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IMPROVING WOMEN'S HEALTH: ISSUES & INTERVENTIONS

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FOREWORD

As we assess our accomplishments since the Fourth World Conference on Women held in Beijing five years ago, I am pleased to present this World Bank update report on women's health issues and interventions.

The goals of improving women's health have been in place and recognized for some time—from the first International Safe Motherhood Conference in 1987 to the International Conference for Population and Development (ICPD) in 1994, the Fourth World Conference on Women in 1995, and ICPD+5 in 1999. The Bank has been financing activities to improve women's health for almost 30 years and significant gains have been made, especially in the areas of maternal and child health and in family planning. More and more, the Bank is increasing the level of policy dialogue with client countries to highlight the need to make good quality care available to women. In addition to engaging clients in policy dialogue, the Bank is working in partnership with other international organizations to raise the profile of reproductive health policies. The Bank has joined the World Health Organization (WHO), the United Nations Population Fund (UNFPA) and the United Nations Children's Fund (UNICEF) in 1999 to produce a joint statement expressing the agencies' commitment to reducing maternal mortality. The key messages of this joint statement are: (i) policy and legislative actions are needed to reduce maternal mortality and (ii) improvement in the health sector must be accompanied by social and community interventions.

The health status of women has improved over the last few decades, however it remains a major development task. Long standing challenges—like reducing unwanted fertility—still exist in some countries while other countries have moved on to new and different challenges. This paper outlines five key areas that represent the "unfinished agenda" in women's health—areas where the Bank and other partners are beginning to develop policies and finance specific activities. These areas include: safe motherhood, sexually transmitted infections (including HIV/AIDS), malnutrition, violence against women, and female genital mutilation. This paper provides useful background on the determinants of women's health in these areas and points to critical policy reforms and cost-effective interventions.

Eduardo Doryan
Vice President, Human Development Network
June 2000

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SUMMARY OF KEY ISSUES AND INTERVENTIONS

Women's low socioeconomic status and reproductive role expose them to risks of poor health and premature death. Yet many women's health problems can be prevented or mitigated through highly cost-effective interventions.

To achieve the greatest health gains at the least cost, national and donor investment strategies should give considerable emphasis to health interventions for women, particularly during their reproductive years.

Biological and social factors affect women's health throughout their lives and have cumulative effects.

A life cycle approach to health involves assessing critical risks and supporting key interventions that can have a positive long-term impact. For example, girls who are fed inadequately during childhood may have stunted growth, leading to higher risks of complications during childbirth and low birth weight babies.

Complications of pregnancy and childbirth constitute a major cause of death and disability among women of reproductive age in the developing world. Of all human development indicators for adults, the maternal mortality ratio shows the largest discrepancy between developed and developing countries.

Improving maternal health requires increasing the proportion of deliveries attended by health providers skilled in midwifery and strengthening the referral system to effectively manage delivery complications. Achieving these successful outcomes also depends on sustained high-level government commitment and behavior change at the community and household levels.

Unequal power between men and women in sexual relationships expose women to involuntary sex, unwanted pregnancy, and sexually transmitted infections (including HIV/AIDS).

Family planning and sexual counseling can empower women and give them more control over their lives. Sex education and counseling that promote mutual consent and condom use are also needed for men and boys. Education of girls, access to microfinance, training, and employment opportunities for women will promote gender equality more broadly.

Malnutrition affects 450 million women in developing countries, especially pregnant and lactating women. Iron, iodine, and vitamin A deficiency are widespread.

A two-pronged strategy is needed. The first aims to decrease energy loss by reducing unwanted fertility, preventing infections and lessening a heavy physical workload. The second focuses on increasing intake by improving diet and providing micronutrient supplements.

Domestic violence, rape, and sexual abuse occur in all regions, classes and age groups—affecting about 30% of women worldwide.

Laws, counseling, support services, and medical care are important for prevention and management of gender-based violence. Often a first step is providing a forum to raise awareness and mobilize support for action.

Female genital mutilation (FGM) is recognized as both a health and human rights issue—it affects two million girls each year, mainly in Africa.

The lesson learned from the Bank's work in combating FGM is that a broad based approach is needed, including public education and involvement of professional organizations and women's groups, as well as interaction with communities to address the cultural reasons for its perpetuation.

Women represent a disproportionate share of the poor and have limited access to health services. Furthermore, country data show that the gap is greater between rich and poor in access to skilled delivery than access to other basic health services.

Efforts are needed to help governments and non-governmental organizations expand health services to the poorest women, especially reproductive health services. Communication programs are also needed to inform poor women and their families about women's health problems and the importance of seeking care.

Quality of care is a significant factor in a woman's decision to seek health care. Even when health services are available and affordable, women may not use them if their quality is poor.

Promoting effective client-provider interaction is key to improving quality of health services for women. This requires skilled staff, an adequate supply of drugs, and sensitivity to cultural factors.

Improving women's health requires a strong and sustained government commitment, a favorable policy environment, and well-targeted resources.

Long-term improvements in education and employment opportunities for women will have a positive impact on the health of women and their families. In the short term, significant progress can be achieved by strengthening and expanding essential health services for women, improving policies, and promoting more positive attitudes and behavior towards women's health.

Improving Women's Health: Issues and Interventions

Introduction

Access by the poor to services that improve health, nutrition and fertility outcomes is one of the three pillars of the World Bank's Health, Nutrition, and Population Sector Strategy. Favorable health policies and effective and equitable health services are critical to the broader development goal of breaking the cycle of poverty, high fertility, poor health, low productivity and slow economic growth. Since women account for over half of the world's poor, improving their health is key to achieving this goal. Investing in women's health also has a significant impact on the health and well being of the next generation.

The World Bank has been financing reproductive health activities for almost 30 years—starting with basic family planning projects and moving on to more comprehensive reproductive health projects. Overall lending for population and reproductive health has totaled over $393 million a year since 1992—about one-third of the Bank's total lending for health, nutrition and population. While statistics on the Bank's lending in women's health overall are not available, projects are increasingly addressing women's health more broadly, as some of the examples in this report will illustrate.

The World Bank continues to examine ways to make financing of reproductive health programs more effective. Policy dialogue focuses on linking population to poverty reduction and human development in countries experiencing high fertility rates. The Bank's approach recognizes that lending for girls' education and microfinance and other income-generating opportunities for women are important for long term improvements in health and overall development. Continuing partnerships with client countries and with other donors and non-governmental organizations (NGOs) have resulted in sustained support for policies that adapt to changing needs. Further, lending is sensitive to country contexts and the Bank is able to mobilize funds quickly to meet new challenges. The World Bank is currently undertaking an evaluation of the effectiveness of our lending program in mainstreaming gender issues. Preliminary findings from this study indicate that the Bank is more effective at addressing women's issues in the area of health and education than in other sectors.

Research in reproductive health underpins both policy dialogue and project design. The World Bank has financed research in women's health in several countries, including India, Jamaica, Pakistan, the Russian Federation and Yemen, and has undertaken regional studies in Latin America and in the Middle East and North Africa. In India, the research was followed by a project financing reproductive and child health on a national scale; in Pakistan, the research was followed by closer collaboration between the Ministries of Health and Population Welfare. Research in Yemen developed a three-pronged strategy to accelerate the demographic transition, while improving its population management policies; the strategy ensures that reproductive health is in the comprehensive health package, expands girls' educational opportunities, and strengthens social programs to complement these two areas of emphasis.

Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks and preventable death. Yet cost-effective interventions exist to stop this unnecessary loss of lives. To achieve the greatest health gains at the least cost, national and donor investment strategies should give considerable emphasis to health interventions for women, particularly during their reproductive years.

