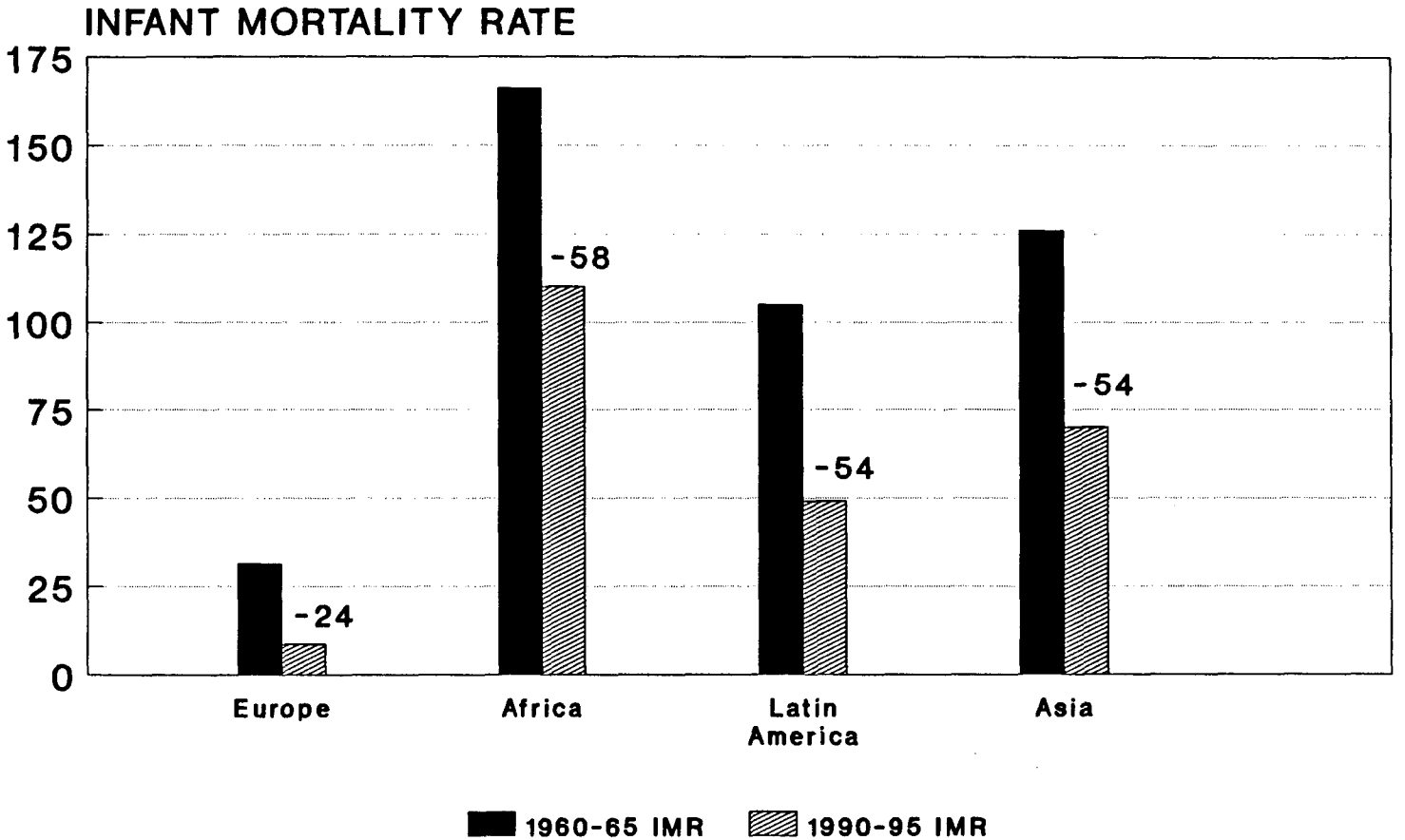
TOTAL FERTILITY RATE* IN LATIN AMERICA 1950-2005



* Children per woman
Source: United Nations 1991, World Population Prospects 1990, New York: UN

