

Population Reports

Opportunities for Women Through Reproductive Choice

Women around the world hope for the future—for better lives for themselves, education and prosperity for their children, and security for their families. A broad array of social and economic changes is necessary to overcome the poverty, lack of education, and limited control over their own lives that often keep women's hopes from coming true. But women can take an important step forward when they make their own reproductive choices—about marriage, sex, childbearing, and contraception.

The great majority of women want to control their own fertility. Growing contraceptive use in nearly every developing country attests to women's desire to plan their pregnancies. Many other women want to space or limit births but are not using contraception. The continuing high number of abortions, often undertaken illegally at great risk, also testifies to women's desire to control their own fertility.

How can reproductive choice improve a woman's life? Making choices about the course of one's own life asserts a person's fundamental human dignity. Thus family planning is a basic human right, although many women are unable to

HIGHLIGHTS

	Page
Family planning can improve women's lives.....	3
Women's many needs assessed.....	6
Son preference endangers girls.....	10
Surveys reveal different lives.....	12
Family planning programs can:	
• Show respect for women.....	15
• Expand reproductive health services.....	16
• Strengthen women's skills.....	23
Reproductive decision-making complex, varied.....	18
New mass-media images.....	20
Helping men to help women.....	26
Field worker brings change to Bangladesh village.....	30
Policy debate for ICPD.....	34

CONTENTS

Family Planning—An Asset for Women.....	3
Family Planning Saves Lives.....	4
Contraceptive Use Helps Women Plan.....	9
How Can Family Planning Programs Benefit Women?.....	15
Encouraging Men's Cooperation.....	25
Employing Women in Family Planning Programs.....	30
Shaping Policies to Meet Women's Needs.....	32
Bibliography.....	36

Published by the Population Information Program, Center for Communication Programs, The Johns Hopkins School of Public Health, 111 Market Place, Suite 310, Baltimore, Maryland 21202-4012, USA

Volume XXII, Number 1

exercise that right. Also, the woman who chooses when she has children, and how many, exerts an important measure of control over her own physical, emotional, and economic well-being. She contributes to her children's well-being, too.

Health. More than half a million women die each year from causes related to pregnancy. Many of these deaths follow unwanted pregnancies: 20% to 40% result from unsafe abortions. For women who want to avoid pregnancy, using contraception means avoiding the risks of pregnancy and childbirth or of unsafe abortion.

Planning. By determining when she will have children and how many, a woman takes a step toward deciding how she will spend much of her life—whether to finish school, to give more attention to each child she has, to better manage household duties, possibly to earn income so that she and her family can live more prosperous lives, or even to contribute more to her community and society as a whole. Internationally comparable surveys find that, in countries where levels of contraceptive use are above average, women start childbearing later, end childbearing sooner, have fewer children, and spend fewer years caring for young children. Of course, a woman's decision to control her fertility does not guarantee her new opportunities. It does, however, help enable her to take advantage of opportunities that present themselves and to provide new resources to the family.

How Can Family Planning Programs Help?

Family planning programs contribute most by helping women prevent unwanted pregnancies. Well-designed, high-quality programs can do even more by delivering services in ways that help women meet other needs as well. They can:

- Show by example that women should be treated with dignity; their opinions, valued; and their decisions, respected;
- Provide additional contraceptive and other reproductive health services that can meet common and serious needs—possibly care for sexually transmitted diseases and information and services for young people, for example;
- Influence public perceptions of women's roles by depicting in the mass media women who act with courage, take responsibility, and succeed in new roles;
- Give women practice and encouragement in dealing with sexual partners about reproductive decisions and health;
- Encourage men to understand their own and women's reproductive health needs, share reproductive decision-making, and take more responsibility for reproductive health, contraceptive use, and their families' welfare; and
- Employ women as family planning professionals, treat them equitably, and offer them opportunities to lead.

With the advice and involvement of the women they serve, well-designed reproductive health programs can help women in a variety of ways to improve the quality of life for themselves, their families, and their communities.

This report was prepared by Ann P. McCauley, Ph.D., Bryant Robey, M.A., Ann K. Blanc, Ph.D., and Judith S. Geller, M.A., M.S.W. Ward Rinehart, Editor. Stephen M. Goldstein, Managing Editor. Design by Linda D. Sadler. Production by Merridy Gottlieb.

The assistance of the following reviewers is appreciated: Adrienne Allison, José Barzelatto, Jane Bertrand, Richard Blackburn, Judith Bruce, Patricia Coffey, Barbara Crane, Margaret A. D'Adamo, Elizabeth DuVerlie, Ruth Dixon-Mueller, Barbara Feringa, Lauren Goodsmith, Carol Haddaway, Karen Hardee, Pamela Harper, Sawon Hong, Jane Hughes, Roy Jacobstein, Bushra Jabre, Miriam Jato, Lily Kak, Nandita Kapadia-Kundu, Dierdre LaPin, James McCarthy, Alice Payne Merritt, Amy Ong Tsui, Christine Oppong, Bonnie Pederson, Barbara Pillsbury, Phyllis Tilson Piotrow, Patricia Poppe, Malcolm Potts, Willa Pressman, Margaret Pruitt Clark, Sunetra Puri, Estelle Quain, Karen Ringheim, Judith Rooks, Sidney Schuler, Timothy Seims, Judith Seltzer, Pramilla Senenayake, James R. Shelton, J. Joseph Spiedel, Sereen Thaddeus, Anne Tinker, Cate Wilcox, Nancy Williamson, and Anne Wilson.

Suggested citation: McCauley, A.P., Robey, B., Blanc, A.K., and Geller, J.S. Opportunities for women through reproductive choice. **Population Reports**, Series M, No. 12. Baltimore, Johns Hopkins School of Public Health, Population Information Program, July 1994.

Population Reports (USPS 063-150) is published four times a year (July, August, October, December) at 111 Market Place, Baltimore, Maryland 21202-4012, USA, by the Population Information Program of The Johns Hopkins School of Public Health and is supported by the United States Agency for International Development. Second-class postage paid at Baltimore, Maryland. Postmaster to send address changes to **Population Reports**, Population Information Program, The Johns Hopkins School of Public Health, 111 Market Place, Baltimore, Maryland 21202-4012, USA.

Population Reports is designed to provide an accurate and authoritative overview of important developments in the population field. It does not represent official statements of policy by The Johns Hopkins University or the United States Agency for International Development.

Population Information Program Center for Communication Programs The Johns Hopkins School of Hygiene and Public Health

Phyllis Tilson Piotrow, Ph.D., Director, **Center for Communication Programs** and **Population Information Program**

Ward Rinehart, Associate Director for Scientific Information and Dissemination

Anne W. Compton, Associate Director for POPLINE computerized bibliographic services

Jose G. Rimon II, Deputy Director, **Center for Communication Programs** and Project Director, **Population Communication Services**, developing family planning communication strategies, projects, training, and materials

Family Planning: An Asset for Women

Women want better lives for themselves, their children, their families, and their communities. They want to do their best in their current roles as mothers, wives, workers, and community members. Many women also want new opportunities in life—chances to learn, to make their own decisions, to have more say in the course of their own lives. Women want to have choices. Family planning is one important way that women can take control of their own lives and make more choices possible.

Choices are essential to human dignity. Without choices and without opportunities, a person cannot hope for a better future. Without choices, a person can have little self-respect. A person imprisoned is punished by being denied choices; a person denied choices is punished even without being imprisoned.

Although poverty and lack of education often limit choices and opportunities for both men and women in the developing world, in general women's choices are especially limited. Social norms, often embodied in a husband, parent, or mother-in-law, prevent many women from having much say in their own lives or much autonomy to choose their own paths. Even if women were allowed to make choices, social and economic options and opportunities are often beyond women's reach. As a result, compared with men, women have less health care, less education, fewer choices of jobs, poorer pay, and less legal protection (see box, pp. 6–7).

Family Planning Can Help

Family planning can help women meet their needs—both their practical need to perform conventional roles more effectively and their strategic need to find new roles and opportunities (see box, p. 4). By enabling a woman to control her own fertility, contraceptive use can help meet a woman's practical needs in several ways. Safe contraception contributes to good health: when women avoid unwanted pregnancy, they avoid the risks of childbearing or abortion. In the developing countries one woman in every 50 or so dies from causes related to childbearing (see pp. 7–8). Also, birth spacing helps her children survive. In addition, contraceptive use may give a woman more choice in the use of her time by helping her avoid unwanted pregnancy, childbearing, and childcare. With better health and more control over her time, a woman may be able to do more in her customary roles for herself, for the children she chooses to have, and for her community (see pp. 9–15).

Beyond meeting these practical needs, contraceptive use can help to meet women's strategic needs. Women who are healthier and have more control over their time are in a better position to take advantage of education, employment, or other opportunities if they are available. Also, by planning their pregnancies, women may find that they can plan more of other aspects of their lives.

Contraceptive use is often necessary but seldom sufficient to change a woman's situation in life. When a woman controls her own fertility, she may have more choice about the course of her life. Whether she can make changes in her life, however, depends on her personal circumstances, social norms, economic development, and law, among other fac-

POPULATION REPORTS

“We Have Family Planning Now”

“I was given in marriage at age 13. I hadn't even reached puberty. My father was dead, so my uncle arranged the marriage with a neighbor. Now it is better; there is a law that says girls mustn't marry before the age of 17. That is good. You know, I hadn't had my period when I married. A month later it came—and a month after that I was pregnant. I had five children—three boys and two girls—but one daughter was stillborn.

“My children go to school, and I want them, both sons and daughters, to go as far as their ability lets them. I want them to have a good future, a profession, a happy life. I don't want them working in the fields, picking up straws and leftovers as I do. I would like so much to have gone to school. I would like to have opened my mind. I would have taught other

people about things. I want to know everything—everything you can learn if you have an education. I won't let my daughters marry earlier than 17. I want them to have time to finish their studies, prepare their trousseau, and prepare themselves for marriage.

“Men are much better these days than they were before. They respect women more. Now they learn things, they are more understanding, they understand the rights of men and of women, too. And now a man can no longer divorce a wife he tires of. Before, a woman could be divorced, beaten, and poorly treated. That kind of thing doesn't exist anymore, thanks to President Bourguiba. Thanks to him and the laws, women are much better off today.

“We have family planning now, and you can take better care of your children. That, too, is different. You can't imagine how many things I tried to swallow to prevent myself from having more children. I even used to eat mothballs, thinking that would help. I am only 36 years old, and I have planned my family now for five years. I have a loop. I don't want any more children. Life is too difficult.

“Before the new laws, all women lived the lives of beasts.”

—Bedouin woman in Sfax, Tunisia (144)



UNICEF/Sean Sprague

tors. Changes in many households and throughout society will be needed before women can realize their full potential.

Family planning *programs* also can help meet women's needs, both practical and strategic. Of course, they do so chiefly because they provide contraceptive methods. In addition, programs can design high-quality services so that to some degree they may help women meet strategic needs (see pp. 15–25). For example:

- Family planning programs can demonstrate to the community that women have a right to be informed and to have their decisions respected.
- Programs can help women recognize the value of their own opinions by seeking and heeding women's views and advice.

Thinking about Family Planning and Women's Lives

How can family planning help women meet their needs? Thinking about this question requires making some basic distinctions.

Women's Practical and Strategic Needs

Women's needs can be grouped into two categories—practical needs and strategic needs. Caroline Moser, writing about women and development (218), defines practical needs as what women need to perform their conventional roles more effectively, such as good child care, better agricultural technology, and better housing. To help meet women's practical needs, women and program planners first analyze women's current activities and then develop ways to help women undertake those activities more effectively and with less burden.

In contrast, strategic needs are what women need to broaden their choices and opportunities. Although circumstances vary in different societies, strategic needs often include training for new jobs, enforcement of equal legal rights, and access to more education. Program planners try to help women meet their strategic needs by looking at the social factors that limit women's choices and then developing opportunities for women to assume new roles and responsibilities.

Practical and strategic needs are not mutually exclusive. Some new opportunities, such as the opportunity to control one's own fertility, help women meet both kinds of needs.

Contraceptive Use and Family Planning Services

The term "family planning" often encompasses two distinct concepts—*contraceptive use* and *family planning services*:

Contraceptive use, of course, is use by an individual or couple of a means to avoid pregnancy. Contraceptive use helps women meet their practical and strategic needs by enabling women to control when and how many children to have.

Family planning services are organized sources of contraceptive methods. Such services include family planning programs of various types, retail sales of contraceptive supplies, and private practitioners' services. The foremost way that family planning services help to meet women's needs is by providing contraceptive methods safely and effectively, thereby enabling women to control when and how many children to have. In the course of providing contraception, however, family planning programs can do more. Program planners can deliberately design services to help meet women's strategic needs (see pp. 15–25).

- Programs can help women practice making decisions in new areas and learn interpersonal skills needed to pursue their own interests.
- Programs can expand services to meet a broader range of women's reproductive health needs.
- Programs can help men both to play their part in contraception and to understand and appreciate women's new roles.
- Programs can provide women with income and skills by hiring, training, and promoting women and by offering them opportunities for leadership.

In these ways family planning programs help prepare women to make decisions and choices that formerly were not available to them. Of course, family planning programs cannot singlehandedly solve all the problems confronting women, but they can seek ways to help.

Family Planning Saves Lives

Each year an estimated 500,000 women die of complications due to pregnancy, childbearing, or unsafe abortion (135, 363, 370). All but about 6,000 of these deaths occur in developing countries (369). Where poor health, frequent childbearing, and little access to good medical care are a way of life, an early death is too often a woman's fate.

Contraceptive use can help protect women's lives and health by avoiding pregnancies. It is one of three crucial measures to improve maternal health: (1) reducing the number of pregnancies, (2) reducing the likelihood of complications during pregnancy, and (3) improving outcomes for pregnant women with complications (210). Reducing complications and improving outcomes require access to better obstetric care, more health care for poor and rural women, and improvements in women's living standards (86, 135, 202, 240, 284, 311). Currently, emergency care often is unavailable.

Women who do not want to become pregnant can reduce their exposure to the risks of pregnancy and childbirth by using effective contraception (135, 203, 227, 284, 318, 363, 380). In this sense, using contraception is a strategy that women themselves can adopt to protect their health (99).

Family planning and concern about maternal health have long been linked. The hope to relieve women's suffering and save lives inspired early advocates of contraception in both developed and developing countries (50, 143) (see box, p. 5). Now, worldwide, policy-makers recognize the importance of contraceptive use to women's health. The Draft Program of Action of the International Conference on Population and Development asserts that countries "should seek...reductions in maternal mortality through measures to reduce high-risk births, including births to adolescents, eliminate all unwanted births and all unsafe abortion, [and] expand cost-effective obstetrical and gynaecological care..." (321). Answering a 1989 UN questionnaire, 62 of 67 countries wishing to modify fertility levels cited improving family well-being as a rationale (324).



Causes of Maternal Deaths

Pregnancy is the main reason that women of reproductive age die at higher rates than men (203). In Matlab, Bangla-

The Death of Sadie Sachs

One stifling mid-July day in 1912, I was summoned to a Grand Street tenement, wrote Margaret Sanger, then a nurse in New York City.

Margaret Sanger arrived at the apartment building to find 28-year-old Sadie Sachs unconscious from complications of a self-induced abortion, with three crying, under-nourished children around her. Her husband Jake spent the last of his meager earnings to pay Sanger and a doctor, who worked together for hours to defeat the infection that had set in. After three weeks under Sanger's care, Sadie Sachs recovered.

Mrs. Sachs then begged the doctor for some way to prevent further pregnancies. "Tell Jake to sleep on the roof!" was his reply.

She then turned to Sanger for help. "Please tell me the secret. I'll never breathe it to a soul! Please!"

I did not know what to say or how to convince her of my own ignorance.... I promised to come back in a few days to talk with her [but] I was helpless to avert such monstrosities. Time rolled by and I did nothing.

The telephone rang one evening three months later. Mr. Sachs begged me to come at once. Mrs. Sachs was sick again from the same cause.... I hurried into my uniform...and started out....

I turned into the dingy doorway and climbed the familiar stairs once more... Mrs. Sachs was in a coma and died within 10 minutes. I folded

her still hands across her breast, remembering how they had pleaded with me, begging so humbly for the knowledge which was her right.... Jake was sobbing.... Over and over again he wailed, "My God! My God!"

When I finally arrived home...I looked out my window upon the dimly lit city.... I could bear it no longer... I went to bed, knowing that no matter what it might cost, I was finished with palliatives and superficial cures. I was resolved...to do something to change the destiny of mothers whose miseries were vast as the sky.

—Margaret Sanger, nurse,
US family planning pioneer,
founder of Planned Parenthood Federation
of America (290)

des, the mortality rate for women ages 15 to 44 was 26% greater than for men in this age range. Some 30% of all women's deaths between ages 15 and 44 were related to childbearing. This study, conducted between 1976 and 1985, is one of the few long-term, detailed examinations of maternal mortality rates and causes (93).

The World Health Organization (WHO) defines a maternal death as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes" (370). Behind the direct causes of maternal mortality—obstetric complications and unsafe abortions—lie the conditions of women's lives: inadequate care during delivery, chronic disease and malnutrition, poverty, isolation, and unwanted pregnancies.

Better care at childbirth and more access to that care would substantially reduce maternal mortality rates (23, 281). Most maternal deaths occur among poor women who live in remote areas (284). Studies in Cuba, Egypt, Indonesia, Jamaica, Tanzania, and Turkey have demonstrated that maternal mortality is higher where access to a hospital is more difficult (370). When access improves, death rates drop. For example, in Oran, Algeria, the maternal mortality ratio fell 42% between 1971–75 and 1976–80 after fees for public hospital services were waived, a policy that greatly reduced the number of home deliveries (269).

Yet many women give birth without any trained help. For example, in 12 of 26 countries surveyed by the Demographic and Health Surveys (DHS) between 1986 and 1989, women had received no trained assistance in half or more of all births in the five years before the survey (122).

Chronic diseases and malnutrition leave many women unable to meet the physical demands of pregnancy (187). For example, anemia, often a result of poor nutrition, affects about 40% to 60% of pregnant women in developing countries excluding China—more than twice the percentage in

developed countries (380). (By comparison, about 20% of men have anemia.) Malaria, sexually transmitted diseases, and infectious hepatitis also cause serious problems for many pregnant women and, unless treated, may kill them or their infants (135).

A woman's age and parity affect her chances of dying in childbirth. Health risks related to age and parity have been summarized as "the four too's"—too young, too old, too many, too close together. First births and births after the fourth are more dangerous than the second through fourth births. Women under age 18 and, more dramatically, those over age 35 face greater risk than women between these ages (275, 363). Of course, age and parity are not risks in themselves; they stand in for the higher likelihood of specific risks associated with age and parity (378). For example, pregnancy can be dangerous to very young women because their pelvises are not yet large enough to accommodate birth. Many of these specific conditions can be managed if high-quality delivery care is available.

Some family planning programs have emphasized serving women in these high-risk age and parity categories, particularly older, high-parity women. The Mexican social security system found that this emphasis interested more doctors in family planning and thus helped expand contraceptive services (265). Still, the "four too's" do not justify overriding women's own informed decisions about whether and when to have children or to pressure them to use a contraceptive method that is not their preference (280).

Deaths from unsafe abortion. Many women resort to abortion to prevent unintended births (227, 363). Because abortions are illegal in most developing countries, many women seek them clandestinely and undergo unsafe procedures. Even in some places where abortion is legal, poor-quality services put women at risk.

An estimated 10 to 20 million illegal abortions are performed worldwide annually, and an estimated 100,000 to 200,000 women die as a result—about one in every 100. These deaths account for 20% to 40% of all maternal deaths (134). In some

Meeting Women's Needs: What Should Be Done?

Women confront many obstacles to better lives. Women need change in many areas simultaneously. Thus the agenda for policies to give women more opportunities must be broad. In addition to assuring women's ability to control their own fertility, important elements include efforts to:

✓ **Improve health.** In the nations with the best health care, the life expectancy of women is 10% longer than that of men (243, 331, 347). In developing countries, however, women's life expectancy is closer to or shorter than men's (203, 331). This occurs because women receive less than their fair share of health care and food, often beginning in childhood (57) (see box, p. 10–11). As adults, many women do not get the food and health care needed for healthy childbearing (306, 371, 374, 380).

✓ **Encourage education.** Over the last 20 years more and more girls have been going to school, but boys still get more education than girls. An estimated two-thirds of the 300 million children without access to education are girls. Two-thirds of the 960 million nonliterate adults are women (329).

✓ **Ensure job opportunities and fair pay.** Most women work long and hard, and they earn less for it than men do (341). Even in developed countries, for example, women earn 75% or less of what men earn (326). Much of women's work is unpaid. Women's unpaid household labor accounts for about one-third of the world's economic production (306). When unpaid agricultural work and housework are considered along with wage labor, women work more hours than men (196, 326).

✓ **Guarantee legal protection.** Legal codes often sanction inequality between husband and wife (341). They may allow marriage of very young women, marriage without the woman's consent, unequal ownership and control over family assets including land and other property, unequal inheritance rights, and unequal access to divorce and to support after divorce (103, 105, 146, 287). In many cases the law does not recognize women as adults with the same capacities and right to make decisions as their husbands (105, 106). Laws that do protect women's rights often are not enforced (127).

Latin American cities abortions account for over half of maternal deaths (284). In Romania unsafe, illegal abortions were responsible for 86% of maternal deaths (230). After the procedure was legalized in 1992, the overall maternal mortality ratio fell in the first year to 40% of the 1989 level (367). Women who survive an unsafe abortion may suffer chronic pelvic pain, chronic pelvic inflammatory disease, and/or infertility. They face a greater risk of ectopic pregnancy, premature delivery, and other adverse health consequences in the future (368).

The majority of deaths due to abortion can be prevented (60). Access to effective contraceptive methods reduces un-

✓ **Permit access to reproductive health care.** The International Planned Parenthood Federation (IPPF) has reported that 46 of 94 surveyed countries require spousal consent for contraception, abortion, or voluntary sterilization—services used primarily or exclusively by women (147). Worldwide, 54 countries require a woman to obtain her husband's approval before voluntary sterilization, but only 20 of these countries also require a man to have his wife's approval (283). Young women and unmarried women often have little or no access to reproductive health services. Yet surveys in eight sub-Saharan countries, for example, find that 20% to 47% of adolescent women become pregnant before marriage (73).

✓ **Prevent violence against women.** Many women live every day in fear of violence, often from their husbands (341). In surveys in Chile, Colombia, Kenya, India, Mexico, Pakistan, Papua New Guinea, San Salvador, South Korea, and Thailand, 40% to 99% of women reported physical abuse by their husbands (43, 133, 264). Most of these women have no choice but to live with this abuse and fear. Leaving the marriage is often not a realistic option when women, denied education, jobs, and inheritance rights, are economically dependent on their husbands (43). Unwanted sexual intercourse is a major form of violence against women (326). In a US national sample survey, 13% of women reported that they had been raped at some time in their lives, not counting marital rape (229). This amounts to one woman raped every minute (133). Half of these women were under age 18 when raped, and 75% knew the man who raped them (229). Detailed data on rape are not available from developing countries.

Fear of desertion or violence prevents women from acting in their own best interests. For example, in Egypt many women do not seek care for gynecological problems such as vaginal discharge or fistula because they fear that their husbands will divorce them for spending time and money on their own health (167). Threats of violence prevent some women even from participating in development projects (43, 150).

✓ **Increase respect for women.** Since most societies value females less than males, many women grow up believing

wanted pregnancies. The procedure itself is safe if the practitioner uses safe techniques (372).

While contraceptive use can greatly reduce unwanted pregnancies, it cannot eliminate them (60). An estimated 25 million women become pregnant each year due to failure of their contraceptive method (31). Many women, especially young women, become pregnant as the result of forced sexual intercourse. A smaller number of women develop health conditions that make continued pregnancy unsafe. Many of these women will choose an unsafe abortion if they do not have access to a safe procedure.

that they are inferior to males. Such perceptions are difficult to change. For example, China has promoted equal roles and rights for women for 40 years. Still, 30% of Chinese women surveyed in 1990 thought that men are born to be more important than women, and 33% agreed that women should hold back so that they are not more successful than their husbands (52).

Programs to Improve Women's Lives

Programs to help women often focus on their economic or legal position. Women themselves have started many of these programs. For example, women in India formed the Self-Employed Women's Association (SEWA) in 1972 and the Working Women's Forum (WWF) in 1977 to change local ordinances that interfered with their ability to work as market traders (49, 282). Both groups broadened their agendas as members began to request help with health, education, and other needs. In Tunisia in the 1970s President Habib Bourguiba led the government to legislate better legal protection of women (see box, p. 28). In Bangladesh university professor Mohammed Yunus convinced the Grameen Bank, a private bank, to give poor women small loans (108).

Development planners have developed two broad approaches to assessing women's needs and designing programs to address them:

- **The status of women approach** compares the positions of women and men in a society or cross-nationally. After identifying the areas in which women are disadvantaged, planners design programs to address the problems.
- **The empowerment of women approach** aims to help women gain more control of their lives. This approach

often begins with women identifying and prioritizing their own needs. Program organizers then help women to design programs that meet those needs.

Both approaches have advantages. Focusing on objective measures of women's status documents the problem for top-level policy-makers and helps motivate their support for policy changes. The United Nations has based its efforts to eliminate discrimination against women on status measures such as years of education and hourly wages. The empowerment approach may bring faster results for individual women, although usually on a smaller scale. Involving women in solving their own problems builds their skills and self-confidence and finds solutions that are locally appropriate (113, 166, 352).

Using both approaches could speed improvements for women, and in practice the two approaches are not always distinct. Program organizers can use the status-of-women approach to influence policy nationally and to evaluate its impact and at the same time can use community-based empowerment programs to begin change locally. Some of the most successful community programs at first address a need that women clearly recognize, such as the need for income, and then build skills that women can use in many areas of life.

Women's advocates are asking that development plans pay more attention to the effects of planned changes on women's lives. Some development plans have required, for example, male labor migration or female volunteer labor, which place additional burdens on women (26, 37, 223). "Gender planning," as the approach is called, considers the impact of a proposed program on women, men, and their relationship (198, 217, 245, 268). Its goals are to ensure that development programs do not inadvertently harm the lives of men or women and to see that women's situation is improved.

Women work long and hard. Yet women are paid less than men for their labors. Women need more access to many types of jobs at higher pay.



United Nations photo

Incidence of Maternal Deaths and Illnesses

While the number of maternal deaths is often estimated at 500,000 per year, the true number may be even larger. In many developing countries official statistics underreport maternal deaths, perhaps by one-fourth to one-half (135). Many maternal deaths go unreported. Others are attributed to other causes. Often deaths are reported but causes are not (42).

Even less is known about the extent of maternal illnesses in developing countries. A frequently cited estimate is 16 illnesses for each maternal death—a figure based on a 1980

study of one village in India (71). Applying this ratio to the entire developing world yields an estimate of eight million cases of nonfatal maternal complications every year (42, 191). Such complications are often chronic and debilitating.

Maternal mortality is usually expressed as the maternal mortality ratio—the number of maternal deaths per 100,000 live births. The maternal mortality ratio measures the risk of dying that a woman faces each time that she becomes pregnant (99, 318, 363). This ratio is often mistakenly called the maternal mortality rate. (A ratio compares the numbers of two differing events; a rate compares a part to the whole.)

Table 1

Mothers' Lives at Risk

Maternal Mortality Ratio, Total Fertility Rate, and Lifetime Risk of Maternal Death by Region

Selected World Regions	Estimated Maternal Mortality Ratio (Maternal Deaths Per 100,000 Live Births), 1988	Total Fertility Rate ¹	Lifetime Risk of Maternal Death (As Odds) ²
AFRICA	630	6.1	1 in 22
North	360	6.0	1 in 28
East	680	6.8	1 in 19
Middle	710	6.1	1 in 20
West	760	6.4	1 in 19
South	270	5.2	1 in 29
ASIA	380	3.9	1 in 57
East	120	2.1	1 in 722
Southeast	340	4.5	1 in 44
South	570	4.4	1 in 34
West	280	4.9	1 in 61
EUROPE	23	1.7	1 in 2,132
NORTH AMERICA	12	2.6	1 in 2,671
SOUTH AMERICA	220	3.3	1 in 165
OCEANIA	600	2.6	1 in 54
WORLD	390	3.7	1 in 58
DEVELOPED COUNTRIES	26	1.9	1 in 1,687
DEVELOPING COUNTRIES	420	3.9	1 in 51

¹ Total Fertility Rate (TFR) = Average number of live births a woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates.

² Lifetime Risk = Risk of dying of pregnancy-related causes by the end of the reproductive period. Calculated as lifetime risk = $1 - (1 - \text{MMR})^{1.2(\text{TFR})}$, where MMR (maternal mortality ratio) is expressed as a decimal. The TFR is multiplied by 1.2 to adjust for pregnancies not ending in live births.

Source: Tinker et al. 1993 (312)
Population Reports

Maternal mortality ratios range widely, from an estimated 12 maternal deaths per 100,000 live births in North America to more than 700 per 100,000 in some parts of sub-Saharan Africa (123, 312). For the developing world as a whole, maternal mortality is estimated at more than 400 deaths per 100,000 live births, while the ratio is below 30 per 100,000 in the developed world (312, 380) (see Table 1).

Due to poor health and poor health care, many women in developing countries face much greater risk in each pregnancy than most women in developed countries. They also face this risk more often because, on the average, they have more pregnancies. Thus the lifetime risk of maternal death—a statistic that reflects both the risk per pregnancy and the number of pregnancies—is far greater in most developing countries than in developed countries (see Table 1). Between one-fourth and one-third of all deaths among women in their reproductive years in developing countries are related to maternity compared with only one-half of 1% in the US (284).

In the developing world as a whole, any one pregnancy is, on average, about 16 times more likely to kill than in the developed world. And the higher fertility levels in developing countries double that relative risk over a woman's lifetime. Thus the average woman in developing countries is about 30 times more likely to die from pregnancy-related causes than the average woman in a developed country.

