

**UNITED NATIONS**

**ECONOMIC COMMISSION  
FOR LATIN AMERICA  
AND THE CARIBBEAN - ECLAC**



Distr.  
GENERAL

LC/G.2015(SES.27/20)  
20 April 1998

ENGLISH  
ORIGINAL: SPANISH

---

Twenty-seventh session  
Oranjestad, Aruba, 11-16 May 1998

**POPULATION, REPRODUCTIVE HEALTH AND POVERTY**

## CONTENTS

	<i>Page</i>
SUMMARY AND CONCLUSIONS.....	1
A.    PURPOSE OF THE DOCUMENT .....	1
B.    MAIN RESULTS .....	3
C.    CONCLUSIONS .....	7
I.    BASIC CONCEPTS .....	11
A.    A GENERAL OVERVIEW OF HUMAN REPRODUCTION.....	11
B.    REPRODUCTIVE BEHAVIOUR, HEALTH AND RIGHTS.....	12
C.    POPULATION, REPRODUCTIVE HEALTH AND SOCIAL INEQUITY .....	13
II.   TRENDS IN REPRODUCTIVE BEHAVIOUR WITHIN DIFFERENT SOCIO-ECONOMIC GROUPS IN LATIN AMERICA AND THE CARIBBEAN.....	15
A.    THE DECLINING BIRTH RATE.....	15
B.    DIFFERENCES IN FERTILITY WITHIN COUNTRIES.....	19
III.  CHANGES IN THE TIMING OF REPRODUCTION: INCREASED CONCENTRATION AND GREATER PROMINENCE OF TEENAGE FERTILITY .....	31
A.    THE CHANGE IN TIMING .....	31
B.    TRENDS IN TEENAGE FERTILITY .....	33
C.    SOCIO-ECONOMIC DIFFERENCES IN TEENAGE FERTILITY.....	36
IV.   REPRODUCTIVE IDEALS AND UNWANTED FERTILITY .....	49
A.    REPRODUCTIVE IDEALS.....	49
B.    UNWANTED FERTILITY .....	55
V.    AN OUTLINE OF THE STATE OF REPRODUCTIVE HEALTH AMONG THE POPULATION OF LATIN AMERICA AND THE CARIBBEAN .....	63
A.    COMMENCEMENT OF SEXUAL AND REPRODUCTIVE LIFE.....	64
B.    FAMILY PLANNING AND CONTRACEPTION.....	72
1. Knowledge and attitudes .....	72
2. Contraceptive practices .....	77

	<i>Page</i>
C. MOTHER AND INFANT HEALTH .....	88
1. Prenatal care .....	91
2. Care during delivery .....	96
3. Maternal mortality .....	101
4. Infant mortality .....	106
D. A SERIOUS SEXUAL HEALTH PROBLEM: THE AIDS/HIV EPIDEMIC .....	111
Bibliography .....	121
Annex .....	129
 BOXES	
1 Recent fertility trends in Latin American countries, by area of residence .....	23
2 The reproductive behaviour of different social groups: the cases of Bolivia, 1994 and Colombia, 1995 .....	29
3 Fertility among Caribbean teenagers: example of programme designed to mitigate its consequences.....	37
4 Fertility during early adolescence and puberty.....	39
5 Poverty and reproductive behaviour: facts and controversies .....	62
6 The role of women and patterns of consensual union in Venezuela .....	70
7 Changes in family planning in Mexico .....	83
8 Declining fertility in Brazil: a change that was not expressly planned for.....	88
9 Women's health during their reproductive years: gender equity and specificity .....	90
10 Reproductive health and ethnic groups. Figures and prospects.....	95
11 Abortion as a social and health problem.....	105
12 Infant mortality and social segmentation in the urban space.....	110
13 AIDS: trends and prospects .....	112
14. Reproductive health programme approaches in situations of advanced demographic transition: notes on the case of Argentina.....	119
 FIGURES	
1 Total fertility rate: changes in the period 1955-2000 by major regions of the world.....	16
2 Latin America and the Caribbean: total fertility rate, 1950-1955, 1970-1975 and 1995-2000, by country .....	17
3 Latin America and the Caribbean: total fertility rates of urban and rural residents and national totals, selected countries, around 1995 .....	21
4 Latin America and the Caribbean: percentage difference in fertility by area of residence, selected countries, around 1995.....	22
5 Latin America and the Caribbean: total fertility rates in the highest and lowest educational groups, selected countries, around 1995 .....	24
6 Latin America and the Caribbean: percentage difference in TFR between women with no schooling and women with higher education, selected countries, around 1995 .....	25