FIGURE 6

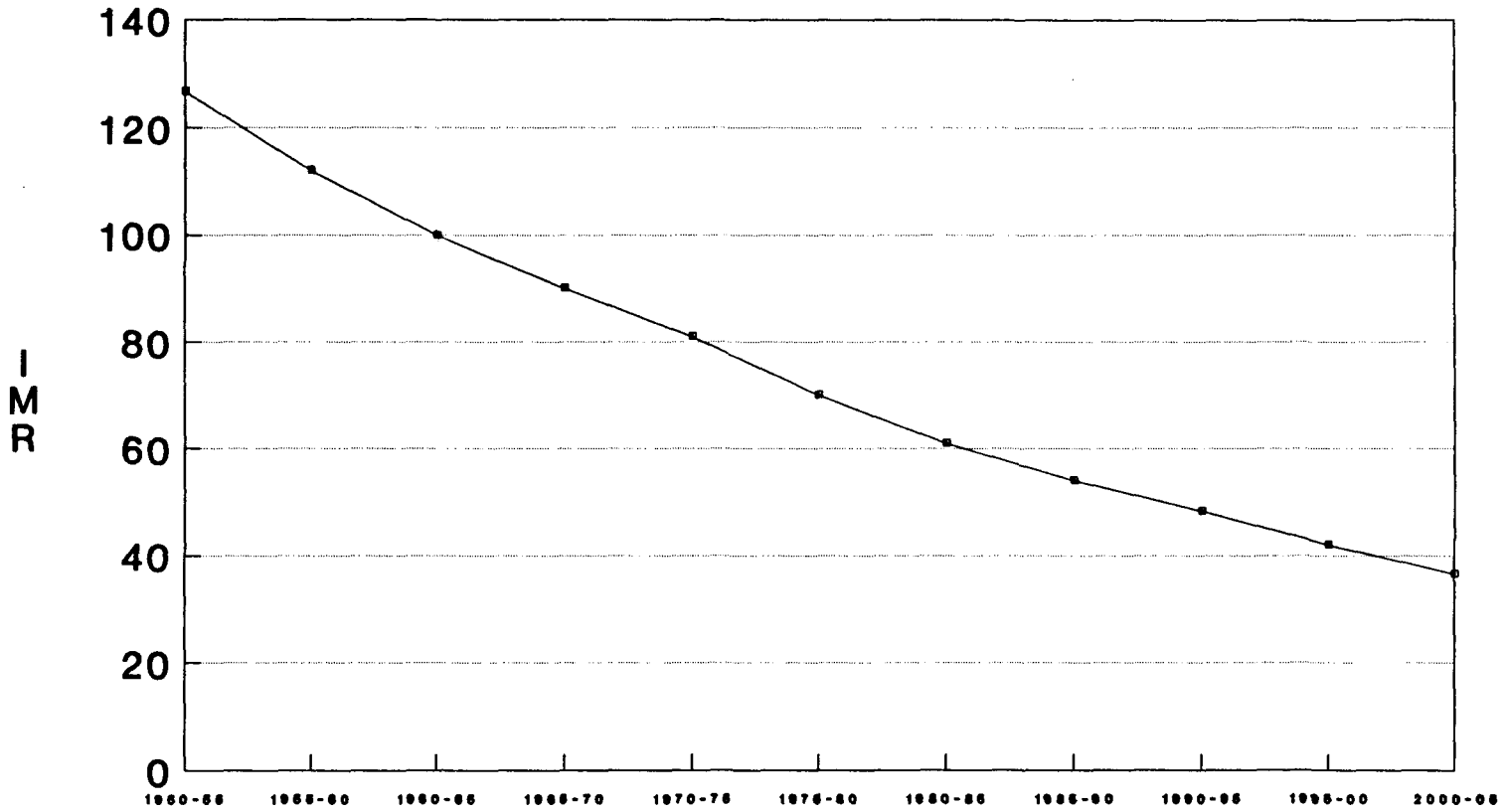
INFANT MORTALITY RATE REDUCTIONS: 1960-65 TO 1990-1995