Contraception Can Safeguard Women's Health

While family planning programs should not be treated as a substitute for urgently needed improvements in delivery care, reducing the number of pregnancies that women have in their lifetimes also substantially reduces the risk of maternal mortality and morbidity, particularly where fertility rates are high and health facilities are poor or unavailable (227). The study in Matlab, Bangladesh, illustrates how fewer preg-

nancies results in fewer maternal deaths. In 1977 more intensive family planning services, including home visits by trained female family planning workers, were introduced in selected Matlab villages. In these test villages the percentage of married women using contraception rose from 8% in 1976 to almost 40% by the end of the study in 1985. In comparison areas, where services were not expanded, the rate rose much less, from 5% to 17%. By the end of the study, maternal mortality in the test villages had fallen to less than half of that in the comparison villages—even though there was no change in the risk of dying from any one pregnancy (92).

Contraception and psychosocial stress. Lack of control over one's own life is a major cause of stress (75).

Thus the use of contraception can improve women's emotional health by providing more reproductive control and greater choice about childbearing (74, 75, 129). Also, because using contraception, like other preventive health practices, reflects an orientation to the future, it can be an important step toward overcoming fatalism and lack of self-worth (129).

In some circumstances, however, obtaining and using contraception can itself be stressful, especially where modern contraceptives are not yet widely accepted. A woman may worry about visiting a family planning clinic and undergoing questioning or a physical examination. She may fear disrespectful treatment or negligent care. She may also fear that visiting a clinic or using contraception will provoke her husband's anger or will bring criticism from her family, her in-laws, or others (74). She may experience painful or worrying side effects from using a contraceptive method. She may hear frightening false rumors about the dangers of contraceptive methods. Family planning managers must recognize these possible stresses and develop strategies to relieve them. As contraceptive use becomes the community norm and as services improve, using contraception may become less stressful.

Spacing Pregnancies Improves Children's Health

A child's serious illness or death is a common event in many places and a cause of great stress and grief. Couples can reduce their children's health risks by spacing births. Children who are born within 17 months after the preceding birth are about twice as likely to die before age 5 as those born 24 to 47 months after the preceding child (137, 261). Even children born after an interval of 18 to 23 months are about one-third more likely to die than children born 24 to 47 months after the preceding child. In Brazil and Egypt the child mortality rate could be cut by up to one-third if all births were spaced more than two years apart (137).



UNICEF/Tom Weber

A Better Life

“The main thing that makes the times different, I think, is the control women have over the number of children in a family. A family can be planned now; it can live a better life. Women have more facilities for everything

because of this. I began to take contraceptives when the last child was eight months old. I take the pill.”

“...we were very poor when I was a child. We were six children, and my father didn’t earn much. That is why I want just two or three children. I don’t want my children [two daughters] to grow up like me—without an education. I feel very ashamed and bad about not having any education. I want my children to go to school and learn many, many things.... I want them to be independent and proud of themselves.”

—19-year-old Mexican woman using contraception without her husband’s knowledge (144)

Many women are having their children closer together than they wish. The World Fertility Survey (WFS) and Demographic and Health Surveys (DHS) indicate that 90% of women who plan to become pregnant would like to space their children at intervals longer than 24 months. More than one-third, however, have a second birth within 24 months (137).

Research also shows that children are more likely to die if their mothers are younger than age 18. According to the WFS and DHS, delaying the first birth until the mother is at least 18 years old reduces the risk of the first child’s death by an average of 20%. In the Dominican Republic, Egypt, Mexico, and Peru, delaying childbearing at least until the age of 18 would reduce the risk of the first child’s death by 30% (137).

Contraceptive Use Helps Women Plan

Women who can decide if and when they will become pregnant are better able to plan other aspects of their lives. In the short term women who use contraception effectively may have more choice about the use of their time because they have fewer children. Women may be better able to make plans to take new educational, economic, and other opportunities (22). Also, in the long term society in general and women themselves may change their expectations of how women lead their lives. Young women probably benefit most from being able to control their own fertility.

The Changing Needs of Young Women

Young women’s lives are changing. Almost everywhere in the developing world, more women are delaying marriage (2). In 29 of 36 countries that have conducted Demographic and Health Surveys, the percentage of women who had married by age 20 was at least 10% lower among women ages 20 to 24 than among the oldest women interviewed, usually those ages 45 to 49 (356). As women delay marriage, they have more opportunity to complete their education, to develop remunerable skills, and to choose their husbands or to choose not to marry at all.

Avoiding unintended pregnancies is critically important to allow women to make these choices, especially in cultures where unplanned preg-

nancy precipitates marriage or where premarital births have particularly disastrous social or economic consequences (74). In Latin America and the Caribbean, the Young Adult Reproductive Health Surveys (YARHS) document that many women are sexually active before marriage but are not consistently using contraception. For example, in a 1985 survey in Mexico City, 13% of women age 15 to 19 and 44% of men reported premarital intercourse. Only 22% of the women and 31% of the men used contraception at their first sexual experience, however. Among unmarried women ages 15 to 24, half of all first pregnancies were unintended. Among married women in this same age group, 11% of first births were conceived before marriage (216).

Nevertheless, offering contraceptives to unmarried adolescents and young adults remains controversial. Some parents and policy-makers assume that the availability of contraception will lead adolescents to have sexual relations before marriage. This assumption is one reason that, formally or informally, many family planning programs refuse to serve unmarried young people (333).

In fact, data do not suggest that the availability of contraceptives encourages early sex (130, 228). Most research on the subject comes from the US and other developed countries. For example, an international comparison found that sex education and contraceptive services were more available



WORLD BANK/PA-Kewill

Education or early pregnancy? The course of many women’s lives is shaped by whether they finish school or become pregnant and are forced to drop out.

Son Preference, Daughter Neglect

In some countries parents tend to prefer sons and to treat them better than daughters. Boys sometimes get more to eat and more medical care, while girls are slighted in education and jobs and in some cases are neglected, abused, and even killed. While the majority of studies on son preference come from countries in South Asia and North Africa, where son preference is believed to be strongest, son preference appears to exist to some degree in other regions of the world as well. The preference for sons is both a symptom and a cause of limited opportunities for women.

Extent of Son Preference

A common index of preference for sons comes from survey responses: the ratio of the number of parents who say that they prefer their next child to be male to the number who prefer their next child to be female (374). A ratio also can be derived from survey responses about desire for additional children among women with different numbers of living daughters and sons (12). Among countries surveyed, those with strong preference for sons—indices of 1.6 or above—are Bangladesh, Jordan, Nepal, Pakistan, South Korea, and Syria. Moderate preference for sons (indices of 1.2 to 1.5) has been documented in many other countries, including the Dominican Republic, Egypt, Mexico, Senegal, Sudan, Turkey, Nigeria, Tunisia, and Yemen. Some countries, such as Colombia, Ghana, and Indonesia, show no preference, and two—Jamaica and Venezuela—show a slight preference for daughters (12, 284, 374). In most countries parents desire at least one daughter as well as sons.

Reasons for Son Preference

Why do many parents favor boys? Often the reasons are both economic and cultural.

in Europe than in the US. Sexual activity among adolescents, however, was about as prevalent in the UK, France, and the Netherlands as in the US, while the US teenage pregnancy rate was much higher (154). Another US study found that teens who had a sexual education program in their school delayed intercourse and were less likely to become pregnant (379). Still other studies have found no link between the presence of contraceptive clinics in the schools and levels of sexual activity among students (176).

Contraception and Education

For many young women the most important fork in life's path is the divide between education and early pregnancy. It is true that many barriers stand between young women and an education. Some parents think that it is wiser to educate sons

Economic security. In many developing countries sons are their parents' only source of security in old age. Particularly where women have little economic independence or cannot inherit property, sons are insurance for a mother against the loss of her husband's support due to death or desertion (39, 267).

Where women have few opportunities to earn income, investing household resources in female children, who will marry and leave the family, is likely to have little pay-off, and so poor families tend to invest what little they have in sons (177, 193). In cultures with dowry systems, such as India's, daughters are more expensive to marry off than sons (80).

Cultural factors. In many countries kinship systems, tradition, and religion value males over females. In parts of Bangladesh, China, Egypt, India, and Tanzania, for example, traditional patrilineal kinship systems require women

to marry out of their families of origin and then not to provide financial or even emotional support to their own parents (126, 177, 211). In both Hindu and Confucian traditions, practiced throughout Asia, only sons can pray for and release the souls of dead parents, and only males can perform birth, death, and marriage rituals (21, 284).

Effects of Son Preference on Female Children

Although females are thought to be genetically more resistant to respiratory and other infectious diseases than males and more likely to survive infancy, in some developing countries this advantage rapidly disappears as female babies grow up (347). Females are more likely than males to die in early childhood (ages 1 to 4), particularly in South Asia, the Near East,

because there are more and better-paying jobs for men than for women (172, 193) (see box, this page). Also, some girls are taken out of school to work at home (172, 197). Some families are not willing to educate girls if the school is distant or the teachers are male (329).

Still, once girls reach puberty, the greatest threat to their staying in school may be pregnancy. Students who become pregnant often drop out of school, or they are expelled by school authorities—a fate that does not befall male students who father children. In many African countries pregnancy is the most common reason that girls leave school and the main reason that the school-leaving rate is higher for girls than for boys (109).

To ensure that girls are not forced to leave school due to unwanted pregnancy, girls need to be able to refuse un-



UNICEF/Balcomb

Where boys get all the attention, girls often suffer. The boy, at right, apparently has received more food and better care than his twin sister, and he is likely to get more education, as well.

and North Africa (4, 12, 17, 79, 117, 292, 328, 337, 338, 374). Poorer nutrition and health care are important reasons (80).

Nutrition. In some places boys get more and better food than girls (44, 48, 69, 72). Breastfeeding and weaning practices also seem to favor boys in some countries (44, 330). In the Indian state of Punjab, for example, boys from both wealthy and poor households are better nourished than girls (374). An analysis of DHS data from 18 countries, however, found few significant differences in the nutritional status of boys and girls (12).

Medical care. Girls are sick as often as boys, but boys sometimes receive more treatment and more medicine. For example, boys were seen 66% more often than girls at a diarrhea treatment center in Bangladesh even though the center provided free ambulance transport and treatment (48). Parents bought drugs and sought medical care three times more often for boys than for girls (141). Girls often receive less preventive health care, as well. Studies in Latin America and India show that girls often are immunized later than boys or not at all (119, 296).

Female infanticide. Some unwanted female children are killed or abandoned soon after birth. It is not clear how common or widespread the practice is, but some demographers have long suspected its existence. They base their conclusions largely on reported sex ratios at birth (310). Others argue that underreporting explains the discrepancy. In China, where sex ratios show that 5% of all infant girls born are unaccounted for, some observers suspect that female infanticide accounts for at least some of these missing girls, although informal adoptions, sending girls to faraway relatives, or raising the girls covertly probably explain most of the cases (10, 382, 383).

Abortion of female fetuses. Selective abortion of female fetuses reportedly is widespread in such Asian countries as China, India, and South Korea (11). Increasing use of prenatal ultrasound and amniocentesis procedures, which make selective abortion possible by revealing the sex of a fetus, may be contributing to a growing gap in the number of males and females born in some countries (153, 181). Although governments in China, South Korea, and three Indian states have banned prenatal gender tests to prevent selective abortions,

wanted sexual intercourse and to have access to contraceptives, information, and counseling if they choose to be sexually active. Also, schools should help young women continue in school, not expel them, even if they are pregnant or have a child.

Policies that help young women avoid pregnancy and stay in school could help change attitudes in the long run. Parents and communities might be more willing to invest in girls' education if they had more confidence that their daughters would not become pregnant and leave school (74). Also, as more women complete an education, and as more women hold paying jobs, the perception of women's potential is likely to change, helping to break the vicious cycle that holds women back.

Some young women recognize that avoiding pregnancy protects their futures. For example, in a Kenyan study female

illegal tests are available, and females are more often aborted than males (10, 11, 21, 181, 225, 382, 383).

Son Preference, Fertility, and Contraceptive Use

Does a preference for sons result in higher fertility? Do more couples adopt family planning after having a son than after having a daughter? The answers may depend on current fertility levels. In general, where most couples have large families, son preference has little impact on fertility levels because most couples will have at least one son by biological chance. As contraceptive use becomes more widespread and average family size decreases, however, in some countries the desire to have at least one son begins to affect fertility decisions: Trying for a son, many couples have more children than they would otherwise (7, 15, 16, 41, 160, 224, 353).

A recent study in Matlab, Bangladesh, indicates that son preference can have a strong effect on contraceptive use and fertility. In Matlab, where intensive family planning services are available, contraceptive prevalence now tops 50%, and couples average four children, researchers calculated that eliminating preference for sons would increase contraceptive use by 10% and continuation rates by 15%. These increases would avert nearly one birth for every two couples (266).

What Can Be Done?

Attempts to improve the position of girls in society often focus on economics. Increasing economic opportunities for women and raising the value of women's labor increases the likelihood that parents will see daughters as economic assets and not as liabilities (48, 51, 177). Also, increasing girls' education may increase their income-earning potential and, thus, their economic value to their parents (27, 182). Other recommendations include better access to food and medical care so that parents will not have to choose between male and female children in allocating household resources (177). Also, better access to pension plans and other forms of old-age security that do not depend on children would relieve some of the pressure to have sons (39). While specific measures can help, some researchers insist that only far-reaching improvements in the cultural, social, legal, and economic position of women will improve the well-being of female children (1, 204).

students of high socioeconomic status viewed contraception favorably. Those who ranked in the top quarter of their class were nearly four times more likely than other female students to have used contraception at their most recent act of intercourse. These young women could afford contraceptives and recognized that an early pregnancy would endanger their chances for academic success and economic security (173).

Children benefit in various ways from their parents' use of contraception. Education appears to be one area in which women pass on the benefit to their daughters: Both sons and daughters from small families have better educational opportunities than children from large families. In a Thai community, in families with three or fewer children, 44% of the children went to lower secondary school, and 31% went to upper secondary school. By comparison, in families with

Changes in Women's Lives: Profiles from Surveys

How do women's lives differ between countries where contraceptive use is common and countries where it is rare? The Demographic and Health Surveys (DHS) are one source of information. Contraceptive prevalence varies widely among surveyed countries, from over 60% in 4 of 30 countries to 5% or lower in 3 countries (see Table 2). The surveys reveal that in countries where contraceptive use is widespread, women:

- Are older when they have their first child,
- Complete their childbearing earlier,
- Spend fewer years pregnant, and
- Spend fewer years with young children in the household.

Age at First and Last Births

Where total contraceptive use is above 40% (the average for use of modern methods in developing countries), women ages 25 to 29 at the time of the surveys first gave birth on average about three years later than in countries where contraceptive use is below the average (see table below). Median age at first birth in the 30 countries shown in Table 2 varies from about 18 years in Niger and Uganda to close to 25 years in Morocco, Sri Lanka, and Tunisia. First births come soon after marriage in most countries. Still, on average women in the countries with higher contraceptive prevalence first give birth more than two years after marriage, while women in countries with lower than average prevalence give birth about a year and a half after marriage.

Last births come sooner in countries where contraceptive use is above average levels. Where contraceptive use exceeds 40%, most women had their last births in their early thirties, while in countries with lower levels of contraceptive use, women last gave birth in their late thirties. Table 2 reports age at last birth for women ages 40 to 49 at the time of the survey, the age group most likely to have completed childbearing. This analysis may underestimate the impact of contraceptive use on average age at last birth, because women in this age group are the least likely to have been affected by recent rises in the use of contraception in many countries.

The median age at last birth ranges from 31 years in a few Caribbean countries where contraceptive use is widespread to 38 or 39 years in several African countries where there is little use of contraception. Of course, other factors besides contraceptive use help to determine the age at last birth, including age-related sterility, divorce, widowhood, and reduced coital frequency at older ages.

The number of years that women can expect to live after the birth of their last child varies tremendously (see Table 2). This

difference reflects both a woman's age at the birth of her last child and her life expectancy. Life expectancy tends to be longer in the more developed countries, where also age at last birth is lower. In all surveyed countries where contraceptive prevalence is above 40% except Peru, a woman still has more than half of her life ahead of her when she last gives birth. In contrast, in most countries where contraceptive prevalence is below 40%, women average fewer years of life after their last birth than before it.

Duration of the Childbearing Years

Where the level of contraceptive use is above average, women devote less of their lives to childbearing and childraising. Also, within countries the length of the childbearing period has decreased as contraceptive use has spread.

Differences across countries. The interval between average ages at first and last births among women ages 40 to 49 ranges from just 11 years in Trinidad and Tobago and in Thailand, where contraception is widely used, to nearly twice as long in Zambia and Senegal, where contraception is little used (see Table 2). In Trinidad and Tobago women ages 40 to 49 averaged four children. The first child was born when the mother was 20 years old, and the last, when she was 31. In contrast, in Zambia women ages 40 to 49 had given birth to an average of seven children. The first was born when the mother was 18, and the last, when she was 38. Because contraceptive use is increasing in nearly every country, the childbearing years probably will be shorter for women who are now in their 20s or 30s.

By comparison, US women have fewer children over a shorter period of time. In the US, where about three-quarters of married women use contraception, those born between 1940 and 1949—and thus about the same age as women ages 40 to 49 in DHS surveys—married at a median age of 20.5 years. They first gave birth a little over a year after marriage and had their last child at age 30. They gave birth to an average of 2.8 children over the course of approximately eight years, and their life expectancy at the time of their last birth was 47.5 more years (325).

Both the number of children that women have and the spacing of their births influence the number of years that mothers spend with young children. In countries where use of contraception is widespread, women spend an average of 14 years with at least one of their children under the age of six. Where contraceptive prevalence is low, women have young children for an average of 20 years (see Table 2).

Summary of
Table 2

Women's Reproductive Lives

Contraceptive Prevalence	Averages Among Countries with Above- and Below-Average Contraceptive Prevalence							
	Median Age at Marriage	Median Age at 1st Birth	Median Age at Last Birth	Additional Years of Life at Age at Last Birth	Years Between 1st and Last Births	Years Spent Pregnant	Years Spent with a Child under Age 6	
>40%	20.6	22.3	34.3	40.1	13.5	2.6	13.7	
<40%	18.0	19.6	37.5	33.0	18.1	4.5	19.5	

Note: For definitions of
column headings, see
footnotes to Table 2.

Population Reports

Changes over time. Women's childbearing patterns have changed as contraceptive prevalence has risen. In 16 countries at least two comparable surveys have been conducted since the 1970s (see Table 3).

Where contraceptive use has increased most, the childbearing period has decreased most. Also, in all 16 countries the time that women had a child under age six in the household decreased, but in some countries the decline was small.

The changes are most obvious in the five countries where three surveys have been taken. For example, in Morocco, where the level of contraceptive use more than doubled between 1979-80 and 1992, women's average childbearing period decreased by almost two years. The number of years spent with a child under age six fell by almost three years. In the Java-Bali region of Indonesia, contraceptive prevalence rose from 26% to 53% between 1976 and 1991. Over the same period the childbearing

period decreased by 3.5 years, and the amount of time spent with at least one young child at home declined by five years. Age at last birth declined substantially in Colombia, the Dominican Republic, and Peru, and so did the length of the childbearing period.

Because the DHS are internationally comparable surveys, they offer a unique comparison of women's lives across a large number of countries with varying levels of contraceptive use. But they cannot tell the whole story. Cross-sectional surveys such as the DHS cannot explain much of how contraceptive use affects individual women. This is because surveys usually have not recorded the sequence of events such as the timing of contraceptive use, births, and employment. Also, surveys can reveal full childbearing patterns only for women whose reproductive years have ended. As noted, these women's experience is least likely to reflect recent changes in contraceptive use. To complete the picture, other, more detailed studies are needed.

Table 2. Relationship Between Contraceptive Prevalence and Other Aspects of Women's Lives, Demographic and Health Surveys, 1986-1992

Country	Contraceptive Prevalence ¹	Median Age at 1st Marriage ²	Median Age at 1st Birth ³	Median Age at Last Birth ⁴	Additional Years of Life at Age at Last Birth ⁵	Years Between 1st and Last Births ⁶	Years Spent Pregnant ⁷	Years Spent with a Child under Age 6 ⁸
Thailand 1987.....	66	21.0	23.0	32.9	40.2	11.4	1.7	10.5
Brazil 1986.....	66	21.1	22.4	33.6	42.2	11.9	2.5	14.0
Colombia 1990.....	66	21.5	22.5	33.3	42.3	12.2	1.6	12.2
Sri Lanka 1987.....	62	23.2	24.7	33.5	43.4	11.6	2.0	11.0
Peru 1991-92.....	59	21.8	22.1	34.7	39.5	13.4	2.6	13.9
Dominican Rep. 1991.....	56	19.8	21.7	31.2	44.7	11.6	2.5	12.4
Mexico 1987.....	53	20.2	21.1	35.1	40.5	14.6	3.0	14.6
Trinidad & Tobago 1987.....	53	19.8	22.2	31.7	42.9	11.3	2.3	12.0
Indonesia 1991.....	50	18.6	20.4	33.3	39.0	13.7	2.3	12.9
Tunisia 1988.....	50	22.9	24.5	36.3	37.0	14.8	3.1	14.3
Ecuador 1987.....	44	19.8	20.7	35.6	38.0	14.6	3.1	15.5
Zimbabwe 1988-89.....	43	18.8	19.5	37.3	35.0	17.9	4.0	19.8
Morocco 1992.....	42	19.4	24.9	36.9	37.2	16.4	3.0	14.6
Egypt 1988-89.....	38	19.5	21.7	34.6	36.3	14.8	3.4	15.7
Togo 1988.....	34	18.4	19.2	38.8	32.1	19.3	4.6	21.8
Botswana 1988.....	33	NA	19.2	37.4	36.4	17.4	3.5	19.1
Bolivia 1989.....	30	20.0	20.6	36.7	35.0	15.5	3.7	16.9
Kenya 1988-89.....	27	18.6	18.7	37.8	34.7	18.9	4.9	20.8
Guatemala 1987.....	23	18.5	19.7	36.1	36.4	16.1	4.1	18.1
Cameroon 1991.....	16	16.9	18.6	36.5	33.7	18.0	4.4	19.1
Zambia 1992.....	15	18.0	18.8	38.5	32.3	20.1	4.9	19.9
Ghana 1988.....	13	18.5	20.0	37.9	33.2	18.9	4.6	20.8
Senegal 1986.....	11	16.7	19.0	38.7	31.2	20.0	4.7	20.6
Burundi 1987.....	9	19.5	20.9	39.2	30.3	18.1	4.9	20.9
Sudan 1989-90.....	9	20.5	22.8	36.4	32.9	17.4	3.5	15.8
Liberia 1986.....	6	17.9	19.0	37.3	32.1	17.7	4.8	19.9
Nigeria 1990.....	6	17.2	19.6	37.3	32.5	17.5	4.5	19.2
Uganda 1988-89.....	5	17.5	18.3	37.8	32.3	19.6	5.4	20.7
Mali 1987.....	5	15.9	19.0	38.2	30.8	19.0	5.2	21.3
Niger 1992.....	4	15.1	17.8	37.6	28.8	19.3	5.3	20.6

¹ Contraceptive Prevalence = Percentage of married women of reproductive age currently using contraception

² Age at First Marriage = Median for women age 25-29

³ Age at First Birth = Median for women age 25-29

⁴ Age at Last Birth = Median for ever-married women ages 40-49 with at least one birth (40-44 for Brazil and Guatemala)

⁵ Life Expectancy at Age at Last Birth = Based on Coale-Demeny model life tables; mortality level from United Nations (389); mortality pattern from United Nations (388)

⁶ Number of Years Between First and Last Births = For ever-married women ages 40-49 with at least one birth (40-44 for Brazil and Guatemala)

⁷ Number of Years Spent Pregnant = TFR (0-2 yrs for women 15-44) x 9/12

⁸ Number of Years with Child under Age 6 = For all women (current status estimate based on proportions with a child under 6 by age)

NA = Not available

**Table 3. Trends in Contraception and Women's Lives:
How Indicators of Women's Lives Have Changed as Contraceptive Use Has Risen,
Demographic and Health Surveys and World Fertility Survey, 1977-1992**

	Years of Surveys	Contraceptive Prevalence ¹			Age at First Birth ²			Age at Last Birth ²			Childbearing Period ³			Years with Child under Age 6 ⁴		
		WFS	DHS-I	DHS-II	WFS	DHS-I	DHS-II	WFS	DHS-I	DHS-II	WFS	DHS-I	DHS-II	WFS	DHS-I	DHS-II
<i>Ghana</i>	1979-80, 88	10	13		20.1	19.0		38.2	37.9		18.1	18.9		21.1	20.8	
<i>Kenya</i>	1977-78, 88-89	7	27		19.9	18.9		39.3	37.8		19.4	18.9		22.9	20.8	
<i>Senegal</i>	1978, 86	4	11		18.1	18.7		38.0	38.7		19.9	20.0		20.8	20.6	
<i>Sudan</i>	1978-79, 88-90	5	9		20.2	19.0		36.3	36.4		16.2	17.4		17.7	15.8	
<i>Egypt</i>	1980, 88-89	24	38		18.9	19.8		35.1	34.6		16.2	14.8		16.2	15.7	
<i>Morocco</i>	1979-80, 87, 92	19	36	42	18.8	19.7	20.5	37.0	37.6	36.9	18.2	17.9	16.4	17.3	15.6	14.6
<i>Tunisia</i>	1978, 88	31	50		21.5	21.5		37.8	36.3		16.3	14.8		16.9	14.3	
<i>Indonesia</i> ⁵	1976, 87, 91	26	48	53	19.5	19.3	19.2	34.9	34.1	32.5	15.4	14.8	11.9	17.0	12.4	11.9
<i>Sri Lanka</i>	1975, 87	34	62		20.5	21.9		35.5	33.5		15.0	11.6		13.2	11.0	
<i>Thailand</i>	1978, 88	37	66		21.6	21.5		37.3	32.9		15.7	11.4		16.2	10.5	
<i>Colombia</i>	1976, 86, 90	43	65	66	21.1	20.6	21.1	36.4	33.6	33.3	15.3	13.0	12.2	15.1	13.1	12.2
<i>Dominican Rep.</i>	1975, 86, 91	33	50	56	19.8	19.6	19.6	36.0	34.0	31.2	16.2	14.4	11.6	16.3	13.3	12.4
<i>Ecuador</i>	1979, 87	35	44		20.8	21.0		36.9	35.6		16.1	14.6		16.8	15.5	
<i>Mexico</i>	1976, 87	30	53		20.2	20.5		37.4	35.1		17.2	14.6		21.5	14.6	
<i>Peru</i>	1977-79, 86, 91-92	31	46	59	20.9	20.5	21.3	37.5	36.2	34.7	16.6	15.7	13.4	17.2	15.4	13.4
<i>Trinidad & Tobago</i>	1977, 87	52	53		19.7	20.4		33.4	31.7		13.7	11.3		11.9	12.0	

WFS = World Fertility Survey; DHS-I = Demographic and Health Survey, first round; DHS-II = Demographic and Health Survey, second round

¹Contraceptive prevalence = Percentage currently using any method among currently married women ages 15-49

²Age at First Birth, Age at Last Birth = Median for ever-married women ages 40-49 with at least one birth

³Number of Years Between First and Last Births = Median age at last birth minus median age at first birth

⁴Number of Years with Child under Age 6 = For all women (current status estimate based on age-specific proportions with a child under age 6)

⁵Java and Bali only

Population Reports

four or more children, 24% went to lower secondary school, and 14% went to upper secondary school. In this study couples with small and large families were matched for wealth, religion, residence, parents' educational attainment, and parents' ambitions for their children's education. All couples had had access to modern contraceptive methods throughout their reproductive years (131, 178). Similarly, in Matlab, Bangladesh, children in small families stayed in school longer because they did not need to care for younger siblings at home (100, 101). Still, in both Thailand and Bangladesh parents provided more education for their sons than for their daughters.

Contraception and Employment

The relationships among women's status, employment, and childbearing are complex. Some statistical studies find lower fertility associated with more female participation in the labor force, while others find the opposite (195). Such inconsistency is not surprising, given the variety of jobs and occupations, demographic and household characteristics, cultural forces, and socioeconomic circumstances around the world.

While statistical research into women's labor-force participation and women's use of contraception has not produced clear findings, the conceptual links are clear. With effective contraception, women are better able to work when they need to without the interruption of unplanned childbearing. Women also may find the burden of household work some-

what lightened. In addition to caring for children, women nurse the sick. Women in developing countries raise 50% to 90% of their families' food (340). In most rural areas women spend long hours carrying water, gathering fuel, and preparing and cooking food. How spacing and limiting births influence the daily lives of women working in the home also deserves research.

Wherever unplanned pregnancy would limit the types of work available to women, effective contraceptive use may help provide women with broader opportunities to obtain the economic security of a job. When a woman cannot be sure of avoiding pregnancy, her occupational choices often are limited. She may have to find employment that can be combined with childcare, that permits flexible hours, and that is easy to enter and leave frequently. Such jobs typically earn low, static wages. Most such jobs are in the informal sector of developing economies—for example, agriculture and petty trade. Even in the formal sector of developed countries, such jobs as nursing and teaching have been held mostly by women since employers did not care if pregnancy forced teachers or nurses to leave after a few years on the job. Seen as jobs that young women held until they had a family, these professions have commonly been paid less and offered less opportunity for advancement and less status (22).

More detailed studies, rather than large-scale statistical analyses of fertility levels and labor force participation, may offer a clearer view of how contraceptive use and employment are linked. For example, in Nigeria researchers found

that young unmarried women out of school were using contraception in order to work longer before marriage. In one area studied, 75% of single women ages 18 to 25 were using contraception, more than five times the contraceptive prevalence of married women in the same age group (40).