	<i>Page</i>
7 Latin America and the Caribbean: specific fertility rates, 1950-1955, 1995-2000 and 2045-2050 .....	34
8 Latin America and the Caribbean: the structure of fertility, 1950-1955, 1995-2000 and 2045-2050 .....	35
9 Latin America and the Caribbean: specific teenage fertility rates (age 15 to 19) by area of residence, selected countries, around 1995.....	41
10 Latin America and the Caribbean: teenage fertility as a proportion of total fertility by area of residence, selected countries, around 1995 .....	42
11 Latin America and the Caribbean: percentage of teenagers with reproductive experience by area of residence and in total for selected countries, around 1995 .....	44
12 Latin America and the Caribbean: percentage differences between rural and urban areas in the number of teenagers with reproductive experience, selected countries, around 1995 .....	45
13 Latin America and the Caribbean: percentage of teenagers with reproductive experience by level of education, selected countries, around 1995.....	46
14 Latin America and the Caribbean: percentage of teenagers with reproductive experience by level of schooling, selected countries, around 1995.....	47
15 Latin America and the Caribbean: total fertility rate and average number of children desired, selected countries, around 1995 .....	51
16 Latin America and the Caribbean: average number of children desired by area of residence and national total, selected countries, around 1995 .....	52
17 Latin America and the Caribbean: average number of children desired by level of education, selected countries, around 1995 .....	53
18 Latin America and the Caribbean: average number of children desired by sex and absolute and relative differences between the reproductive aspirations of men and women, selected countries, around 1995 .....	56
19 Latin America and the Caribbean: percentage of fertility that is unwanted, in total and by area of residence and level of education, selected countries, around 1995 .....	57
20 Latin America and the Caribbean: total fertility rate and total rate of desired fertility, selected countries, around 1995.....	59
21 Latin America and the Caribbean: total rate of desired fertility, in total and by area of residence and level of education, selected countries, around 1995 .....	60
22 Latin America and the Caribbean: average age at time of first sexual relationship and first conjugal union, women aged from 25-29, selected countries, around 1995 .....	66
23 Latin America and the Caribbean: average age at time of first sexual relationship and first conjugal union, men aged from 25-49, selected countries, around 1995 .....	67
24 Latin America and the Caribbean: percentage difference between the age of the first conjugal union and of the first sexual relationship, by area of residence and level of education, selected countries, around 1995.....	69
25 Latin America and the Caribbean: percentage who have knowledge of contraceptive methods, selected countries, around 1995 .....	73
26 Latin America and the Caribbean: percentage of women in conjugal unions who know of some modern contraceptive method, by area of residence and level of education, selected countries, around 1995 .....	74

	<i>Page</i>
27 Latin America and the Caribbean: percentage of women who reject messages about and use of contraceptives, by level of education and area of residence, selected countries, around 1995.....	76
28 Latin America and the Caribbean: percentage of couples in which the woman approves and her partner disapproves of family planning, by area of residence and level of education, selected countries, around 1995.....	78
29 Latin America and the Caribbean: women currently in conjugal unions, by use of contraceptive methods, selected countries, around 1995.....	79
30 Latin America and the Caribbean: percentage of women in conjugal unions with unmet family planning needs by area of residence and level of education, selected countries, around 1995.....	82
31 Latin America and the Caribbean: prevalence of sterilization among women in conjugal unions, selected countries, around 1995.....	86
32 Latin America and the Caribbean: use of sterilization as a percentage of all contraceptive methods employed, in total and by area of residence and top and bottom educational groups, selected countries, around 1995.....	89
33 Latin America and the Caribbean: percentage of expectant mothers with prenatal monitoring, selected countries, around 1995.....	92
34 Latin America and the Caribbean: percentage of expectant mothers with prenatal monitoring, by area of residence and level of education, selected countries, around 1995.....	94
35 Latin America and the Caribbean: percentage of births attended by trained personnel during the five years prior to the survey, selected countries, around 1995.....	98
36 Latin America and the Caribbean: percentage of births attended by trained personnel during the five years prior to the survey, by mother's area of residence, selected countries, around 1995.....	99
37 Latin America and the Caribbean: percentage of births attended by trained personnel during the five years prior to the survey, by mother's level of education, selected countries, around 1995.....	100
38 Latin America and the Caribbean: maternal mortality rate per 100,000 births, selected countries, around 1995.....	103
39 Latin America and the Caribbean: overall infant mortality rates, by area of residence and by level of education, selected countries, around 1995.....	109
40 Latin America and the Caribbean: percentage of people who are aware of AIDS by gender, selected countries, around 1995.....	115
41 Latin America and the Caribbean: percentage of women of child-bearing age who are aware of AIDS by area of residence and level of schooling, selected countries, around 1995.....	116
42 Latin America and the Caribbean: percentage of women of child-bearing age who state that they have knowledge of how to prevent AIDS, selected countries, around 1995.....	117