Women's health concerns are both biological and gender-based. More boys than girls are born, and females have a natural biological advantage over males throughout the life cycle. Under optimal conditions for both men and women, a woman's life expectancy at birth is 1.03 times that of men. In some developing countries, however, the ratio is lower, dropping below 1.0 in parts of Asia—a sign of socioeconomic conditions particularly unfavorable to women and girls.

Women can generally expect to live longer than men but this does not necessarily ensure a better quality of life. Even in countries where women live longer, studies have found that they are more sickly and disabled than men throughout the life cycle. Country comparisons on key health indicators for women are provided in the Appendix.

There has been much progress in improving women's health; some challenges remain and new ones have emerged. The purpose of this paper is to identify key determinants of women's health, discuss women's health needs in the developing world, and recommend cost-effective interventions that address the major causes of death and disability among women in developing countries. Because social, economic, and cultural factors influence women's health and well being, the paper also recommends policy reforms and education and communication programs that promote positive attitudes and practices regarding women's health. The World Bank is committed to supporting programs that improve the health and well being of women. The project activities described in this report are just a sample of the various ways in which the Bank is working with governments, NGOs, and civil society to make a change.

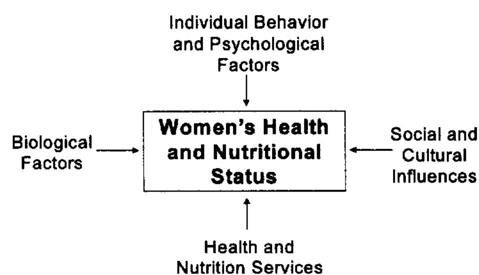
DETERMINANTS OF WOMEN'S HEALTH

My husband and I are no longer as close as when we used to be when I was working—I think it is because he knows that I am solely dependent on him, especially because the children are still young. I am scared of him...But I know that I have to do my best and listen to what he tells me to do, for the sake of the children.—South Africa, Voices of the Poor

Health status is influenced by complex biological, social, and cultural factors that are highly interrelated (Figure 1). These factors affect men and women differently. Women's reproductive biology, combined with their lower socioeconomic status, result in women bearing the greater burden from unsafe sex—which includes both infections and the complications of unwanted pregnancy. For example, among young adult women in Sub-Saharan Africa, unsafe sex accounts for one-third of their total disease burden. The burden of disease was calculated as the present value of future disability-adjusted life years (DALYS) lost as a result of death, disability, or injury in 1990, and revised in 1996. On the other hand, men are more likely than women to consume alcohol and use tobacco and have a higher risk for most injuries. These behavior factors explain the unusually high adult male mortality in Russia, where a man is almost three times more likely to die between the ages of 15 to 60 years of age than a woman.

Biological and social factors affect women's health throughout their lives and have cumulative effects. Therefore, it is important to consider the entire life cycle when examining the causes and consequences of women's poor health. For example, girls who are fed inadequately during childhood may have stunted growth, leading to higher risks of complications during and following childbirth. Similarly, sexual abuse during childhood increases the likelihood of mental depression in later years, and repeated reproductive tract infections can lead to infertility.

Figure 1. Determinants of women's health and nutritional status throughout the life cycle



Biological determinants

Unlike men, women are subject to risks related to pregnancy and childbearing. Where fertility is high and basic maternity care is not available, women are particularly vulnerable. In some Sub-Saharan African countries, for example, one out of every seven women will die of pregnancy-related causes.

Certain conditions, including hepatitis, anemia, malaria, and tuberculosis, can be exacerbated by pregnancy. For example, the incidence of viral hepatitis for pregnant women is twice as high as for non-pregnant women and more likely to prove fatal. Complications of pregnancy can also cause permanent damage, such as uterine prolapse and obstetric fistulae.

Because of biological factors, women have a higher risk per sexual exposure of contracting sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV) than do men. In addition, because women with STIs are less likely to have recognizable symptoms, they may delay treatment until an advanced stage, with more severe consequences. Human papillomavirus infection results in genital cancer much more frequently in women than in men, and it is the single most important risk factor for cancer of the cervix. Gynecological cancers (including breast, cervical, uterine, and ovarian) account for 27 percent of all malignancies occurring to women in developing countries.

Socioeconomic factors

Poverty underlies the poor health status of developing country populations, and women represent a disproportionate share of the poor. Furthermore, the cultural and socioeconomic environment affects women's exposure to disease and injury, their diet, their access to and use of health services, and the manifestations and consequences of disease.

In all regions reproductive health continues to be worst among the poor. Women in the poorest households have much higher fertility rates than those in the wealthiest—and far fewer births in the presence of skilled health professionals, contributing to higher maternal mortality ratios. Indicators of reproductive health by income level (Table 1) can help focus interventions where they are needed most.

Table 1. Total fertility and access to reproductive health care among the poorest and the richest, various years, 1990s

	Total fertility rate births per woman			Antenatal care received % of pregnant women			Births attended by skilled staff % of deliveries		
	Poorest quintile	Richest quintile	Average	Poorest quintile	Richest quintile	Average	Poorest quintile	Richest quintile	Average
Bolivia	7.4	2.1	4.2	39	86	65	20	98	57
Cameroon	6.2	4.8	5.8	53	99	79	32	95	64
Guatemala	8	2.4	5.1	35	90	53	9	92	35
India	4.1	2.1	3.4	25	89	49	12	79	34
Indonesia	3.3	2	2.8	74	99	89	21	89	49
Morocco	6.7	2.3	4	8	74	32	5	78	31
Vietnam	3.1	1.6	2.3	50	92	71	49	99	77

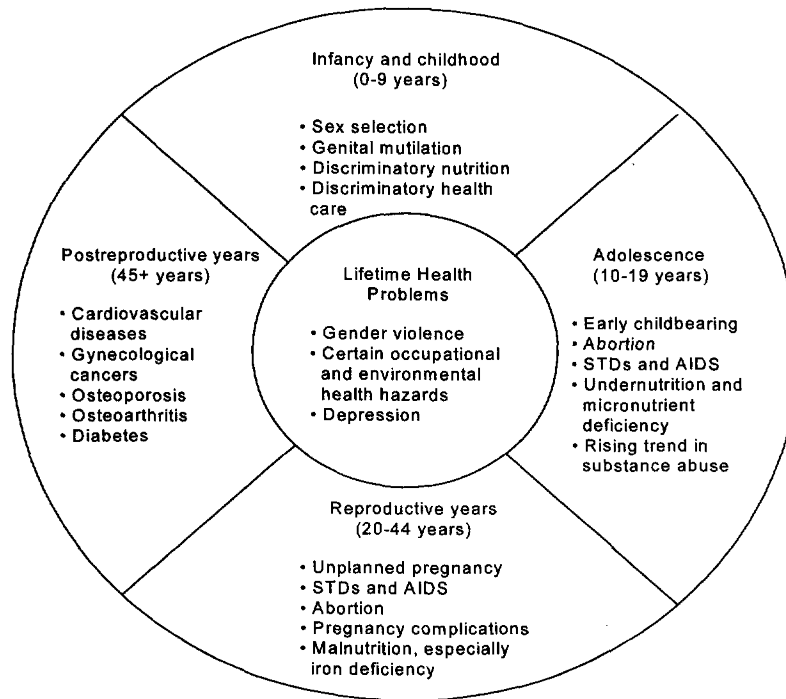
Note: Households are grouped into quintiles by assets.