Source: The Task Force for Child Survival, updated by PAHO

FIGURE 7

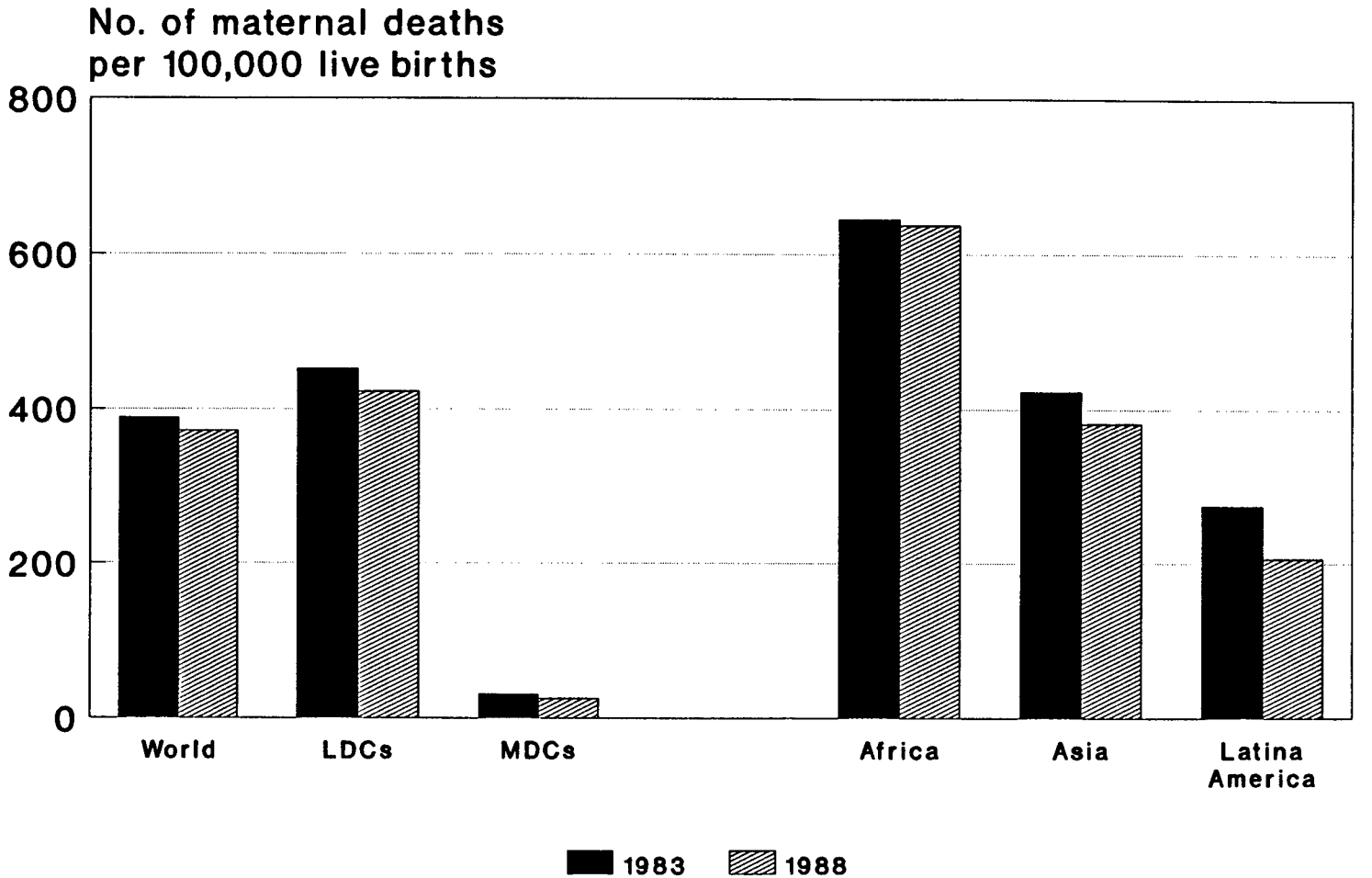
LATIN AMERICAN INFANT MORTALITY RATE* MEDIUM VARIANT, 1950-2005