## SUMMARY AND CONCLUSIONS

### A. PURPOSE OF THE DOCUMENT

There are three reasons which make this document relevant: (i) the general agreement among the countries of the region about the need to respect and promote reproductive rights, including the ability to regulate fertility; (ii) the awareness that there is a demographic pattern associated with poverty which tends to act as yet another obstacle among the many that hinder the poor from escaping from marginalization; (iii) the conviction that reproductive health care must form part of any strategy that aims simultaneously to improve people's living conditions, raise the quality of human resources and reduce socio-economic inequalities.

In 1993, as part of their activities to prepare for the International Conference on Population and Development held in Cairo in 1994, the countries of the region organized the Latin American and Caribbean Regional Conference on Population and Development in Mexico City, and signed up to the Latin American and Caribbean Consensus on Population and Development. In this document it is recognized that *"the opportunity to regulate fertility is a universally recognized human right"*; it is recommended that Governments *"ensure the full exercise of this right as one of their prime objectives"* and, to this end, *"provide access to family planning services, expand their coverage and improve their quality, providing care without restriction to all men and women who want it, in a framework of full respect for individual freedoms and for the diversity of sociocultural and religious beliefs and values"* (p. 15).

This Consensus also recognizes the existence of chronic social inequalities within the countries, one of the most dramatic manifestations of which is the high proportion of people living in poverty. These inequalities manifest themselves demographically as *"differences in morbidity and mortality rates, particularly among mothers and infants, in patterns of territorial mobility and in fertility between different sectors of society and ethnic groups. In particular, there has been a lack of family planning programmes that live up to the principles of total care for women and children. If these requirements and others of a social nature (such as health and education) were met, this would not only meet the need for equity, but would have positive effects for the development of human resources"* (pp. 4 and 5). The links between the particular reproductive behaviour of the poor and the transmission of poverty between generations are dealt with more specifically in a document that the Secretariat of ECLAC presented at the Conference referred to above (ECLAC/CELADE, 1995): *"The decline in birth rates has not occurred with the same intensity in all social groups. Women in the poorest socio-economic strata have, on average, more children; analogously, the higher fertility rates in rural areas are found among small farmers, landless workers and ethnic minorities, who are excluded from the benefits of progress. A fact of singular importance is that many of the women of these sectors systematically declare that a high proportion of their pregnancies are undesired. Thus, family planning seems to have followed the lines of*

*inequity; its unavailability to certain groups virtually prevents them from exercising an essential reproductive right and limits the freedom of couples belonging to these groups to decide how many children they wish to have... The differences in birth rate by social sector provide clear evidence of the inequity which prevails in the countries of the region* (p. 44). Again, the follow-up report on the Latin American and Caribbean Regional Plan of Action on Population and Development presented by the Secretariat of ECLAC at its Twenty-sixth Session (1996) sums up the role played by the high fertility rates of the poor in the sequence of events that shapes the process whereby poverty is transmitted from generation to generation in individual families: "...a high level of fertility is an element that contributes to the intergenerational perpetuation of poverty. Indeed, children born in poor homes —i.e., in homes where the parents, because of their limited participation in production and labour markets, have access only to low incomes— grow up under unfavourable circumstances as regards nutrition and care, health services and education. Thus, when they grow up, they are poorly equipped to gain access to highly productive occupations, and they end up replicating the low income of their parents, i.e., they become poor adults. This cycle is reinforced when the number of children in poor homes is relatively high, since in such cases, each child receives a smaller share of nutrition, education, etc. Moreover, because they grow up in poverty, they are quite likely to reproduce the fertility patterns of their parents. In this connection, it should be noted that poor households not only have different fertility rates, but they also have higher rates of early fertility (teenage pregnancy)..." (p. 7).