Source: World Bank. *2000. World Development Indicators.*

Women's disadvantaged social position, which is often related to the economic value placed on familial roles, helps perpetuate poor health, inadequate diet, early and frequent pregnancy, and a continued cycle of poverty. For example, women in many parts of the world receive medical treatment less often when sick, and then only at a more advanced stage of disease. In countries where women are less educated and have less control over decision-making and family resources, they are also less apt to recognize health problems or to seek care. Restrictions in some South Asian and Middle Eastern countries on women traveling alone, or being treated by male health care providers, inhibit their use of health services.

Women's low socioeconomic status makes them more vulnerable to physical and sexual abuse and mental depression. Unequal power in sexual relationships exposes women to unwanted pregnancy as well as STIs. Their low social status has also led to more and more women in forced prostitution.

Figure 2. Health and nutrition problems affecting women exclusively or more severely than men during the life cycle in developing countries



MEETING WOMEN'S HEALTH NEEDS IN THE DEVELOPING WORLD

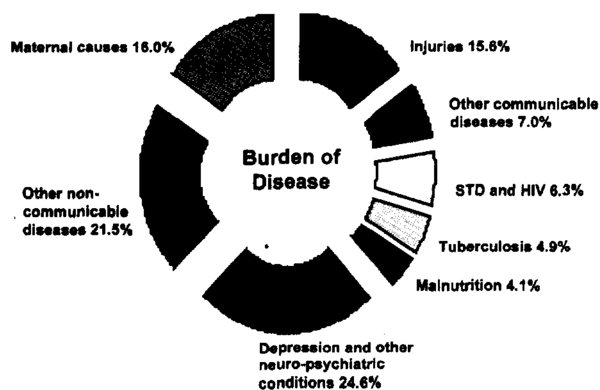
When women are sick, there is no one to look after them. When men are sick, they can be looked after by women.—South Africa, Voices of the Poor

In developing countries, women's health status is changing in response to several emerging trends. On the positive side, more girls are attending school, delaying marriage and childbearing, and having smaller families. However, the rate of HIV/AIDS infection is accelerating among women, with young women particularly at risk.

The world has witnessed an increase in life expectancy at birth, primarily because of the improved survival of infants and young children. Developing countries are now faced with an unfinished health agenda of problems such as continuing high maternal mortality ratios and malnutrition, and the new challenge of an increasing prevalence of chronic diseases such as cardiovascular disease resulting from an aging population. Socio-medical problems, such as gender-based violence, are also an increasing source of concern.

Many health concerns merit attention to improve women's health (Figure 2). This paper will focus on those that are most pressing in the developing world: safe motherhood, sexually transmitted infections (including HIV/AIDS), malnutrition, gender-based violence, and female genital mutilation. More than one-fifth of the disease burden among women aged 15 to 44 results from reproductive health problems which can be prevented or treated cost-effectively (Figure 3). In Sub-Saharan Africa their proportion is nearly two-fifths. Malnutrition is a major contributory factor to women's poor health and preventable mortality. Domestic violence and sexual abuse carry a heavy physical and mental toll, and constitute an intolerable violation of basic human rights. Other health problems, such as mental disorders, occupational health hazards, and chronic diseases are important, particularly as countries move through the demographic and epidemiological transition. They are, however, more costly and difficult to manage and are not covered in this brief paper.

Figure 3. Burden of disease in females aged 15 to 44 in developing countries



Source: Murray and Lopez eds. (1996). *The Global Burden of Disease*

SAFE MOTHERHOOD

We are all poor here, because we have no school and no health center. If a woman has a difficult delivery, a traditional cloth is tied between two sticks and we carry her 7 km to the health center. You know how long it takes to walk like that? There is nobody who can help here...—Togo, Voices of the Poor

Complications of pregnancy and childbirth are major causes of death and disability among women of reproductive age in developing countries. Every day at least 1,600 women die from the complications of pregnancy and childbirth. Of all the adult health statistics monitored by WHO, maternal mortality ratios show the largest discrepancy between developed and developing countries. Poor maternal health, nutrition, and quality of obstetric care not only takes a toll on women, but also is responsible for 20 percent of the burden of disease among children less than five years old. World Bank President James Wolfensohn stated the Bank's commitment on World Health Day in 1998: "Safe motherhood is a human right... Our task and the task of many like us ... is to ensure that in the next decade safe motherhood is not regarded as a fringe issue, but as a central issue."

Investment in pregnancy and safe delivery programs is a cost-effective way to meet the basic health needs of women in developing countries. Prevention of unwanted or ill-timed pregnancies is also essential to improving women's health and giving them more control over their lives.

The World Bank is now the largest source of external assistance for safe motherhood. In 1999, the Bank reviewed its experience in supporting safe motherhood programs over the last decade. While only 10 Bank-financed projects addressed maternal and child health and family planning by 1987, since then there have been about 150 such projects. Several key lessons emerge from the Bank's review.

Improving maternal health requires a continuum of services, including, in particular, referral capacity for the management of complications. This requires staff trained in midwifery skills at various levels of the health system, as well as functioning facilities accessible to clients and equipped with essential obstetric drugs and supplies.

Safe motherhood interventions can strengthen the performance of the overall health system. The effectiveness of maternal health services is often hampered by organizational and institutional constraints. Improving access to good-quality maternal health care remains a challenge in many countries because it requires a functioning primary health care system in the community and a referral system to a health facility capable of providing emergency obstetric care. Safe motherhood interventions designed to integrate various levels of the health sector can thus bring about improvements that more broadly affect the health system.

Safe motherhood programs must do what is feasible and adapt to local conditions. Initial activities in the poorest countries should emphasize expanding family planning, promoting good nutrition and hygienic births, training more health providers in midwifery skills, and improving the capacity of district hospitals to manage obstetric complications. Increasing

the number of female health workers can improve service quality and use, particularly in cultures that discourage women from consulting male health providers. In nations with more developed health care systems, efforts should be focused on improving the quality of case management and counseling in family planning and maternity care, paying particular attention to marginalized groups such as adolescents.

CHAD: DOING WHAT'S FEASIBLE IN DIFFICULT LOCAL CONDITIONS

Maternal mortality in **Chad** is among the highest in the world—due in part to the continuing desire for large families and the very limited use of family planning. One out of every nine women die of pregnancy-related causes. Only one in four women have access to skilled assistance during delivery; this situation is further complicated by limited use of antenatal care, difficult access to health care, and clandestine abortions. World Bank assistance for women's health in Chad has demonstrated that improvements in women's health services can be made, even under the most difficult circumstances. The Health and Safe Motherhood and Population and AIDS Control Projects have contributed to improvements in women's health by increasing access to services, despite severe geographic constraints. Chad is a land-locked country on very inhospitable terrain with limited infrastructure. Both projects were implemented in a spirit of innovation and with local participation and devised several ways to improve health outcomes for women. The lessons learned during these two projects have been incorporated in the follow-on project that was recently approved by the Bank.

Efficient transport—which is key to handling obstetric emergencies—is a major challenge in Chad. Roads are nearly impassable during the rainy season, which is nearly six months of the year. The Bank has financed ambulances placed at the district hospitals, supported by radio communication to health outlets, which are being used to transport women with obstetric emergencies. Since the ambulances cannot possibly cover the entire country, the Safe Motherhood project experimented with using motorcycles pulling stretchers to transport women to district hospitals. However, this experiment was unsuccessful in the remote areas due to the rough terrain. In response, the Bank will assist Chad through the follow-on project to establish maternity waiting homes near district hospitals; women may move in toward the end of their pregnancy, thereby eliminating the need for urgent transport should complications arise. The plan builds on the lessons learned by local NGOs, which have successfully implemented this type of temporary shelter.