* Per 1000 live births
Source: United Nations 1991, World Population Prospects 1990, New York: UN

FIGURE 8

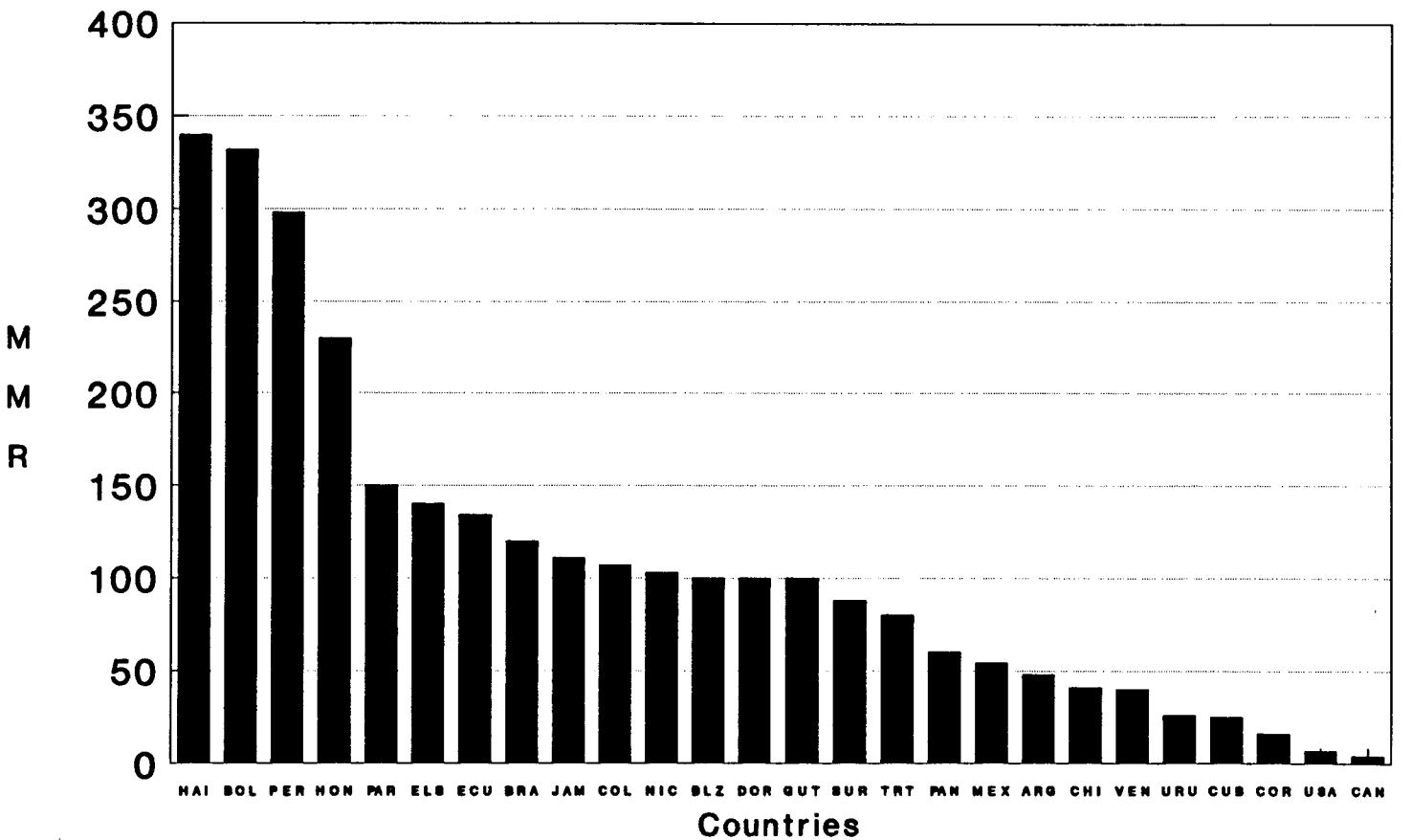
MATERNAL MORTALITY RATIOS



Source: Family Planning and Child Survival, as assessed in 1991
Ross, Mauldin, et al p. 3