Of course, many factors other than contraception affect women's employment. Women's autonomy within the family is one such factor (194). In some countries cultural norms call for women to remain at home no matter what their own preferences are. Also, some employers discriminate against women, partly because employers assume that women's commitment to their jobs is weaker than men's. Nevertheless, in modernizing economies women are an increasingly important part of the labor force (340). Where contraception is widely available and its use is accepted, employers can be more confident that female workers will not be forced to leave because of unplanned pregnancies. At the same time, however, the possibility that a woman may become pregnant is not legitimate grounds for denying her a job.

When women have access to contraception and new economic opportunities, many take advantage of both. In Bangladesh the Grameen Bank offers poor women small loans for income-generating projects. The women attend regular meetings at which they receive advice on their projects. They also learn the "Sixteen Decisions"—resolutions to make changes in their lives including planting vegetables, educating their children, and having small families. Women who have taken advantage of this new economic opportunity are more likely to be using contraception than women who are not receiving loans (293).

How Can Family Planning Programs Benefit Women?

Contraceptive use protects women from the health risks of unwanted pregnancy and gives women more control over their own lives. Family planning programs help women primarily by providing contraceptive methods. What more can family planning programs do to meet women's needs? Women interact with family planning programs only briefly and infrequently. Still, in addition to providing contraception, those brief contacts can be designed to strengthen women's abilities to fulfill current roles and take on new ones. Program managers can seek to:

- Encourage respect for women,
- Provide a range of reproductive health care, and
- Design program activities to strengthen the skills that enable women to take new opportunities.

Encouraging Respect for All Women

By showing respect for women, family planning programs help women build self-confidence and self-esteem and thus strengthen their ability to make their own decisions and to act in their own interests. Also, showing respect for women as clients sets a good example for the community.

Family planning programs have an excellent opportunity to promote respect for women. Unfortunately, some programs have missed that opportunity—perhaps because program

personnel share widespread social attitudes that denigrate women, because a program focuses on enrolling more clients rather than meeting clients' needs, because personnel are simply not aware that courtesy is important, or because service providers have too little time for each client.

Program managers can encourage respect for clients in several ways:

- **Ensure informed choice.** Programs that help women make their own informed choices about their fertility show respect for their clients' right and ability to make decisions. To ensure informed choice, managers can see that clients are (1) offered a choice of methods, (2) given the information they want about each method, and (3) allowed to choose the method that they want, provided there is no medical reason to withhold it (67).
- **Communicate respectfully.** All personnel, no matter what their function, can act politely and in a respectful, friendly manner with all clients at all times. Program personnel demonstrate their respect for clients by paying attention to what clients say, answering their questions fully, never belittling their concerns and questions, and understanding and honoring their clients' wishes (294, 344). Also, programs must be sensitive to clients' modesty and preserve client-provider confidentiality (186).
- **Train staff.** Program managers can train staff to think of clients' needs and to communicate with clients. Staff also can learn how to communicate respect.
- **Reward respect.** Managers can reward personnel who treat female clients respectfully. They can measure the success of programs and providers by client satisfaction rather than just by numbers of clients. To measure client satisfaction, managers can survey clients about the care that they received (see p. 35). Whether clients return for further services when needed also indicates whether they are satisfied.
- **Improve staff morale.** Family planning personnel may treat clients poorly if personnel themselves have to work with insufficient time, supplies, space, or pay. If so, managers can acknowledge the problems, remedy them if possible, and at the same time make clear that the staff's frustrations are not an excuse for treating clients disrespectfully. Also, public promotion that enhances the image of providers, along with training, improves morale and inspires staff to live up to their new image (259).
- **Set an example.** Managers are role-models for other program personnel. If they do not treat clients and staff with respect, they cannot expect their staff to do so.

Clients know when they are treated with respect. Among Chilean women interviewed at a family planning clinic run by the Instituto Chileno de Medicina Reproductiva (ICMER), "being treated like a human being" was the most frequently identified element in high-quality care (344). In a clinic run by the Bangladesh Women's Health Coalition, a woman commented on the care that she had received: "I'd heard about family planning before, but not this way. This is the only clinic where I was asked to sit down and where I was treated as an equal. If I knew about it in this way, do you think I'd have six children?" (161).

People who are treated with respect develop self-respect. Brief contacts with a family planning program are not likely to revolutionize women's lives. Still, for some women, contact with high-quality family planning services can be a start; for others, a step forward; and perhaps for a few, a big step. A young mother in Chile credited a family planning service

Learning More About Family Planning and Women's Lives

Not enough is known about the way contraceptive use affects women's lives. Researchers know that women's education, economic position, household characteristics, and social status influence use of contraception and thus fertility. In contrast, little is known about the opposite perspective—how changes in contraceptive use and thus in fertility affect other aspects of women's lives, particularly the ability to take on new roles (140, 206).

The Rockefeller Foundation funded early research on the relationship between the status of women and fertility. Findings indicated that the status of women is defined differently in different cultures and that multiple factors affect both fertility and women's status (206, 207, 250). The researchers did not find any universal relationship between the status of women and fertility.

Assessing current understanding of this issue, Sawon Hong and Judith Seltzer observed, "1) good data and rigorous analysis are scarce; 2) the relationship is complex and varies by social, cultural, and economic setting; and 3) no simple conceptual model has yet been set forth" (140).

To improve understanding of how contraceptive use affects women's lives, the United States Agency for International Development has funded a 5-year, US\$8.6 million research project, begun in late 1993 by Family Health International. Its purposes are (1) to support social and behavioral research on the immediate and long-term consequences for women of both family planning programs and contraceptive methods and (2) to help improve family planning and related reproductive health policies and programs through increased knowledge of the needs and perspectives of women. The project will support qualitative and quantitative research in six to eight countries. In-country advisory committees will help establish the research agenda (360). Based on its findings, the project will recommend improvements in program design and implementation from the perspective of women's interests and needs (339).

with improving her self-esteem: "I am valuing myself more. I am realizing that I am really worth something. I am a person, and I should take care of myself..." (344).

Offering Other Reproductive Health Care

A reproductive health approach to family planning services can improve women's health and therefore women's choices. Judith Bruce and Anrudh Jain define a reproductive health care approach as one that helps clients reach their fertility goals in a healthful manner (151). This approach focuses first on ensuring that clients receive high-quality family planning services and then on offering additional services to help women meet multiple health needs at the same time and place.

To attain high quality, family planning services require two components: respectful, helpful interaction between provider and client (see p. 15) and technically skilled personnel. To assure high quality, family planning programs can (1) determine the services that they can offer, (2) develop

locally defined standards of care, and (3) establish quality-monitoring procedures (31). For example, those who counsel clients about contraceptive use must be trained to explain whichever methods are offered, to understand clients' needs, and to help them consider their options. Those who perform medical procedures need technical training. All training should raise providers' skills to a demonstrated standard of competence. Monitoring and supervision reinforce quality standards to assure that programs offer an informed choice of methods, hygienic care, and safe medical procedures. AVSC International has developed the COPE technique and the Population Council has developed the Situational Analysis approach to evaluate the quality of both client-provider interaction and providers' technical skills (200, 213).

Many medical professionals favor a reproductive health approach because they see a visit to a family planning clinic as a rare opportunity to inform, screen, and treat women for a variety of reproductive health conditions, such as certain common sexually transmitted diseases (STDs) (87, 114, 362) and conditions of pregnancy (156, 167). Also, girls and adolescent women can be counseled about nutrition, anemia, and general health to help prevent later pregnancy-related morbidity and mortality (115, 288, 362). Some programs, too, may want the convenience of dealing with multiple health needs on one clinic visit (33, 87).

Women often see little distinction among family planning, other reproductive health needs, and still other health needs, including their children's. When family planning personnel cannot help, some women feel that program personnel are not really interested in their health (301). In the ICMER clinic in Peru, women wanted a clinic visit to be an opportunity to learn more about their reproductive health and how to protect it. They preferred to discuss all their health problems with one provider (344).

Meeting a variety of needs encourages women to use services. For example, in Tunisia a family planning program recognized that new mothers have multiple concerns—about their new infants' health, their own health, and their ability to breastfeed (59). Therefore a clinic in Sfax began to offer neonatal, postpartum, and family planning services on one visit. Women are encouraged to come to the clinic on the fortieth day after giving birth, the traditional day on which a new mother first leaves the house. In 1987, 83% of postpartum women came for this visit, and 56% of these women adopted a family planning method (59). The approach is now being applied nationwide.

Not all women want all services, however. For example, some women may want a contraceptive method but not a pelvic exam or Papanicolaou smear. Requiring clients to accept services that they do not want could discourage them from getting any services at all (61).

In counseling women, programs also might broaden their focus beyond preventing pregnancy and disease (76, 91, 94). For example, women have a right to refuse unwanted sexual intercourse but often cannot do so. Helping women with such matters requires learning more about their private lives. Ruth Dixon-Mueller argues that providers cannot truly meet women's needs for contraception, disease prevention, or safety from violence without knowing something about how each client is sexually active (76). Providers may need to find out, for example, if a client has multiple sexual partners or is forced into unwanted sexual acts. Few family planning providers are prepared to elicit such information, which must

be discussed in a sympathetic and reassuring manner. Training and a new way of thinking about the providers' role will be required. Of course, clients should not be required to disclose intimate information if they choose not to.

Weighing program options. Each program must determine its own ability to offer new services. Some programs may be strained to capacity, already serving as many clients as possible. For such programs, the scarcity of resources limits how much more they can offer. Other programs may want to attract more clients. For these programs, broadening services—and improving quality—may help. In choosing which services to add, each program has to assess clients' needs as well as program resources.

Still, some general principles apply to making these decisions. Elizabeth Maguire, Acting Director of the Office of Population, United States Agency for International Development, urges that family planning programs consider adding other reproductive health services "that will benefit the most women at an affordable cost and have the highest public health impact" (201). Under these criteria a common, serious condition that is easily treated or prevented would have highest priority. Providers and other public health experts should involve clients in deciding which conditions are deemed serious (14, 33, 161, 344), but without abandoning their professional judgement.

Many family planning managers are considering whether to offer services for sexually transmitted diseases. Adding STD services to family planning services can be appropriate because (1) many people need care, (2) combined services would be convenient for clients, (3) most STDs can be treated, (4) counseling could help women avoid STDs, and (5) most family planning programs offer condoms in any case. Also, STDs are spreading and have serious health consequences. It is now known that infection with the AIDS-causing human immunodeficiency virus (HIV) is more likely in those with other STDs (see **Population Reports, Controlling Sexually Transmitted Diseases**, L-9, June 1993). Some family planning programs may find it difficult, however, to add STD services. Of course, family planning program managers can choose among several different levels of STD services: (1) prevention—information, counseling, and providing condoms and spermicides; or (2) in addition, initial screening and referral of suspected STD cases for diagnosis and treatment elsewhere; or (3) diagnosis and treatment as well as prevention and initial screening. The potential for impact and costs differs at each level.

Treatment after a septic abortion is also a serious need because so many women die from unsafe procedures (see p. 5). At the 1984 International Conference on Population in Mexico City, delegates urged governments to help women avoid abortion and to treat them humanely if they have had an abortion (368). Policy-makers can reduce the number of abortion deaths by improving treatment for septic abortion and by linking postabortion care with contraceptive counseling and services (361). While offering contraception to all who want it, family planning programs can reduce abortion by reaching out especially to women at high risk of unwanted pregnancy, including adolescents, and by providing postabortion counseling and family planning services in hospitals where women receive postabortion treatment.

Around the world a variety of reproductive health programs are developing. For example, some affiliates of the International Planned Parenthood Federation (IPPF) in Africa and

Latin America provide counseling and referrals for clients with STD symptoms (185). In Colombia the Asociación Pro-Bienestar de la Familia (Profamilia) offers contraceptive methods, screening for sexually transmitted diseases, sex counseling, clinics for men, AIDS prevention, and even legal services to low-income men and women (316, 345).

In Bolivia a coalition of 18 public and private health institutions recently launched a national campaign to promote reproductive health services. The Bolivian National Reproductive Health Program encourages couples to use services that will improve family health including reducing the high maternal mortality rate. These services include family planning, prenatal care, safe delivery and postdelivery care, breastfeeding promotion, and abortion prevention. To inform people about these services, the organizations, with technical assistance from Johns Hopkins Population Communication Services (JHU/PCS), have developed a campaign logo, clinic signs, posters, radio and television spots, in-clinic videos, client-provider materials, and audio cassettes for play on buses (285) (see photo, this page). The campaign tells couples that they have the right and responsibility to protect the health of women and children.

(Continued on page 23)



"Ask for information and services here. Reproductive Health is in your hands," says this poster for the Bolivian National Reproductive Health Campaign. The poster, for display outside a clinic, is part of a nationwide multimedia campaign promoting services for family planning, prenatal and delivery care, breastfeeding, and prevention of abortion.

Who Makes Reproductive Decisions?

Who makes reproductive decisions? How and why are these decisions made? Family planning programs can better serve their clients, both male and female, if they can answer these questions. They also can better find ways to help women express their needs and to help men understand and respect women's concerns.

Complex Situations, Complex Decisions

The reproductive decision-making process reflects tradition, religious belief, community norms, family structure, household economics and the value of children, and access to new ideas and innovations, all expressed in peoples' attitudes and opinions (36, 89, 348). Research on the reproductive decision-making process is limited and scattered, but a study in areas of North and South India illustrates the complexity of the process. Women in southern India are valued agricultural workers, marry later than women in the North, have more contact with and support from their parents and families, and are closer emotionally to their husbands. Their daughters are less likely to die in infancy. Women in southern India are better treated because they marry within their own extended families—groups of people who depend upon each other for continuing support. In contrast, women in northern India marry out of their extended families into families that have no on-going relationship with the women's parents and other relatives and that permit married women little contact with their own families. Meanwhile, men's families form close, mutually supportive groups. Most men are not close to their wives. In the northern system women have little value to their own parents and are valued by their husbands' families chiefly when they produce sons. Women in the southern kinship system are better able to make reproductive choices such as using contraception because they are more valued, less isolated, and more autonomous. They also are under less pressure to produce sons (80).

As this example illustrates, the extended family or the community is often the ultimate decision-maker in matters of reproduction, even in countries as diverse as China, India, and Mexico (29, 125, 262, 282, 297). Such influence can extend even to decisions about what contraceptive method to use (222) (see Table 5).

While the web of influences on decision-making is complex, people nonetheless have perceptions of who actually makes decisions in the household or who has the most say. Here and there surveys and focus-group research have asked people who makes household decisions including decisions about reproduction.

When Men Decide

Within marriage, in many cultures men typically have more say than women in the decision to use contraception and in the number of children that the couple will have (138). In Ghana, for example, both Demographic and Health Survey (DHS) data and focus-group research reveal that the husband is usually the effective decision-maker about fertility.

Furthermore, husbands' family planning attitudes and fertility goals usually are not influenced by those of their wives (88). When partners disagree on whether to use family planning, the man's preference usually dominates (193). In South Korea researchers found that 71% of women whose husbands approved of family planning had used contraception at some time compared with 23% of women whose husbands did not approve (168).

When Women Decide

Within marriage some women make the decision to use family planning. In the few studies comparing various household decisions, women seem to have more say about using contraception than about most other important decisions. In Turkey, for example, 62% of the semi-urban wives surveyed made their own decisions about contraceptive use (see Table 5). In general, better educated women have more decision-making power within marriage, including more influence over decisions about reproduction and family planning (168, 272, 359).

Some women decide to use contraception without telling their husbands. In DHS in African countries, a small minority of women report doing so because they think that their husbands would disapprove. In rural Nigeria, as elsewhere around the world, some women secretly use contraceptives, use patent medicines as abortifacients, or make secret trips for abortions even though they risk eviction from their homes if found out (272, 273).

Many unmarried women make reproductive decisions by themselves, of course (193). These decisions add up; in many countries women spend much of their lives outside marriage. For example, in Botswana women older than age 20 spend an average of 46% of their remaining reproductive years unmarried. In Colombia women spend an average of 40% of their entire reproductive lives unmarried (193).

Discussion Between Partners and Joint Decision-Making

Married couples together sometimes make household decisions of various kinds, including the decision to use contraception (see Table 5). Whether a couple discusses family planning can affect the decision to use contraception (see p. 25).

In many places such communication is the exception rather than the rule, however. In Kenya, for example, lack of communication between spouses proved to be a more common obstacle to contraceptive use than male opposition (237). In a study of monogamous couples in Ghana, 35% of the wives and 39% of the husbands reported discussing family planning during the previous year. Even among women who said that they had discussed family planning with their husbands, however, 39% reported their husbands' attitudes to be different from what their husbands independently told interviewers. Still, contraceptive use was higher among the couples who had discussed the subject (289).

Focus-group discussions in Tanzania found that different people had different reasons for not discussing contraception (309). Older people did not discuss using contraceptives because they believed that God determined the number of their children or because they used abstinence or herbal medicines to space pregnancies. Women did not discuss the topic because they thought that their husbands did not approve of contraception. Married men said that discussion was unnecessary because the women decided on their own the number and timing of pregnancies. Young people did not talk about contraceptives for fear of being considered promiscuous.

Program managers need to be aware of the variety of ways that individuals and couples make decisions about contraception—a variety that reflects not only the social position of women relative to men but also the different types of sexual relationships, from longterm monogamous marriages to one-time contacts between strangers. Communication campaigns and counseling are most likely to be effective when they recognize existing patterns of communication and decision-making. In some cases that means reaching out to couples. At the same time, communication needs to address men and women as individuals (289). In many cases communication programs may seek to influence men's and women's roles in the decision-making process as well as its outcome.

FAMILY PLANNING IS TEAM WORK



Plan it together

CONSULT YOUR NEAREST CLINIC

Family planning works best when a couple discusses and decides together, as this poster from Ghana notes. But many couples do not talk about family planning.

Table 5

Who Decides?

Percentage of Couples, by Who Decides and Nature of Decision, Survey Responses in Three Countries

Place/No. of Respondents, Family Member Deciding	Use of Family Planning	Number of Children	Nature of Decision				
			Major Purchase	House- hold Budget	Education of Children	Visiting Friends	Child's Marriage
Semi-Urban Turkey/366 women							
Wife	62	NA	5	49	11	23	3
Husband.....	8	NA	59	27	32	53	24
Joint	25	NA	28	16	45	14	31
Extended family	1	NA	6	8	1	9	2
Other	4	NA	2	1	11	2	40
Rural Turkey/358 women							
Wife	29	NA	2	11	4	13	<1
Husband.....	23	NA	54	52	36	40	21
Joint	46	NA	10	7	39	7	38
Extended family	1	NA	23	20	10	33	11
Other	1	NA	11	10	11	7	30
Rural India/250 women							
Wife	4	5	1	NA	1	NA	1
Husband.....	24	11	6	NA	19	NA	1
Joint	38	44	58	NA	50	NA	32
Extended family	22	28	34	NA	20	NA	44
Data missing	12	12	1	NA	11	NA	22
Egypt/9,000 women							
Wife	14	6	NA	15	3	3	1
Husband.....	25	32	NA	48	34	62	36
Joint	61	62	NA	27	63	32	61
Other	1	1	NA	9	1	2	2
Data missing	—	—	NA	—	—	—	1
Upper Egypt/1,053 men							
Wife	4	4	NA	7	1	2	1
Husband.....	59	67	NA	84	72	82	68
Both	36	26	NA	9	27	16	26
Other	1	4	NA	1	—	—	4

NA = Not asked

Sources: Turkey: Cilingiroglu (56); India: Murty (222); Egypt: Demographic and Health Surveys; Upper Egypt: Sayed et al. (291)

Population Reports

Competent Women and Caring Men:

Rabia: You are a selfish man, Amir. You care only for yourself.

Amir: I don't like to hear this rubbish.

Rabia: This is not rubbish. It's a matter of me and my children's life. I won't let them be ruined.... I still have enough strength to take my children and myself away from you.

In this pivotal scene from the Pakistani television drama *Aahat* (*An Approaching Sound*), the heroine Rabia confronts her husband Amir for the first time. He has neglected his daughters and demanded that his wife have repeated pregnancies so that he can have a son. Standing up for herself,

Rabia presents a new, more powerful image of women.

By portraying new role models of women and men, the mass media can create awareness, generate discussion, and suggest new

ways for men and women to behave. Such images are particularly powerful when they are presented in programs that entertain. Popular performers and gripping stories attract large audiences, and viewers can emulate the behavior of attractive male and female characters (170). Productions such as *Aahat*, designed to encourage communication about reproductive health issues, use the mass media to promote contraception and, at the same time, to present new images of women and men.

Throughout the world television, radio, and advertisements in all media continually present images of men and women. Usually, these images reinforce stereotypes. For example, Egyptian television serials and dramas present central male characters as attractive because they are mature and successful. In contrast, women are presented as attractive because they are young and pretty (81). Similarly, in India television programming portrays the ideal woman as a

submissive wife who sacrifices herself for her family and helps men achieve their goals. The ideal man on India television is one who is diligent, fights for just causes, and protects and controls his home (180). Stereotypes are commonly depicted in broadcasting in the US and other developed countries as well (70, 112).

New Images

Instead of reinforcing society's stereotypes, script writers and producers can present new images of men and women. Materials produced to promote reproductive health bear a special responsibility to present male and female characters who are positive role models.

Images of competent women. The mass media can promote the image that women are competent in whatever they choose to do, whether they are strong mothers in the village or glamorous urban entrepreneurs. For example, in Peru a multimedia campaign promotes women as "*las tromes*," a popular expression for people who are resourceful and capable. The campaign features women who skillfully manage their family and work situations. They get the information that they need to solve their problems, including accurate information about contraceptive methods. These women are depicted in television spots and in posters promoting reproductive health services.

By showing women who overcome fear, mass-media presentations can help women in the audience learn to overcome their own fears. The 6-part drama *Aahat*

depicts growing tension between Rabia and Amin. Their early romance fades. Within six years the couple has four daughters. But Amir wants sons, and Rabia becomes depressed by her husband's disappointment and her mother-in-law's nagging. Increasingly, Amir blames Rabia until she, supported by a strong female friend, demands respect for herself and her daughters. Surveyed audiences in Pakistan reported great sympathy for Rabia. Also, of 2,000 survey respondents, 9% visited a family planning clinic, and 12% said they had taken action to space their children as a result of seeing the film. About 87% of viewers said they were likely or very likely to improve communication with their spouses, and 5% said that they had already done so (199).

Mass-media portraits are most powerful when they portray women struggling with situations that viewers understand.

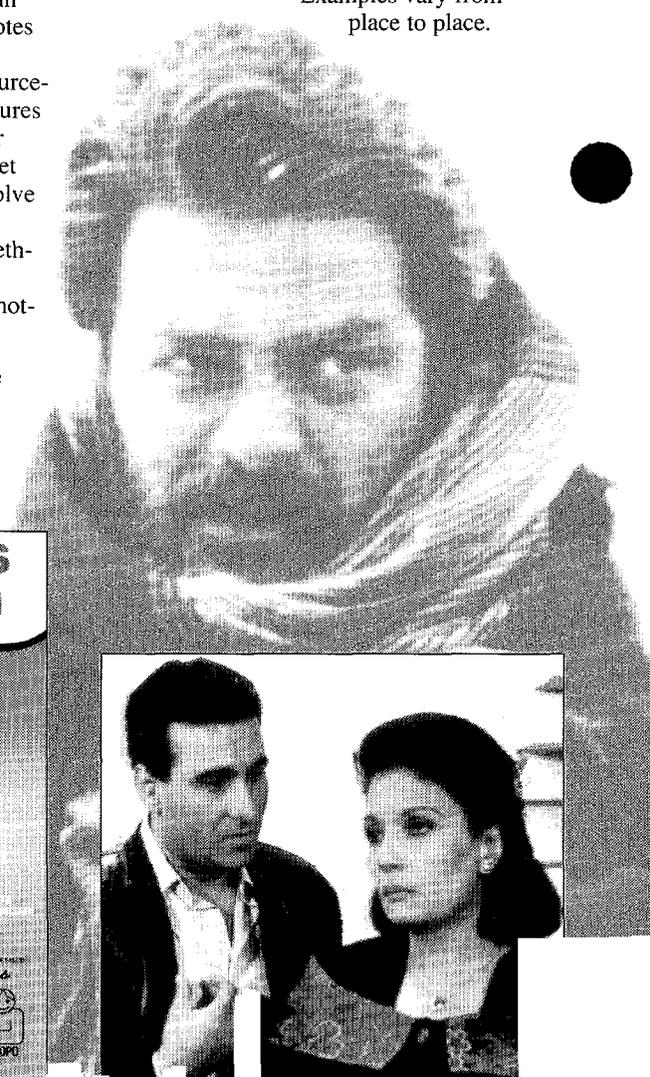
Examples vary from place to place.



Pakistan: *Aahat*



Peru: *Las tromes*





Bangladesh: *Jiggasha*

Consequences, a film made in Zimbabwe to discourage teenage pregnancy, focuses on a young woman who becomes pregnant and must leave school, nearly dies in childbirth, and must struggle to support her child. Another dramatic film from Zimbabwe, *Neria*, tells the story of a widow who at first accepts poor treatment from her husband's family but then begins to fight for herself and her children.

Media Images Can Inspire New Behavior

Documentary films, too, depict competent women and show others how they achieved success. Some focus on women who find strength in collective action. The Indian film *Kamala and Raji* shows how poor women formed the Self-Employed Women's Association to provide themselves with services they wanted. A video, *Women Speak Out in East Africa*, interviews professional women and also describes the efforts of women's groups to win more rights for women. A video from Bangladesh, *Jiggasha*, focuses on a family planning field worker who helps women in village groups discuss their reproductive health needs (see pp. 30-31).

Images of women at work. Mass-media presentations of women working outside the home help people accept women in such roles. As in all dramas, these stories are most compelling when the characters must overcome difficulties to establish their new roles. A television film about a Turkish midwife, *Umut Hep Vardi* (*Hope Was Always There*), depicts an idealistic young woman on her first assignment as a village midwife. To help women and children, she struggles against harsh living conditions and opposition from local male leaders. In the Pakistan television serial drama *Nijaat* (*Deliverance*), a rural nurse attempts to persuade a man to use contraception to protect his wife's health. He agrees after the family endures a series of disasters.

Turkey:
Umut Hep Vardi



Zimbabwe: *Consequences*

Informational films and programs, too, can portray women as leaders with authority. Egyptian television spots, for example, have featured the popular actress Karima Moukhtar as a hardworking doctor explaining contraceptive methods. The Indonesian Blue Circle campaign urges people to get information about contraceptive methods from a pleasant, smiling female midwife.

Images of caring men.

Attractive mass-media images of couples who cooperate can show men and women how to support each other. A cartoon drama made in Mexico, *Los Mejores Deseos* (*Best Wishes*), tells the story of a young couple. Gaspar dreams of getting a better job so that he can marry Sara and provide a home. They begin to quarrel when it is Sara who finds a job. Gaspar is jealous of the men she meets at work. In the end, however, they accommodate each other so that they can reach their common goals of a home and family. The video helps young people communicate with each other, see women as equal partners, and plan their children.

The film *Dangerous Numbers*, made in Ghana, shows that couples who cooperate can solve their problems. The tire repairman Kwame and his wife Akua discuss the pressures in their lives and find solutions together. Despite criticism from Kwame's mother, they use contraception and plan their family. Their small family gives both of them time to earn money so that they can send their two children to school. The Egyptian television serial drama *And the Nile Flows On* showed a female doctor and a progressive religious leader working together to bring peace to the village.

Effective Media Images

How do depictions of new roles influence people? First, viewers may learn of new options. Researchers held focus-group discussions among poor women who watched the Indian TV soap opera *Hum Raahi* (*We, the Traveling Companions*). Having seen what happened to the characters, some women said that they would try to resist pressure



Pakistan:
Nijaat

to marry off their daughters young and would dare to go out and shop in the market. They recognized that, in the program, educated women were better able than uneducated women to express their opinions. As a result, they wanted more education for themselves and their children. Noting that they had had experiences like those of the television characters, one woman said, "People watching TV feel that they become the equals of those who can read and write" (46).

Dramas can give men and women insight into each other's concerns. In Egypt 60% of surveyed women who



Ecuador: *Entre nosotras*

watched *And the Nile Flows On* said they identified with the heroine, Dr. Omazma, and 11% said they identified with the hero, Sheikh Hashem. Among surveyed male viewers 29%

identified with the heroine, and 53% with the hero (387.)

Social dramas speak most clearly when they portray a contrast of positive and negative characters. The Arabic-language television series *Beit al'eyla* (*The Family House*) portrays several families, including the family of a mother who was deserted by her husband and must raise her children alone and that of a competent social worker and her father, a gentle physician. In contrast to



Egypt: taping *The Family House*

the other characters, the social worker and her father work in harmony in their clinic for the good of their neighbors.

Furthermore, drama can show characters rewarded for their positive behavior (18). India's first television soap opera promoting social themes, *Hum Log* (*We, the People*), ran in 1984 and 1985. The program intended to promote respectful treatment of women and a wider range of social roles for women. Research found, however, that many viewers missed the point. Many praised

New Video Available

Competent Women, Caring Men: Images That Inspire

A new video produced by Johns Hopkins Population Communication Services (JHU/PCS) shows how modern mass media and effective health communication can present new images of couples who cooperate to improve reproductive health. The 10-minute video, entitled *Competent Women, Caring Men: Images That Inspire*, highlights media projects produced with assistance from JHU/PCS, including social dramas and serial television, music videos, animation, radio or TV documentaries, public performances, and billboards, to show how dramatic images of men and women can be a powerful tool in encouraging people to adopt new behavior.