The projects have implemented other very pragmatic activities to benefit pregnant women. While the doctor and head nurse have always had accommodations at the hospital, now the project provides midwives with housing as well. Not only does this elevate their status in the health community, but it also makes them available round-the-clock, since babies arrive at all hours. The severe shortage of female nurses is being addressed partly through decentralized basic training—so that women who must still attend to family duties can participate in training closer to their homes. To meet current needs, the project has facilitated the formation of teams comprised of a male nurse and a female traditional birth attendant. Pregnant women feel more secure with a female attendant while benefiting from a skilled health provider during delivery. In one pilot area of this teaming arrangement, the percent of facility-based births rose from almost none to 40 percent.

Effective programs promote increased utilization of maternal health services as well as improve the quality of services. Activities to promote awareness of maternal and reproductive health services are needed to increase the demand for services. Well-informed and educated families and communities will take responsibility for the health of women in their community by supporting and encouraging them to seek good maternal health care and nutrition and will recognize the danger signs in pregnancy and act quickly to transport women with complications to appropriately trained health professionals.

Research and analysis are important for policy reforms and for setting program priorities, especially since data related to maternal health are scarce. Project achievements should be assessed by indicators that measure the variables affecting maternal health, such as the percentage of births attended by skilled providers and pregnant women's access to basic and comprehensive emergency obstetric care. More detailed information about maternal morbidity is also needed. In addition, information should be fed back to health planners and providers for more rational decision-making and adjustments to improve program implementation.

CHINA: THE IMPORTANCE OF MONITORING AND EVALUATION

The **China** Comprehensive Maternal and Child Health Project has given particular attention to reducing maternal mortality. The project has been able to build the program from the bottom up with a firm commitment by the Government of China to provide sufficient resources to reduce maternal mortality. The project in China demonstrated that with Government commitment and a system in place, monitoring of women's health is possible—including studies to estimate maternal mortality, investigations into maternal deaths, and ongoing data collection of client responses to services. The project was approved in October 1994 and baseline data collected for key maternal health indicators, including the maternal mortality ratio by province, along with site of death and the cause. Project activities focus on increasing the number of prenatal and postpartum visits, increasing the number of hospital-based deliveries, and ensuring deliveries with sterilized methods.

After only two years there was a dramatic increase in the utilization of services—both antenatal services and attendance by skilled personnel during delivery—and an improvement in the quality of services provided. In more than half of the project provinces, the proportion of deliveries conducted in hospitals more than doubled. In most provinces, the maternal mortality ratio dropped by more than one-half by the mid-point of the project.

Collecting data on maternal health and routinely using it for decision-making has contributed significantly to China's success in reducing maternal mortality. The data reveals that most maternal deaths occurred at home or en route to a facility. In response to this, the Ministry of Health has modified training programs to emphasize identifying complicated pregnancies and conducted further investigation of transportation issues.

Detailed investigations of maternal and child deaths are conducted with the cooperation of health workers at all levels, not just where the death occurred. The investigation includes questions to determine whether or not the family and the health care providers understood the complexity of the case and how it was managed.

Sustained high-level government commitment and partnerships are essential to effective safe motherhood programs. Even though maternal health is a cost-effective and achievable objective, progress in reducing maternal death and disability has been slow, often because interventions are not properly phased or focused. Changes may be needed both in the health system itself and in the understanding of good maternal health practices at the household, community, and national levels to provide an effective continuum of care. Behavioral change is an important element of an effective pregnancy and safe delivery program, but achieving that change takes time.

INDONESIA: GOVERNMENT COMMITMENT IS CRITICAL

The lesson learned in **Indonesia** is that Government commitment to maternal health at the highest level will spur action. The program also demonstrates the gains that can be made from strengthening the linkages between communities and midwives. A commitment to reduce maternal mortality has been high on the agenda of the Government of Indonesia since 1988, when the President formally launched the Safe Motherhood Initiative in that country.

The World Bank has been a major source of support to Indonesia's health sector. Early efforts were focused on family planning, basic health and nutrition. Specific maternal health activities began during the Fifth Population Project, completed in 1997, including support for the training and deployment of 16,000 village midwives in 13 of Indonesia's 27 provinces. The Third Community Health and Nutrition Project, which began in 1993, is strengthening the district referral systems for maternity care and establishing transportation and communication systems to provide village midwives in remote areas with direct radio contact to health centers and district hospitals. The project also introduced maternal audits to evaluate maternity care and investigate maternal deaths. The current Safe Motherhood Project continues to finance these activities, giving particular attention to the sustainability of the village midwife program.

Between 1991 and 1997, the percent of deliveries attended by skilled midwives increased—from about 30 percent to over 40 percent—with a corresponding decrease in the percent attended by traditional birth attendants. The aim is to develop a client-focused approach to providing maternal health services, by first understanding the concerns that lead to under-utilization of certain services, and then working to address those concerns. The project is also working to complement the increased quantity of services by giving more attention to improving the quality of services provided.

SEXUALLY TRANSMITTED INFECTIONS INCLUDING HIV/AIDS

Women who become suddenly poor through the loss of a male partner are frequently forced into prostitution to earn a living. In fact HIV/AIDS is largely seen as a women's illness.— South Africa, Voices of the Poor

Every day, more than 1 million people are infected with a curable sexually transmitted infection (STI). Evidence since the early 1960s indicate that STIs enhance the transmission of HIV, the virus that causes AIDS. HIV, which is primarily transmitted sexually, is spreading rapidly among reproductive aged women, who now represent 40 percent of all new HIV infections. A number of factors place women at greater risk than men of contracting HIV/AIDS. Empirical evidence shows that men are four times more likely to transmit the virus to women than women are to men. Women are more likely than men to have asymptomatic, untreated STIs, which increases their susceptibility to HIV infection. Furthermore, women's sex partners tend to be older than they are and thus more likely to be infected. Social norms that require female passivity and economic dependence on men as well as lack of legal empowerment make it difficult for women to insist on mutual fidelity or condom use. In addition, women may be exposed to HIV infection when they receive blood transfusions to combat pregnancy-related anemia or hemorrhage.

Due to age asymmetry in sexual partnerships, seroprevalence among women is highest in the 15-25 age group, whereas most men are infected 10 years later, between the ages of 25-35. In countries such as Malawi, Ethiopia, Tanzania, Zambia, and Zimbabwe, for every 15-19 year old boy who is infected, there are five or six girls infected in the same age group. In some societies, men seek out young girls whom they believe are virgins and free of HIV. Other studies have shown that some men believe that they can rid themselves of HIV by having sex with a virgin.

Studies have shown that interventions do work, such as:

1) education, STI treatment, and condoms targeted at commercial sex workers and truck drivers (Uganda, Democratic Republic of Congo and Kenya);
2) social marketing of condoms (Brazil);
3) systematic treatment of STIs (Tanzania); and
4) voluntary testing and counseling (Rwanda).

Thailand has taken a multi-sectoral approach which has reduced the number of girls entering the sex industry, decreased brothel visits, and increased condom use, with dramatic impact on the rate of HIV infection. For example, since child prostitution is relatively high and HIV prevalence among sex workers is close to 30 percent, a national effort was initiated to eliminate entry into the sex industry by children under 18 years of age. Several projects are underway, including education and vocational training, which seem to have the best promise of reducing the number of girls entering the sex industry.