The Programme of Action approved at the International Conference on Population and Development devotes a chapter to *reproductive rights and reproductive health* (pp. 32 to 41). Without entering into the debate about the ethical aspects implicit in the different points of view held about reproductive rights, but accepting the position agreed by the countries in the Consensus mentioned above, affirming "*the right of individuals, couples and those in conjugal unions to have access to a wide range of methods for regulating their fertility*" (p. 16), there is a consensus that reproductive health is of vital importance for people's health, and therefore that caring for people's reproductive health contributes to their physical and mental well-being and their ability to play a productive and participative role in society. Prevention and treatment in the area of reproductive health presuppose the active involvement of the individuals concerned, who need to have some knowledge about their physiology, and in particular about the repercussions of their sexual and reproductive behaviour, if they are to be in a position to opt for types of behaviour that are consistent with their aspirations and well-being. As well as being a substantive advance in terms of equity, the freedom to take informed decisions without distinction of sex, social class, ethnic origin or nationality is a legitimate means for promoting changes in reproductive behaviour, in particular among groups that are more vulnerable in socio-economic terms, and especially if the people who belong to these groups have revised their reproductive preferences downwards, but cannot as yet implement these new preferences.

In short, it needs to be borne in mind that as reproductive health is given greater prominence, the traditional focus of mother and infant health care is being widened to include the entire reproductive cycle and sexual behaviour, requiring the medical and sociocultural approaches to be combined and emphasizing gender aspects in relation to both sexes.<sup>1</sup> Furthermore, the new emphasis on reproductive health is giving rise to fresh ways of dealing with some traditional issues (between population growth and

---

<sup>1</sup> This is clearly apparent in the definition of reproductive health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" (United Nations, 1995a, p. 30).

economic and social development, for example) in the context of population and development; the promotion of reproductive health, in fact, requires the community as a whole to become aware of the sexual and reproductive aspirations, behaviour and practices of individuals and couples. As such, the links between patterns of reproduction and development will not be addressed solely from the governmental angle, which typically is macrosocial, as in the case of public health policies or official approaches to fertility levels and trends, but also from the point of view of families and individuals, which typically is microsocal, being a process of decision-making about everyday concerns.

## **B. MAIN RESULTS**

How have socio-economic and demographic changes in the region affected the reproductive health of the population? What information is available on the current state of inequities in the area of reproductive health and behaviour and the interrelationship between these and social inequalities and poverty in Latin America and the Caribbean? What policy challenges lie ahead on the road to securing full enjoyment of reproductive rights and ensuring that reproductive health care is available to the entire population of Latin America and the Caribbean? In this section an attempt will be made to give some answers to these questions in the light of available secondary information and of the analysis carried out in the main body of this document.

The rapidity of the decline in fertility has been the distinguishing feature of demographic trends and patterns among the population of Latin America and the Caribbean over the last 30 years. Although all the countries in the region have seen their fertility rates drop, the differences between them have become slightly more pronounced. According to current estimates, at present (the five-year period 1995-2000) there is a small group of countries with total fertility rates that are lower than the replacement level (less than 2.1 children per woman on average), a large group, including most of the countries and the bulk of the region's population, with values that are above the replacement level but lower than the world average of 3 children per woman, and a third group of countries with total fertility rates in excess of this average. In general, the nations with the highest fertility rates are those that are the least developed and have the lowest indices of human development. The decline in fertility has been particularly marked among women aged over 35, and this, combined with the rise in intervals between pregnancies, has helped to bring down the incidence of high-risk births. At the other end of the age range, teenage fertility has also fallen, but more slowly and, in some countries, more erratically.

This decline in fertility has taken place in all groups in society, a development that may be regarded both as indicative of the success of policies implemented in certain countries to secure precisely this objective, and as an unequivocal manifestation of how potent and far-reaching are the structural forces that are impelling couples to have less children. Nonetheless, the most disadvantaged groups in society, such as the poorer strata, segments with little or no schooling, inhabitants of the countryside and indigenous peoples, still show levels of fertility that are higher than, and in some cases multiples of, the averages for the countries in which they live; in a number of countries the total fertility rates of these groups are of the order of 5 children per woman, reaching a maximum of 7 among women without schooling. Although the urbanization process and the inclusion of more of the population in the school system have meant the size of the illiterate and rural population diminishing as a proportion of the total in certain countries, there are still areas whose population shows a high level of fertility, existing in conjunction with poverty and marginalization.



Whether because of the globalization of socio-economic relationships or due to the uniformity of cultural messages, the number of children declared to be ideal by women in the different strata of society varies less than does actual fertility. Among poorer groups this discrepancy translates into a larger number of offspring than desired; as against this, in some countries the actual fertility rates of more highly educated groups are lower than the number of children declared to be ideal. Thus, reproductive rights may be vulnerable in both poorer groups and highly educated segments, although for different reasons and with different consequences. While society is failing to provide the former with the means to match actual fertility to desired fertility—as is clearly demonstrated by the low indices of contraceptive use—the demands that this same society imposes on the latter, in terms of what they have to do to maintain a standard of living that is compatible with their qualifications, tend to make it difficult for them to have children; in this case, the decision to have a smaller number of offspring than desired is a result of pressure exerted by the economic and sociocultural context in which this decision is made.

