How far have we come toward ICPD goals?

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I. Introduction

The Programme of Action (PoA) adopted in 1994 at the International Conference on Population and Development (ICPD) called for a comprehensive approach in achieving universal access to a package of basic reproductive health services by 2015, in the context of a particular focus on women and the interrelationship between population and sustainable development. The PoA's recognition of the role that gender relations plays in sustainable development and effective reproductive health programming was a major accomplishment. By adopting a comprehensive approach, the PoA resulted in the need for a broader monitoring framework that should include more qualitative measures of women's empowerment in addition to quantitative ones.

Reaching the goals set at ICPD required changes in government policies and additional financial resources, calling for commitments from both developed and developing country governments. Providing these actors with an understanding of how certain political changes can yield specific outcomes enables them to enact policies that will address the goals laid out by ICPD. However, the PoA did not render the group of indicators within its comprehensive approach into a manageable set that policymakers can use in policy-setting, resource allocation and monitoring progress. It did not clearly propose a core set of measurable indicators for monitoring and evaluation purposes.[1]

For the tenth anniversary of ICPD, Population Action International – working in collaboration with an expert advisory groupa and core partners Family Care International and the International Planned Parenthood Federation -- attempted to gauge country-level reproductive health status by combining the range of indicators into one single measure. We created a composite index based on indicators of reproductive health and gender equality. The selected indicators reflect priorities set by the PoA and data availability.

This paper discusses national level reproductive health status and progress made over the past decade. It also discusses the data issues and measurement challenges we encountered in our analysis. In the ten years that have passed since ICPD success has been made, but much remains to be done.

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II. Measuring current status and progress in reproductive health

As an independent policy advocacy group working to strengthen policies and strategies that advance universal access to reproductive health services and to educational and economic opportunities, especially for girls and women, PAI has policymakers and those who influence them as its key target audiences. To reach them, PAI attempts to bridge the research and policymaking communities. To that end, it aims to communicate research findings in clear and concise formats. With these target audiences in mind, our analysis of country-level status and progress in reproductive health was based on rendering the group of ICPD indicators into one measure that would be useful for policymakers.

A. Methodology

Status of national reproductive health

The first part of the analysis measures the current reproductive health status of 133 countries with a population of one million or greater. We constructed a composite index, the Reproductive Risk Index (RRI), based on 13 indicators of reproductive health and socio-economic development.[b] The 13 indicators composing the RRI are: share of women in non-agricultural wage employment, male secondary gross enrolment ratio, female secondary gross enrolment ratio, percent of parliamentary seats held by women, maternal mortality ratio, percent of births attended by skilled personnel, restrictiveness of abortion policy, infant mortality rate, contraceptive prevalence, unmet need for contraception, adolescent fertility, HIV/AIDS prevalence among males 15-24 years old, and HIV/AIDS prevalence among females 15-24 years old. The choice of indicators was partly determined by the availability of comparative datasets on overlapping ICPD+5 targets and Millenium Development Goals (MDGs). All countries included had data for at least eight indicators. Nineteen countries were not included in the study for lack of data for five or more of the indicators included.[c] The report used the most recent, reliable and consistent national-level data available at the time of research (June 2004).

For seven of the indicators, the observed range was transformed into a range of 0 (best) to 100 (worst). Each country was located in the new range; the country at the top of the range (non-desirable outcome/higher reproductive risk) had a score of 100 and the country at the bottom (desirable outcome/lower reproductive risk) had a score of zero. For the remaining six indicators,[d] scores were assigned as shown in the Annex; actual data were not used due to the possible lack of uniformity and consistency in reporting.

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[b] Primary sources for the report were the World Health Organization (WHO) and other United Nations agencies' databases, Demographic and Health Surveys (DHS) conducted by Macro International for U.S. Agency for International Development, and Reproductive and Health Surveys conducted by the United States Centers for Disease Control and Prevention (CDC).