Women-controlled barrier methods for disease prevention and contraception are acutely needed. Since 1997, female condoms have become more widely available, but many

women find that they are difficult to use, or that men object to them. Research is underway to develop vaginal microbicides, which women can use to protect against STIs/HIV and unwanted pregnancy.

An AIDS Campaign Team for Africa has been established to expedite support to HIV/AIDS programs throughout Africa, including innovative forms of financing that will put resources directly in the hands of communities and ensure sustainable capacity. While the World Bank continues to regard Africa as a funding priority, it is also increasing its support to other regions. Last fiscal year, the Bank approved major HIV/AIDS projects in India and Brazil, as a follow-up to earlier projects.

ARGENTINA: TARGETING IN A COUNTRY WITH LOW HIV PREVALENCE

The World Bank-financed project in **Argentina** was approved in 1997 and aims to reduce HIV/AIDS transmission by targeting specific high-risk and vulnerable male and female groups; NGOs have been contracted to conduct prevention activities within high-risk groups. The project has a significant health promotion and education component that focuses on providing information to commercial sex workers as well as providing information through a toll-free hotline. Training and monitoring activities are being supported to ensure safety of the blood supply. The project aims to reach all centers that handle blood donations and transfusions.

KENYA: A MORE COMPREHENSIVE APPROACH IN A COUNTRY WITH HIGH HIV PREVALENCE

The World Bank financed STI/AIDS control project in **Kenya** began in 1995. The HIV/AIDS epidemic is still broadening in Kenya and the annual economic loss to Kenya from AIDS deaths will soon exceed US$2 billion annually. Promotion of condom use, screening of blood before transfusion and the management of STIs are the main interventions financed by the Bank project in Kenya. Efforts to educate people on HIV and AIDS have resulted in a massive awareness of the problem. More women are aware of how to prevent STIs and more women have been diagnosed and received treatment. The project teaches women how to recognize STIs and encourages them to seek treatment. The project also offers screening for STIs among pregnant women seeking care in health clinics, and information, education, and communication activities. The Bank is also financing drug kits for the management of STIs.

The various World Bank-financed projects targeting HIV/AIDS reinforce the lesson that targeting high-risk groups such as sex workers is a cost-effective intervention crucial to all AIDS control strategies, but more is needed. Several projects also emphasize the importance of environmental and social influences on sexual behavior, such as gender-based power imbalances within relationships, and the role that NGOs can play in addressing them. Social norms that require female passivity and economic dependence on men make it difficult for women to negotiate whether or when to have sex, or to insist on condom use.

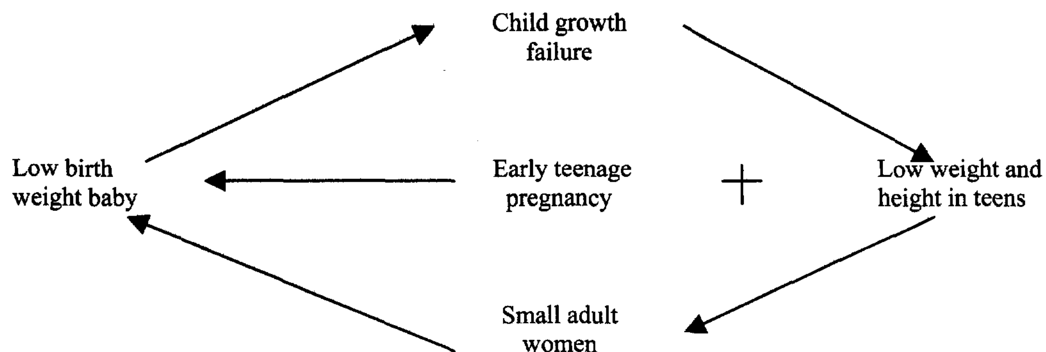
MALNUTRITION

When a meal is served in a house, the men eat first then women eat if something is left.— Pakistan, Reproductive Health Matters

An estimated 450 million adult women in developing countries are stunted as a result of protein-energy malnutrition during childhood, and underweight is a common problem among women in developing countries. More than 50 percent are anemic and about 250 million women suffer the effects of iodine deficiency, and, although the exact numbers are unknown, millions are probably blind due to vitamin A deficiency. The highest levels of malnutrition among women are found in South Asia, where about 60 percent of women suffer from iron deficiency anemia. This proportion rises to 80 percent among pregnant women in India.

Studies in India, Bangladesh and Pakistan have shown chronic energy deficiency in nearly 70 percent of women. In Africa, between 20-40 percent of women are malnourished, depending upon whether there has been a catastrophe, war, famine, or drought.

Figure 4. **Intergenerational cycle of growth failure**



Children of malnourished mothers are born with low birth weight, are disadvantaged from birth, fail to grow normally, and face a higher risk of disease and premature death (Figure 4). Malnourished mothers also face a higher risk of complications and death during pregnancy and childbirth. Malnutrition reduces women's productivity, increases their susceptibility to infections, and contributes to numerous debilitating and fatal conditions.

A two-pronged strategy to improve women's nutrition is needed. The first aims to decrease energy loss by reducing unwanted fertility, preventing infections, and lessening a heavy physical workload. The second focuses on increasing intake by improving the diet, reducing inhibitors that limit the efficiency of food absorption (such as intestinal worms), and providing food and micronutrient supplements. Nutrition programs should assess the nutritional status of girls and women at risk and provide supplements as needed, improve nutritional habits through counseling and public education, and identify appropriate local

food sources. Adding micronutrients (such as iron, vitamin A, and iodine) to processed foods can also be effective, as long as the fortified foods are readily available, widely consumed by women, and relatively inexpensive.

BANGLADESH: A COMMUNITY APPROACH TO IMPROVING WOMEN'S NUTRITION

It is estimated that about half of the women in **Bangladesh** are underweight and more than 70 percent of pregnant women are anemic. The Bangladesh Integrated Nutrition Project, which was launched in 1995, has been successful in reducing levels of severe malnutrition—more than 120,000 children and 140,000 malnourished pregnant women have directly benefited from the project. Under the project, more than half of enrolled pregnant and lactating mothers receive supplementary foods; 80 percent of these pregnant women received iron tablets and 90% of women received a vitamin A supplement during the postpartum period.

The Bangladesh project has shown the importance of a "bottom-up" approach when behavior change is critical to health outcomes. The project also demonstrates the additional gains that can be made in improving women's status when they are involved in a meaningful way from the very beginning. The project includes training of women and women's groups as well as income generating opportunities for women.

The project is being implemented at the grass roots level by 9,000 community nutrition centers donated and managed by village committees and 14 NGOs contracted by the Government. The project provides training to nutrition workers as well as ongoing supervision and is financing key inputs—like simple scales that are used to monitor weight gain in pregnant women. By 1998, the number of low birth weight babies decreased by 30 percent, reflecting an improvement in weight gain by at least half of pregnant women. This weight monitoring is just part of an integrated package of services available to pregnant women. Most nutrition workers are already established as health workers or traditional birth attendants. As such, they are able to provide the expectant mother with general health counseling for pregnancy and post-partum care, including family planning counseling. Data also indicate that 40 percent of women in project areas have had two or more antenatal visits compared to only 16 percent in non-project areas.

The project also targets newly-wed women and aims to "break the cycle" of poorly nourished mothers giving birth to low weight, nutritionally disadvantaged newborns. Newly-weds are counseled on the importance of good quality food in appropriate quantities, before, during and after pregnancy. They also receive family planning counseling, along with some nutritional supplements.