FIGURE 9

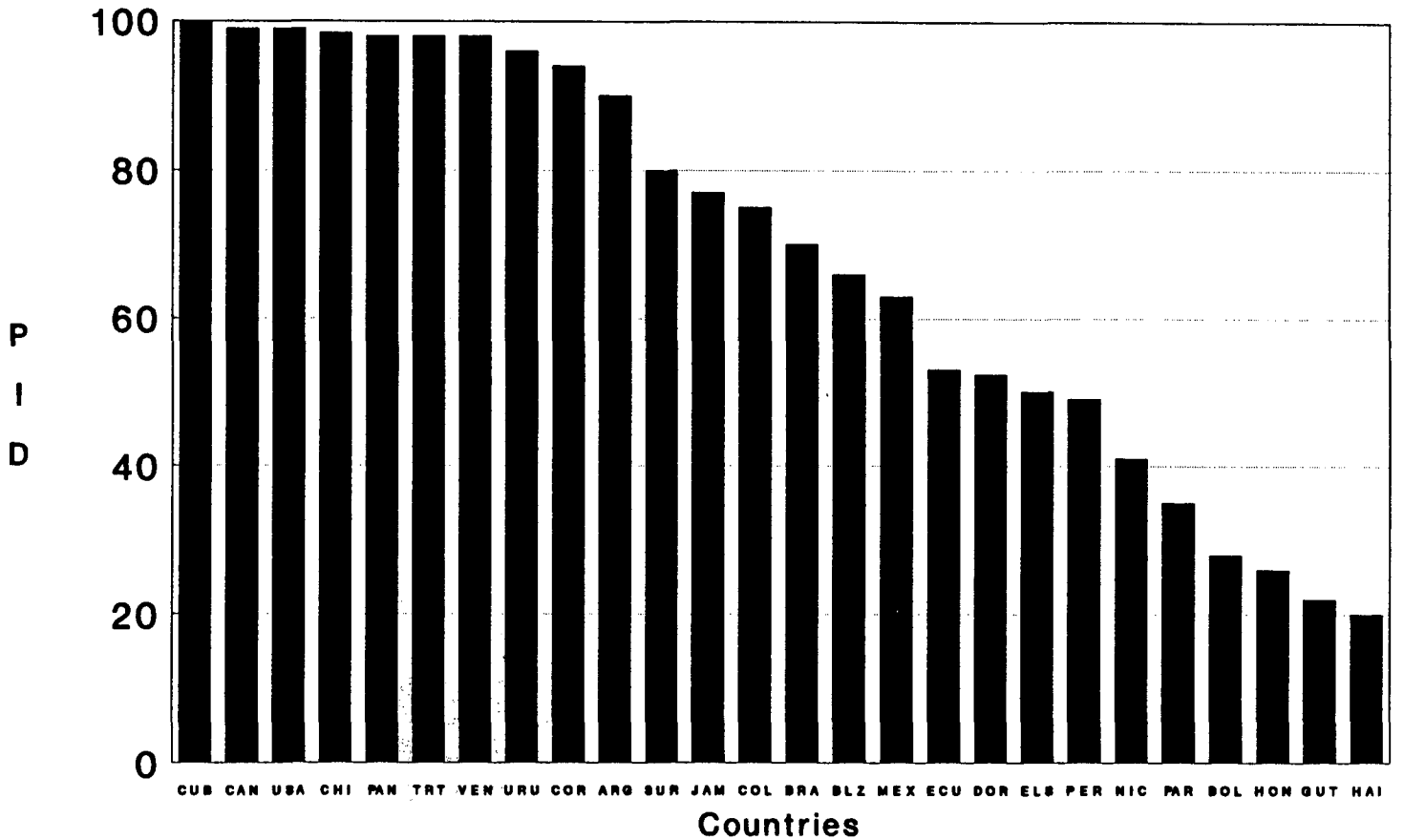
MATERNAL MORTALITY RATE IN THE AMERICAS
1990