[c] These countries are Afghanistan, Bhutan, Bosnia/Herzegovina, North Korea, Democratic Republic of the Congo, Denmark, Hong Kong, Iraq, Ireland, Israel, Liberia, Libya, Myanmar, Occupied Palestinian Territory, Oman, Puerto Rico, Somalia, Venezuela, and Yemen.

[d] Share of women in non-agricultural wage employment, abortion policy, maternal mortality ratio, infant mortality rate, and HIV/AIDS prevalence among girls or boy 15-24.

For the construction of the RRI, equal weights were given to all 13 indicators. The final composite index score was derived by dividing the sum of the seven scaled indicators and the six assigned scores by 13. Countries were ranked based on each country's RRI.[e] Countries were finally grouped into five quintiles as follows: Highest Risk, Elevated Risk, Moderate Risk, Reduced Risk and Lowest Risk.

Progress in national reproductive health over past decade

The second portion of the report ranks 62 developed and developing countries with a population of one million or greater on the progress over the period preceding and following ICPD in 1994. Seven reproductive health and socio-economic indicators were used to measure progress over the past decade.[f] The selection of these indicators was determined chiefly by the availability of time-series data for each. All countries included have time-series data for at least six of the seven indicators. The earlier data point used to measure pre-ICPD status is from the late 1980's through 1994, and the later point charts activity post-1994. A range of at least five years was required in order to measure progress. Ninety countries with a population of one million or greater were not included in this section of the report for lack of data for 4 or more of the indicators included. Time-series data on contraceptive prevalence, births attended by skilled personnel and unmet need for family planning are lacking for almost all 90 countries. For each indicator, the annual percent change was calculated. The average of the percent annual changes for the seven indicators was then taken. Equal weight was given to all indicators. Countries were ranked based on average annual percent change (see Annex).

B. Findings

Status of national reproductive health

In measuring current reproductive health status, we found that countries in the first quintile -- Highest Risk -- share the same risk factors. Likewise, countries falling in the last quintile -- Lowest Risk -- share the same risk factors as the first quintile but in the opposite direction. However, risk factors varied more widely among countries in the other three quintiles.

All 27 countries in the high risk category have low incomes; all but Haiti – the poorest country in Latin America and the Caribbean – are in sub-Saharan Africa. Early fertility and limited skilled care during pregnancy and childbirth contribute to high levels of maternal mortality. Contraceptive use is generally low and there is very high unmet need for contraception; at 40%, Haiti has the highest unmet need for family planning in the world. Data on the share of women in non-agricultural wage employment and on school

[e] The RRI has a minimum and maximum values of the RRO for a country are 1.9 and 96.5 respectively because scores assigned to some indicators are greater than zero or less than 100.

[f] The seven indicators used to measure progress are: female secondary gross enrolment ratio, ratio of female secondary gross enrolment ratio to male secondary enrolment ratio, percent of births attended by skilled personnel, infant mortality rate, contraceptive prevalence, total unmet need for family planning, and adolescent fertility. The choice of indicators is determined by the availability of time-series and global comparative datasets on overlapping ICPD+5 goals and MDGs.

enrolment of boys and girls at the secondary level is unavailable for most countries; but where available, data show low levels for both indicators and higher levels of enrolment among boys than girls. With few exceptions, safe and legal abortion is all but unavailable. Average fertility rates among adolescent girls are high. Levels of HIV infection are significant, and for all countries in this category girls have higher levels of HIV infection than boys, especially where infection rates are highest.

By contrast, all 26 countries in the lowest risk category have high incomes, including all Nordic countries and Western Europe, Japan and the industrialized countries of Northern America and Oceania, and many countries in Southern, Eastern and Northern Europe. Cuba is the only country in the developing world in this category. In almost all countries the share of women in non-agricultural wage employment is at least 40 percent. Secondary school enrolment is almost universal, and is higher among girls than boys. The proportion of seats in parliament held by women ranges from 10 percent in Greece, Japan and Lithuania to 45 percent in Sweden; in Nordic countries, around two-fifths of seats in the parliament are held by women. Infant mortality is rare. Motherhood is safe; skilled care at childbirth is universal and the risk of death from pregnancy or delivery is extremely low. Abortion is available on request in nearly all countries in this category (except in Portugal, Spain and New Zealand). Contraceptive use is high; data on unmet need for family planning is unavailable for fully 24 of the 25 countries. Adolescent fertility and HIV prevalence are generally low in this category.