Competent Women, Caring Men: Images That Inspire will be available in late 1994 in VHS. For more information, write to: JHU/PCS, Media/Materials Collection, 111 Market Place, Suite 310, Baltimore, MD 21202, USA. Specify PAL, NTSC, or SECAM.

the long-suffering woman who accepted abuse from her husband. Viewers noted that she kept peace in her family and thus benefited from her self-effacing behavior (304). Analysis of the *Hum Log* episodes indicated that the positive role models did not consistently benefit from treating women better, and the negative role models were not consistently punished for treating women poorly (28). *Hum Raahi*, which started in 1992, built on this lesson. The soap opera has a diverse group of male and female characters. Those with respectful attitudes toward women are rewarded (46).

How do writers and producers know what works? Thoughtful planning and pre-testing help media producers design effective materials (226, 255). The Peruvian producers of the "las tromes" campaign portrayed a middle-class family in their television spots rather than the wealthy families usually seen in advertisements. Research had shown that the many lower- and middle-class women who need information about reproductive health issues would find the information more credible if the characters were more like them. Also, in preliminary versions of spots the male characters were washing dishes. In pre-testing focus groups, male viewers thought this was too demeaning a task for men (246). In the final spots men are painting walls or changing light bulbs and are therefore more admirable to other men.

The Reach and Impact of the Mass Media

Mass-media messages reach vast audiences (226). Each broadcast of *Hum Raahi* reaches about 100 million people

(46). In Mexico over 950,000 people saw a film about young adults, *Va de Nuez* (*Let's Try It Again*), when the Ministry of Health showed it in theaters (54). A new 10-minute radio talk show in Ecuador, *Entre nosotras* (*Between Us*), reaches about 30,000 women with each episode about health, sexuality, and contraceptive methods (286). In Egypt 75% of men and 70% of women interviewed in 1992 said that they had heard about contraceptives on television (83).

Mass-media messages influence behavior, as family planning communication efforts around the world have demonstrated (255). For example, after a multimedia campaign in Zimbabwe, a survey of married men found that contraceptive use in certain areas had increased from 56% to 59%, and condom use, from 5% to 10% (254). A study of DHS data in Kenya found that women who had heard about contraceptive methods in the mass media were more likely to be using them (358). In a television and radio campaign in Nigeria in 1992, short public service announcements in five languages presented dramatic situations and brief messages. During the campaign use of contraceptives rose from 25% to 32% of surveyed men and women of reproductive age (174).

The mass media provide a powerful way to reach many people with new images of competent women and caring men. Producers who can create well-designed images in high-quality films, videos, radio programs, and other mass media have an opportunity to help change women's lives for the better.

For a detailed list of the materials mentioned here, see p. 39.

Table 4. Gender and Family Planning Services: Assumptions and Possible Consequences

ASSUMPTIONS	POLICY RESULTS	SERVICE CONSEQUENCES	GENDER CONSEQUENCES
<p>NEGATIVE ASSUMPTIONS:</p> <ul style="list-style-type: none"> • Women cannot make wise choices. • Women cannot tell rumor from fact, and they will stop using methods. 	<ul style="list-style-type: none"> • Select method for client. • Offer only long-term methods. • Ignore or play down side effects during counseling. 	<ul style="list-style-type: none"> • Women distrust providers. • Women fear family planning services. • Women do not return. • Women who want short-term methods stay away. 	<ul style="list-style-type: none"> • Women given no opportunity to make choices. • Women denied opportunity to take responsibility. • Women's opinions dismissed. • Image of women suggests incompetence, dependency.
<p>POSITIVE ALTERNATIVE:</p> <ul style="list-style-type: none"> • Women can make good choices. 	<ul style="list-style-type: none"> • Provide thorough counseling for informed choice. • Expect women to change methods as needs change. 	<ul style="list-style-type: none"> • Women trust providers. • Women return for help or new method if dissatisfied rather than discontinue contraceptive use. 	<ul style="list-style-type: none"> • Women learn to weigh choices and make decisions in new subject areas. • Women gain confidence in making new choices; learn to trust own judgement. • Image of women suggests competence, self-determination.
<p>NEGATIVE ASSUMPTION:</p> <ul style="list-style-type: none"> • Women, not men, should take care of contraception. 	<ul style="list-style-type: none"> • Provide services that are convenient only for women. 	<ul style="list-style-type: none"> • Only women seek services. • Men have little access to services. 	<ul style="list-style-type: none"> • Women bear all responsibility for contraceptive use. • Men distrust contraceptive use. • Men suspect their wives of being unfaithful. • Spousal communication not improved.
<p>POSITIVE ALTERNATIVES:</p> <ul style="list-style-type: none"> • Couples can decide matters together. • Men and women both need family planning services. 	<ul style="list-style-type: none"> • Provide information and counseling for couples. • Provide convenient services for men and women. 	<ul style="list-style-type: none"> • Increased use of contraception. • Both men and women use family planning information and services. 	<ul style="list-style-type: none"> • Husband-wife communication improves in other areas as well. • All individuals recognize that they can and should take care of their reproductive health needs.
<p>NEGATIVE ASSUMPTIONS:</p> <ul style="list-style-type: none"> • Men do not care about family planning. • Men do not like condoms and will not choose vasectomy. 	<ul style="list-style-type: none"> • Provide and/or promote only female methods; neglect vasectomy and condoms. 	<ul style="list-style-type: none"> • Only women seek family planning. • Protection against STDs not maximized. 	<ul style="list-style-type: none"> • Women seen as solely responsible for family planning. • Men do not feel responsible or able to control fertility.
<p>POSITIVE ALTERNATIVE:</p> <ul style="list-style-type: none"> • Men care about preventing unintended pregnancies. 	<ul style="list-style-type: none"> • Provide convenient services for men. • Provide methods that men can use. • Inform men about reproductive health, including women's health. 	<ul style="list-style-type: none"> • Men use more services. 	<ul style="list-style-type: none"> • Men share responsibility for contraceptive use. • Men understand and trust family planning services.

Strengthening Women's Skills

Women often need to build skills and self-confidence before they can take on new opportunities (140). Family planning program activities that strengthen women's assertiveness, communication, and decision-making skills can help prepare women to obtain fair treatment and to take new opportunities. In the process of delivering health services, high-quality family planning programs can help to build such skills by:

- Helping women learn to make informed choices in new areas of their lives,
- Supporting women's choices,
- Encouraging women to recognize their strengths and to build on them,
- Improving women's skills at communicating with their husbands and with people outside their families, and
- Creating new images and models of competent women and caring men.

These skill-building efforts do not necessarily require major new training, large new expenditures, or more staff. Much can be done in the everyday process of serving clients. A change of attitude and a change of emphasis can make a lot of difference.

Self-awareness can be the first step. Whether services meet women's needs can depend on providers' most basic assumptions about women and men (see Table 4). For example, if providers assume that women are solely responsible for contraceptive use, they may design services that make it difficult for men to obtain information and services. If, instead, providers assume that both men and women need services, they are more likely to design services that both men and women can use easily.

Making informed choices. Women make many decisions throughout their lives, but they may need to gain confidence in making new kinds of decisions, such as decisions to control their fertility or to seek new social roles. In a Mexican study young women with unplanned pregnancies seemed to be women with little awareness that they could make decisions for themselves. They were less likely than nonpregnant young women to know about contraceptives, to have discussed sex with their girlfriends, and to have aspirations and plans for the future (249). Women surveyed in parts of such countries as Bangladesh, Ghana, Jordan, Mali, Nigeria, Pakistan, and Tanzania say that they do not participate in decisions about having children. Many say that they obey their husbands' wishes or the will of God (88, 184, 205, 231, 242, 317, 384) (see box, pp. 18–19).

Reproductive health programs can help women make wider choices. By discussing reproductive needs and goals with clients, providers can give women practice in assessing a situation and making thoughtful decisions. Since making fertility decisions may be unfamiliar to some clients, the process requires skill and patience on the part of the provider. Ideally, the provider imparts information, listens attentively, encourages discussion, helps clients recognize their own needs, and answers clients' questions. The clients themselves make the decisions about whether and when to have children and how to carry out their plans (186).

Supporting women's choices. Respecting clients' wishes builds women's confidence in their own decision-making and their right to make decisions. For example, many women already know what contraceptive methods they want before they come to a family planning provider (68, 82). Honoring a woman's preference is important to her satisfaction with family planning (32). In Indonesia, for example, 91% of women who were given the method that they chose were still using that contraceptive method after one year compared with only 28% of women who were given a method that was not their first choice (244). A 6-country IPPF study also found that women were more likely to continue contraceptive use when they received the method that they wanted (142).

Women's choices reflect their own needs. Providers cannot assume what women need or want. For example, in Peru some women in focus groups said that they preferred the rhythm method because it gave them the right to make choices about when to have sex. Also, its use implied the intelligence to take charge of one's life. Women chose this method because it requires cooperation between sexual partners, and that cooperation enhanced the relationship (247).

Therefore, to create the best services, managers can ask clients what they want and design programs and train staff

accordingly. Even better, they can directly involve female clients and community members and groups in planning and monitoring services (see p. 35). Such a client-oriented approach is rare. Indeed, providers' biases often block access to contraception and to a choice of methods (299). Often because of misinformation about methods, providers may favor one method over all others or shun certain methods. Because of negative assumptions about clients, particularly about women, providers may deny clients a choice of methods or discourage use of methods that require clients to act—for example, using barrier methods at each act of coitus or taking an oral contraceptive tablet daily.

Recognizing women's strengths. Successful counseling helps women identify their strengths and build upon them in planning their lives. In India group leaders from the Institute of Health Management ask groups of women who is the most important person in their homes. At first, the women never mention themselves. Then the group leaders recite a list of household chores and ask the women who does each chore in their homes. The women repeatedly answer that they do the chores. When the leaders ask again who is the most important person in their house, the women laughingly answer that they are most important (386). Good counseling can help women recognize that they already plan their time, save money or grain, and care for their families and homes. Building on these skills, women may learn to plan other aspects of their lives, including their reproductive lives, in which they may have depended previously on others. Recognizing their own managerial role in the home, women can have more confidence applying these skills elsewhere. A manual prepared by the United Nations Educational, Scientific, and Cultural Organization (UNESCO) suggests an exercise to help women build their self-esteem: Women list their skills, such as planning their time and organizing their families. Then they say how those skills would help them in a business situation (336).

Improving communication skills. Family planning programs can help women speak up on matters that concern them. In particular, programs can encourage and enable women, and men, to talk about contraceptive use and reproductive health. Women's discussion groups have been the approach most widely used to help women bring up and discuss these issues.

To help women learn to talk about family planning, a program in rural Bangladesh designed with assistance from JHU/PCS organizes volunteer discussion groups. The program was set up to reach more people than family planning field workers could reach in home visits and because women were isolated and unaccustomed to discussing family planning with each other or with their husbands. The discussion groups, called *Jiggasha* ("to enquire" in Bangla), are formed for men and women separately. Leaders and meeting places are chosen to take advantage of the existing networks of communication in the community (see box, pp. 30–31).



Client-centered programs can offer women reproductive health services and information about protecting their own health. By providing services with respect and in ways that strengthen women's skills, such programs also can help women to take on new roles.

The *Jiggasha* meetings have encouraged women to discuss and use family planning. About 65% of participants report that, after

attending several meetings, they have discussed family planning with their husbands or with other women in the group, and about 50% report talking to people outside the group or to a family planning field worker. Some 30% of the women began to use a modern contraceptive method, and 20% visited a health clinic (169).

In Bolivia in the early 1990s client-provider materials produced to improve the quality of reproductive health services and counseling contributed to communication between spouses. Before-and-after surveys found that significantly more clients had talked with their spouses about family planning after seeing and receiving the materials—95% compared with 84% before they had seen the materials in clinics. By comparison, the increase among those who had not seen the materials—from 83% to 88%—was not statistically significant (343). Later a video drama entitled *Hablemos en Pareja (Let's Talk Together)* was produced and shown in clinic waiting areas to help clients overcome barriers to communication between spouses.

Couples may find talking about family planning and reproductive health easier if they have discussed the subject first with someone of their own sex. Programs such as *Jiggasha* can help. For example, women in a rural area of northern India could not talk to their husbands about sexually transmitted diseases, even though they feared that their husbands might infect them. Health advisors organized the women into groups that discussed the problem and decided how to approach their husbands. After practicing the conversation in groups, the women were better able to talk with their husbands (332).

Family planning providers can help couples communicate better if they are aware of social conventions. For example, in Mexico a survey revealed that couples thought it immodest for the wife to start a discussion of family planning. These couples said that husbands should start such discussions and decide whether the couple uses a family planning method. In response, family planning providers designed counseling services for men and women advocating that women start discussion and that the couple make a decision together (256).

Strengthening communication skills is important to women and men who want their partners' support and cooperation in planning their families and protecting their reproductive health. For some, discussion may be a necessary step to taking an action they desire. For example, according to DHS data from six African countries, women who approved of family planning were more likely to use a modern contraceptive method if they had discussed family planning with their husbands in the year before the interview than were women who approved of family planning but had not discussed it (see Table 6). Studies in Java and South Korea have found that the more often couples discuss family planning, the more likely they are to use a contraceptive method (168, 359). Discussion between partners may make continued contraceptive use easier, too. In

the IPPF 6-country study, women who thought that their partners agreed with their use of a family planning method were significantly more likely to continue using that method than women who did not know that their partners approved (142). Although studies link spousal communication with contraceptive use, the nature of the link is not obvious. It is not always clear whether more communication leads to more contraceptive use or, instead, couples talk more about contraception because they already use or plan to use a method. Also, some couples may not have an immediate reason to discuss family planning—for example, the woman is pregnant, the couple wants a child, or they have no access to contraceptives.

New images of women and men. It will be easier for women to take new opportunities when society respects them as strong and competent. Men will find it easier to help women when they see positive images of men who support those qualities in women. Family planning communication can provide these images by portraying competent women and caring men in radio drama, videos, films, advertisements, and users' testimonials (see pp. 20-22).

Encouraging Men's Cooperation

Women's situation will improve faster if men help. Protecting reproductive health particularly requires commitment from both men and women. While a woman can control her fertility without a man's cooperation—and many do—men's understanding and help make contraception and family planning easier and widen the choice of methods that a couple can use. Also, to prevent sexually transmitted disease, a woman must have the cooperation of her male sexual partner, who must remain faithful to her or use condoms. What can family planning and reproductive health programs do to encourage men's cooperation?

Changing Times and Changing Attitudes

Encouraging men's cooperation can start with understanding men's points of view. Many men approve of family planning and contraception. Even where few people use contraceptives, such as Burundi, Ghana, Kenya, Mali, and Pakistan, at

Table 6
Discussion with Husbands

Use of Family Planning in Seven Sub-Saharan African Countries Among Women Who Approve of Family Planning

*In the year preceding the survey
Source: Demographic and Health Surveys

Country & Year of Survey	% Using Family Planning Among Those Who:	
	Discussed with Husband*	Did Not Discuss with Husband*
Botswana 1988.....	40	18
Burundi 1987.....	14	2
Ghana 1988.....	24	7
Kenya 1989.....	36	11
Senegal 1986.....	23	9
Sudan 1989-90.....	19	3
Togo 1988.....	39	31

Population Reports

“My Husband... Was a Great Help”

Amina Said—successful journalist, business woman, and grandmother in Egypt—remembers the importance of the encouragement of her father and husband. Her father urged his four daughters and one son to do their best.

“By the time [my father] died, we were already full of pride, self-respect, and the belief that women were not less than men in any way—or rather, as he said to us, that ‘they are not better than you.’ He wanted us to be everything that men can be. He wanted to give us all the opportunities possible.”

Her husband also encouraged her when she began to write and decided on a career as a journalist.

“You see, there were no women in the press then. I was the first one to do it.... I was engaged to my husband and he was a great help.... From the very beginning he was supportive of my career and helped me a great deal.”

Source: Huston (144)

least half of men surveyed approved of contraception (see Table 7).

Still, many men have negative attitudes about women choosing and using contraception. Some men fear that contraceptive use will make their wives independent of their control (98). They fear that their wives will have sex with other men if they no longer risk pregnancy (84, 98, 241). Some men may be unwilling to have their wives adopt family planning because they themselves know little about it. Some do not want their wives talking with strangers about sex and reproduction. Some worry that contraceptive use will harm their wives' health or their own (3). Some oppose contraceptive use for religious reasons (84, 155). Some men think that large families reflect their masculinity or their wives' faithfulness in serving them (84, 98).

These male attitudes about contraceptive use are part of some men's broader fears. Traditional social norms often have required men to maintain the honor and position of their extended family, village, religious group, or other social organization. Therefore men feel responsible for the behavior of their wives and children and think that women have no right to make decisions for themselves (88, 132, 295).

Men are not alone in imposing limits on women. Many mothers, even wealthier, better educated women, prefer sons and take better care of them (1, 374) (see pp. 10–11). In some places women dominate their sons' wives, pressure them to have many children, and even physically abuse them (80, 211, 262, 297).

Paternalistic traditional norms are no excuse for the mistreatment of women, however. Violence against women, including violence from their husbands and other family members, can be condemned by religious and political leaders and prohibited by law, and the law, enforced. Also, legal changes in a variety of areas affecting women's well-being can be the catalyst to changing community norms (see box, p. 28).

Economic and social changes, too, are requiring couples to be more flexible about gender roles. More and more, both partners must produce income to support the family. As a result, men are finding that a wife with many skills can help support the family. In 1990 women made up 42% of the paid labor force in the developed world and 33% in the developing world (331). The need for women to earn income has changed gender roles. In the US some husbands and wives are arranging to work different hours, and more men are caring for the children. In 1991, 20% of children under age five were cared for by their fathers at home while their mothers went to work (233).

Some men find that they have gained through improvements in their wives' status. For example, in Colombia the Instituto Colombiano Agropecuario provides poor women with small loans and on-going help with planning and decision-making. The women and their husbands have worked together to make their enterprises succeed and to take care of their homes. Both husbands and wives said that they benefited from the project. The women became more self-confident and knowledgeable about dealing with local institutions such as schools and markets. Their new confidence made them better advocates for the family (278). In Zimbabwe and other areas of Africa, husbands report that their wives' employment as family planning field workers enhanced the prestige of their family. These men support their wives in their new positions even if the women do not bring in additional income (188).

Some men may see that, in the future, their daughters will need to be more self-sufficient than their mothers were. These men may favor more education for their daughters and better access to other opportunities as well.

Encouraging Male Responsibility

Reproductive health programs can help men cooperate with their sexual partners to avoid unwanted pregnancies and to prevent sexually transmitted diseases. Specifically, programs can:

- Inform men about family planning, reproductive health, and contraceptive methods,
- Encourage and improve communication between spouses,
- Design convenient services for men,
- Provide contraceptive choices for men, and
- Promote images of male role-models who cooperate with women both in the family and in the community and who share the burden of ensuring reproductive health.

Informing men. Many men want to know more about contraception and family planning and to be more involved. For example, in Malaysia, Nigeria, and Turkey, most men surveyed wanted to learn more about family planning (13, 236). In Peru men in focus groups complained that false stereotypes of dominating men (*machismo*) limited their opportunities to obtain information about sexuality and family planning (247). In Tunisia men often accompanied their wives to the family planning clinic but then waited outside, talking among themselves. When asked, some said that they would like to be more involved. Men commented, “We are made to feel like strangers.” “We are pushed aside...,” and

"From the way we are treated, one would think that this doesn't concern us" (59).

Women, too, want men to have information. In Chile women asked that men be allowed to come to the classes at the clinic. One woman said that her husband did not always believe her and that she would "love to have him come to some of the talks" (344).

Men need information about contraceptive methods for women as well as about those for men. Well-informed men can use a method themselves or support their partners in using a method. Well-informed men also can talk with their wives and cooperate in assessing their needs and choosing a family planning method.

Men especially need information about sexually transmitted diseases since men play a big role in the spread of sexually transmitted diseases including AIDS (23). Although there is much variation among cultures, except for female prostitutes men are likely to have more sexual partners than women. Men have more control over condom use. Men are more likely to control the frequency of sexual relations and the possibility of abstinence within a relationship. To reduce risk, men can: (1) reduce the number of sexual partners, (2) use condoms, and/or (3) practice sexual fidelity or abstinence (271).

Encouraging communication between spouses. Men can support women's choices better when couples can talk about reproductive health and family planning (see p. 25). But surveys show that even men who approve of family planning do not always discuss it with their wives. For example, in Burundi 94% of surveyed men approved of contraceptive use, but only 48% had discussed it with their wives in the preceding year (see Table 7).

Family planning communication campaigns can change men's role in contraceptive decision-making. The Zimbabwe Male Motivation Project in 1988 and 1989 sought to inform men, promote more favorable attitudes, increase contraceptive use, and promote male involvement and joint decision-making. The project appeared to increase condom use particularly. Its impact on men's attitudes about decision-making was ambiguous, however. Men who heard the campaign radio soap opera, attended a lecture, or saw a

pamphlet were more likely to say that the man alone should make the decision to practice family planning. At the same time, these men also were more likely to say that the couple should decide jointly how many children to have. Researchers concluded that future campaigns should put more emphasis on joint decision-making and discussion between spouses (254).

Some family planning programs welcome husbands and wives who seek family planning counseling and services together. While counseling a couple, a provider can encourage the woman to ask her own questions and express her own opinions. The provider also can encourage the man to understand and respect the woman's opinions and choices; Program managers seeking to improve women's situation need to make clear, however, that the program also welcomes women and men who come alone, does not require a husband's permission before serving a woman, and keeps the names of clients and all information about clients confidential, even from spouses.

Designing convenient, appealing services. Men cannot share responsibility for reproductive health and family planning if services and information do not reach them. Few men go to facilities that offer services primarily for women. Men must be reached in other ways. There are five main approaches:

- **Separate clinics.** Male-only clinics can inform men about all family planning methods and provide condoms and vasectomy. Separate male clinics have been successful in Asia and particularly in Latin America, including Brazil, Colombia, Guatemala, Honduras, Mexico, and Peru (111, 124, 279). Some offer a range of reproductive health services including care for sexually transmitted diseases and infertility.
- **Better service for men at existing clinics.** Some conventional family planning clinics have hired male staff, offered hours convenient for men, and offered additional reproductive health services for men. In Colombia Profamilia serves men at its women-oriented family planning clinics as well as in clinics for men only.
- **Workplace services.** In India, Kenya, the Philippines, Turkey, and elsewhere, employers or trade unions provide family planning services to workers, often as part of

Table 7

Men's Role in Family Planning

Husbands' Knowledge, Approval, Discussion, and Use of Family Planning in Seven Countries

Country & Year of Survey	Number of Husbands	% Who Know at Least One Method	% Who Approve FP ¹	% Who Have Discussed FP with Their Wives in the Last Year ¹	% Who Have Ever Used Contraception		% Currently Using Contraception		
					Modern	Any	Modern	Any	
Burundi 1987	542	92	94	48	2	52	NA	NA	
Cameroon 1991	814	74	37	30	17	48	6	20	
Egypt 1988-89									
Cairo	469	100	92	61	78	81	65	70	
Upper Egypt	1,053	96	84	47	52	56	40	44	
Ghana 1988	943	79	77	46	26	41	9	20	
Kenya 1989	1,170	95	91	65	35	65	25	49	
Mali 1987 ²	970	65	16	28	2	16	1	4	
Pakistan 1990-91	1,354	79	56	NA	18	25	10	15	

FP = Family planning
NA = Not applicable

¹ Among those who know at least one contraceptive method
² Includes all men, regardless of marital status

Source: Demographic and Health Surveys; Egypt: Sayed et al. (291)

Population Reports

Efforts for Legal Change

What can be done to eliminate the inequities that women face? While laws alone are seldom enough to change women's lives, legal change can be crucial. Change can start at every level, from international organizations to local women's groups.

International Leadership

The United Nations has advocated equality between men and women since its start in 1945. The UN Charter affirms the equal rights of men and women and prohibits discrimination based on sex (63, 315). The United Nations considers reproductive choice a basic human right.

In 1979 the UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women (64). The Convention specifies steps to prevent discrimination against women in education, employment, public life, health, family planning, and other areas. It also suggests actions to change laws and attitudes. As of June 1993, 116 countries had ratified or acceded to the Convention (149). Many nations attached reservations to their acceptance, however. For example, Austria, Brazil, Ireland, Jordan, Libya, Malta, Thailand, Tunisia, Turkey, and the United Kingdom attached reservations to Article 15, which gives women full legal capacity. Some 52 countries have not yet signed the Convention, including India, Pakistan, South Africa, and the United States (149, 315).

The UN called attention to the need to improve women's lives by declaring 1976–1985 the Decade of Women. The 1985 World Conference on Women set forth strategy to achieve equality between men and women by 2000, and the UN General Assembly endorsed the plan (64). This endorsement obligates all UN members to implement measures ending discrimination against women in such areas as access to education, rural development resources, legal protection, marriage, and access to health and family planning services (105). In 1995 the UN will convene the Fourth World Conference on Women, in Beijing.

National Initiatives

National efforts to improve the status of women are organized in various ways. Among 50 countries answering a 1989 questionnaire from the UN Commission on the Status of Women, some had set up separate bureaus or offices for women's affairs while others gave the ministry for social welfare authority over programs for women. Eleven of 14 industrialized countries and 22 of 36 developing countries reported programs to make people aware of gender inequality. All 50 countries said that they were promoting economic equality for women. In addition, developing countries sought to improve women's access to education, health services, family planning services, and child care (346). Most countries identified public attitudes favoring the subordination of women as the greatest problem facing their efforts.

Specific efforts vary widely. Recently, for example, Barbados gave priority to reducing violence against women; China reported programs to involve men in family planning; and Guatemala adopted a policy to incorporate women into development efforts through specific projects (346).

Of course, such policies make a difference only when government leaders have the political will to carry them out. Some national leaders have championed legal reforms on behalf of women. In Tunisia President Habib Bourguiba issued a new Personal Status Code in 1956 requiring that a bride consent to her marriage, abolishing polygamy, giving women the right to divorce while limiting men's ability to divorce at will, setting minimum ages for marriage, and establishing equal rights to custody of children (19, 118). Bourguiba's government also provided family planning services for men and women. In Zimbabwe the courts have enforced the 1982 Legal Age of Majority Act, which asserts equality between men and women even in matters covered by customary law (106).

Often policy-makers' opinions are divided, however, and inaction results. In Kenya the constitution asserts equality between men and women but at the same time allows customary law to take precedence in cases of alleged discrimination. Revisions to the Marriage Act proposed in 1979 would have required a first wife's permission for her husband to take a second wife, given women a share of the couple's property at divorce, and recognized the possibility of a woman's having custody of her children after divorce (106). Heated debate arose, and the bill has never passed. As a result, customary law, which grants women few rights, takes precedence in these matters. In some cases legal advances have even been reversed. Laws giving Egyptian women the right to seek divorce within a year after her husband's taking a second wife were passed in 1979 but repealed in 1985 (81).

Women have few opportunities to change laws and policies because their political influence is limited. So is their direct participation in policy-making. In 1987 women comprised no more than 35% of members of parliament and government ministers in any country. In fact, women rarely made up even 25% of parliamentary representation (326).

Women's Organizations

Women's organizations have been powerful agents for change. They were early advocates for reproductive choice. Women's welfare organizations in Bangladesh, Egypt, and Pakistan were pioneers in supporting reproductive health services for women. In Thailand and Ecuador in the early 1970s women's medical and nursing organizations were among the first to provide family planning services (34).

Around the world women (sometimes joined by men who believe in equal rights) have formed groups to see that women receive fair treatment under the law. For example, in Brazil women's rights advocates began a campaign in 1985 to influence legislators writing the new constitution. They organized vigils, sent letters to newspapers, and aired television spot announcements. As a result the new constitution gives women equal rights and protection from domestic violence (251). Women's advocates in Brazil, Malaysia, and Zimbabwe have helped to train police to handle domestic violence and to involve police in drawing up laws to prohibit domestic violence (85, 95, 307).

broader health services (274). Other possibilities include working with male-oriented educational or fraternal organizations, cooperatives, or the military (111).

- **Community-based services.** Male community-based distributors can provide men with condoms and information about family planning. For example, in 1987 the Katibougou Family Health Project in Mali recruited men from the community who distributed condoms from stocks kept in their homes, just as female community health workers distributed supplies to women (158).
- **Commercial and social marketing.** Commercial sales have long been men's chief source of condoms. To make supplies more affordable and to increase promotion, social marketing programs, which sell contraceptives at subsidized prices through established commercial outlets, operate in more than 20 countries. Men can buy social-marketing condoms along with other goods. In many Muslim countries particularly, men do the household shopping.

Providing contraceptive choices. Currently, there are only two contraceptive methods for men—vasectomy and condoms—and there are two methods in which male cooperation is crucial—periodic abstinence and withdrawal (111). Research on new methods for men is underway, but it is unlikely that a radically new male method will be available for at least 10 years (276). In the meantime, family planning programs and the private practitioner should make sure that current methods are readily available.

In most developing countries neither condoms nor vasectomies are widely used. Just under 5% of married couples in developing countries use each of these methods. Condoms probably are more widely used outside marriage than in marriage, however, and use may be growing because of concern about AIDS (190). Neglect by policy-makers and providers may help explain the low prevalence of vasectomy. Where the procedure is accessible and promoted, men use it. For example, in Colombia the annual number of vasectomies performed by Profamilia rose by 77%, to more than 1,000, after the organization opened its first two men-only clinics in 1985. In 1991 Profamilia's eight men-only clinics performed about 5,000 vasectomies (189).

Promoting male methods and men's services. Promoting men's family planning methods and services boosts their use. For example, in Turkey a social marketing campaign to promote condoms involved a television comedy, video tapes, sponsorship of a soccer team and tournament, billboards, and gift packs to medical schools (377). The program sold 4.5 million condoms in 1991, its first year of sales (319). Men's response suggests that some men are willing to take responsibility for contraception if programs make the effort to reach out to them.