The particular reproductive behaviour of the poor is due in part to the pattern of early sexuality/union.<sup>2</sup> This pattern tends to lead both to teenage and early adolescent fertility, since reproduction is still one of the main purposes of unions, and to high rates of fertility, because in the absence of extended family planning the age at which reproductive life begins becomes a determining factor in the final overall fertility of women. Of course, the consequences of this pattern of nuptiality are not limited to fertility alone; in a number of countries the figures available show that among disadvantaged groups the average age at which the first union is formed is generally the same as or lower than the age at which schooling ends, a fact that is indicative of the potential that these patterns of union may have for disrupting the training of human resources among the poorer groups in the population. In addition, there are difficulties involved, irrespective to some extent of the socio-economic situation of the family, in the raising and education of the children of teenage parents, who are generally not mature enough to cope with the emotional and economic demands of having children.

It seems that a determined effort to deal with the consequences that the pattern of early sexuality/union entails is one of the keys to addressing the problem of teenage fertility, which, as the governments recognized in the Latin American and Caribbean Consensus on Population and Development, is one of priority concern in the region: *"teenage pregnancy gives cause for concern because of its impact on maternal and child health, especially in view of the high incidence of maternal morbidity and mortality, and because of its psychological and social repercussions, such as the disruption of schooling, its interference with the mother's training to enter the labour market and the difficulties it entails for the maintenance of unions"* (p. 16). Consequently, the Consensus urges Governments *"to devote their efforts, on a priority basis, to designing and adopting global reproductive health care models for teenagers, focusing particular attention on population education, and within that field, family life education, comprehensive sex education and family planning"* (p. 16). This concern is entirely appropriate, since teenage fertility rates are still high, and trends erratic, in some countries. Comparative analysis of the situation in the different countries, however, does reveal progress in some of them, and this demonstrates that effective action can be taken to mitigate this problem.

Although knowledge of contraceptive methods has become widespread in the region, there are still gaps in some countries, particularly among the most marginalized segments of the population.

---

<sup>2</sup> A greater degree of commitment and stability is what distinguishes regular sexual relationships from casual ones. While regular sexual relationships are regarded by demographers as being synonymous with marriage, such relationships take widely differing forms, ranging from formal unions approved under civil or religious law, to less formal unions (United Nations, 1998). In this document, the term "union" is used to refer to any of these forms.

Furthermore, it has been found that claimed knowledge about contraceptive measures is often accompanied by ignorance about basic aspects of the physiology of reproduction, and this has implications for the effectiveness with which methods to regulate fertility can be used, particularly in the case of traditional or natural methods which presuppose the ability to track the woman's fertility cycle.

Positive attitudes to family planning are also widespread, but in all the countries there is a proportion of women who reject contraceptive use for ideological reasons, including disapproval on religious grounds or for reasons linked to cultural norms, or because of personal inclination; there are indices that show this objection to be more frequent among the poorer groups of the population, and this constitutes a further barrier to the objective of reducing social discrepancies in the area of family planning. In addition to ideological grounds, refusal to use contraceptives may be due to obvious reasons (the woman is pregnant, sterile, trying to become pregnant or not sexually active) or may be justified by arguments that, although valid for the woman concerned, may be based on prejudice (adverse health effects or loss of sexual potency).

Gender conflicts manifest themselves clearly in the way methods to regulate fertility are used. In the case of nearly all methods of contraception, it is the responsibility of the woman to use them (condom use and vasectomy are not widespread in the region), something that reflects both an imbalance of power within couples and a certain nonchalance among men as regards their sexual behaviour, or at least the reproductive consequences of this. Likewise, campaigns to promote family planning tend to be directed at women. Also illustrative of gender conflicts is the fact that in most cases where couples disagree about whether contraception should be used or not, it is the man who is opposed; this situation is more common among poorer groups in the population and is probably one of the manifestations of the machismo that still survives in social strata where the value set on women in society is often based on their role as wives and mothers. In most couples, however, both partners are willing to use methods to regulate fertility, and the data available are sufficient to rule out the possibility that ignorance about contraception on the part of men may be a reason why couples do not practise family planning.

To complete this brief reference to the factors that limit access to family planning, it needs to be noted that, across the board, economic causes (monetary cost of contraceptives) or physical ones (proximity of medical posts) are barely mentioned as reasons for not using methods to regulate fertility. Sociocultural barriers, including the concentration of responsibility on women, and fears about collateral effects, whether founded or unfounded, seem to be the main forces preventing family planning from becoming more widespread in the region.