Two similar country-level reproductive risk assessments PAI conducted in 1995 and 2001[2,3] show a similar clustering of countries for the snapshot of the current reproductive health status, especially for high and low reproductive risk categories. Obviously, despite some progress in improving access to health services, many countries still face major hurdles in achieving the ICPD agenda.

Progress in national reproductive health over past decade

Of the 62 countries for which measuring progress was possible, 23 nations -- including Thailand, Mexico, and the southern Asian countries of Bangladesh, India and Nepal -- stood out as having achieved significant progress in the past 10 years. Malawi ranked as a leader in its strong efforts in expanding access to education; though far from universal, school enrolment rose significantly from very low levels. Moderate progress was made by 22 countries specifically by Madagascar and Kenya which have both seen an increase in use of contraceptives and a decrease in unmet need for family planning. Fifteen countries showed little or no progress. For the most part, these were wealthy countries, such as the US, Japan, Kuwait and Botswana, that had already achieved progress on most indicators. Only two countries, Burkina Faso and Cameroon, charted a decline in meeting the objectives outlined by ICPD.

III. Discussion

For this discussion, we grouped the indicators used in the assessment into three types of indicators: gender equality, access to services, and health outcomes. This assessment of

reproductive risk differs from the two previous ones, we conduced in 1995 and 2001 and mentioned above, in that it included measures of gender inequality.

A. Gender equality

The Programme of Action included new gender-based goals within a comprehensive women-centered framework. Countries were encouraged to develop mechanisms for increasing women's participation in the government, promote education for girls, and increase employment opportunities for women, among other actions. In the 10 years that have passed, countries have made some progress in closing the gender gap. The five measures we included on gender equality in development were the following: (1) Share of women in non-agricultural wage employment, (2) Secondary gross enrolment rate among boys, (3) Secondary gross enrolment rate among girls, (4) Seats in parliament held by women, and (5) Women who report ever having experienced physical violence by a male spouse/partner.

Share of women in non-agricultural wage employment

Non-agricultural employment is an area of expanding employment and is somewhat an indication of equal access to the rewards of labour force participation. It tends to put money directly into the hands of women and the pay is likely to be higher than the pay for self-employment. Data on female share of non-agricultural wage employment, however, is relatively scarce and often out of date, especially for sub-Saharan Africa, South Asia and for countries experiencing violent conflict. In the past decade, only about half of the countries for which data are available have seen increases in the female share of non-agricultural employment, while some countries in Central Europe and sub-Saharan Africa have seen a decline. Today, women claim the highest shares of non-agricultural work in industrialized countries and in Eastern Europe. Countries in sub-Saharan Africa and in the Middle East, North Africa and Central Asia have the lowest share. However, in most countries of Latin America and Asia, more than half of the female non-agricultural workforce is in the informal sector, therefore lacking adequate earning and social protection.[4]

Statistics on female participation in the labour force do not reveal information on such issues as equality in income, women's unemployment rates, level of earnings, types of jobs (full time or part time, seasonal or permanent), or security of employment. Thus while women's participation may equal or in some cases exceed that of men's, their actual share in the formal monetary workforce may be limited and may not be an indication of equal access to the rewards of labour force participation. Furthermore, women who do earn wages in the formal sector may not have control over their salaries due to gender inequality in the home.[5]

Secondary school enrolment

There has been some significant progress since 1994 in achieving gender parity in school enrolment at the secondary level in all regions. Latin American countries have had much success in closing the gender gap. However, despite internationally established goals for gender equality in education, like those established in 2000 at the World Education