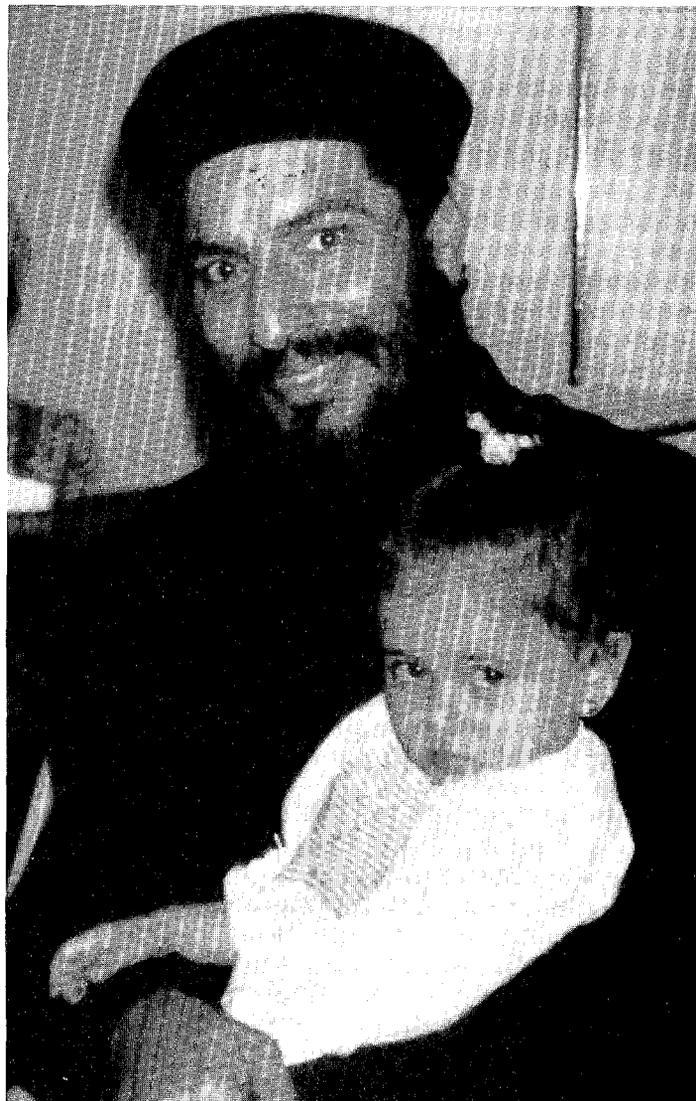
Social marketing programs have been directed more to men than to women. They have emphasized the economic value of small families. They also depict men as the protectors of their families (314). While most promotion has touted condoms, some social marketing programs now address advertisements for oral contraceptives to men as members of the "contraceptive decision-making team." In Morocco radio and print advertising, display boxes, and posters depict condoms as offering men the opportunity to share responsibility for reproductive decision-making (314).

Promotion also has brought men to clinics. In Colombia Profamilia has promoted its men's services in the mass media

and through field workers (189). In Brazil Pro-Pater increased the number of vasectomies performed monthly in 1989 at its São Paulo clinic by nearly 80% with television spots, billboards proclaiming that "vasectomy is an act of love," and resulting press coverage (171).

Promoting positive images. Family planning communication can depict new images of men as well as of women (see centerspread, pp. 20–22). Also mass-media depictions of couples discussing family planning and making joint decisions suggest to the public that such discussions are appropriate. They also suggest to both men and women *how* to discuss family planning and sex and can even provide an occasion to start discussion.

Men's organizations are involved, too. In Jamaica, Fathers Incorporated assists men who want to help children. The group points out that in the past men have been seen solely as providers of goods for their children. To change that image, group members are holding workshops to promote men as care-givers as well (8).



Mohammed Wajidi/IFI

An Egyptian father holds his daughter. Men's hopes for their daughters' future in a changing world may lead to new attitudes about women.

Family Planning Field Worker Helps Create New Roles for Women

"Because I have that job, our family is better off, and we are able to raise our children in a better way," says Zanati Begum. Zanati is an especially effective and articulate family planning field worker in rural Bangladesh. "And given the situation [of large families and poverty] prevalent in the society, it is our duty and responsibility as conscientious people to help solve the problem." Zanati's example is helping to change attitudes toward women's roles among men and women in her community.

The Route to a New Role

Zanati believed in the importance of family planning before she became a field worker. After the birth of their first child, a daughter, in 1984, Zanati and her husband Sarkee decided to delay the birth of their second child. Zanati took oral contraceptives for four years before the couple decided to have their second child. Both Zanati and Sarkee thought that many of their neighbors had more children than they could afford to raise. The poverty of some large families saddened the couple. When they saw a newspaper announcement in 1988 asking for family planning field workers, they agreed that Zanati should apply.

"At the beginning some of my neighbors and relatives were against my work," Zanati recalls. "They felt working as a family planning worker, going house to house and talking to people about it, was degrading. They also didn't think it was right for a wife to earn for the family. A wife's taking up a job was a sign that her husband wasn't capable of supporting his family, they thought."

But now the neighbors' attitudes are changing. "Now people realize that women, too, can take up jobs and help their communities and families," Zanati says.

Employing Women in Family Planning Programs

By employing women, family planning programs provide many thousands of women with new roles and opportunities. Family planning programs make a point of hiring women, especially as front-line providers. In most societies a woman-to-woman approach is the best way to communicate about family planning and to offer services. Female family planning providers can talk to other women and understand their needs better than men can (45).

The United States Agency for International Development estimates that currently about 500,000 women work in family planning programs in developing countries—about half of the nearly one million family planning workers estimated by the World Bank to be employed in both

Sarkee has become increasingly committed to his wife's work. At first he thought only that her small income as a field worker would benefit their family. He also knew that his friendly and energetic wife would get satisfaction from working with others. But after Zanati began discussing her work with him, he became interested in the problems of her clients. Now he feels that she should be a field worker even if she were not paid. In fact, he tells her that, if a household task would keep her from her work, he will do that task for her. Her work, he says, will prevent hunger and hardship in the community.

Sarkee is not troubled that some might criticize him. "If my wife...can do good for the society, I will allow her [to work]. No matter what obstacles come, I will overcome them. And if anyone comes and asks me directly, 'Hey, how come you allowed your wife to go outside the house?'...I will explain to them why I allowed her to do that." Besides, Sarkee says, men now recognize that small families are necessary. "Even in the men's circle...everyone says the same thing, 'We have no choice but to adopt this.'"

Learning New Skills

Zanati has learned new skills from her job. She works with the *Jiggasha* program of the Bangladesh government and Johns Hopkins Population Communication Services (see p. 24). She meets with groups of women, who listen to tape recordings of songs and dramas and discuss family planning and other maternal and child health issues. The women enjoy this rare entertainment, and they become less timid about talking about their needs and desires. Zanati also notes, "If people know that their neighbors practice [family planning], then they are more ready to adopt. That's why the *Jiggasha* idea works so well."

developed and developing countries (139, 385). Jobs held by women range from community-based distributors to program administrators to doctors, nurses, and midwives.

Benefits from Family Planning Employment

What do women gain by working in family planning? Almost all research has concerned community-based distributors. Studies in seven countries conclude that women working as community-based distributors benefit because they earn money, receive useful training, and gain status in their communities (157, 302). Of course, other kinds of work, outside family planning, might benefit women similarly or more, while still other kinds of jobs can make life worse.

Income. The salaries, honoraria, or fees for service paid to family planning workers can make a difference to their quality of life. In a survey by the Center for Development and Population Activities (CEDPA) of 305 field workers employed in 11 family planning projects in Bangladesh, India, Kenya, Mali, Nepal, Pakistan, and Turkey, 76% reported that the income they received from their jobs improved their economic status (157).

Zanati uses her new skills in other areas of her life. "...There are things which I'd never done before, for example, going house to house, holding meetings, keeping records of each day's work.... I do try to use these skills in my personal life and even to teach them to my neighbors."

As a result of her training in counseling, Zanati encourages women to talk and ask questions. "There are certain techniques we learn in counseling.... We learn that during counseling we must give the client greater opportunity to speak.... I should help a client to select a method according to *her* taste—according to *her* likes and dislikes." Zanati feels that she has done a good job when the women whom she counsels are willing to tell their friends openly that they use family planning.

Changing Attitudes Toward Women

Zanati says that her work is helping to change community attitudes toward women. "I've set an example in the community, by taking up a job in the family planning office. In the past it was hard to imagine women coming out of their homes to work. Now many of them realize that a girl's place in the family is just as important as a boy's," she says. "That's why they've begun to send their daughters to school as well.

"Society's attitudes toward women going to work have also changed. After I've taken up a job, people have begun to realize that there is nothing wrong with women going to work and that, like men, they can contribute to their societies, localities, and families...."

Many women have become interested in Zanati's work. Some have asked her advice about working. "Two of them are now teachers at the BRAC [Bangladesh Rural Advancement Committee] semi-formal education center," Zanati observes.

"Women are no longer working only at home, as they have been doing for a very long time. The reason is an increasing awareness of their place in society and the family. For example, there are women in my family who say with regret, 'If we could only take up a job like you, we would have greater value in the family and society. Most of us who look after our

families don't have any authority. Our opinions are never heeded.'"

Men's attitudes are changing, too. "After I began working in the field, the men have also given up their age-old ideas about women and their place in society. For example, they used to think that women should only look after the household affairs and their children, husbands, and mothers- and fathers-in-law. But now many of them realize that women should also be educated and allowed to work outside the home and that their work can bring prosperity to the family."

Zanati and Sarkee have two daughters. They do not plan to have more children. In Bangladesh most couples wish to have sons for support in old age. But Zanati and Sarkee say that, if parents can give daughters a good education, daughters can do just as much for their parents in their old age. Zanati says that her mother-in-law used to advise her to have a son, but no longer. "I explain to my mother-in-law that since my parents educated me and since I have a job, I can give my mother two saris every year if I want. I can take all the burden."



Zanati Begum, right, field worker in the Bangladesh Jiggasha family planning program, sets an example that has changed attitudes and opened opportunities for women in her village.

Most of these women use their income to help their families (24, 162, 163). In the CEDPA study 51% used their earnings largely for general household expenditures; 29%, for their children's education; 10%, for themselves; and 6%, for other miscellaneous, unessential expenses. The remaining 4% gave the money to their husbands (157).

By earning money, some women improve their position in the household. Most women in the CEDPA study gained more control over their children's education, medical care, and household expenditures. Many also found that relations with husbands and in-laws improved (157). Just earning money does not guarantee better status at home, however. Some case studies of women earning money in the informal sector (not in family planning) experienced no increase in household influence (126, 193).

Of course, many programs ask women to work as volunteers. Even if women cannot be paid for their work, programs can make special efforts to recognize their contributions and publicly honor their contribution to their communities.

Competence in new skills. Family planning providers can learn new information and skills. In the CEDPA study com-

munity-based distributors' reports suggest that their leadership and communications skills improved, as did their knowledge of family planning methods and service delivery (157). For many, this is their first paying job. Unlike physical labor such as sewing, farming, or typing, family planning field work teaches women skills that meet the social needs of the community and that enable women to teach others. Community-based family planning providers often help people obtain medical care at clinics. Some are trained to provide directly and/or to teach oral rehydration therapy, immunization, nutrition services, safe delivery practices, and broader maternity care (302).

Professional status and respect. Female family planning workers often win respect for their knowledge. These women become community authorities in family planning and other health matters. In Matlab, Bangladesh, both field workers and community members report that field workers are important community resources not only for family planning services but also for general medical advice and referral. Community members even seek field workers' advice on financial matters and neighborhood disputes (302).



Many women working in family planning programs find their earnings bring them respect at home. Also, their work makes them leaders in the community, where they can serve as role-models for other women.

Respect is not always easily earned, however. New roles for women sometimes threaten community norms, and those who break the rules may be scorned. For example, in Muslim countries where *purdah* is practiced, custom prohibits women from moving about alone in public, and yet family planning field workers must visit homes and clinics.

In the face of initial hostility from the community, female workers often find ways to maintain their self-respect. For example, Bangladeshi family planning workers redefined for themselves the traditional norms of *purdah* and female modesty (302). They spoke of "inner *purdah*," shifting emphasis from physical seclusion to an internalized moral code of conduct (302).

In various cultures and countries, female family planning workers have experienced initial rebuke, then gradual acceptance, and eventual respect (157, 188, 302). For example, in Bangladesh the field workers initially scorned for violating *purdah* eventually regained their prestige and at the same time legitimized family planning services (302). In a few cases female field workers have been unable to win community respect. A study of auxiliary nurse-midwives who provided family planning services in Maharashtra, India, found that many of the women had been abandoned by their husbands or had difficulty finding a husband (152).

In general, women working as community-based distributors feel strengthened by their work. They reported in the CEDPA study that their achievements and value to the community enhanced their self-esteem and sense of autonomy (157). Particularly in cultures that generally isolate women, work in family planning is a gateway to new ideas, new information, and new opportunities (140).

Models of Change

Women working in family planning offer other women more than family planning information and supplies. They often are agents of change and new role-models for their communities.

By persevering and winning respect, women working in family planning set an example for other women (see box, pp. 30-31). They legitimize women's employment, and family planning workers can serve as examples that young women can aspire to emulate (140).

Family planning workers can stimulate change in their communities in many ways. Their work can loosen taboos detrimental to women and even help other women assert themselves. For example, after three years of a women-staffed community-based project in Mali, villagers were more willing to discuss such previously taboo topics as family planning and contraceptives (157). In Nairobi, Kenya, female volunteers in a family planning project spoke with confidence in public gatherings (157). In both India and Bangladesh community acceptance has enabled female field workers to intervene in family disputes, rebuking and advising men and providing moral support to women (157, 302).

Challenges for Family Planning Programs

Through careful selection, training, and support, family planning programs can make special efforts to see that their female employees benefit from their work. Women's employment in family planning needs more study. Other female providers, not just community-based distributors, need to be surveyed. Also, pay scales, working conditions, and potential for training and career advancement should be analyzed with an eye to increasing opportunities for women.

Workers selected with their communities' input may have a better chance of being accepted than workers chosen by outsiders, as a review of community-based programs in Africa suggests (248). In some cases newly employed family planning workers may displace traditional practitioners, such as traditional birth attendants and midwives, who play a vital social role. Collaboration may be important to win support from traditional practitioners and avoid resistance that could make the task of family planning workers more difficult.

Promoting family planning providers helps women win community respect as qualified, trustworthy professionals. Strengthening both the image and the skills of providers can attract and keep clients. Johns Hopkins Population Communication Services has dubbed this the PRO approach—Promoting Professional Providers (259). A survey in Kenya showed that people who had heard the radio drama in the *Haki Yako* ("It's Your Right") PRO approach campaign were less likely to have a negative image of family planning providers than people who had not heard it (320).

Visible symbols of family planning employment help, too. In Kenya and Zimbabwe, for example, female community-based distributors wear uniforms and have signs outside their homes signifying official endorsement of their work. Recognized as community leaders and authorities, family planning workers are often the only women who sit on the podium at official village events (188).

Shaping Policies To Meet Clients' Needs

While family planning programs can do much to help women meet their needs, debate continues about how meeting women's needs can be made more central to population policy. Some have criticized population policies as aiming at national goals such as slower population growth, environmental protection, or economic development while neglecting the needs of women as individuals and as a group. Some critics argue that such policies focus on only one aspect of

women—their ability to bear children (165). Ruth Dixon-Mueller has argued that population and development policies must change to reflect “a thoughtful engagement of the difficulties that women face around the world in the struggle to take control over their own fertility and their own lives” (74).

How can population policies better reflect women’s interests? Improving the quality of care and protecting women’s health have long been concerns of family planning advocates. The United Nations has declared that the goal of family planning should be “the enrichment of human life, not its restriction,” pointing out that women in developing countries need a broad range of economic, health, and social rights and services (47, 322). Many family planning programs are still struggling to meet more modest goals, however. As demand for contraception has risen rapidly in developing countries over the past two decades, programs often have not been able to serve all the people who want family planning.

Recognition is growing that population policies—and development policies in general—must pay attention to their clients’ needs and preferences if they are to succeed. J. Brian Atwood, Administrator of the United States Agency for International Development, describes the need in this way (14):

Attention to gender roles is fundamental to the success of programs we assist. We must support full participation of women at all levels of family planning and—indeed—all health and development programs. We must help women overcome the obstacles they face in obtaining services or using contraceptive methods. We must see that programs are designed to benefit women. And, we must help programs strengthen men’s support and participation.

To accomplish this at the program level, family planning program managers are increasing their efforts to learn from clients. At the same time, women’s advocates are seeking more opportunities for women to participate in planning services (38, 220, 313). Thus program managers and women’s groups have begun to work together. At the policy level, policy-makers, family planning organizations, women’s groups, and other nongovernmental organizations have been building links between population policy-makers and women’s advocates (323). This discussion and debate has grown as world attention has focused on the United Nations International Conference on Population and Development (ICPD) in Cairo in September 1994 (see box, pp. 34–35).

In this discussion diverse policy-makers are recognizing that their various goals can be achieved by the same means—offering services that people want. Policies that serve clients:

- Recognize that reproductive choice is a human right,
- Focus on meeting clients’ unmet needs for reproductive health services, and
- Involve clients, especially women, in program design.

Reproductive Choice Is a Basic Human Right

Today there is widespread agreement that reproductive choice is a human right. This means that women have the right to control their own fertility and the right to refuse unwanted sexual intercourse, including the right to protect themselves against the violence of men, including husbands, who force intercourse (120).

Women’s advocates have had to struggle to gain recognition of women’s reproductive rights. Early in the 20th century
POPULATION REPORTS

women’s advocates established the first programs to provide contraceptive information and services so that women could exercise their rights to protect their own health and control their own fertility (121, 143, 212, 263). Often religious, medical, and government leaders stood in their way (121, 214). It was not until the 1940s that contraception began to be accepted in developed countries as a medical service and become more widely available (212, 221, 270).

In recent years international organizations have recognized the right of all individuals and couples to make reproductive choices. In 1968 the International Conference on Human Rights in Teheran affirmed the right of reproductive choice. This right was reaffirmed at the first UN World Population Conference, held in Bucharest in 1974, and again at the second such conference, in Mexico City in 1984. In the words of the report of the Bucharest conference, “All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children, and to have the information, education, and means to do so” (327).

International institutions consider securing reproductive choice to be an important part of improving women’s well-

Ten Program Strategies To Meet Women’s Needs

How can family planning programs improve their response to women’s reproductive health needs? Ten possible strategies include:

1. **Meeting unmet need** by identifying and overcoming the institutional, cultural, and personal barriers to family planning that women face (see p. 34).
2. **Widening the clientele** to serve neglected groups such as young people, unmarried people, and men (see p. 34).
3. **Training personnel** to respect and communicate with clients, provide good technical care, and ensure informed choice (see p. 15).
4. **Offering more services** to meet a broader range of reproductive health needs (see p. 16).
5. **Seeking women’s opinions**, including involving women in program planning (see p. 35).
6. **Helping men and women to communicate, cooperate, and share responsibility** by informing and educating men as well as women about men’s and women’s reproductive health and by providing convenient services (see p. 26).
7. **Presenting new images in the mass media of competent women and caring men** communicating and collaborating (see p. 20).
8. **Adding criteria for evaluation** of programs and personnel to assess how well clients’ needs are met.
9. **Promoting capable women employed in family planning programs** (see p. 30).
10. **Speaking out on behalf of women** and in favor of policies that support women’s rights to personal autonomy and more opportunities.

Debate over Policy

Many people involved in family planning policy and programs seek to balance a variety of concerns. Most agree that couples and individuals should be able to plan the number of their children and the timing of their births. They do not always agree, however, on how to prioritize the goals of family planning programs. Some focus primarily on reducing the rate of population growth; others, on the reproductive health needs of couples and individuals; and still others, on adhering to ethical or religious beliefs.

In preparation for the International Conference on Population and Development (ICPD) in Cairo, September 1994, many voices have spoken up, advocating differing, but not always mutually exclusive, priorities.

Population growth. Those concerned about rapid population growth emphasize that:

- Rapid population growth threatens the progress of all other efforts to improve the standard of living.
- Environmental resources are threatened by increasingly large populations.
- Family planning programs should provide services to as many people as possible as soon as possible.
- Family planning programs should focus first and foremost on providing contraceptive supplies and services.

Needs of couples and individuals. Those concerned about the needs of couples and individuals emphasize that:

- The preferences, satisfaction, and safety of current family planning clients should receive higher priority than increasing the number of contraceptive users.

being. For example, the Committee on the Elimination of Discrimination Against Women (CEDAW), established by the United Nations to gauge progress toward ending discrimination against women, monitors access to family planning as an important indication of women's situation (see box, p. 28).

The declarations of international institutions and global conferences put governments on notice that women should have the right to control their fertility and their own lives—and that family planning programs can help women to achieve these rights. Governments and reproductive health programs face the challenge of turning these broad principles into policies and programs.

Meeting Unmet Need for Reproductive Health Care

Over the past decade the percentage of surveyed women who say they do not want to have more children has grown substantially in every region except sub-Saharan Africa (354). Even in Africa, although most women want large families, there is great interest in spacing births. In nearly all sub-Saharan countries surveyed by the Demographic and Health Surveys (DHS), between one-third and one-half of married women said that they wanted to space their next births by at least two years (277, 354).

- Family planning services should be part of programs that help women and men not only with avoiding pregnancy but also with a range of other reproductive health needs.
- Reproductive health care programs should devote more attention to improving the quality of care that they offer.
- Family planning programs should help women to achieve equity in society as well as to meet their reproductive goals and health needs.
- Environmental degradation and resource conservation should not be addressed primarily by emphasizing limitation of childbearing in developing countries.

Strongly felt ethical and religious beliefs underlie many people's differing positions on population and family planning issues, including the positions of people concerned about population growth or about the needs of couples and individuals. Some advocates, however, particularly identify themselves as speaking from an ethical or religious point of view.

Ethical considerations. Those concerned primarily about ethical considerations emphasize that:

- All individuals and couples should have the right to make their own decisions about their fertility, free of coercion or pressure.
- Family planning programs should not set targets for numbers of new contraceptive users, incentives for contraceptive use, or field workers' quotas that might result in pressure on people to use contraceptive methods.
- Clients should be given an informed choice of contraceptive methods.

Religious beliefs. Some, but not all, who express a religious viewpoint emphasize their contentions that:

Such statistics imply large potential demand for family planning services. Even though contraceptive use has risen substantially in recent years, in most surveyed countries between 20% and 30% of married women of reproductive age report that they are not using contraception but do not want any more children or else want to delay their next birth at least two years (357). Rates of abortion, even where abortion is illegal and unsafe (see p. 5), also testify to women's strong desire to control their own fertility.

Demographers describe women who are not using contraception but want to space or limit births as having an unmet need for family planning. Using this definition, **Population Reports** has estimated, based on DHS data, that 120 million married women of reproductive age in developing countries have an unmet need for contraception (see **Population Reports**, *The Reproductive Revolution: New Survey Findings*, M-11, 1992). Ruth Dixon-Mueller and Adrienne Germain suggest widening the definition of unmet need to include unmarried women, women who need better or more suitable contraceptive methods, women who need abortion services, and women who need more comprehensive reproductive health services than are currently available (78). These numbers cannot be easily estimated, but they would surely add substantially to the 120 million figure.

Men also have unmet needs for family planning. In DHS in Burundi, Egypt, Ghana, Kenya, and Pakistan, over half of

- Abortion is not acceptable.
- Only married couples should have access to contraceptive methods because sexual activity outside marriage is immoral.

Alone among major religions, the leadership of the Catholic Church objects to all contraceptive methods other than periodic abstinence. This position seems to have had more impact on policy-makers and the availability of services in some countries than on the attitudes of individual Catholics.

Labels Polarize Positions

Most policy-makers and advocates recognize that many of these viewpoints are legitimate and yet prioritizing program goals is necessary. In the public debate, however, labels are often used—sometimes unfairly and inaccurately—to imply that individuals and groups advocate extreme positions, ignore other points of view, or have malicious intentions. For example, those who focus on rapid population growth are sometimes labeled “population controllers” who disregard women, and those concerned with reproductive rights are sometimes portrayed as “radical feminists” who ignore the consequences of rapid population growth. As a result, positions have sometimes become polarized, focusing on disagreement rather than on the broader areas of accord.

Seeking Common Ground

In reality the serious debate concerns allocating scarce resources to achieve the multiple goals of meeting clients’ needs, slowing population growth, and protecting the environment in ways that respect individuals’ religious, ethical, and cultural beliefs.

Can population policies both satisfy demographic goals and advance individual rights? A growing number of experts and policy-makers argue that conflicts, although they cannot be

men approve of family planning, but very few are using a contraceptive method (see Table 7). In smaller, qualitative studies as well, men have asked for more information about reproductive health services including both contraception and treatment for sexually transmitted diseases (see p. 26).

Effectively serving all who want to avoid pregnancy but are not using contraception could help reconcile the dual goals of (1) serving individual clients and (2) slowing global population growth (74, 303). Steven Sinding has suggested that family planning programs replace demographic objectives with the objective of meeting unmet need. In 9 of 12 countries studied, levels of contraceptive use would be higher if all unmet need were met than if current demographic objectives were reached (303).

To translate this unmet need to control fertility into utilization of reproductive health services, policy makers must let clients know that these services are a safe and effective way to achieve their personal goals. Reproductive health programs can identify the obstacles that prevent women from using services and can design services and communication that will help overcome some of those obstacles. Obstacles may range from lack of supplies and services to dissatisfaction with current services to fears of contraceptive side effects, to social limits on women’s mobility or decision-making. Beyond the need to control their own fertility, women also need other reproductive health services, and family planning programs may be able to meet these needs, as well (see p. 16).

completely resolved, need not be as great as they sometimes appear. Suggested approaches include:

- **Base national population policy on human rights as well as economic concerns.** Policy often focuses on the economic benefit to all citizens of slower population growth. Policy-makers can emphasize more strongly, at the same time, that control over one’s own fertility is a human right and that providing services that satisfy clients is as important a program goal as reducing total fertility rates (62, 74) (see p. 33).
- **Focus on unmet need.** Millions of women do not want more children, want to delay their first or next pregnancy (25, 355), or need better reproductive health services (78). High-quality services that meet these people’s existing needs would increase use of contraception, lengthen continuation, and in the process often reach demographic goals (303) (see p. 34).
- **Support public policies that indirectly reduce population growth.** If policies support roles for women other than childrearing and make these roles socially acceptable and economically independent, some women may choose to have fewer children. Also, women who can provide for themselves and their children can better protect themselves from coerced sex and unwanted pregnancy. Changes that support more options for women include ending policies that encourage parents to favor sons over daughters, eliminating arranged marriages of young girls, enacting and enforcing minimum marriage ages, eliminating policies or tax provisions that favor large families, and assuring equitable male financial responsibility for women and children during marriage and after divorce (74).

Involving Clients in Program Design

Serving clients’ needs requires learning and heeding what clients want. Since most family planning clients are women, women should be involved at all levels in population and reproductive health programs and policy-making. Women can offer valuable insights as policy-makers, program managers, and health professionals. Most importantly, programs should consult with clients about their reproductive health care priorities.

Policy-makers can use various means to learn what clients and the public want. A recent review has identified a range of approaches (33). Many of these approaches are routinely used in the audience research that is part of designing and monitoring family planning communication programs (255):

- Observation of client-provider interactions,
- Feedback from “mystery” or “simulated” clients—people who use services and then report on their experience,
- Patient flow studies to determine how long patients spend in such activities as waiting and talking to providers,
- Focus-group discussions with clients and potential clients about their experience and their preferences,
- Exit interviews or other postservice interviews with clients,
- Interviews with service personnel about what they think would constitute a good client visit and what they see as difficulties,



UNICEF

Reproductive health care programs can serve women better if they find out what women want. To learn women's opinions, programs can interview clients and potential clients as well as work with women's groups and involve women as program administrators and advisors.

- Involving women directly in program design as program administrators or on advisory groups,
- Working with women's health advocacy groups to benefit from their analyses of women's health needs,
- Open discussion meetings in the community, sometimes specifically for women or for men, and
- Learning from other programs with services that clients like.

In Chile, for example, researchers interviewed women who had come in for clinic services. The clients wanted cleanliness, a reasonable waiting time, accessible services such as pharmacies, enough time with providers to ask questions about such topics as physiology and childrearing, and staff with a positive, respectful attitude toward clients (344).

Some women's grass-roots organizations have identified their own reproductive needs and responded to them. For example, the Working Women's Forum in India and the Mothers' Clubs in South Korea offer family planning services that complement the economic help and other services that they provide to members (5, 49, 53). The seven clinics run by the Bangladesh Women's Health Coalition each have a local advisory committee to ensure that the clinics meet local needs (161).

Some women's organizations have focused on informing other women. In 1991 a collective of Egyptian women wrote a nontechnical book on women's reproductive health (145). In Peru women in focus groups helped Peru Mujer, a non-governmental organization, design educational materials for nonliterate women like themselves (96). Women in Fiji made videos for women's groups on topics that they wanted discussed, such as sexually transmitted diseases and women's attitudes toward menstruation and family planning (364). Other family planning organizations can learn from such groups and perhaps collaborate with them.

Involving women more deeply in program design should not mean excluding men. Men and women share responsibility for reproductive health. Policies and programs will work best if they are planned by, and for, both women and men. Ideally, the insight and experiences of both women and men will create better programs that improve the lives of all clients.

Improving the lives of women and men should be a primary goal of population policy. Reproductive health care programs contribute by enabling men and women to live healthier lives and to plan when they will have children. Women, and men who enjoy better health and more control over their reproductive lives can have more opportunity to fulfill their hopes for their children, themselves, their families, and their communities.

Bibliography

An asterisk (*) denotes an item that was particularly useful in the preparation of this issue of **Population Reports**.