In addition, the project supports various training, including training for women's groups in preparing, packaging, and distributing nutrition supplements. This activity has improved the nutritional status of women in the community, as well as increased the awareness of the importance of nutrition across the entire community. Enhancing the role of women involved in the nutrition program has done much to build their esteem and raise their status in the community. They are earning income and able to be mobile in a culture that often places restrictions on women. The key to success has been the involvement and support of the community throughout the process.

VIOLENCE AGAINST WOMEN

Men rape within the marriage. Men believe that paying dowry means buying the wife, so they use her anyhow at all times. But no one talks about it.—Uganda, Voices of the Poor

Domestic violence, rape, and sexual abuse are widespread across all regions, classes and age groups. Globally, about 30 percent of women are coerced into sex, beaten, or otherwise abused at least once in their lives. Women are most at risk at home and from men whom they know. Violence against women affects their productivity, autonomy, quality of life, and physical and mental well being.

The world is becoming increasingly aware of the horror of organized violence against women during warfare from research in Bosnia, Croatia, and Rwanda. With many countries involved in armed conflicts today, women are increasingly affected. Compared with the estimated 5 percent civilian casualty rate in World War I, an estimated 90 percent of war casualties in 1990 were civilians. Globally, women and children represent 80 percent of the 13.2 million refugees and the 30 million people displaced within their country's borders. The needs of women refugees differ from that of male refugees. They are particularly concerned with physical protection, food security, primary heath care and education. In some cultures, when food supplies are low, men in refugee camps will be fed at the expense of women, as is the case in many households.

In 1994, the first population-based study of war-time violence against women found that half of the randomly selected women surveyed in Liberia had experienced at least one act of physical or sexual violence by a soldier or fighter. In 1999, there were allegations of systematic rape of ethnic Albanian refugees by Yugoslav and Serbian forces. The extent of sexual assaults will likely never be known, since in this Muslim society, a sexual assault is considered a disgrace to a woman and her family and often goes unreported.

In addition to efforts to improve women's socioeconomic status, guidelines for preventing and responding to sexual violence include:

1) ensuring access to information and medical care, including information about emergency contraception and sexually transmitted infections (STIs/HIV/AIDS), and offering blood tests with follow-up and counseling;
2) identifying and working with women's and youth groups;
3) providing psychosocial support, such as encouraging support groups and making available experienced counselors;
4) ensuring the security of refugee settings by involving women in the design and on-going operation of camps; and
5) taking appropriate legal action.

The World Bank's experience in working to eliminate violence against women indicates that providing a forum for the various groups involved—women, NGOs, the Government, the health community—to raise awareness and begin to discuss the issues is an important first step. The United Nations International Day for Elimination of Violence Against Women

was marked on November 25, 1999. The World Bank participated in national conferences around the world and was particularly active in East Asia. The World Bank office in Bangkok worked with the Office of the National Commission on Women's Affairs to help organize a national conference on violence against women. On the same day in Vietnam, the World Bank hosted, together with the Vietnam Women's Union, the United Nations Development Programme (UNDP) and the Canadian International Development Association (CIDA) a discussion on gender-based violence. At this meeting, a study on domestic violence in Vietnam commissioned by the World Bank was presented. The study indicates that the two major contributing factors to domestic violence are economic hardship and alcohol abuse. It also suggests that domestic violence is influenced by many factors, but underlying all the factors that can lead to domestic violence are traditional gender roles and responsibilities.

In the Latin America and Caribbean region, violence is widespread and is seen as an inevitable part of life. In response, the Bank commissioned a study on methodologies to measure the gender dimensions of crime and violence. The report includes tools to help distinguish between the various types of violence—political, economic and social—and explains the various levels of causality—in the home, in communities as well as at the macro country level. The data available on acts of violence against women, like wife beating, are limited. However, worldwide evidence suggests that women are much more receptive to participating in research and in sharing their experiences. Since the health burden of violence against women in both industrialized and developing countries has been clearly demonstrated, the paper suggests the need for national-level population and reproductive health surveys to include inquiry into the prevalence rates of violence against women.

KOREA: RAISING AWARENESS ABOUT VIOLENCE

Domestic violence increased in **Korea** as a result of the economic crisis and prompted the introduction of a new government policy on the elimination of violence against women. Using a grant fund facility, the World Bank is working in partnership with the Korean government to address this issue. One of the first activities was a workshop that was sponsored by the Government and facilitated by the Bank. The workshop was a huge success—with approximately 400 participants, twice the number originally anticipated.

FEMALE GENITAL MUTILATION

Why Mum? Why did you let them do this to me? Those words continue to haunt me. ...It's now four years after the operation and my children continue to suffer from its effects. How long must I live with the pain that society imposed on me and my children?—Gambia, Female Genital Mutilation: A Call For Global Action

It is estimated that over 132 million women and girls have experienced female genital mutilation (FGM), and that some two million girls are at risk of undergoing some form of the procedure every year. At least 90 percent of women have undergone the operation in Dijbouti, Egypt, Eritrea, Mali, Sierra Leone, and Somalia.

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons. Genital mutilation has serious and sometimes fatal physical consequences, as well as psychological effects. Complications may include hemorrhage, tetanus, and infection, as well as severe pain since the majority of procedures are performed without anesthetic. Long-term consequences may include scarring, urinary tract infections, urinary incontinence, complications in childbirth, and painful intercourse.

Female genital mutilation has been the cause of mental and physical trauma and sometimes even death among girls and women in several African countries. Traditional "elders" (male and female) carry out the procedure, most often for some remuneration. The procedure is rarely carried out by anyone with health training and little attention is given to ensuring sterile conditions. Because this is a very complex issue involving beliefs and cultural practices, communities have been reluctant to change and there have been only modest achievements.

FGM has been recognized as both a health and human rights issue. The Declaration and Platform for Action of both the International Conference on Population and Development and the Fourth World Conference on Women, held in 1994 and 1995 respectively, call for an end to the practice of FGM. Since ICPD, nearly one-third of the 28 African countries where FGM is practiced have legally banned it. In 1994, Ghana became the first independent African state to pass a law against FGM. Senegal and Cote d'Ivoire adopted a law against it in 1999. In Senegal, women in several villages have collectively abandoned FGM at pledging ceremonies, and a national committee has been established to educate the population on the consequences of the practice and to encourage other villages to pledge.

Governments and non-governmental organizations, including professional organizations and women's groups, should receive encouragement and material support to work for the elimination of genital mutilation. Laws and clear policy declarations prohibiting the practice may help, but more broadly based efforts are also needed. Widespread public education programs can publicize the harmful effects of genital mutilation and address its cultural roots. Local research may be needed to determine the cultural reasons for its perpetuation, as well as to test effective approaches for preventing it, such as alternative rituals. When researchers asked women in Egypt about the best way to abolish the practice, they

recommended educational campaigns directed toward parents. Training for health providers on the elimination of the practice and on management of its health consequences is also needed.

The lesson learned from the World Bank's work in combating FGM is that legislation can only be effective when it is complemented by more broadly-based efforts. These include public education programs and involvement of professional organizations and women's groups, as well as interaction with communities to address the cultural reasons for its perpetuation.

The Government of Guinea has passed legislation to ban FGM and imposed strict punishment on those whose practice resulted in the death of a woman or girl. However, it has been difficult for the government to enforce the legislation. In response, the Bank financed reproductive health project is collaborating with several NGOs to end this practice. The project has implemented a public awareness campaign to educate communities about the harmful consequences of this practice. NGOs, financed by World Bank grant funds, have complemented this campaign by focusing on the issues confronting those engaged in the practice—including their fear of losing status and income. NGOs will coordinate with communities and assist former practitioners to find alternative employment opportunities that will benefit the entire community. The Bank's assistance programs in Burkina Faso and Chad also include information, education and communication activities as well as training to reduce the practice of FGM.