Forum in Senegal,[6] large gaps in enrolment ratios remain prevalent in Western Africa and South-eastern Asia. Females are at the greatest disadvantage compared to males in Togo, Cambodia and Cote d'Ivoire, where less than 60 percent of the same number of males are enrolled in secondary education. Of the estimated 104 million children who began the third millennium out of school, 57 percent were girls. Multiple factors constrain countries from improving their male to female secondary enrolment ratios, among them primary school completion rates, cultural practices, armed conflicts, poverty, conservative educational systems, and high rates of gender-based violence within schools.[7]

In some countries, education may be equally accessible to some males and females, but still largely unavailable to most. For example, Rwanda has achieved gender parity, but at a 14 percent enrolment rate. Moreover, gender parity in education does not necessarily reflect training in access to equal opportunities for women within society. Oftentimes, families send their daughters to schools where the quality of teaching does not necessarily help women achieve equal opportunities within society.

Seats in parliament held by women

With regard to women's equality in the public sphere, most countries now allow women to vote and be elected to national office, but few have succeeded in truly enabling women to exercise these rights.[8] The level of participation of women in political life is better now than it was a decade ago. In about 80 percent of countries for which data is available, the share of parliamentary seats held by women has increased.[9] However, women remain largely absent from these decision-making bodies; globally, in 2003, only one in seven national level parliamentary seats were held by women. The Nordic countries have the highest rates of female participation with percentages ranging from 36 to 45. Africa and Western and South-central Asia have the lowest rates. It should be noted that the ratio of women to men in governing bodies is not always linked with their autonomy and equal status at the level of the household or community.

Women who report ever having experienced physical violence

If female empowerment is "the capacity of individual women or of women as a group to resist the arbitrary imposition of controls on their behaviour or the denial of their rights, to challenge the power of others if it is deemed illegitimate, and to resolve a situation in their favour," then freedom from domestic violence is directly related to women's empowerment.[10] Because data on this indicator are scant, we conducted a global survey to collect any and all national and regional data sources for estimates of violence against women. Networks of in-country experts on women's issues were asked to report national-level survey data on four measures.[g] The respondents were requested to provide the name of the study and its publishing organization, the age and size of its sample, its year of publication, and the definition of violence used in the study.

[g] The four measures are : (1) percent of women age 15-49 who report having experienced physical violence by a male spouse or partner (ever/in the past 12 months/in current relationship); (2) percent of women 15-49 who report having experienced sexual violence, including rape, by a male spouse or partner (ever/in the past 12 months/in current relationship); (3) percent of women 15-49 who report having experienced physical violence by anyone (ever/in the past 12 months/in current relationship); (4) and percent of women 15-49 who report having experienced sexual violence, including rape, by anyone (ever/in the past 12 months/in current relationship).

The measure for which there was the greatest amount of data was the percent of women who report ever experiencing physical abuse by a spouse or partner; we found that national level data on domestic violence was only available for ten countries and are equally scarce for other measures of gender-based violence. Where data are available studies lacked consistency; studies varied in sample size, definition of violence, and in the age of women surveyed. Data collection must be strengthened and made more uniform in order for this indicator to be accurately measured. The World Health Organization's *Multi-country Study on Women's Health and Domestic Violence Against Women* should address some of these problems.[11]

B. Access to services

Increasing women's access to life-saving reproductive health care and services is a key objective of the ICPD PoA. Among these are the availability of contraceptives and skilled care at delivery. The five indicators we included on this are (1) Births attended by skilled personnel, (2) Abortion policies, (3) Post-abortion care, (4) Currently married women using any method of contraception, and (5) Currently married women having unmet need for family planning. The indicator on access to post-abortion care was not included in the Index because of the lack of data on it for most countries. The inclusion of an indicator on emergency obstetric care was also not possible due to a lack of data.