1. ACSADI, G.T.F. and JOHNSON-ACSADI, G. Socioeconomic, cultural and legal factors affecting girls' and women's health. *Washington, D.C., World Bank*, 1993. 93 p.
2. ADLAKHA, A., KUMAR, S., and AYAD, M. The role of nuptiality in fertility decline: A comparative analysis. In: *Macro International. Proceedings of the Demographic and Health Surveys World Conference*, Aug. 5-7, 1991. Washington, D.C. Columbia, Maryland, Macro International, 1991. p. 947-964.
3. AGHA, H.Y. Male attitudes towards fertility regulation in rural Punjab, Pakistan. (Study for Population Services International on behalf of USAID/Pakistan.) 18 p. (Unpublished)
4. AHMED, F.A.E.-K. Gender difference in child mortality. *Egyptian Population and Family Planning Review* 24(2): 60-79. Dec. 1990.
5. AHN, K.C. Integration of family planning activities with the Community Development Program. In: Cho, N.-H. and Kim, H.-O., eds. *Korean experience with population control policy and family planning program management and operation*. Seoul, Republic of Korea, Korea Institute for Health and Social Affairs, Sep. 1991. p. 189-202.
6. AKANDE, B. Some socio-cultural factors influencing fertility behaviour: A case study of Yoruba women. *Biology and Society* 6(4): 165-170. Dec. 1989.
7. ALY, H.Y. Son preference and contraception in Egypt. *Economic Development and Cultural Change* 39(2): 353-370. Jan. 1991.
8. ANONYMOUS. Fathers' Inc.—Changing ideas about men and the family. *Children in Focus* 5(3): 6. Jul.-Sep. 1993.
9. ANONYMOUS. Indonesia updates its laws. *POPULI* 20(4): 5-6. Apr. 1993.
10. ANONYMOUS. Where are the missing Chinese girls? *Women's Global Network for Reproductive Rights Newsletter* 36: 15. Jul.-Sep. 1991.
11. ANONYMOUS. Women—An endangered species. *World Development Forum* 5(21): 1-2. Nov. 30, 1987.
12. ARNOLD, F. Sex preference for children and its demographic and health implications. In: *Macro International. Proceedings of the Demographic and Health Surveys World Conference*, Aug. 5-7, 1991. Washington, D.C. Columbia, Maryland, Macro International, 1991. p. 249-273.
13. AROKIASAMY, J.T. Attitudes of 110 married men towards family planning. *Medical Journal of Malaysia* 35(11): 22-27. Sep. 1980.
14. ATWOOD, J.B. Keynote address. Presented at the 1994 Meeting of the United States Agency for International Development Office of Population Co-operating Agencies, Washington, D.C., Feb. 22, 1994. 8 p.
15. BAIRAGI, R. and BHATTACHARYA, A.K. Parental sex preference and its effects on fertility intention and contraceptive use in Calcutta. *Rural Demogra-*

phy 16(1-2): 43-56. 1989.

16. BAIRAGI, R. and LANGSTEN, R.L. Sex preference for children and its implications for fertility in rural Bangladesh. *Studies in Family Planning* 17(6, Pt. 1): 302-307. Nov.-Dec. 1986.
17. BALEPA, M., FOTSO, M., and BARRERE, B. Enquête Démographique et de Santé Cameroun, 1991. [Cameron Demographic and Health Survey, 1991.] I.F.R.E. [Yaounde, Cameroon] and Columbia, Maryland, Direction Nationale du Deuxième Recensement Général de la Population et de l'Habitat. and Macro International Inc., 1992. 285 p.
18. BANDURA, A. *Social learning theory*. Englewood Cliffs, New Jersey, Prentice-Hall, 1977. 255 p.
19. BEAUJOT, R. and BCHIR, M. Fertility in Tunisia: Traditional and modern contrasts. *Washington, D.C., Population Reference Bureau*, 1984. 59 p.
20. BELTRAN, L.R. Your health is in your hands. Presented at Johns Hopkins Center for Communication Programs, May 13, 1994. [Notes from presentation]
21. BENJAMIN, J. Socio-religious status of girl child in India. In: Devasia, L. and Devasia, V.V., eds. *Girl child in India*. New Delhi, Ashish Publishing, 1991. p. 75-83.
22. BIRDSALL, N. and CHESTER, R.A. Contraception and the status of women: What is the link? *Family Planning Perspectives* 19(1): 14-18. Jan.-Feb. 1987.
23. BLAKESLEE, K. Human rights, violence against women, and development. Presented at Harvard School of Public Health Symposium on Violence and Human Rights, Boston, Apr. 8, 1994. 19 p.
24. BLUMBERG, R.L. Making the case for the gender variable: Women and the wealth and well-being of nations. *Washington, D.C., United States Agency for International Development, Office of Women and Development*, Oct. 1989. p. 5.
25. BONGAARTS, J., MAULIDIN, W.P. and PHILLIPS, J.F. The demographic impact of family planning programs. *Studies in Family Planning* 21(6): 299-310. Nov.-Dec. 1990.
26. BOSERUP, E. *Women's role in economic development*. New York, St. Martin's, 1970. 283 p.
27. BOURNE, K.L. and WALKER, G.M., jr. The differential effect of mothers' education on mortality of boys and girls in India. *Population Studies* 45(2): 203-219. Jul. 1991.
28. BROWN, W. and CODY, M. Effects of a pro-social television soap opera in promoting women's status. *Human Communication Research* 18(1): 114-142. 1991.
29. BROWNER, C. Poor women's fertility decisions: Illegal abortion in Cali, Colombia. (Doctoral dissertation, University of California at Berkeley, Department of Anthropology) 1976. 88 p. (Unpublished)
30. BRUCE, J. Fundamental elements of quality of care: A simple framework. *Studies in Family Planning* 21(2): 61-91. Mar.-Apr. 1990.
31. BRUCE, J. (Population Council) [Reproductive health programs] Personal communication, May 17 and May 19, 1994.
32. BRUCE, J. User's perspectives on family planning: Some operational and research issues. *New York, Population Council*, 1983. 66 p. (Mimeo)
33. BRUCE, J. Women's interests: How can family planning managers respond? In: Jain, A. *Managing quality of care in population programs*. West Hartford, Connecticut, Kumari, 1992. p. 35-50.
34. BRUCE, J. Women's organizations: A resource for family planning and development. *Family Planning Perspectives* 8(6): 291-297. Nov.-Dec. 1976.

35. BUFFINGTON, S. DE C., PAYNE MERRIT, A., CASTRO, M.P.P. DE, and CASTRO, B. DE. Promoting male involvement in Brazil: Vasectomy in the media. Presented at the 117th Annual Meeting of the American Public Health Association, 1989.
36. BURCH, T.K. The impact of forms of families and sexual unions and dissolution of unions on fertility. In: Bulatao, R.A. and Lee, R.D., eds. *Determinants of fertility in developing countries*. (Vol. 2) Fertility regulation and institutional influences. New York, Academic Press, 1983. (Studies in Population) p. 532-561.
37. BUVINIC, M. *Projects for women in the Third World: Explaining their misbehavior*. Washington, D.C., International Center for Research on Women, 1984. 29 p.
38. BUVINIC, M. The design and implementation of development projects: Accounting for women. In: *International Center for Research on Women (ICRW). Financing women in the Third World and the design and implementation of development projects: Accounting for women*. Background papers for the ICRW panels at the NGO World Meeting for Women, Nairobi, Kenya, Jul. 10-19, 1985. Washington, D.C., ICRW, Apr. 1985. p. 15-26.
39. CAHN, M. Women's status and fertility in developing countries: Son preference and economic security. *Washington, D.C., World Bank*, 1984. (World Bank Staff Working Papers No. 682; Population and Development Series No. 7) 68 p.
40. CALDWELL, J.C., ORUBULOYE, I.O., and CALDWELL, P. Fertility decline in Africa: A new type of transition? *Population and Development Review* 18(2): 211-242. Jun. 1992.
41. CAMPBELL, E.K. Sex preferences for offspring among men in the western area of Sierra Leone. *Journal of Biosocial Science* 23(3): 337-342. Jul. 1991.
42. CAMPBELL, O.M.R. and GRAHAM, W.J. Measuring maternal mortality and morbidity: Levels and trends. London, London School of Hygiene and Tropical Medicine, Maternal and Child Epidemiology Unit, May 1991. 76 p.
43. CARILLO, R. Battered dreams: Violence against women as an obstacle to development. *New York, United Nations Development Fund for Women*, 1992. 38 p.
44. CARNEIRO, P. Breast-feeding patterns and lactational amenorrhoea among the Warli tribals: A socioanthropological inquiry. *International Journal of Fertility (Suppl.)*: 35-39. 1988.
45. CENTRE FOR REPRODUCTIVE AND POPULATION ACTIVITIES (CEDPA). *Extending family planning services through Third World women managers: Final report*. Washington, D.C., CEDPA, Mar. 31, 1992. 35 p.
46. CHANDRAN, A.S. Raising a feminist consciousness: Pro-social television in India. 1993. 34 p. (Unpublished)
47. CHARLTON, S.E.M. *Women in Third World development*. Boulder, Colorado, Westview Press, 1984. 256 p.
48. CHEN, L.C., HUQ, E., and D'SOUZA, S. Sex bias in the family allocation of food and health care in rural Bangladesh. *Population and Development Review* 7(1): 55-70. Mar. 1981.
49. CHEN, M. The working women's forum: Organizing for credit and change. *New York, SEEDS*, 1983. (SEEDS No. 6) 20 p.
50. CHESLER, E. *Woman of valor: Margaret Sanger and the birth control movement in America*. New York, Simon & Schuster, 1992. 640 p.
51. CHIANG, L.-H.N. Status of women in Taiwan. In: Mahadevan, K., ed. *Women and population dynamics: Perspectives from Asian countries*. New

- Delhi, Sage, 1989. p. 90-98.
52. CHINA STATE STATISTICAL BUREAU. Survey: Moderate improvement of women's status. *China Population Today* 8(6): 13-14. Dec. 1991.
53. CHUNG, K.K. Studies on FP mothers' clubs: A manual for organization and management of women's clubs. Seoul, Korea, Planned Parenthood Federation of Korea, 1987. 105 p.
54. CHURCH, C.A. and GELLER, J. Lights! Camera! Action! Promoting family planning with TV, video, and film. *Population Reports, Series J, No. 38*. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Dec. 1989. 32 p.
55. CHURCH, C.A. and GELLER, J.S. Voluntary female sterilization: Number one and growing. *Population Reports, Series C, No. 10*. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Nov. 1990. 24 p.
56. ÇILINGIROLU, N.E. Intra-familial relations and the woman's situation: A cross-sectional study in two settlements. *Turkish Journal of Population Studies* 13: 57-64. 1991.
57. COALE, A.J. Excess female mortality and the balance of the sexes in the population: An estimate of the number of "missing females." *Population and Development Review* 17(3): 517-523. Sep. 1991.
58. COCHRANE, S. and GUILKEY, D.K. How access to contraception affects fertility and contraceptive use in Tunisia. Washington, D.C., World Bank, Jan. 1992. (Population, Health, and Nutrition Working Papers no. WPS 841) 61 p.
59. COEYTAUX, F. Celebrating mother and child on the fortieth day: The Sfax, Tunisia postpartum program. *Quality/Calidad/Qualité* 1: 1-24. 1989.
60. COEYTAUX, F.M., LEONARD, A.H., and BLOOMER, C.M. Abortion. In: Kobinsky, M., Timyan, J., and Gay, J., eds. *The health of women: A global perspective*. Boulder, Colorado, Westview Press, 1993. p. 133-146.
61. COHEN, S.A. Competition, or consensus? *Populi* 20(9): 11-13. Oct. 1993.
62. COHEN, S.A. The road from Rio to Cairo: Toward a common agenda. *International Family Planning Perspectives* 19(2): 61-66. Jun. 1993.
63. COOK, R.J. International human rights and women's reproductive health. *Studies in Family Planning* 24(2): 73-86. Mar.-Apr. 1993.
64. COOK, R.J. and HAWES, J.M. The United Nations convention on the rights of women: Opportunities for family planning providers. *International Family Planning Perspectives* 12(2): 49-53. Jun. 1986.
65. COOK, R.J. and MAINE, D. Spousal veto over family planning services. *American Journal of Public Health* 77(3): 339-344. Mar. 1987.
66. COOK, R.J. and PLATA, M.I. Spousal consent for voluntary surgical contraception. *Comunicación* 7(1): 14-15. Jul. 1986.
67. COOPERATING AGENCIES TASK FORCE. Informed choice: Report of the Cooperating Agencies Task Force. Baltimore, Johns Hopkins School of Public Health, Center for Communication Programs, Jul. 1989. 34 p.
68. DARNLEY, P.D., KLAISLE, C.M., TANNER, S., and ALVARADO, A.M. Sustained reproductive contraceptives. *Current Problems in Obstetrics, Gynecology and Fertility* 13(3): 90-125. May-Jun. 1990.
69. DAS GUPTA, M. Selective discrimination against female children in rural Punjab. *Population and Development Review* 13(1): 77-100. 1987.
70. DATES, J.L. and GANDY, O.H., Jr. How ideological constraints affected coverage of the Jesse Jackson campaign. *Journalism Quarterly*: Autumn 1985. p. 595-625.
71. DATTA, K.K., SHARMA, R.S., RAZACK, P.M.A., GHOSH, T.K., and ARORA, R.R. Mobility pattern amongst rural pregnant women in Alwar, Rajasthan—A cohort study. *Health and Population—Perspectives and Issues* 3(4): 282-292. Oct.-Dec. 1980.
72. DEEB, M.E. Household structure as related to childhood mortality and morbidity among low income areas in Amman. [Doctoral dissertation, Johns Hopkins University, Nov. 1987]. Ann Arbor, Michigan, University Microfilms, 1987. (No. 881904D) 182 p.
73. DEMOGRAPHIC AND HEALTH SURVEYS (DHS). IRD/MACRO INTERNATIONAL, INC. Adolescent women in sub-Saharan Africa: A chartbook on marriage and childbearing. Columbia, Maryland, Macro International, Mar. 1992. 25 p.
74. DIXON-MUELLER, R. Population policy and women's rights: Transforming reproductive choice. Westport, Connecticut, Praeger, 1993. 287 p.
75. DIXON-MUELLER, R. Psychosocial consequences to women of contraceptive use and controlled fertility. In: Parnell, A.M., ed. *Contraceptive use and controlled fertility: Health issues for women and children: Background papers*. Washington, D.C., National Academy Press, 1989. p. 140-159.
76. DIXON-MUELLER, R. The sexual connection in reproductive health. *Studies in Family Planning* 24(5): 269-282. Sep.-Oct. 1993.
77. DIXON-MUELLER, R. and GERMAIN, A. Four essays on birth control needs and risks. New York, International Women's Health Coalition, 1993. 20 p.
78. DIXON-MUELLER, R. and GERMAIN, A. Stalking the elusive "unmet need" for family planning. *Studies in Family Planning* 23(5): 330-335. Sep.-Oct. 1992.
79. DOMINICAN REPUBLIC. INSTITUTO DE ESTUDIOS DE POBLACION Y DESARROLLO (IEPD) DE PROFAMILIA, and OFICINA NACIONAL DE PLANEACION (ONAPLAN) and DEMOGRAFIA AND HEALTH SURVEYS: IRD/MACRO INTERNATIONAL (IRD). República Dominicana Encuesta Demográfica y de Salud 1991. Informe preliminar [Dominican Republic Demographic and Health Survey 1991: Preliminary report.] ISP/PA. Santo Domingo, Dominican Republic, and Columbia, Maryland, IEPD, and ONAPLAN, and IRD, Dec. 1991. 28 p.
80. DYSON, T. and MOORE, M. On kinship structure, female autonomy, and demographic behavior in India. *Population and Development Review* 9(1): 35-60. Mar. 1983.
81. EGYPT. CENTRAL AGENCY FOR PUBLIC MOBILIZATION AND STATISTICS (CAPMAS). WOMEN AND CHILD RESEARCH UNIT. AND UNITED NATIONS CHILDREN'S FUND (UNICEF) EGYPT. The situation of women in Egypt. Cairo, CAPMAS, and UNICEF, 1991. 61 p. (Mimeo)
82. EGYPTIAN FERTILITY CARE SOCIETY (EFCs). Nonplant acceptability in Egypt survey results of EFCs clientele: Summary report 1990. Cairo, EFCs, 1990. 32 p. (Mimeo)
83. EL-ZANATY, F.H., SAYED, H.A.A., ZAKY, H.H.M., and WAY, A.A. Egypt Demographic and Health Survey 1992. Cairo and Calverton, Maryland, National Population Council and Macro International, Nov. 1993. 317 p.
84. ELLERTSON, C. African men and family planning. Sep. 13, 1991. 49 p. (Unpublished)
85. ELUF, L.N. A new approach to law enforcement: The special women's police stations in Brazil. In: Schuler, M., ed. *Freedom from violence: Women's strategies from around the world*. New York, United Nations Development Fund for Women, 1992. p. 199-212.
86. ESCHEN, A. Acting to save women's lives: Report of the Meeting of Partners for Safe Motherhood. Washington, D.C., Population Council, 1992. 90 p.
87. ESCHEN, A. and WHITTAKER, M. Family planning: A base to build on for women's reproductive health services. In: Kobinsky, M., Timyan, J., and Gay, J., eds. *The health of women: A global perspective*. Boulder, Colorado, Westview Press, 1993. p. 105-131.
88. EZEH, A.C. The influence of spouses over each other's contraceptive attitudes in Ghana. *Studies in Family Planning* 24(3): 163-174. May-Jun. 1993.
89. FAPOHUNDA, E.R. and TODARO, M.P. Family structure, implicit contracts, and the demand for children in southern Nigeria. *Population and Development Review* 14(4): 571-594. Dec. 1988.
90. FATHALLA, M.F., ROSENFELD, A., INDRISO, C., SEN, D.K., and RATNAM, S.S., eds. *Reproductive health: Global issues*. Park Ridge, New Jersey, Parthenon, 1990. (Vol. 3, F-I-G-O manual of human reproduction) 224 p.
91. FAUNDES, A., HARDY, E., and PINOTTI, J.A. Commentary on women's reproductive health: Means or end? *International Journal of Gynecology and Obstetrics (Suppl. 3)*: 115-118. 1989.
92. FAUVEAU, V., KOENIG, M.A., WOJTYNIAK, B., and CHAKRABORTY, J. Impact of a family planning and health services programme on adult female mortality. *Health Policy and Planning* 3(4): 271-279. Dec. 1988.
93. FAUVEAU, V., WOJTYNIAK, B., KOENIG, M.A., CHAKRABORTY, J., and CHOWDHURY, A.I. Epidemiology and cause of deaths among women in rural Bangladesh. *International Journal of Epidemiology* 18(1): 139-145. Mar. 1989.
94. FERINGA, B. Reproductive rights under the Chilean military dictatorship. [Draft] [Prepared for submission to the Chilean Commission of Human Rights] Jul. 27, 1992. 58 p.
95. FERNANDEZ, I. Mobilizing on all fronts: A comprehensive strategy to end violence against women in Malaysia. In: Schuler, M., ed. *Freedom from violence: Women's strategies from around the world*. New York, United Nations Development Fund for Women, 1992. p. 101-120.
96. FIGUEROA, B. Adding color to life: Illustrated health materials for women in Peru. In: Population Council (PC). *By and for women: Involving women in the development of reproductive health care materials*. [Summaries in FRE, SPA] Quality/Calidad/Qualité No. 4. New York, PC, 1992. p. 12-18.
97. FORD FOUNDATION (FF). Reproductive health and population program: A progress report. 1990-1992. [New York, FF, 1992.] [Discussion Paper prepared for the Sep. 1992 Trustees' Meeting.] 70 p. (Mimeo)
98. FORT, A.L. Investigating the social context of fertility and family planning: A qualitative study in Peru. *International Family Planning Perspectives* 15(3): 88-95. Sep. 1989.
99. FORTNEY, J.A. The importance of family planning in reducing maternal mortality. *Studies in Family Planning* 18(2): 109-114. Mar.-Apr. 1987.
100. FOSTER, A.D. Program effects and the allocation of resources within the household. Apr. 29, 1994. 25 p. (Unpublished)
101. FOSTER, A.D. and ROY, N. The dynamics of education and fertility: Evidence from a family planning experiment. [Draft] Sep. 12, 1993. 27 p.
102. FRASER, A. and KAZANTSI, M. CEDAW #11: The Convention on the Elimination of All Forms of Discrimination Against Women and Violence Against Women. Minneapolis, Minnesota, International Women's Rights Action Watch, Aug. 1992. 44 p.
103. FREDMAN, L.P. Women and the law in Asia and the Near East. Prepared for the USAID Conference on Women, Economic Growth and Demographic Change in Asia, the Near East and Eastern Europe, Washington, D.C., May 14-15, 1991. 44 p.
104. FREDMAN, L.P. and ISAACS, S.L. Human rights and reproductive choice. *Studies in Family Planning* 24(1): 18-30. Jan.-Feb. 1993.
105. FREEMAN, M. Women's human rights and reproductive rights: Status, capacity and choice. Inter-American Parliamentary Group on Population and Development Bulletin 8(9): 1-6. Oct. 1991.
106. FREEMAN, M.A. Measuring equality: A comparative perspective on women's legal capacity and constitutional rights in five commonwealth countries. *Berkeley Women's Law Journal* 5: 110-138. 1989-90.
107. FUGELANG, A. and CHANDLER, D. The paradigm of communication in development: From knowledge transfer to community participation—Lessons from the Grameen Bank, Bangladesh. Rome, Food and Agriculture Organization of the United Nations, 1987. 29 p.
108. FUGELANG, A. and CHANDLER, D. Participation as process: What we can learn from Grameen Bank, Bangladesh. Oslo, Norway, Norwegian Ministry of Development Cooperation, 1986. 234 p.
109. GACHUKIA, E.W. Options for a better life for young women: Issues overview. Presented at the Centre for Development and Population Activities Africa Regional Conference for Women Leaders, Nairobi, Feb. 8-10, 1989. 26 p.
110. GAGE-BRANDON, A.J. and MEEKERS, D. Sex, contraception and childbearing before marriage in sub-Saharan Africa. *International Family Planning Perspectives* 19(1): 14-18. 1993.
111. GALLEN, M.E., LISKIN, L., and KAK, N. Men—New focus for family planning programs. *Population Reports, Series J, No. 33*. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Nov.-Dec. 1986. 32 p.
112. GANDY, O.H., Jr. Beyond agenda setting: Information subsidies and public policy. Norwood, New Jersey, Ablex, 1982. 243 p.
113. GARZA, R.T., ISONIO, S.A., and GALLEGOS, P.I. Community development in rural Mexico: The social psychological effects of adult education. *Journal of Applied Social Psychology* 18(8), Pt. 2: 640-653. Jun. 1988.
114. GERMAIN, A. Reproductive health and dignity: Choices by third world women. Prepared for the International Conference on Better Health for Women and Children Through Family Planning, Nairobi, Oct. 1987. 31 p.
115. GERMAIN, A. and ORDWAY, J. Population control and women's health: Balancing the scales. New York, International Women's Health Coalition, Jun. 1989. 17 p.
116. GHANA STATISTICAL SERVICE (GSS), and INSTITUTE FOR RESOURCE DEVELOPMENT/MACRO SYSTEMS (IRD). Ghana Demographic and Health Survey 1988. Accra, Ghana, and Columbia, Maryland, GSS, and IRD, Sep. 1989. 214 p.
117. GHOSH, S. Discrimination all the way. *Health for the Millions* 17(2): 19-23. Apr. 1991.
118. GHURAYIB, R. The women of the Maghreb. *Al-Raïda* 10(57): 13-16. Spring 1992.
119. GOMEZ, E. Sex discrimination and excess female mortality among children in the Americas. [Prepared for the 18th National Council for International Health Conference, Arlington, Virginia, Jun. 23-26, 1991.]
120. GORDON, L. Voluntary motherhood: The beginnings of feminist birth control ideas in the United States. In: Leavitt, J.W., ed. *Women and health in America: Historical readings*. Madison, Wisconsin, University of Wisconsin Press, 1984. p. 104-116.
121. GORDON, L. Woman's body, woman's right: Birth control in America. Rev. ed. New York, Penguin Books, 1990. 592 p.
122. GOVINDASAMY, P., STEWART, M.K., RUTSTEIN, S.O., BOERMA, J.T., and SOMMERFELD, A.E. High-risk births and maternity care. Columbia, Maryland, Macro International, Jun. 1993. [Demographic and Health Surveys Comparative Studies No. 8] 53 p.
123. GRAHAM, W.J. and CAMPBELL, O.M.R. Measuring maternal health: Defining the issues. London, London School of Hygiene and Tropical Medicine, Maternal and Child Epidemiology Unit, May 1991. 42 p.
124. GREEN, C.P. Male involvement programs in family planning: Lessons learned and implications for AIDS prevention. [Draft] Geneva, World Health Organization, Mar. 6, 1990. 65 p.
125. GREENHALGH, S. Negotiating birth control in village China. New York, Population Council, 1992. (Working Papers No. 38) 46 p.
126. GREENHALGH, S. Women in the informal enterprise: Empowerment or exploitation? New York, Population Council, 1991. (Working Papers No. 33) 43 p.
127. GUILKEY, D.K. and COCHRANE, S. Zimbabwe: Determinants of contraceptive use at the leading edge of fertility transition in sub-Saharan Africa. Apr. 23, 1992. p. 17-21. (Unpublished)
128. HAMMERSTROUGH, C.R. Women's groups and contraceptive use in rural Kenya. Prepared for IUSSP seminar on the Course of Fertility Transition in sub-Saharan Africa, Harare, Zimbabwe, Nov. 19-22, 1991. 30 p.
129. HASHEMI, S.M. and SCHULER, S.R. Defining and studying empowerment of women: A research note from Bangladesh. (Revision) Boston, Massachusetts, John Snow, Oct. 1993. [JCI Working Paper, No. 3] 19 p.
130. HAUSSER, D. and MICHAUD, P.-A. Condom promotion does not increase sexual activity among adolescents. Presented at the 8th International Conference on AIDS/3rd STD World Congress, Amsterdam, the Netherlands, Jul. 19-24, 1992. 3 p.
131. HAVANON, N., KNODEL, J., and SITTIRAL, W. Family size and family well being in Thailand. 1989. (Family Health International Briefing Paper) 5 p. (Unpublished)
132. HECTOR, O., RUSSELL-BROWN, P., and HENRY, V. Increasing male use of contraceptives. St. Kitts-Nevis, Ministry of Health, Education and Community Affairs, 1990. 35 p.
133. HEISE, L. Violence against women: The missing agenda. In: Kobinsky, M., Timyan, J., and Gay, J., eds. *The health of women: A global perspective*. Boulder, Colorado, Westview Press, 1992. p. 171-195.
134. HENSHAW, S.K. Induced abortion: A world review. 1990. *Family Planning Perspectives* 22(2): 76-81. Mar.-Apr. 1990.
135. HERZ, B. and MEASHAM, A.R. The safe motherhood initiative: Protocols for action. Washington, D.C., World Bank, 1987. 52 p.
136. HINDIN, M.J., KINCAID, D.L., KUMAH, O.M., MORGAN, W., and KIM, Y.M. Gender differences in media exposure and action during a family planning campaign in Ghana. *Health Communication* 6(2): 117-135. 1994.
137. HOBRAFF, J. Child spacing and child mortality. In: Macro International. Proceedings of the Demographic and Health Surveys World Conference, Aug. 5-7, 1991, Washington, D.C. Columbia, Maryland, Macro International, 1991. p. 1157-1181.
138. HOLLERBACH, P.E. Fertility decision-making processes: A critical essay. New York, Population Council, Oct. 1982. [Center for Policy Studies Working Paper No. 90] 55 p.
139. HONG, S. (USAID) [Number of women fieldworkers in family planning programs worldwide]. Personal communication, Apr. 22, 1993.
140. HONG, S. and SELTZER, J.R. The impact of family planning on women's lives: A conceptual framework and research agenda. Apr. 1992. 71 p. (Unpublished)
141. HOSSAIN, M.M. and GLASS, R.I. Parental son preference in seeking medical care for children less than five years of age in a rural community in Bangladesh. *American Journal of Public Health* 78(10): 1349-1350. Oct. 1988.
142. HUEZO, C. and MALHOTRA, U. Choice and use-continuation of methods of contraception: A multicentre study. London, International Planned Parenthood Federation, 1993. 163 p.
143. HUSTON, P. Motherhood by choice: Pioneers in women's health and family planning. New York, Feminist Press, 1992. 182 p.
144. HUSTON, P. Third world women speak out: Interviews in six countries on change, development, and basic needs. New York, Praeger, 1979. 153 p.
145. IBRAHIM, B. and FARAH, N. Women's lives and health: The Cairo Women's Health Book Collective. In: Population Council. *By and for women: Involving women in the development of reproductive health care materials*. [Summaries in FRE, SPA] Quality/Calidad/Qualité No. 4. New York, PC, 1992. p. 4-11.
146. ILUKOMA, A. Legal issues in maternal mortality. [In.d.] 13 p. (Unpublished)
147. INTERNATIONAL PLANNED PARENTHOOD FEDERATION (IPPF). Reproductive rights. [Wall chart] London, IPPF, Nov. 1991. 1 p.
148. INTERNATIONAL PLANNED PARENTHOOD FEDERATION. Women and family planning: issues for the 1990s: Discussion note. Prepared for the Expert Group Meeting on Population and Women, Gaborone, Botswana, Jun. 22-26, 1992. 8 p.
149. INTERNATIONAL WOMEN'S RIGHTS ACTION WATCH (IWRAP). Status report as of Jun. 1993 of the Convention on the Elimination of All Forms of Discrimination Against Women. Minneapolis, Minnesota, IWRAP, 1993. 7 p.
150. JACOBSON, R. Domestic violence as a development issue. *Focus on Gender* 1(2): 37-39. Jun. 1993.
151. JAIN, A. and BRUCE, J. Implications of reproductive health for objectives and efficacy of family planning programs. New York, Population Council, 1993. (Working Papers No. 8) 37 p.
152. JESANI, A. Limits of empowerment: Women in rural health care. *Economic and Political Weekly* 25(20): 1098-1103. 1990.
153. JOHANSSON, S. and NYGREN, O. The missing girls of China: A new demographic account. *Population and Development Review* 17(1): 35-51. 1991.
154. JONES, E.F., et al. Teenage pregnancy in industrial countries. New Haven, Connecticut, Yale University Press, 1986. 324 p.
155. JORDAN. DEPARTMENT OF STATISTICS (JDOS), and CENTERS FOR DISEASE CONTROL (CDC), DIVISION OF REPRODUCTIVE HEALTH. Jordan Husbands' Fertility Survey: 1985. Report of principal findings. Amman, Jordan, and Atlanta, Georgia, JDOS, and CDC, Mar. 1987. 129 p.
156. KABER, N. From fertility reduction to reproductive choice: Gender perspectives on family planning. Brighton, England, Institute of Development Studies, Mar. 1992. (Discussion Paper No. 299) 38 p.
157. KAK, L.P. and NARASIMHAN, S. The impact of family planning employment on field workers' lives: A strategy for measuring empowerment. Washington, D.C., Centre for Development and Population Activities, 1992. (Working Paper No. 1) 26 p.
158. KAK, L.P. and SIGNER, B. The introduction of community-based family planning services in rural Mali: The Katiabougou Family Health Project. Washington, D.C., Centre for Development and Population Activities, 1993. (Working Paper No. 2) 12 p.
159. KANE, T.T. and SIVASUBRAMANIAM, S. Husband-wife attitudes toward family planning in Sri Lanka: Husband-wife communication, contraceptive decision-making and consistency of reporting of contraceptive use. Presented at the 1987 Annual Meeting of the Population Association of America, New Orleans, Louisiana, Apr. 20-23, 1988. 30 p.
160. KARKI, Y.B. Sex preference and the value of sons and daughters in Nepal. *Studies in Family Planning* 19(3): 169-178. May-Jun. 1988.
161. KAY, B.J., GERMAIN, A., and BANCSE, M. The Bangladesh Women's Health Coalition. [Summaries in FRE, SPA] Quality/Calidad/Qualité No. 3. New York, PC, 1991. p. 1-24.
162. KENNEDY, E., and PETERS, P. Household food security and child nutrition: the interaction of income and gender of household head. *World Development* 20(8): 1077-1085. Aug. 1992.
163. KENNEDY, E.T. and COGILL, B. Income and nutritional effects of the commercialization of agriculture in southwestern Kenya. Washington, D.C., International Food Policy Research Institute, 1987. (Research Report 63) 60 p.
164. KENYA. NATIONAL COUNCIL FOR POPULATION AND DEVELOPMENT (NCPD), and INSTITUTE FOR RESOURCE DEVELOPMENT/MACRO SYSTEMS (IRD). Kenya Demographic and Health Survey 1989. Columbia, Maryland, NCPD, and IRD, Oct. 1989. 158 p.
165. KEYSERS, L. Population-and-environment from women's perspective. *WGNRR Newsletter* 36: 11-15. Jul.-Sep. 1991.
166. KHAN, M.E. and PARVEEN, S. Subjective efficacy and acceptance of family planning. *Journal of Family Welfare* 33(4): 40-47. Jun. 1977.
167. KHATTAB, H.A.S. The silent endurance: Social conditions of women's reproductive health in rural Egypt. New York, United Nations Children's Fund, and Population Council, 1992. 59 p.
168. KIM, C.H. and LEE, S.J. Role of husband in family planning behavior. *Psychological Studies in Population/Family Planning* 1(5): 1-23. May 1973.
169. KINCAID, D.L. Community networks and family planning promotion: Impact of the 'jiggasha' approach in Trishal, Bangladesh. [Abstract] Presented at the 121st Annual Meeting of the American Public Health Association, San Francisco, Oct. 24-28, 1993. 8 p.
170. KINCAID, D.L., ELIAS, J.R.J., COLEMAN, P., and SEGURA, F. Getting the message: The Communication for Young People Project. Washington, D.C., United States Agency for International Development, 1988. (A.I.D. Evaluation Special Study No. 56) 28 p.
171. KINCAID, D.L., MERRITT, A.P., NICKERSON, L., BUFFINGTON, S.D., DE CASTRO, M.P., and DE CASTRO, B.M. The mass media vasectomy promotion campaign in Brazil: Impact on clinic inquiries attendance, and performance.