The differing economic, sociocultural and political circumstances of the countries leave their imprint on every aspect of reproductive health and behaviour. In the Caribbean and Central America, for example, the ages of sexual initiation and union tend to be earlier than in the Andean area, and this is associated with much higher fertility rates among teenagers in the former subregions; the reasons for this pattern would appear to be overwhelmingly of a cultural type. Contraceptive use also varies widely, between countries like Brazil and Colombia where more than 80% of women in conjugal unions have at some time used a modern method of contraception, and others like Guatemala and Haiti where less than a third of these women have ever used some form of modern contraception. These peculiarities are also to be found in patterns of inequity within countries; for example, whereas in some countries access to family planning differs only slightly between social strata (although the difference is always to the detriment of poorer groups), in others the differences are staggering. Perhaps the clearest manifestation of these inequities is to be found in *unmet demand for family planning*. If the situation of the groups at the top and bottom of the educational spectrum is compared, it is found that the proportion of women

with a low level of education in conjugal unions who are unable to meet their family planning needs is from 4 to 10 times higher (depending on the country) than the proportion of women with higher education who are in this position. The reasons for reluctance to use family planning methods also have national peculiarities; in some countries, the main reason is the wish to conceive, while in others health fears predominate, and in a few —generally the most underdeveloped in terms of the coverage of family planning services— the most common causes are ideological objections or ignorance of methods or sources of supply.

It should be stressed that the national peculiarities referred to are not attributable exclusively to public policies that specifically promote family planning. The case of Brazil, which has never had an official policy of this kind, shows that fertility can fall in the different groups in society without there having been any obvious support from the state. Where such support is lacking, however, there are potential risks for society, the stability of couples and the health of women, such as high rates of abortion and limited choice in the supply of contraceptive methods.

In any strategy that aims to address the different aspects of reproductive health in a comprehensive way, it is essential for progress to be made in the provision of care during pregnancy, childbirth and puerperium, and in the area of sexual health, including prevention of sexually transmitted diseases and others that are associated with the reproductive system. As health programmes have concentrated on mother and infant issues, there has been a general improvement in the indicators that measure care given during pregnancy and childbirth. Nonetheless, these indicators, and those relating to morbidity and mortality, still lag behind those of industrialized regions. Indeed, a select few countries have managed to achieve virtually universal coverage with mother and infant services, and have thereby succeeded in reducing infant mortality rates to just over 10 per thousand, which is close to the average for the developed world; by contrast, two countries in the region (Bolivia and Haiti) still have infant mortality rates of over 60 per thousand.

A number of factors have been instrumental in enabling certain countries to make more progress than others in controlling infant mortality. The first factor is the political will to set in train, and the perseverance to continue with, infant health programmes that include primary care components with wide coverage nationally and initiatives directed especially at the most vulnerable sectors of the population. The second factor is consolidation of mother and infant health strategies, with a strong emphasis on monitoring and tracking individuals and applying preventive medicine measures. A third factor, which is peculiar to the area of reproductive health, is that these programmes and strategies have been applied within the context of a steady decline in fertility and in the number of high-risk births. Finally, the whole process of reducing infant mortality has taken place in a context of rising educational levels among the population at large, increasingly widespread knowledge about how people can protect and safeguard their own health, substantial improvements in the coverage of environmental sanitation services and enhanced communications and transport networks. The experience of these countries should be considered with a view not just to reducing the disparities between the countries of the region but also to easing the inequalities found within countries. The differences in infant mortality rates between social strata are acute manifestations of social inequality, as the rates found among poor and marginalized groups are generally several times higher than the averages for the countries concerned; even in those countries that have made the most progress in preventing infant mortality there are substantial relative differences between socio-economic segments.

Although, in general, maternal mortality accounts for only a small proportion of all deaths in the countries of the region, the very fact of its existence is a cause for concern, since in virtually all cases

death can be avoided by means of fairly simple preventive measures or treatments. Although only fragmentary information is available on this health problem, which obviously has a gender bias, Bolivia, Peru and Haiti are countries that can be identified as having high maternal mortality rates in the context of the region as a whole (over 250 per 100 thousand). The information obtained shows, furthermore, that maternal mortality is overwhelmingly a problem of poor and marginalized groups in the population: in Mexico, the rate of maternal mortality is eight times higher in the state of Oaxaca than it is in Nuevo León, and in Bolivia it has been estimated that, in the decade 1984-1994, the rate was six times higher in the rural areas of the Altiplano than in the plains.