GUINEA: AN INNOVATIVE APPROACH TO REDUCING FGM

The World Bank's Development Market Place Program recently awarded $150,000 to test an approach to retraining village traditional practitioners who perform FGM in Kouroussa, **Guinea**. The project recognizes that performing FGM is an important income earning activity for village women. The project provides an alternative income source to traditional practitioners by giving them access to microfinancing, training and market support for agriculture products. Funds can be accessed for vegetable farming and for the purchase of equipment for milling local crops. In addition to funding from the Development Market Place, the pilot is supported through funds from a World Bank loan to the Government of Guinea and microfinance funding from the International Finance Corporation (IFC).

CONCLUSIONS

Improving women's health requires a strong and sustained commitment by governments and other stakeholders, a favorable policy environment, and well-targeted resources. Long-term improvements in education and employment opportunities for women will have a positive impact on the health of women and their families. In the short term, significant progress can be achieved by strengthening and expanding essential health services for women, improving policies, and promoting more positive attitudes and behavior towards women's health, summarized in Table 2.

In the design and implementation of programs, constraints to women's access to care need to be taken into account, such as cultural restrictions against women's ability to travel and limits on women's control over family resources. Outreach, mobile clinics and community-based services can be helpful. Clustering services for women and children at the same place and time often promotes positive interactions in health benefits and reduces women's time and travel costs, as well as costs of service delivery. Women should be empowered to make more informed decisions and to act on them. For example, public education and counseling can increase access to information about self-care and about when care is needed or where it is available.

Even where health services are readily available and affordable, women may not use them if their quality is poor. Quality of care is a significant factor in a woman's decision to seek care, to give birth at a clinic instead of at home, or to continue using contraception. Effective client-provider interaction is increasingly recognized as a key factor for improving quality of services. Health programs achieve better outcomes when clients believe that their needs are being met and when they are treated with respect and technical competence. Quality can be improved through adequately trained staff, drugs, and supplies, increasing the number of female health providers, establishing convenient hours, reducing overcrowding, and ensuring privacy and confidentiality.

In addition to strengthening services, countries can take additional steps to meet women's health needs. Through legislation, legal enforcement, and information, education and communication, harmful practices such as gender discrimination, domestic violence and FGM can be curbed. Close collaboration among government, non-governmental organizations, communities, and women's groups will make services more responsive to women and improve utilization and impact.

Efforts to improve women's health must include activities oriented to men. Reaching boys at a young age through school-based and mass media programs can be particularly effective in shaping later attitudes and practices. Programs directed to boys and men are needed to promote safe sex, increase awareness of women's health and nutrition needs, decrease gender bias, and reduce violent behavior.

The task ahead is to apply what we know about women's health needs to concrete actions. It is clear that many women's health problems could be effectively managed through low-cost interventions in low-income settings. The World Bank is currently addressing these

issues through policy dialogue, lending, research and support to several non-governmental organizations through the Bank's small grants facility. The problems vary by region—as do the type of approaches and specific activities. In order to ensure that we make progress in these important areas, the Bank has put in place a mechanism to ensure that lessons learned are disseminated—and used—in new projects. For the World Bank, human development is crucial to eliminating poverty and women have a key role to play. Investments in women's health and nutrition promote equity and generate multiple payoffs for families, the community, the national economy, and the next generation. It is time to complete the unfinished agenda for the women of this generation and their daughters who follow.

Table 2. Essential services for women's health

Essential health interventions	*Essential interventions for behavioral change*
<u>Prevention and Management of Unwanted Pregnancies</u> • Family planning • Management of complications from unsafe abortion • Termination of pregnancy where not against the law <u>Pregnancy Related Services</u> *Prenatal care* • Birth planning • Prompt detection, management, and referral of pregnancy complications • Tetanus toxoid immunization • Nutrition promotion, including iron and folate and, where warranted, iodine supplements • Management and treatment of sexually transmitted infections, malaria, and tuberculosis *Safe Delivery* • Hygienic delivery by skilled attendant • Detection, management, and referral of obstetric complications • Facility-based obstetric care *Postpartum care* • Monitoring for infection and hemorrhage <u>Prevention and Management of Sexually Transmitted Infections and Gynecologic Cancers</u> • Condom promotion and distribution • Prenatal screening and treatment for syphilis • Symptomatic case management • Screening and treatment of commercial sex workers • Screening and treatment for cervical cancer from age 35 and for breast cancer from age 50, as resources permit	<u>Promotion of Positive Health Practices</u> • Education, employment opportunities, and micro-credit to give women more information and control over decisions regarding their health • Counseling and public education to promote safe sex • Public education and programs to ensure adequate nutrition • Strategic efforts to increase male involvement in women's health • In-school education about reproductive physiology, sexuality, reproductive health, and gender relations, as well as dangers of substance abuse • Training to improve the quality of care, including respect for women's privacy, dignity, and informed choice <u>Elimination of Harmful Practices</u> • Laws, public education, and services to eliminate gender discrimination, domestic violence, rape, and female genital mutilation. • Laws, public education and policy dialogue to eliminate trafficking of girls, and forced prostitution • Laws, education and services to reduce marriage and childbearing among adolescents • Training and regulation to reduce overuse or abuse of medical technologies, such as unwarranted cesarean sections and episiotomy during childbirth.

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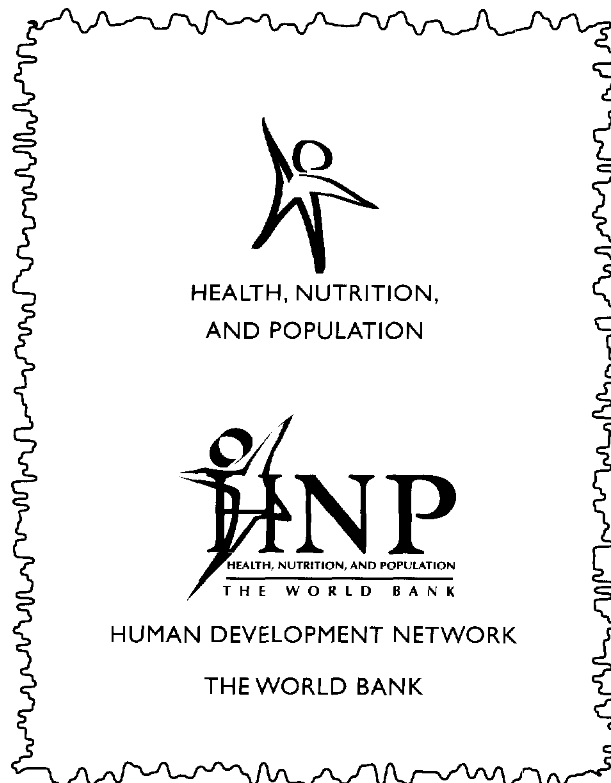
APPENDIX: KEY INDICATORS OF WOMEN'S HEALTH