- Baltimore, Johns Hopkins School of Public Health, Population Communication Services, 1991. (Mimeo)
172. KING, E.M. Educating girls and women: Investing in development. Washington, D.C., World Bank, 1990. 19 p.
173. KIRAGU, K. Factors associated with sexual and contraceptive behavior among school adolescents in Kenya: The 1989 Nakuru District Adolescent Fertility Survey, final report. Baltimore, Johns Hopkins School of Public Health, 1991. 38 p.
174. KIRAGU, K. Nigeria: The PSA/logo campaign: Results of the evaluation. [Draft] Baltimore, Johns Hopkins Population Communication Services, Mar. 20, 1994. 55 p.
175. KIRBY, D., RESNIK, M.D., DOWNS, B., et al. The effects of school-based health clinics in St. Paul upon schoolwide birth rates. [To be published in Family Planning Perspectives]
176. KIRBY, D., WASZAK, C., and ZIEGLER, J. Six school-based clinics: Their reproductive health services and impact on sexual behavior. Family Planning Perspectives 23(1): 6-16. Jan.-Feb. 1991.
177. KISHOR, S. "May God give sons to all": A study of gender inequality in India, 1981. Presented at the annual meeting of the Population Association of America, Washington, D.C., Mar. 21-24, 1991. 32 p.
178. KNODEL, J., HAWANON, N., and SITTITRAI, W. Family size and the education of children in the context of rapid fertility decline. Ann Arbor, Michigan, University of Michigan, 1989. (Population Studies Center Research Report No. 89-155) 49 p.
179. KOENIG, M.A., FAUVEAU, V., CHOWDHURY, A.I., CHAKRABORTY, J., and KHAN, M.A. Maternal mortality in Matlab, Bangladesh: 1976-85. Studies in Family Planning 19: 69-80, 1988.
180. KRISHNAN, P. and DIGHE, A. Affirmation and denial: Construction of femininity on Indian television. Newbury Park, California, Sage, 1990. 128 p.
181. KRISTOF, N.D. Peasants of China discover new way to weed out girls. New York Times, Jul. 21, 1993. p. A-1, A-6.
182. KRITZ, M.M. and GURAK, D.T. Women's position, education and family formation in sub-Saharan Africa. Ithaca, New York, Cornell University, 1989. (Population and Development Program, 1989 Working Paper Series 1.06) 22 p.
183. KUJENYHIA, A. In Ghana: Legal aid services for women. In: Schuler, M.A., ed. Women, law and development—Action for change. Washington, D.C., OEF International, 1990. (Series on Women, Law, and Development: Issues and Strategies for Change No. 2) p. 53-59.
184. LADIPPO, P. Women in a maize storage co-operative in Nigeria: Family planning, credit and technological change. In: Oppong, C., ed. Sex roles, population and development in West Africa. Portsmouth, New Hampshire, Heinemann, 1987. p. 101-117.
185. LANDE, R. Controlling sexually transmitted diseases. Population Reports, Series L, No. 9. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Jun. 1993. 32 p.
186. LETTENMAIER, C. and GALLEN, M.E. Counseling guide. Population Reports, Series J, No. 36. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Dec. 1987. 28 p.
187. LETTENMAIER, C., LISKIN, L., CHURCH, C.A., and HARRIS, J.A. Mothers' lives matter: Maternal health in the community. Population Reports, Series L, No. 7. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Sep. 1988. 32 p.
188. LEWIS, G. [Empowerment of family planning field workers.] Presented at the Johns Hopkins School of Public Health Center for Communication Programs, Baltimore, Jan. 28, 1993. [Notes from presentation]
189. LISKIN, L., BENOIT, E., and BLACKBURN, R. Vasectomy: New Opportunities. Population Reports, Series D, No. 5. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Mar. 1992. 24 p.
190. LISKIN, L., WHARTON, C., BLACKBURN, R., and KESTELMAN, P. Condoms—Now more than ever. Population Reports, Series H, No. 8. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Sep. 1990. 36 p.
191. LISKIN, L.S. Maternal morbidity in developing countries: A review and comments. International Journal of Gynecology and Obstetrics 37: 77-87, 1992.
192. LIVI-BACCI, M. Le changement démographique et le cycle de vie des femmes. [Demographic change and the life cycle of women.] In: E. Sullerot, ed. Le Fait Féminin. [The feminine reality.] Paris, Fayard, 1978. p. 467-478.
193. LLOYD, C. Family and gender issues for population policy. Prepared for the Expert Group Meeting on Population and Women, Gaborone, Botswana, Jun. 22-26, 1992. 31 p.
194. LLOYD, C. What is the family (and who does the planning)? Populi 20(4): 8-11. Apr. 1993.
195. LLOYD, C.B. The contribution of the World Fertility Surveys to an understanding of the relationship between women's work and fertility. Studies in Family Planning 22(3): 144-161. May-Jun. 1991.
196. LLOYD, C.B. and BRANDON, A.J. Women's role in maintaining households: Poverty and gender inequality in Ghana. New York, Population Council, 1991. (Working Paper No. 25) 55 p.
197. LLOYD, C.B. and GAGE-BRANDON, A.J. High fertility and the intergenerational transmission of gender inequality: Children's transition to adulthood in Ghana. Presented at a seminar on Women and Demographic Change in sub-Saharan Africa, Dakar, Senegal, Mar. 3-6, 1993. 24 p.
198. LONGWE, S.H. Gender awareness: The missing element in the Third World development project. Presented at a training program in WID issues for FINNIDA staff, Helsinki, Finland, Jan. 30-Feb. 15, 1989. 11 p.
199. LOZARE, B.V., GILL-BAILEY, A., HESS, R., VALMADRID, C., YUN, S.H., LIVESAY, A., KHAN, S.R., and SIDDIQUI, N. Husband-wife communication and family planning: Impact of a national TV drama. Presented at the 1993 Meeting of the American Public Health Association, San Francisco, California, Oct. 25, 1993. 11 p.
200. LYNAM, R., RABINOVITZ, L.M., and SHOBOWALE, M. Using self-assessment to improve the quality of family planning clinic services. Studies in Family Planning 24(4): 252-260. Jul.-Aug. 1993.
201. MAGUIRE, E.S. USAID's Office of Population: Program Priorities and Challenges. Presented at the 1994 Meeting of the United States Agency for International Development Office of Population Cooperating Agencies, Washington, D.C., Feb. 22-25, 1994. 12 p.
202. MAINE, D. Safe motherhood programs: Options and issues. New York, Center for Population and Family Health, Columbia University, 1991. 61 p.
203. MAINE, D., ROSENFELD, A., WALLACE, M., KIMBALL, A.M., KWAST, B., PAPIERNIK, E., and WHITE, S. Prevention of maternal deaths in developing countries: Program options and practical considerations. (Prepared for the International "Safe Motherhood" Conference, Nairobi, Kenya, Feb. 10-13, 1987) 50 p.
204. MANNAN, M.A. Sexual division of labour and son preference in rural Bangladesh. Demography India 17(2): 242-272, 1988.
205. MAANSA, E. Growing confidence: Villagers in Ghana's IP pilot areas learn the power of self-help. Integration 29: 35-37, Sep. 1991.
206. MASSON, K.O. A feminist perspective on fertility decline. (Rev.) Presented at the Annual Meeting of the Population Association of America, New Orleans, Louisiana, Apr. 21-23, 1988. 19 p.
207. MASSON, K.O. The status of women: A review of its relationships to fertility and mortality. [New York], Rockefeller Foundation, 1984. 86 p.
208. MAYOUX, L. Integration is not enough: Gender inequality and empowerment in Nicaraguan agricultural co-operatives. Development Policy Review 11(1): 67-89, Mar. 1993.
209. MBILINYI, M. Struggles over patriarchal structural adjustment in Tanzania. Focus on Gender 1(3): 26-29, Oct. 1993.
210. MCCARTHY, J. and MAINE, D. A framework for analyzing the determinants of maternal mortality. Studies in Family Planning 23(1): 23-34. Jan.-Feb. 1992.
211. MCCALEULEY, A.P., WEST, S., and LYNCH, M. Household decisions among the Moga people of Tanzania: Determining the roles of men, women and the community in implementing a trachoma prevention program. Social Science and Medicine 34(7): 817-824, 1992.
212. MEDAWAR, J. The history of family planning in Britain. In: Medawar, J. and Pyke, D., eds. Family planning. Harmondsworth, England, Penguin, 1971. p. 45-57.
213. MENSCH, B. Using situation analysis to develop quality of care indicators: Examples from Ghana, Nigeria and Tanzania. Presented at the Africa Operations Research and Technical Assistance Project Conference, Nairobi, Oct. 4-7 1993.
214. MOHR, J.C. Patterns of abortion and the response of American physicians, 1790-1930. In: Leavitt, J.W., ed. Women and health in America: Historical readings. Madison, Wisconsin, University of Wisconsin Press, 1984. p. 117-123.
215. MORRIS, L. Sexual behavior and use of contraception among young adults: What have we learned from the young adult reproductive health surveys in Latin America? Presented at the 1st Inter-African Conference on Adolescent Health, Nairobi, Mar. 24-27, 1992. 31 p.
216. MORRIS, L. Sexual experience and use of contraception among young adults in Latin America. Presented at the 1990 Annual Meeting of the Population Association of America, Toronto, May 3-5, 1990. 33 p.
217. MOSER, C.O.N. Gender planning and development: Theory, practice and training. London, Routledge, 1993. 285 p.
218. MOSER, C.O.N. Gender planning in the Third World: Meeting practical and strategic gender needs. World Development 17(11): 1799-1825, 1989.
219. MOTT, F.L. and MOTT, S.H. Household fertility decisions in West Africa: A comparison of male and female survey results. Studies in Family Planning 16(2): 88-99, Mar.-Apr. 1985.
220. MUCHENA, O. Are women integrated into development? Africa Report 7(1): 4-6, Mar.-Apr. 1983.
221. MURAMATSU, M. Family planning: History, programs and practice. In: Population Problems Research Council, The Mainichi Newspaper, and the Japanese Organization for International Cooperation in Family Planning (JOICFP), eds. Fertility and family planning in Japan. Tokyo, JOICFP, 1977. p. 21-51.
222. MURTY, R. Conjugal interaction patterns and fertility behaviour: A multivariate study. Journal of Family Welfare 33(1): 38-51, Sep. 1986.
223. MVAANI, N. Against many odds: The dilemmas of women's self-help groups in Mbere, Kenya. Africa 56(2): 210-227, 1986.
224. NAG, M. Sex preference in Bangladesh, India, and Pakistan, and its effect on fertility. New York, Population Council, 1991. (Working Papers No. 27) 43 p.
225. NANDAN, G. India to ban prenatal sex determination. British Medical Journal 306: 353, 1993.
226. NARIMAN, H.N. Soap operas for social change: Toward a methodology for entertainment-education television. Westport, Connecticut, Praeger, 1993. 143 p.
227. NATIONAL RESEARCH COUNCIL. Contraception and reproduction: Health consequences for women and children in the developing world. Washington, D.C., National Academy Press, 1989. 127 p.
228. NATIONAL RESEARCH COUNCIL. Risking the future: Adolescent sexuality, pregnancy, and childbearing. Washington, D.C., National Academy Press, 1989. 143 p.
229. NATIONAL VICTIM CENTER (NVC) and CRIME VICTIMS RESEARCH AND TREATMENT CENTER (CVRTC). Rape in America: A report to the nation. Arlington, Virginia, and Charleston, South Carolina, NVC and CVRTC, Medical University of South Carolina, Apr. 23, 1992. 16 p.
230. NEWMAN, K., ed. Progress postponed: Abortion in Europe in the 1990s. London, International Parenthood Federation, 1993. 173 p.
231. NGALLABA, S., KAPIGA, S.H., RUYOBYA, I., and BOERMA, J.T. Tanzania Demographic and Health Survey 1991/1992. Dar es Salaam, Tanzania, and Columbia, Maryland, Tanzania. Bureau of Statistics, and Macro International, Jun. 1993. 306 p.
232. NHALAPO, T. Women and the Constitution: What to do when culture strikes back. Southern Africa Political and Economic Monthly 2: 49-51, Nov. 1992.
233. O'CONNELL, M. Where's Papa? Fathers' role in child care. Washington, D.C., Population Reference Bureau, Sep. 1993. (Population Trends and Public Policy Paper No. 20) 20 p.
234. OBERMEYER, C.M. Islam, women, and politics: The demography of Arab countries. Population and Development Review 18(1): 33-60, Mar. 1992.
235. OGAWA, N. and HODGE, R.W. Fertility and the locus of family control in contemporary Japan. Population Research Leads, No. 14, 29 p. 1983.
236. OKPERE, E.F., NICHOLS, D.J., OLUSANYA, O., and FRIED, D. Contraceptive knowledge, attitudes and behavior among Nigerian males: Benin City, Udo, 1986. Research Triangle Park, North Carolina, Family Health International, Jun. 1988. 74 p.
237. OMONDI-ODHIAMBO, M. Men and family planning in Kenya: Alternative policy intervention strategies for reducing population growth. [Doctoral dissertation, Florida State University, 1992.] Ann Arbor, University Microfilms, 1992. (No. 93-34242) 276 p.
238. OPPONG, C., ed. Responsible fatherhood and birth planning. In: Sex roles, population and development in West Africa: Policy-related studies on work and demographic issues. Portsmouth, New Hampshire, Heinemann Educational Books, 1987. p. 165-178.
239. OPPONG, C. Women's roles, opportunity costs, and fertility. In: Bulatao, R.A., Lee, R.D., Hollerbach, P.E., and Bongaarts, J., eds. Determinants of fertility in developing countries: 1. Supply and demand for children. New York, Academic Press, 1983. p. 547-589.
240. OTSEA, K. Progress and prospects: The Safe Motherhood Initiative 1987-1992. (Rev. ed.) Washington, D.C., World Bank, Jul. 1992. 182 p.
241. OYERDIRAN, M.A. Family planning in Nigeria. British Journal of Family Planning 9(4): 110-112, Jan. 1984.
242. PAKISTAN NATIONAL INSTITUTE OF POPULATION STUDIES (NIPS) and IRD/MACRO INTERNATIONAL. Pakistan Demographic and Health Survey 1990/91. Islamabad, Pakistan, and Columbia, Maryland, NIPS, and IRD, Jul. 1992. 291 p.
243. PAN AMERICAN HEALTH ORGANIZATION (PAHO). Health of women. [JENG, SPA] In: Health conditions in the Americas. (Vol. 1) Washington, D.C., PAHO, 1990. (Scientific Publication No. 524) [Extract of 24 p.]
244. PARIANI, S., HEER, D.M., and VAN ARSDOL, M.D., Jr. Does choice make a difference to contraceptive use? Evidence from East Java. Studies in Family Planning 22(6): 384-390, Nov.-Dec. 1991.
245. PARKER, R.A. Another point of view: A manual on gender analysis training for grassroots workers. New York, United Nations Development Fund for Women, 1993. 106 p.
246. PAYNE MERRITT, A. (Population Communication Services). [Peruvian television spots] Personal communication, Apr. 9, 1993.
247. PAYNE MERRITT, A. (Population Communication Services). [Research on attitudes towards contraceptive methods in Peru] Personal communication, Feb. 1, 1994.
248. PHILLIPS, J.F. and GREENE, W.L. Community based distribution of family planning in Africa: Lessons from operations research: Final report. New York, Population Council, Nov. 1993. 99 p.
249. PICK DE WEISS, S., ATKIN, L.C., GRIBBLE, J.N., and ANDRADE-PALOS, P. Sex, contraception, and pregnancy among adolescents in Mexico City. Studies in Family Planning 22(2): 74-82, Mar.-Apr. 1991.
250. PILLSBURY, B. The status of women and fertility: Program evaluation for the Rockefeller Foundation. Malibu, California, International Health and Development Associates, Aug. 1992. 33 p.
251. PIMENTEL, S. In Brazil: Women participate in crafting the new Constitution. In: Schuler, M.A., ed. Women, law and development—Action for change. Washington, D.C., OEF International, 1990. (Series on Women, Law, and Development: Issues and Strategies for Change No. 2) 43-52 p.
252. PIOTROW, P.T. The population explosion. In: World population crisis: the United States response. New York, Praeger, 1973. (Law and Population Book Series No. 4) p. 3-11.
253. PIOTROW, P.T. World population: The present and future crisis. New York, Foreign Policy Association, Oct. 1980. (Headline Series 251) 80 p.
254. PIOTROW, P.T., KINCAID, D.L., HINDIN, M.J., et al. Changing men's attitudes and behavior: The Zimbabwe Male Motivation Project. Studies in Family Planning 23(6, Pt. 1): 365-375, Nov.-Dec. 1992.
255. PIOTROW, P.T., TREIMAN, K.A., RIMON, J.G. 2nd, YUN, S.H., and LOZARE, B.V. Strategies for family planning promotion. Washington, D.C., World Bank, 1994. (World Bank Technical Paper No. 223) 58 p.
256. POPPE, P. (Population Communication Services). [Couples' communication about family planning in Chiapas, Mexico] Personal communication, Oct. 25, 1992.
257. POPULATION ACTION INTERNATIONAL (PAI). Closing the gender gap: Educating girls. 1993 report on progress towards world population stabilization. [Wall chart] Washington, D.C., PAI, 1993. 2 p.
258. POPULATION ACTION INTERNATIONAL (PAI). Expanding access to safe abortion: Key policy issues: Questions and answers. Washington, D.C., PAI, Sep. 1993. 9 p.
259. POPULATION COMMUNICATION SERVICES (PCS). Promoting professional providers: The PRO approach. (Packet 17) Baltimore, Johns Hopkins School of Public Health, Population Communication Services, 1993.
260. POPULATION REFERENCE BUREAU (PRB). Adolescent women in sub-Saharan Africa: A chartbook on marriage and childbearing. Washington, D.C., PRB, Mar. 1992. 25 p.
261. POPULATION REFERENCE BUREAU (PRB). Family planning saves lives. (2nd ed.) Washington, D.C., PRB, Sep. 1991. 22 p.
262. POTTER, S.H. and POTTER, J.M. China's peasants: The anthropology of a revolution. Cambridge, England, Cambridge University Press, 1990. 572 p.
263. POTTS, M. and DIGGORY, P. Textbook of contraceptive practice. 2nd ed. Cambridge, England, Cambridge University Press, 1983. 467 p.
264. PROFAMILIA. ASOCIACION PRO-BIENESTAR DE LA FAMILIA COLOMBIANA, and INSTITUTO FOR RECURSO DEVELOPMENT/MACRO INTERNATIONAL (IRD). Encuesta de Prevalencia, Demografía y Salud 1990. [Survey of prevalence, demography and health, 1990.] ISPA Bogota, Colombia, PROFAMILIA and IRD, Jun. 1991. 290 p.
265. RABAGO, A. Delivery of family planning services at the Mexican Social Security Institute (IMSS) on the basis of reproductive risk. In: Rooks, J. and Winikoff, B. A reassessment of the concept of reproductive risk in maternity care and family planning services. Proceedings of a seminar, Feb. 12-13, 1990. New York, Population Council, 1992. p. 100-116.
266. RAHMAN, M., AKBAR, J., PHILLIPS, J.F., and BECKER, S. Contraceptive use in Matlab, Bangladesh: The role of gender preference. Studies in Family Planning 23(4): 229-242, Jul.-Aug. 1992.
267. RAM, M. The importance of surviving sons in India: An analysis of the risk-fertility relationship. Presented at the annual meeting of the Population Association of America, Denver, Colorado, 1992. 45 p.
268. RAO, A., ANDERSON, M.B., OVERHOLT, C.A., eds. Gender analysis in development planning: A case book. West Hartford, Connecticut, Kumarian Press, 1991. 103 p.
269. RAVINDRAN, S. The untold story: How the health care system contributes to maternal mortality. In: Maternal mortality and morbidity: A call to women for action. Amsterdam and Santiago, Chile, Women's Global Network for Reproductive Rights, and Latin American and Caribbean Women's Health Network/Isis International, May 28, 1990. p. 11-14.
270. REED, J. Public policy on human reproduction and the historian. Journal of Social History 18(3): 383-398, Spring 1985.
271. REID, E. Placing women at the centre of the analyses. Presented at Canadian International Development Agency's Women and AIDS: Strategies for the Future, Quebec, Canada, Dec. 6, 1990. 10 p.
272. RENNE, E.P. Gender ideology and fertility strategies in an Ekiti Yoruba village. Studies in Family Planning 24(6, Pt. 1): 343-353, Nov.-Dec. 1993.
273. RENNE, E.P. The pregnancy that doesn't stay: the practice and perception of abortion by Ekiti Yoruba women. [To be published in Social Science and Medicine]
274. RINEHART, W., BLACKBURN, R., and MOORE, S.H. Employment-based family planning programs. Population Reports, Series J, No. 34. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Sep.-Oct. 1987. 32 p.
275. RINEHART, W., KOLS, A., and MOORE, S.H. Healthier mothers and children through family planning. Population Reports, Series J, No. 27. Baltimore, Johns Hopkins School of Public Health, Population Information Program, May-Jun. 1984. 40 p.
276. RINGHEIM, K. Factors that determine prevalence of use of contraceptive methods for men. Studies in Family Planning 24(2): 87-99, Mar.-Apr. 1993.
277. ROBEY, B., RUTSTEIN, S.O., MORRIS, L., and BLACKBURN, R. The reproductive revolution: New survey findings. Population Reports, Series M, No. 11. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Dec. 1992. 44 p.
278. ROCHA, L., GOMEZ, M.C., and ACOSTA, A. Consolidating income-generation projects for women in Colombia: The ICA, SENA and CDV cases. New York, United Nations Children's Fund, 1990. (UNICEF Staff Working Paper No. 6) 59 p.
279. ROGOW, D., BRUCE, J., and LEONARD, A. Man/hombre/homme: Meeting male reproductive health care needs in Latin America. Quality/Qualité 2: 1-24, 1990.
280. ROOKS, J. and WINIKOFF, B. A reassessment of the concept of reproductive risk in maternity care and family planning services. Proceedings of a seminar, Feb. 12-13, 1990. New York, Population Council, 1992. 185 p.
281. ROONEY, C. Antenatal care and maternal health: How effective is it? A review of the evidence. Geneva, World Health Organization, 1992. 75 p.
282. ROSE, K. Where women are leaders: The SEWA movement in India. London, Zed Books, 1992. 286 p.
283. ROSS, J.A., MAULDIN, W.P., GREEN, S.R., and COOKE, E.R. Family planning and child survival programs as assessed in 1991. New York, Population Council, 1992. 182 p.
284. ROYSTON, E. and ARMSTRONG, S., eds. Preventing maternal deaths. Geneva, World Health Organization, 1989. 233 p.
285. SABA, W. (Population Communication Services). [Bolivia National Reproductive Health Program] Personal communication, May 16, 1994.
286. SABA, W. (Population Communication Services). [Radio programs and health in Latin America] Personal communication, Apr. 14, 1993.
287. SADIK, N. The state of world population 1989. New York, United Nations Population Fund, 1989. 34 p.
288. SAI, F.T. and NASSIM, J. The need for a reproductive health approach. International Journal of Gynecology and Obstetrics 30(Suppl. 3): 103-113, 1989.
289. SALWAY, S. How attitudes toward family planning and discussion between wives and husbands affect contraceptive use in Ghana. International Family Planning Perspectives 20(2): 44-47, Jul. Jun. 1994.
290. SANGER, M. Margaret Sanger: An autobiography. New York, W.W. Norton,