Good sexual health is a prerequisite for safe reproduction. Although the information available on sexual health conditions in the region is likewise incomplete, it can be said that there are still numerous shortcomings in the timeliness and effectiveness of preventive care and treatment for a number of diseases, among them certain venereal diseases (syphilis and gonorrhea), some neoplastic diseases (cervical cancer, breast cancer and cancer of the testes) and, of growing importance, diseases related to AIDS/HIV. AIDS is a major concern in the region because of the rapidity with which it has spread, and because it is so lethal; despite the awareness campaigns that have been mounted, there are still segments of the population that are unaware of the existence of AIDS (only a third of rural women in Bolivia and 47% of illiterate women in Peru have heard of AIDS); ignorance about how to prevent AIDS is widespread among groups with a low level of education. Although information and education campaigns dealing with these issues need to be continued, particular importance should be given to those directed at segments of the population that are not covered, i.e., those that have the least exposure to the messages of the communications media and the most difficulty in understanding written public information material, especially if the conditions in which they live pose a high risk of infection.

### C. CONCLUSIONS

What can be done about persistent shortcomings and inequities in the coverage and quality of reproductive health care and infringements of reproductive rights, among the poor in particular?

The Latin American and Caribbean Consensus on Population and Development, the Programme of Action adopted at the International Conference on Population and Development and the Latin American and Caribbean Regional Plan of Action on Population and Development provide a set of objectives, suggestions, recommendations and measures aimed at this very objective. The countries have already agreed upon a basic operating strategy: *"offer access to safe motherhood services, particularly those related to sex education, care during pregnancy, childbirth and puerperium, and family planning. These services should offer high quality, integral attention, taking into account the sociocultural identity of the users and assigning priority to the most vulnerable population groups"* (ECLAC/CELADE, 1996, p. 33).

There are great difficulties involved in implementing the above strategy successfully:<sup>3</sup> (i) the deficiencies in material, financial and human resources that need to be overcome are substantial and are

---

<sup>3</sup> In this section, rather than reiterating the contents of the two instruments for action approved unanimously by the countries of the region (the Latin American and Caribbean Consensus on Population and Development and the Latin American and Caribbean Regional Plan of Action on Population and Development), the focus will be on examining the strategic conclusions that emerge from the results discussed in the document.

particularly acute for the poor and marginalized segments of society, as these require free or subsidized care, implying a considerable charge on public funds; (ii) there is a lack of institutional experience in implementing health services that combine the different aspects of reproductive health (the rather traditional approach of family planning and mother and infant health programmes still predominates in the region); (iii) persistent sociocultural and psychosocial barriers that prevent reproductive health services from being generally accepted, in particular as regards sexual behaviour and the regulation of fertility. These difficulties mainly affect the poorer groups in the population.

Given the diversity of the situations in different countries, which is confirmed in the analysis, reproductive health policies and programmes, although based on reasoning that is generally accepted, need to be given justifications, features and contents that are appropriate to the circumstances of the country concerned. In some countries, existing material, sociocultural and psychosocial conditions are such that a very large proportion of the population could quickly be covered by comprehensive reproductive health care, since there is already massive and structured demand for family planning and mother and infant health services; thus, the main task appears to be to institutionalize reproductive health care, improve its quality and pursue integrated programmes that cover its different aspects, concentrating in particular on promoting the right to have the number of children desired, and to have them safely. In some countries, on the other hand, there are more serious material and sociocultural problems which manifest themselves, among other indicators, in higher levels of fertility, higher rates of ignorance about contraceptive measures, and higher indices of unmet family planning needs and infant mortality; these are countries in which even basic family planning and mother and infant health-care services have not yet been consolidated. National commitment, international support and cooperation from other countries in the region appear to be vital if progress is to be made in improving reproductive health care and in protecting reproductive rights in these countries. In all cases, special care needs to be taken to ensure that the strategy adopted treats men and women as active participants in caring for their own reproductive health and, in addition, ensures that there is a transparent and adequate supply, without coercion, of methods for controlling fertility.