Country	*Total fertility rate births per woman 1998*	*Contraceptive prevalence rate % of women aged 15-49 1990-98*[a]	*Births attended by skilled health staff % of total 1996-98*[a]	*Maternal mortality ratio per 100,000 live births 1990-98*[a]		*Prevalence of anemia % of pregnant women 1985-99*[a]	*Illiteracy rate % of females 15 + 1998*
Albania	2.5	..	99	..		..	24
Algeria	3.5	51	77	..		42	46
Angola	6.7	..	17	..		29	..
Argentina	2.6	..	97	38	b	26	3
Armenia	1.3	..	95	35	b	..	3
Azerbaijan	2.0	..	99	37	b	36	..
Bangladesh	3.1	49	8	440	c	53	71
Belarus	1.3	..	..	22	d	..	1
Benin	5.7	16	60	500	c	41	77
Bolivia	4.1	49	46	390	c	54	22
Bosnia and Herzegovina	1.6	..	..	10	b	..	..
Botswana	4.2	..	77	330	d	..	22
Brazil	2.3	77	92	160	c	33	16
Bulgaria	1.1	..	99	15	d	..	2
Burkina Faso	6.7	12	42	..		24	87
Burundi	6.2	..	24	..		68	63
Cambodia	4.5	..	31	..		..	80
Cameroon	5.0	19	55	430	c	44	33
Central African Republic	4.8	14	46	1,100	c	67	68
Chad	6.4	4	15	830	c	37	69
Chile	2.2	..	99	23	b	13	5
China	1.9	85	..	65	c	52	25
Colombia	2.7	72	85	80	b	24	9
Congo, Dem. Rep.	6.3	..	45	..		..	53
Congo, Rep.	6.0	..	50	..		..	29
Costa Rica	2.6	..	97	29	c	27	5
Côte d'Ivoire	5.0	11	45	600	c	34	64
Croatia	1.5	..	..	12	b	..	3
Cuba	1.5	..	99	27	b	47	4
Czech Republic	1.2	69	100	9	d	23	..
Dominican Republic	2.9	64	96	..		..	17
Ecuador	2.9	57	64	160	c	17	11
Egypt, Arab Rep.	3.2	48	46	170	c	24	58
El Salvador	3.3	60	87	..		14	25
Eritrea	5.7	8	21	1,000	c	..	62
Estonia	1.2	..	100	50	d	..	..
Ethiopia	6.4	4	8	..		42	70
Gabon	5.1	..	80	..		..	..
Gambia, The	5.6	..	44	..		80	73
Georgia	1.3	..	100	70	b	..	..

Country	Total fertility rate births per woman 1998	Contraceptive prevalence rate % of women aged 15-49 1990-98[a]	Births attended by skilled health staff % of total 1996-98[a]	Maternal mortality ratio per 100,000 live births 1990-98[a]		Prevalence of anemia % of pregnant women 1985-99[a]	Illiteracy Rate % of Females 15 + 1998
Ghana	4.8	20	44	..		64	40
Guatemala	4.4	32	29	190	c	45	40
Guinea	5.4	2	31	..		..	..
Guinea-Bissau	5.6	..	25	910	d	74	83
Haiti	4.3	18	21	..		64	54
Honduras	4.2	50	47	220	d	14	27
Hungary	1.3	73	96	15	d	..	1
India	3.2	41	35	410	c	88	57
Indonesia	2.7	57	36	450	c	64	20
Iran, Islamic Rep.	2.7	73	74	37	c	17	33
Iraq	4.6	..	54	..		18	57
Jamaica	2.6	65	92	..		40	10
Jordan	4.1	50	97	41	b	50	17
Kazakhstan	2.0	59	..	70	e	27	..
Kenya	4.6	39	45	590	c	35	27
Korea, Dem. Rep.	2.0	..	100	110	d	71	..
Korea, Rep.	1.6	..	98	20	d	..	4
Kyrgyz Republic	2.8	60	98	65	b	..	..
Lao PDR	5.5	25	30	650	b	62	70
Latvia	1.1	..	100	45	d	..	0
Lebanon	2.4	..	89	100	c	49	21
Lesotho	4.6	23	50	..		7	7
Libya	3.7	45	94	75	c	..	35
Lithuania	1.4	..	100	18	d	..	1
Macedonia, FYR	1.8	..	95	11	b	..	..
Madagascar	5.7	19	57	490	c	..	42
Malawi	6.4	22	55	620	c	55	56
Malaysia	3.1	..	98	39	b	56	18
Mali	6.5	7	24	580	c	58	69
Mauritania	5.4	..	40	..		24	69
Mauritius	2.0	75	97	50	b	29	20
Mexico	2.8	65	68	48	c	41	11
Moldova	1.7	74	..	42	d	20	2
Mongolia	2.5	..	99	150	d	45	49
Morocco	3.0	59	31	230	c	45	66
Mozambique	5.2	6	44	..		58	73
Myanmar	3.1	..	57	230	c	58	21
Namibia	4.8	29	68	230	c	16	20
Nepal	4.4	29	9	540	c	65	78
Nicaragua	3.7	60	65	150	b	36	31
Niger	7.3	8	15	590	c	41	93
Nigeria	5.3	6	31	..		55	48

Country	*Total fertility rate births per woman 1998*	*Contraceptive prevalence rate % of women aged 15-49 1990-98*[a]	*Births attended by skilled health staff % of total 1996-98*[a]	*Maternal mortality ratio per 100,000 live births 1990-98*[a]		*Prevalence of anemia % of pregnant women 1985-99*[a]	*Illiteracy rate % of females 15 + 1998*
Oman	4.6	..	91	19	b	54	43
Pakistan	4.9	24	18	..		37	71
Panama	2.6	..	84	85	d	..	9
Papua New Guinea	4.2	26	53	..		16	45
Paraguay	3.9	59	61	190	c	44	9
Peru	3.1	64	56	270	c	53	16
Philippines	3.6	47	53	170	c	48	5
Poland	1.4	..	98	8	d	..	0
Puerto Rico	1.9	78	90	..		..	7
Romania	1.3	57	99	41	d	31	3
Russian Federation	1.2	34	99	50	b	30	1
Rwanda	6.1	21	26	..		..	43
Saudi Arabia	5.7	..	90	..		..	36
Senegal	5.5	13	47	560	c	26	74
Sierra Leone	6.0	..	25	..		31	..
Slovak Republic	1.4	..	100	9	d	..	..
South Africa	2.8	69	82	..		37	16
Sri Lanka	2.1	..	..	60	d	39	12
Sudan	4.6	10	69	..		36	57
Syrian Arab Republic	3.9	40	67	..		..	42
Tajikistan	3.4	..	92	65	b	50	1
Tanzania	5.4	18	38	530	c	59	36
Thailand	1.9	72	78	44	c	57	7
Togo	5.1	24	50	480	c	48	62
Trinidad and Tobago	1.8	..	98	..		53	8
Tunisia	2.2	60	81	70	b	38	42
Turkey	2.4	..	76	..		74	25
Turkmenistan	2.9	..	96	110	b	..	..
Uganda	6.5	15	38	510	c	30	46
Ukraine	1.3	..	..	25	b	..	1
Uruguay	2.4	..	96	21	b	20	2
Uzbekistan	2.8	56	98	21	b	..	17
Venezuela, RB	2.9	..	97	65	c	29	9
Vietnam	2.3	75	79	160	c	52	9
West Bank and Gaza	5.9	42	..	..		..	..
Yemen, Rep.	6.3	21	43	350	c	..	77
Yugoslavia, FR	1.7	..	99	10	d	..	..
Zambia	5.5	26	47	650	c	34	31
Zimbabwe	3.7	48	69	400	d	..	17

Notes for Table
a. Data are for most recent year available. Maternal mortality ratios are currently being updated by WHO and UNICEF. b. Official estimate. c. Estimate based on survey data. d. Estimate by the World Health Organization and Eurostat. e. Estimate by UNICEF.
Source: World Bank. 2000. *World Development Indicators*



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