*per 100,000 live births
Source: HPM Data Base

FIGURE 10

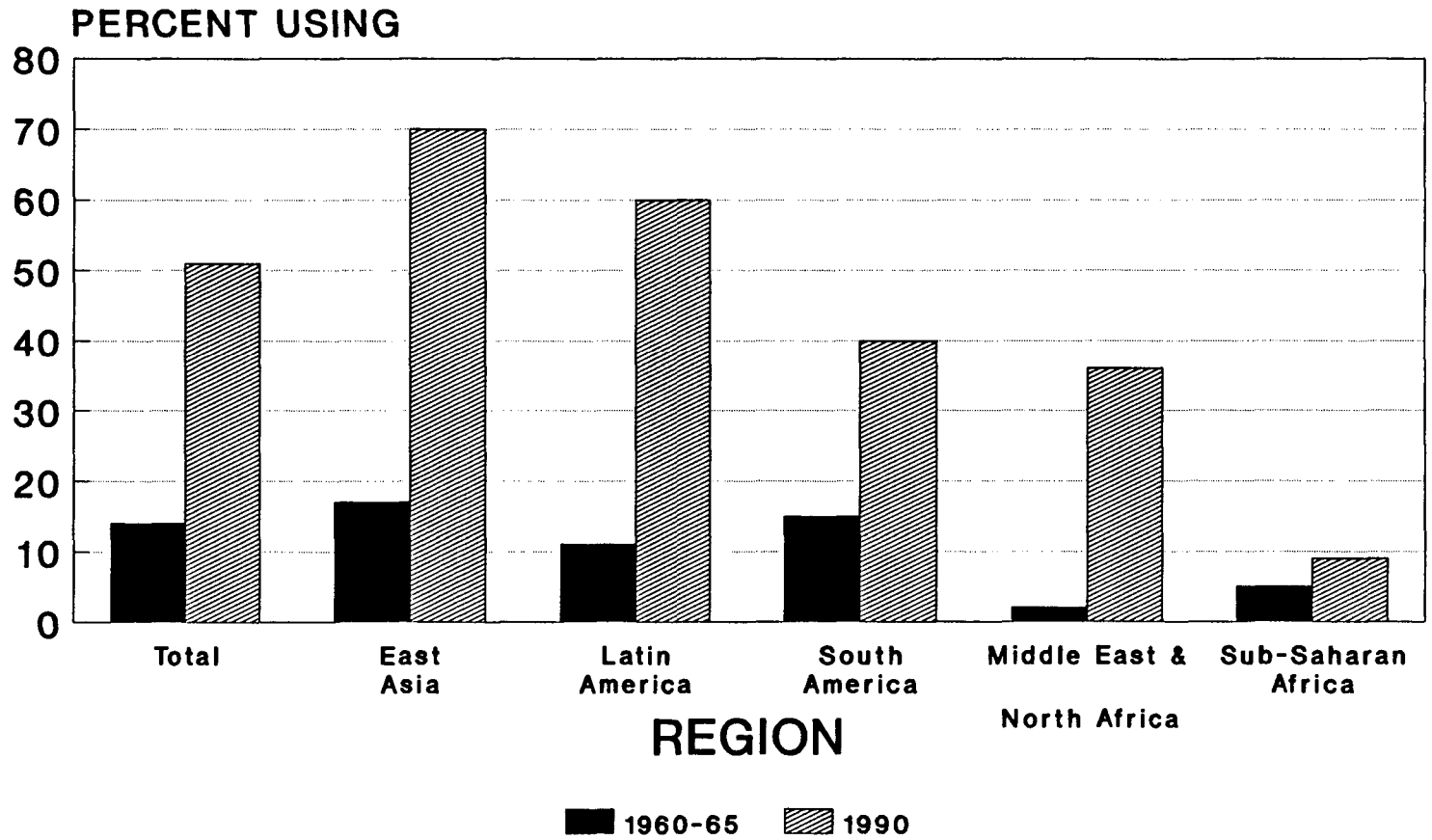
PERCENTAGE OF INSTITUTIONAL DELIVERIES* IN THE AMERICAS - CIRCA 1990



*per 100 live births
Source: HPM Data Base

FIGURE 11

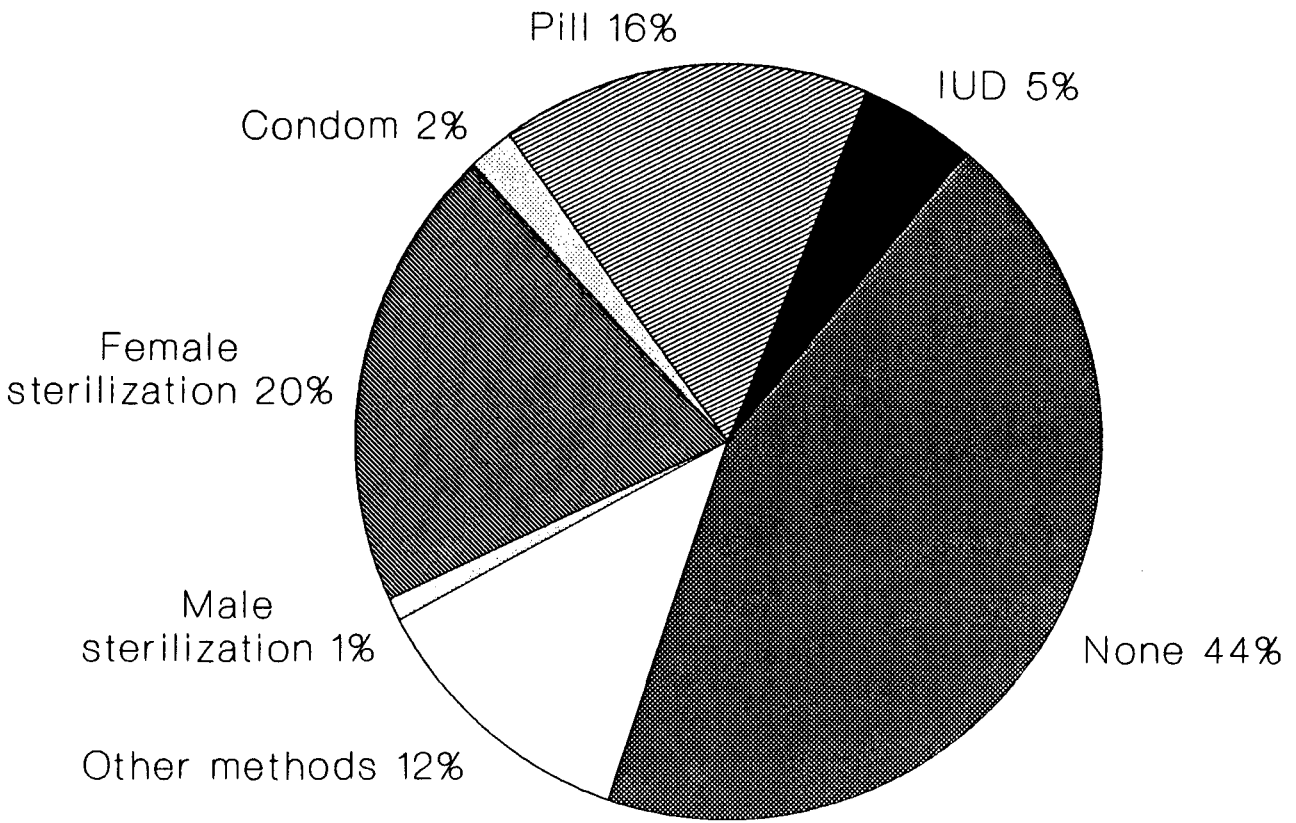
TRENDS IN CONTRACEPTIVE PREVALENCE IN THE DEVELOPING WORLD, BY REGION



Source: Family Planning and Child Survival Programs, as assessed in 1991
Ross, Mauldin, et al, p. 3

FIGURE 12

CONTRACEPTIVE USE BY TYPE, CIRCA 1990 LATIN AMERICA AND THE CARIBBEAN



Source:: Contraceptive use around the World, as assessed in 1989

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