Given the differences between social strata and groups, something that is also established in the analysis, reproductive health policies and programmes need to be adapted to the specific characteristics of these groups. For reproductive health services to be expanded, both promotional programmes and those relating to the supply of services need to be specially tailored to the target groups, which in most cases will be characterized by a situation of poverty linked with: (i) geographical disadvantages, as in the case of people living in the countryside or in thinly populated areas; (ii) cultural peculiarities, such as those that characterize indigenous groups; (iii) social disadvantages, like those faced by segments with little or no schooling; (iv) vulnerability inherent in the stage they are at in the life cycle, as in the case of adolescents; (v) risks due to age, as in the case of women aged under 20 or over 34; (vi) physiological predisposition, as when pre-existing illnesses or genetic factors linked with disease are present; (vii) reproductive history, such as a large number of deliveries or short intervals between pregnancies; (viii) incautious sexual behaviour, one of the consequences of which is manifested in the frequency of sexually transmitted diseases.

Comprehensive and general care for reproductive health is in itself a contribution to people's well-being, particularly in poor groups that have the greatest deficiencies in this area, and at the same time can help to reduce the inequalities that now exist. Achieving this, however, does not guarantee social mobility or an end to poverty. Although the struggle against this scourge may be less complicated if the reproductive patterns of the poor can be prevented from setting up a vicious circle that perpetuates their condition, for poverty to be eradicated it is necessary to remove its immediate causes, which are

associated, among other aspects, with economic growth, structural patterns of income distribution, participation in the labour market, educational performance and social investment. Furthermore, although it is true that if the basic reproductive right could be fully exercised there would be a fall in fertility within the region, since this is consistently higher than the average number of children desired, in the short term it is unlikely that fertility rates will fall below the replacement level, since current reproductive preferences are of the order of 2.5 children per woman. Furthermore, the issue of women who do not succeed in having the average number of children that they wish for, because of either infertility or the demands their environment places upon them, needs to be opened up for thorough debate to find ways for them to exercise their basic reproductive right. The European experience shows that actual fertility, at an advanced stage in the demographic transition, may be lower than the number of children desired, and that measures aimed at bringing the two indicators into line are not very successful.

Education is a powerful factor in changing potentially harmful sexual and reproductive behaviour. Providing the poor with a normal educational career should encourage them to delay forming their first union until they are older, thereby delaying sexual initiation and reducing the incidence of pregnancy in the teenage years and early adolescence. Again, sex education is a central pillar of risk prevention; furthermore, it can help encourage people to take an active approach to reproductive health and the exercise of reproductive rights. It is vital for efforts to be made in this direction within the sphere of education if the effectiveness with which contraceptive methods are used is to be increased, especially in the case of natural or traditional methods; these efforts would also be helpful in meeting the need for wide availability of contraceptive methods and reducing the risks of coercive programmes. Again, both formal education and sex education help to make people receptive to modern medicine, particularly in the case of ethnic groups, while improving the ability of mothers and fathers to prevent illnesses during childhood and giving people greater access to information about sexually transmitted diseases or diseases related to the reproductive system.

Now, formal education and sex education cannot by themselves guarantee responsible sexual and reproductive behaviour. Teenagers need special programmes that are carefully designed to influence sexual, nuptial and reproductive patterns. The figures show clearly that the highest indices of teenage fertility, and of sexual initiation and formation of first unions at early ages, are found among the most disadvantaged groups in society. Yet these groups are not characterized by having greater sexual freedom than others; on the contrary, a substantial proportion of the most disadvantaged segments seem to be virtually "destined" to early sexual initiation and union, due to the scarcity of alternative prospects in life. The wider horizons that education and access to labour market opportunities give young people are fundamental in enabling them to develop plans for their lives that do not include parenthood during their teenage years. As against this, modernization does entail a certain relaxation in social controls on sexual behaviour; although greater sexual freedom is not synonymous with a higher rate of teenage pregnancy, lack of access to the means for regulating fertility may bring about this result, and could also mean a rise in illegitimate births and unions at early ages that are forced on by pregnancy.

Given that maternal mortality can occur at any point during pregnancy, childbirth or puerperium, monitoring of pregnant women by mother and infant health services and institutional care during delivery are both key factors in reducing it. These measures are inadequate, however, because a substantial proportion of maternal mortality appears to be due to the effects of abortion, particularly when this is carried out under poor conditions. This being the case, it is essential for family planning services to be extended so that unwanted fertility can be prevented, and the need for abortion removed.

Finally, increasing gender equity is one of the most promising paths for generating active and structured demand for reproductive health care. Gender equity is also a prerequisite for reproductive rights to be exercised effectively. Experience shows unequivocally that when men and women are regarded as being on an equal footing in society, among the socially desirable results that follow is that women are able to plan their lives in a different way, and the cost structure that pregnancy and child rearing entail for couples is altered for the better. Thus, gender equity tends, in a strategic way, to alter patterns of reproduction and attitudes to birth control, contributing to convergence between actual and desired fertility.