1938. 504 p.
291. SAYED, H.A.-A., EL-ZANATY, F.H., and CROSS, A.R. Egypt male survey: 1991. Cairo, and Columbia, Maryland, Cairo Demographic Center, and Macro International Inc., Dec. 1992. 124 p.
292. SAYED, H.A.-A., OSMAN, M.L., EL-ZANATY, F., and WAY, A.A. Egypt Demographic and Health Survey 1988. Cairo, and Columbia, Maryland, Egypt National Population Council, and Institute for Resource Development/Macro Systems, Oct. 1989. 250 p.
293. SCHULER, S.R., and HASHEMI, S.M. Increasing use of contraception by decreasing women's dependence and isolation: Credit programs and family planning outreach in Bangladesh. Boston, John Snow, Apr. 18, 1994. (ISI Working Paper Series No. 7) 19 p.
294. SCHULER, S.R., MCINTOSH, E.N., GOLDSTEIN, M.C., and PANDE, B.R. Barriers to effective family planning in Nepal. *Studies in Family Planning* 16(5): 260-270. Sep.-Oct. 1985.
295. SHAHEED, F. The cultural articulation of patriarchy: Legal systems, Islam and women. *South Asia Bulletin* 6(1): 38-44. Spring 1986.
296. SHARMA, V. and SHARMA, A. Is the female child being neglected? Immunization in India. *Health Policy and Planning* 6(3): 287-290. Sep. 1991.
297. SHEDLIN, M.G. and HOLLERBACH, P.E. Modern and traditional fertility regulation in a Mexican community: The process of decision making. *Studies in Family Planning* 12(6-7): 278-296. Jun.-Jul. 1981.
298. SHEFNER, C. (Population Communication Services) (Haki Yako family planning promotion campaign in Kenya) Personal communication, Jul. 23, 1993.
299. SHELTON, J.D., ANGLE, M.A., and JACOBSTEIN, R.A. Medical barriers to access to family planning. *Lancet* 340(8831): 1334-1335. Nov. 28, 1992.
300. SHERRES, J.D., RAVENHOLT, B.B., BLACKBURN, R., GREENBERG, R.H., KAK, N., PORTER, R.W., 3rd, and SAUNDERS, S. Contraceptive social marketing: Lessons from experience. *Population Reports, Series J, No. 30*. Baltimore, Johns Hopkins School of Public Health, Population Information Program, Jul.-Aug. 1985. 40 p.
301. SIMMONS, R., KOENIG, M.A., and HUQUE, A.A.Z. Maternal-child health and family planning: User perspectives and service constraints in rural Bangladesh. *Studies in Family Planning* 21(4): 187-196. Jul.-Aug. 1990.
302. SIMMONS, R., MITA, R., and KOENIG, M.A. Employment in family planning and women's status in Bangladesh. *Studies in Family Planning* 23(2): 97-109. Mar.-Apr. 1992.
303. SINDING, S.W. Getting to replacement: Bridging the gap between individual rights and demographic goals. In: Senanayake, P. and Kleinman, R.L., eds. *Family planning: Meeting challenges: Promoting choices*. The proceedings of the IPPF Family Planning Congress, New Delhi, Oct. 1992. New York, Parthenon, 1993. p. 23-34.
304. SINGHAL, A. and ROGERS, E.M. Planned social change. In: Bettinghaus, E.P. and Cody, M., eds. *Persuasive communication*. 5th ed. New York, Holt, Rinehart and Winston, Oct. 6, 1994. 38 p.
305. SINGHAL, A. and ROGERS, E.M. Television soap operas for development in India. Presented at the International Communication Association Meeting, Montreal, Canada, May 21-25, 1987. 25 p.
306. SIVARD, R.L. *Women: A world survey*. Washington, D.C., World Priorities, 1985. 44 p.
307. STEWART, S. Working the system: Sensitizing the police to the plight of women in Zimbabwe. In: Schuler, M., ed. *Freedom from violence: Women's strategies from around the world*. New York, United Nations Development Fund for Women, 1992. p. 157-171.
308. SULLEROT, E. Fatherhood in crisis. *Entre Nous* 24: 4-5, Oct. 1993.
309. TANZANIA. MINISTRY OF HEALTH (TMOH). HEALTH EDUCATION DIVISION, and JOHNS HOPKINS UNIVERSITY SCHOOL OF PUBLIC HEALTH/POPULATION COMMUNICATION SERVICES (PCS). Attitudes and beliefs regarding child spacing: Focus group discussions with men and women from six regions of Tanzania. (IDAR-e-Salaam, Tanzania) and Baltimore, TMOH, and PCS, Dec. 1991.
310. TAUER, I.B. *The population of Japan*. Princeton, New Jersey, Princeton University Press, 1958. 461 p.
311. THADDEUS, S. and MAINE, D. Too far to walk: Maternal mortality in context. *Social Science and Medicine* 38(8): 1091-1110. 1994.
312. TINKER, A., KOBILINSKY, M.A., DALY, P., ROONEY, C., LEIGHTON, C., GRIFFITHS, M., HUQUE, A.A.Z., and KWAST, B. Making motherhood safe, Washington, D.C., World Bank, 1993. (World Bank Discussion Papers No. 202) 145 p.
313. TINKER, J. The adverse impact of development on women. In: Tinker, I. and Bransen, M.B., eds. *Women and world development*. Washington, D.C., Overseas Development Council, 1976. p. 22-34.
314. TIPPING, S. Creative approaches to encourage male responsibility and involvement in family planning. Presented at the 117th Annual Meeting of the American Public Health Association, Chicago, Oct. 22-26, 1989. 16 p.
315. TOMASEVSKI, K. *Women and human rights*. London, Zed Books, 1993. (Women and World Development Series) 162 p.
316. TORO, O.L. Commentary on women-centered reproductive health services. *International Journal of Gynecology and Obstetrics (Suppl. 3)*: 119-123. 1989.
317. TRAORE, B., KONATE, M., and STANTON, C. Enquête Démographique et de Santé au Mali 1987. (Demographic and Health Survey in Mali 1987) (FREI) Columbia, Maryland, Centre d'Etudes et de Recherches sur la Population pour le Développement, and Institute for Resource Development/Westinghouse, Jan. 1989. 187 p.
318. TRUSSELL, J. and PEBLEY, A.R. The potential impact of changes in fertility on infant, child, and maternal mortality. *Studies in Family Planning* 15(6): 267-280. Nov.-Dec. 1984.
319. TURKISH FAMILY HEALTH AND PLANNING FOUNDATION (TFHPF). Report of activities 1992-1993. Istanbul, TFHPF, 1993. 47 p.
320. TWEDDIE, I. (Population Communication Services). (The PRO approach in Kenya) Personal communication, Jun. 3, 1994.
321. UNITED NATIONS (UN). Draft final document of the conference: Draft programme of action of the Conference. Note by the Secretary-General. Geneva, UN, Feb. 18, 1994. 82 p.
322. UNITED NATIONS. A gender perspective on population issues: Discussion note. (Prepared for the Expert Group Meeting on Population and Women, Gaborone, Botswana, Jun. 22-26, 1992.) 8 p.
323. UNITED NATIONS. Proposed conceptual framework of the draft recommendations of the conference: Note by the Secretary-General of the conference. 1993. 19 p. (Unpublished)
324. UNITED NATIONS (UN). Results of the Sixth Population Inquiry Among Governments. New York, UN, 1990. (Population Policy Paper No. 31) 245 p.
325. UNITED NATIONS (UN). World population trends and policies: 1987 monitoring report. New York, UN, 1988. (Population Studies No. 103) 425 p.
326. UNITED NATIONS (UN). The world's women 1970-1990: Trends and statistics. New York, UN, 1991. (Social Statistics and Indicators Series K, No. 8) 120 p.
327. UNITED NATIONS (UN). CENTRE FOR ECONOMIC AND SOCIAL INFORMATION. Action taken at Bucharest. New York, UN, 1974. 63 p.
328. UNITED NATIONS CHILDREN'S FUND (UNICEF). An analysis of the situation of children in India. New York, UNICEF, 1984.
329. UNITED NATIONS CHILDREN'S FUND (UNICEF). Educating girls and women: A moral imperative. New York, UNICEF, Jan. 1992. 38 p.
330. UNITED NATIONS CHILDREN'S FUND (UNICEF). Sex differences in child survival and development. Amman, Jordan, UNICEF, Regional Office for the Middle East and North Africa, 1990. (Evaluation Series No. 6) p. 17.
331. UNITED NATIONS DEVELOPMENT PROGRAMME. Human development report 1993. New York, Oxford University Press, 1993. 230 p.
332. UNITED NATIONS DEVELOPMENT PROGRAMME (UNDP), and SINGH, N. Positively women: Focus: AIDS, 7, UNDP, [1992]. VHS NTSC, 28 min. (Video)
333. UNITED NATIONS ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC (ESCAP). Adolescent reproductive behaviour: Asian and Pacific region. *Population Research Leads*, No. 41. 10 p. 1992.
334. UNITED NATIONS ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC (ESCAP). Characteristics of the population under study. In: Husband and wife communication and practice of family planning. Bangkok, ESCAP, 1974. (Asian Population Studies Series, No. 16) p. 8-24.
335. UNITED NATIONS ECONOMIC AND SOCIAL COMMISSION FOR ASIA AND THE PACIFIC. Population growth and poverty alleviation: A survey of issues in an Asian and Pacific perspective. *Population Research Leads*, No. 40. 1992. 14 p.
336. UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION (UNESCO). PRINCIPAL REGIONAL OFFICE FOR ASIA AND THE PACIFIC. Integrating women's issues into population education (A handbook). Bangkok, UNESCO, 1992. 206 p.
337. UNITED NATIONS SECRETARIAT. Sex differentials in survivorship in the developing worlds: Levels, regional patterns and demographic determinants. *Population Bulletin of the United Nations* 25: 51-64. 1988.
338. UNITED NATIONS. POPULATION DIVISION. Patterns of sex differentials in mortality in less developed countries. In: Lopez, A.D. and Ruzicka, L.T., eds. *Sex differentials in mortality: Trends, determinants and consequences*. Canberra, Australia, Australian National University, Department of Demography, 1983. p. 7-32.
339. UNITED STATES. AGENCY FOR INTERNATIONAL DEVELOPMENT (US AID). Request for applications (RFA): Impact of family planning programs on women's lives. Washington, D.C., US AID, May 20, 1993. 53 p.
340. UNITED STATES. DEPARTMENT OF COMMERCE. BUREAU OF THE CENSUS (USBC). Gender and generation in the world's labor force. (Wall chart) Washington, D.C., USBC, [1994].
341. UNITED STATES (US). DEPARTMENT OF STATE. Country reports on human rights practices for 1993: Report submitted to the Committee on Foreign Affairs U.S. House of Representatives and the Committee on Foreign Relations U.S. Senate. Washington, D.C., US Government Printing Office, 1994. 1409 p.
342. VALENTE, T.W., KIM, Y.M., LETTENMAIER, C., GLASS, W., and DIBBA, Y. Radio and the promotion of family planning in the Gambia. (Draft) May 27, 1993. 33 p.
343. VALENTE, T.W., NICKERSON, L.D., MERIDA, M., COCA, M.E., SOLARES, L., and CABALLERO, R. First things first: The Bolivia National Reproductive Health Program print materials evaluation. Baltimore, Johns Hopkins School of Public Health, Population Communication Services, Jun. 1993. 22 p.
344. VERA, H. The client's view of high-quality care in Santiago, Chile. *Studies in Family Planning* 24(1): 40-49. Jan.-Feb. 1993.
345. VERNON, R., OJEDA, G., and MURAD, R. Incorporating AIDS prevention activities into a family planning organization in Colombia. *Studies in Family Planning* 21(6): 335-343. Nov.-Dec. 1990.
346. VIENNA INTERNATIONAL CENTRE (VIC). CENTRE FOR SOCIAL DEVELOPMENT AND HUMANITARIAN AFFAIRS. DIVISION FOR THE ADVANCEMENT OF WOMEN. Activities of national machinery. *Women 2000* (3): 1-22. 1989.
347. WALDRON, I. The role of genetic and biological factors in sex differentials in mortality. In: Lopez, A.D. and Ruzicka, L.T., eds. *Sex differentials in mortality: Trends, determinants and consequences*. Canberra, Australia, Australian National University, Department of Demography, 1983. (Department of Demography Miscellaneous Series No. 4) p. 141-164.
348. WARD, V.M., BERTRAND, J.T., and PUAC, F. Exploring sociocultural barriers to family planning among Mayans in Guatemala. *International Family Planning Perspectives* 18(2): 59-65. Jun. 1992.
349. WARE, H. Does development lead to greater equality of the sexes. Prepared for the Expert Group Meeting on Population and Women, Gaborone, Botswana, Jun. 22-26, 1992. 17 p.
350. WARREN, C.W., HIYARI, F., WINGO, P.A., ABDEL-AZIZ, A.M., and MORRIS, L. Fertility and family planning in Jordan: Results from the 1985 Jordan Husband's Fertility Survey. *Studies in Family Planning* 21(1): 33-39. Jan.-Feb. 1990.
351. WARREN, C.W., POWELL, D., MORRIS, L., JACKSON, J., and HAMILTON, P. Fertility and family planning among young adults in Jamaica. (Summary in FRES/PA) *International Family Planning Perspectives* 14(4): 137-141. Dec. 1988.
352. WEDEEN, L. and WEISS, E. Women's empowerment and reproductive health programs: An evaluation paradigm. Presented at the Annual Meeting of the Population Association of America, Cincinnati, Ohio, Mar. 30, 1993. 15 p.
353. WEN, X. The effect of sex preference on subsequent fertility in two provinces of China. *Asia-Pacific Population Journal* 7(4): 25-40. Dec. 1992.
354. WESTOFF, C.F. Reproductive preferences: A comparative view. Columbia, Maryland, Institute for Resource Development, Feb. 1991. (DHS Comparative Studies No. 3) 27 p.
355. WESTOFF, C.F. The potential demand for family planning: A new measure of unmet need and estimates for 17 Latin American countries. *International Family Planning Perspectives* 14(2): 45-53. Jun. 1988.
356. WESTOFF, C.F., BLANC, A.K., and NYBLADE, L. Marriage and entry into parenthood. *Calverton, Maryland, Macro International Inc., Mar. 1994. (Demographic and Health Surveys Comparative Studies No. 10) 42 p.*
357. WESTOFF, C.F. and OCHOA, L.H. Unmet need and the demand for family planning. Columbia, Maryland, Institute for Resource Development, Jul. 1991. (DHS Comparative Studies No. 5) 37 p.
358. WESTOFF, C.F. and RODRIGUEZ, G. The mass media and family planning in Kenya. Columbia, Maryland, Macro International, Aug. 1993. (DHS Working Papers No. 4) 32 p.
359. WILLIAMS, L.B. Development, demography, and family decision-making: The status of women in rural Java. Boulder, Colorado, Westview Press, 1990. (Brown University Studies in Population and Development) 157 p.
360. WILLIAMSON, N. (Family Health International) (Activities of the Women's Studies Projects) Personal communication, May 12, 1994.
361. WILSON, A. Prepared remarks. Presented at the International Planned Parenthood Federation Conference on Unsafe Abortion and Post Abortion Family Planning in Africa, Mauritius, Mar. 24-29, 1994. 2 p.
362. WINIKOFF, B. Women's health: An alternative perspective for choosing interventions. *Studies in Family Planning* 19(4): 197-214. Jul.-Aug. 1988.
363. WINIKOFF, B. and SULLIVAN, M. Assessing the role of family planning in reducing maternal mortality. *Studies in Family Planning* 18(3): 128-143. May-Jun. 1987.
364. WINN, M. Taboo talk: Reproductive health videos by Pacific Island women. In: *Population Council*. By and for women: Involving women in the development of reproductive health care materials. (Summaries in FRE, SPA) Quality/Calidad/Qualité No. 4. New York, PC, 1992. p. 19-22.
365. WIRTH, T.E. Population and Development: Toward consensus and action. Presented at the 1994 Meeting of the United States Agency for International Development Office of Population Cooperating Agencies, Washington, D.C., Feb. 22-25, 1994. 8 p.
366. WIRTH, T.E. Statement by the Honorable Timothy E. Wirth, United States Representative to the Second Preparatory Committee for the International Conference on Population and Development, at the preparatory meeting, May 11, 1993. (Press Release) New York, United States Mission to the United Nations, May 11, 1993. 5 p.
367. WORLD BANK. World development report 1993: Investing in health. Oxford, Oxford University Press, 1993. 329 p.
368. WORLD HEALTH ORGANIZATION (WHO). Abortion: A tabulation of available data on the frequency and mortality of unsafe abortion. Geneva, WHO, 1990. 115 p.
369. WORLD HEALTH ORGANIZATION (WHO). Maternal mortality ratios and rates: A tabulation of available information. 3rd ed. Geneva, WHO, 1991. 100 p.
370. WORLD HEALTH ORGANIZATION (WHO). Prevention of maternal mortality. Report of a WHO Interregional Meeting, Geneva, 11-15 Nov. 1985. Geneva, WHO, 1986. 23 p. (Mimeo)
371. WORLD HEALTH ORGANIZATION (WHO). The prevalence of anaemia in women: A tabulation of available information. 2nd ed. Geneva, WHO, 1992. 100 p.
372. WORLD HEALTH ORGANIZATION (WHO). The prevention and management of unsafe abortion: Report of a Technical Working Group, Geneva, 12-15 Apr. 1992. Geneva, WHO, 1993. 23 p.
373. WORLD HEALTH ORGANIZATION (WHO). The status of women, maternal health and maternal mortality. 1987. 21 p. (Unpublished)
374. WORLD HEALTH ORGANIZATION (WHO). Women's health: Across age and frontier. Geneva, WHO, 1992. 107 p.
375. WORLD HEALTH ORGANIZATION (WHO). SPECIAL PROGRAMME OF RESEARCH, DEVELOPMENT AND RESEARCH TRAINING IN HUMAN REPRODUCTION, and INTERNATIONAL WOMEN'S HEALTH COALITION. Creating common ground: Women's perspectives on the selection and introduction of fertility regulation technologies. Report of a meeting between women's health advocates and scientists, Geneva, 20-22 Feb. 1991. Geneva, WHO, 1991. 45 p.
376. WUEST, J. Institutionalizing women's oppression: The inherent risk in health policy that fosters community participation. *Health Care for Women International* 14(5): 407-417. Sep.-Oct. 1993.
377. YASER, Y. Turkey: Extensive advertising. *Integration*, Dec. 1993. p. 32.
378. YUNES, J. PAHO's perspective on the Latin American experience. In: Rooks, J. and Winkoff, B. A reassessment of the concept of reproductive risk in maternity care and family planning services. Proceedings of a seminar, Feb. 12-13, 1990. New York, Population Council, 1992. p. 116-137.
379. ZABIN, L.S., HIRSCH, M.B., SMITH, E.A., STREET, R., and HARDY, J.B. Evaluation of a pregnancy prevention program for urban teenagers. *Family Planning Perspectives* 18(3): 119-126. May-Jun. 1986.
380. ZAHN, C.A. and ROYSTON, E. Maternal mortality: A global factbook. Geneva, World Health Organization, 1991. 606 p.
381. ZEIDENSTEIN, G. Getting family planning programs right. (Transcript of speech to IPPF Family Planning Congress) Oct. 24, 1992. 8 p. (Unpublished)
382. ZENG, Y., TU, P., GU, B., XU, Y., LI, B., and LI, Y. Causes and implications of the recent increase in the reported sex ratio at birth in China. *Population and Development Review* 19(2): 283-302. Jun. 1993.
383. ZHU, H., ed. Sex ratio of China's population deserves attention. *China Population Today* 9(6): 3-5. Dec. 1992.
384. ZOU'BI, A.A.A., POEDJASTOETI, S., and AYAD, M. Jordan population and family health survey 1990. Amman, Jordan, and Columbia, Maryland, Ministry of Health, Department of Statistics, and IRD/Macro International, Aug. 1992. 205 p.

ADDENDA

385. BULATAO, R.A., LEVIN, A., BOS, E.R., and GREEN, C. Effective family planning programs. Washington, D.C., World Bank, 1993. 110 p.
386. KAPADIA-KUNDU, N. (JHSPH). [Programs for rural women.] Personal communication, Nov. 10, 1992.
387. UNDERWOOD, C., KEMPRECOS, L.F., IABRE, B., and WAFAL, M. *And the Nile Flows On*. [Arabic] Egypt State Information Service (SIS), IEC Center, producer. Cairo, SIS, 1992. VHS/PAL, 17 episodes, 698 min. total. *Consequences*. IENG, FRE, Ndebele, Portuguese, Setswana, Shona, Swahili (Development Through Self-Reliance (DSR), producer.) Columbia, Maryland, DSR, 1988. VHS, 16 mm, 3/4" PAL, 54 min.
388. DANGEROUS NUMBERS. Marshall, B. (Chana Ministry of Health/Health Education Division (GMH/HED), National Film and Television Institute, Population Communication Services, producers; Marshall, B., writer.) Accra, Chana, GMH/HED, 1991. 3/4" PAL-HI, 47 min.
389. *Beit A'eyla*. [The Family House.] [Arabic] (Center for Development Communication (CDC), producer.) Mohandissien, Giza, Egypt, CDC, 1992. VHS/PAL, 5 episodes, 45 min. each.
390. *Entre Nosotros*. (SPA) (Planificación Familiar de Ecuador, producer.) 1993. 40 min. [radio program]
391. *Hum Log*. [We, the People.] [Hindi] (Doctor, S., producer; Joshi, S., writer.) 1984-85. 139 episodes, 35 min. each.
392. *Hum Rahi*. [We, the Travelling Companions.] [Hindi] (Roger Pereira Associates (RPA), producer; Joshi, S., writer.) Bombay, RPA, 1992-1993. 96 episodes, 35 min. each.
393. *Jiggasha: A Community Network Approach to Family Planning*. Groff, C. (Groff, C. and Center for Communication Programs (CCP), producers.) Baltimore, Maryland, CCP, 1993. VHS-PAL, 29 min.
394. *Kamala and Raji*. Camerini, M. (Michael Camerini, Inc., producer.) New York, Michael Camerini, Inc., 1990. VHS/NTSC, 46 min.
395. *Las Buenas Costumbres: Va de Nuez*. [Police Story: Let's Try It Again.] (SPA, subtitles in ENG) (Desarrollo e Investigación de la Planificación Familiar (DIPIAF and Telerey, producers.) Mexico, D.F., Telerey, 3/4" PAL, 30 min.
396. *Las Tromes*. (SPA, subtitles in ENG) (Ministerio de Salud de Peru, IPSS, and APROPO, producers.) 1993. VHS-NTSC BetacamSP, 1 min., 30 sec.
397. *Los Mejores Deseos—Best Wishes*. (JENG and SPA) Carrera, C. (JOICFP and MEXFAM, producers) Tlalpan, Mexico, MEXFAM, 1992. 16 mm, NTSC, Beta, 14 min.
398. *Neria*. (JENG, PORT, Swahili) (Media for Development Trust (MDR), producer; John Riber, director.) Harare, MDR, 16 mm and 35 mm, VHS, NTSC, and PAL, 103 min.
399. *Nijaat*. [Deliverance.] [Urdu] Kazmi, S. (Kazmi, S. and Pakistan Television Corporation (PTC), producers; Sayed, A.N., writer.) Islamabad, PTC, 1993. 3/4" PAL, 7 episodes, 336 min. total.
400. *Umüt Hep Vardı*. [Hope was always there.] [Turkish, subtitles in ENG] Olçak, B. (Yaser, G.G., producer; Olçak, B., writer; Andak, S., music.) Istanbul, Turkey, and Baltimore, Maryland, Türkiye Aile Sağlığı Ve Planlaması Varlığı and Population Communication Services, 1991. 3/4" PAL, 55 min.
401. *Women Speak Out In East Africa*. Willis, D. (United Nations Population and Development Fund (UNFPA) and Willis, D., producers; Willis, D. writer.) New York, UNFPA, 1989. VHS-NTSC, 12 min.

VIDEO BIBLIOGRAPHY

- Aahat. [An Approaching Sound.] [Urdu] Kazmi, S. Islamabad, Pakistan Television Corporation (PTC), 1991. 3/4" PAL-HI, 6 segments, 293 min. total.
- And the Nile Flows On. [Arabic] Egypt State Information Service (SIS), IEC Center, producer. Cairo, SIS, 1992. VHS/PAL, 17 episodes, 698 min. total.
- Consequences. IENG, FRE, Ndebele, Portuguese, Setswana, Shona, Swahili (Development Through Self-Reliance (DSR), producer.) Columbia, Maryland, DSR, 1988. VHS, 16 mm, 3/4" PAL, 54 min.
- Dangerous Numbers. Marshall, B. (Chana Ministry of Health/Health Education Division (GMH/HED), National Film and Television Institute, Population Communication Services, producers; Marshall, B., writer.) Accra, Chana, GMH/HED, 1991. 3/4" PAL-HI, 47 min.
- Beit A'eyla. [The Family House.] [Arabic] (Center for Development Communication (CDC), producer.) Mohandissien, Giza, Egypt, CDC, 1992. VHS/PAL, 5 episodes, 45 min. each.
- Entre Nosotros. (SPA) (Planificación Familiar de Ecuador, producer.) 1993. 40 min. [radio program]
- Hum Log. [We, the People.] [Hindi] (Doctor, S., producer; Joshi, S., writer.) 1984-85. 139 episodes, 35 min. each.
- Hum Rahi. [We, the Travelling Companions.] [Hindi] (Roger Pereira Associates (RPA), producer; Joshi, S., writer.) Bombay, RPA, 1992-1993. 96 episodes, 35 min. each.
- Jiggasha: A Community Network Approach to Family Planning. Groff, C. (Groff, C. and Center for Communication Programs (CCP), producers.) Baltimore, Maryland, CCP, 1993. VHS-PAL, 29 min.
- Kamala and Raji. Camerini, M. (Michael Camerini, Inc., producer.) New York, Michael Camerini, Inc., 1990. VHS/NTSC, 46 min.
- Las Buenas Costumbres: Va de Nuez. [Police Story: Let's Try It Again.] (SPA, subtitles in ENG) (Desarrollo e Investigación de la Planificación Familiar (DIPIAF and Telerey, producers.) Mexico, D.F., Telerey, 3/4" PAL, 30 min.
- Las Tromes. (SPA, subtitles in ENG) (Ministerio de Salud de Peru, IPSS, and APROPO, producers.) 1993. VHS-NTSC BetacamSP, 1 min., 30 sec.
- Los Mejores Deseos—Best Wishes. (JENG and SPA) Carrera, C. (JOICFP and MEXFAM, producers) Tlalpan, Mexico, MEXFAM, 1992. 16 mm, NTSC, Beta, 14 min.
- Neria. (JENG, PORT, Swahili) (Media for Development Trust (MDR), producer; John Riber, director.) Harare, MDR, 16 mm and 35 mm, VHS, NTSC, and PAL, 103 min.
- Nijaat. [Deliverance.] [Urdu] Kazmi, S. (Kazmi, S. and Pakistan Television Corporation (PTC), producers; Sayed, A.N., writer.) Islamabad, PTC, 1993. 3/4" PAL, 7 episodes, 336 min. total.
- Umüt Hep Vardı. [Hope was always there.] [Turkish, subtitles in ENG] Olçak, B. (Yaser, G.G., producer; Olçak, B., writer; Andak, S., music.) Istanbul, Turkey, and Baltimore, Maryland, Türkiye Aile Sağlığı Ve Planlaması Varlığı and Population Communication Services, 1991. 3/4" PAL, 55 min.
- Women Speak Out In East Africa. Willis, D. (United Nations Population and Development Fund (UNFPA) and Willis, D., producers; Willis, D. writer.) New York, UNFPA, 1989. VHS-NTSC, 12 min.

ISSN 0887-0241

POPULATION REPORTS

Population Reports are free in any quantity to developing countries. In USA and other developed countries, multiple copies are \$2.00 each; full set of reports in print, \$35.00; with binder, \$40.00. Send payment in US\$ with order. **Population Reports** in print in English are listed below. Many are also available in Arabic, French, Portuguese, and Spanish, as indicated by abbreviations after each title on the order form below.

POPLINE

POPLINE is a comprehensive guide to family planning and population information—a computerized collection of over 200,000 citations with abstracts. Searches of **POPLINE** are **free of charge to developing countries**. You may use the form below to request a search. In the United States users can subscribe to **POPLINE** through the National Library of Medicine, Bethesda, MD 20209. In other developed countries searches can be obtained through MEDLARS search centers or from the Population Information Program for a fee. **POPLINE** is now available on **compact disc**, making the entire database accessible with a microcomputer. Write for details.

POPLINE production is funded primarily by the United States Agency for International Development. The compact disc version of **POPLINE** is funded by the Interregional Branch of the United Nations Population Fund.

TO ORDER POPULATION REPORTS OR TO REQUEST A POPLINE SEARCH, please complete the form below. (PRINT or TYPE clearly.) Mail to:

**Population Information Program, The Johns Hopkins School of Public Health
111 Market Place, Suite 310, Baltimore, MD 21202, USA Fax: (410) 659-6266**

Family name _____ Given name _____
Organization _____
Address _____

Population Reports in Print

- Send ___ copies of each future issue of **Population Reports**.
 I am already on the **Population Reports** mailing list.
 Please send me a binder (in developed countries, US\$7.00 for binder only).
- Language: English French Portuguese Russian Spanish.
- Check () the issues you want:
ORAL CONTRACEPTIVES—Series A
___ A-7 Lower-Dose Pills [1989] (F,R,S)
___ A-8 Counseling Clients About the Pill [1990] (F,S)
STERILIZATION, FEMALE—Series C
___ C-9 Minilaparotomy and Laparoscopy: Safe, Effective, and Widely Used [1985] (P)
___ C-10 Voluntary Female Sterilization: Number One and Growing [1991] (F,S)
STERILIZATION, MALE—Series D
___ D-5 Vasectomy: New Opportunities [1992] (F,S)
___ D-5 Quick Guide to Vasectomy Counseling [1992] (F,S)
LAW AND POLICY—Series E
___ E-6 Legal Trends and Issues in Voluntary Sterilization [1981] (P)
BARRIER METHODS—Series H
___ H-8 Condoms—Now More Than Ever [1991] (F,S)
FAMILY PLANNING PROGRAMS—Series J
___ J-23 Films for Family Planning Programs [1981] (F,P)
___ J-33 Men: New Focus for Family Planning Programs [1986] (P,S)
___ J-35 Counseling Makes a Difference [1987] (F,P,S)
___ J-36 Counseling Guide [1987] (F,P,R,S)
___ J-38 Lights! Camera! Action! [1990] (F,S)
___ J-38 Poster: Entertainment Educates! [1990]
___ J-39 Paying for Family Planning [1991] (F,S)
___ J-40 Making Programs Work [1994]
___ J-40 Poster: Family Planning Helps Everyone [1994]
INJECTABLES AND IMPLANTS—Series K
___ K-4 Decisions for Norplant Programs [1992]
___ K-4 Guide to Norplant Counseling [1992]
___ K-4 Norplant at a Glance [1992]
ISSUES IN WORLD HEALTH—Series L
___ L-7 Mothers' Lives Matter: Maternal Health in the Community [1989] (F,P,S)
___ L-8 AIDS Education—A Beginning [1989] (F,P,S)
___ L-9 Controlling Sexually Transmitted Diseases [1993]
___ L-9 Wall Chart: STDs—Diagnosis, Treatment, Follow Up [1993]
SPECIAL TOPICS—Series M
___ M-5 Contraceptive Prevalence Surveys: A New Source of Family Planning Data [1981] (F,P)
___ M-6 Population Education in the Schools [1982] (P)
___ M-10 The Environment and Population Growth: Decade for Action [1992] (S)
___ M-10 Poster: The Environment & Population Growth [1992] (F,S)
___ M-10 Wall Chart: Environment and Population [1992] (S)
___ M-11 The Reproductive Revolution: New Survey Findings [1992]
___ M-12 Opportunities for Women Through Reproductive Choice [1994]

POPLINE Search Request

Subject: _____

Purpose: _____