Births attended by skilled personnel

In the least developed countries of the world, only about 32 percent of births are attended by skilled personnel.[12] In Ethiopia, less than 10 percent of women receive trained care during childbirth. Except for Sri Lanka, South Asian countries also have particularly low rates of skilled attendance at delivery-- rates similar to those in East, West and Middle Africa. Haiti, unlike other Caribbean countries, has a low percentage of births attended by skilled personnel. Overall, some progress has been made since ICPD in increasing the proportion of births attended by skilled personnel with the greatest increases (between 6 and 11 percent annually) occurring in Asia and North Africa.[13] Bolivia stood out among other Latin American countries with a 10 percent increase (at least twice that of its neighbors) in skilled attendants between 1994 and 1998. Real progress remains somewhat unclear, however, due to varying definitions of "skilled attendant." While a skilled attendant is generally defined as a doctor, nurse, midwife or nurse-midwife with adequate midwifery training, the term may be interpreted differently depending upon the classification of health care providers in each country and how titles such as 'doctor,' 'nurse,' etc. are translated into local languages used for surveying.[14]

Abortion policies and post-abortion care

Making abortion safe, where legal, is key to improving women's reproductive health. In Africa, one in every 150 abortions leads to death compared to one in every 85,000 procedures in the developed world. This high risk leads to around 70,000 deaths annually and to hundreds of thousands of women developing chronic health problems.[15] The past decade has seen a general liberalization of abortion laws especially the historically highly restrictive abortion laws in French-speaking West Africa.[16] In Latin America, there are

active reform efforts in Uruguay and Brazil. Since 1994, 12 countries have relaxed legal restrictions on abortion, and most countries allow abortion in instances beyond saving the life of the mother. Still, women in some countries where abortion is legal continue to face difficulties in obtaining safe abortion services in part because laws are not enforced or are misinterpreted.

Access to safe post-abortion care (PAC) is critical to saving women's lives. Because data for measures of PAC national programmes development were lacking for most countries, we sent questionnaires to regional and reproductive health and family planning networks to gather information for these indicators. Country-level experts were asked to categorize the level of national post-abortion care programme development based on a four-phase system adapted from the Global Evaluation of USAID's Post-Abortion Care Programme, conducted by the Population Technical Assistance Project in 2001.[h] We were able to assess the state of national PAC programming for 33 countries, but this information did not reveal the true accessibility of post-abortion care services and counseling. More comprehensive surveying of actual PAC availability is necessary.

Contraception use

Meeting women's need for contraception helps women avoid unintended pregnancies and thus helps prevent abortions and maternal mortality. Contraceptive use continues its upward trend in the developing world. This trend is a direct factor behind fertility decline that began in the 1960s. However, the levels of contraceptive uptake remain extremely low in sub-Saharan Africa. While around ten countries in sub-Saharan Africa have seen their fertility rates drop by about 1 percent each year since 1990, overall fertility has changed very little over the past forty years – and remains high -- especially as compared to other parts of the world. Contraceptive use is lowest in Sierra Leone where, as in another dozen countries in sub-Saharan Africa (as well as in Afghanistan), less than 10 percent of women use a family planning method. Contraceptive use is highest, at 80 percent or higher, in South Korea, Spain, Switzerland, China, the United Kingdom, and Hong Kong. In over 40 developing countries (including central Asian countries), contraceptive use exceeds 50 percent.

Unmet need for family planning

In the developing world and in former countries of the USSR, around 123 million couples – or about one in six couples -- have an unmet need for effective methods contraception. Young women, aged 15-24, account for a full one-third of unmet need. Unmet need for contraception ranges from 6 percent in Romania, Moldova and Colombia to 40 percent in Yemen and Haiti. Among regions, sub-Saharan Africa has the highest unmet need, much of it for spacing births; there is an average 20-35 percent unmet need for family planning

[h] The four phases are: (1) No known effort; (2) Pilot (includes operations research, work with policymakers and stakeholders, and intensive efforts to establish PAC); (3) Training (focuses on training of providers in tertiary level hospitals); and (4) Expansion (programmes that have moved beyond major tertiary hospitals to lower-level health care facilities, such as district hospitals). Considering the potential overlap, respondents were asked to check all that applied. A fifth category – part of routine medical care – was added based on comments from respondents in industrialized countries.

in around 20 African countries. In Asia, unmet need for spacing and limiting births is nearly equal. Such differences call for different kinds of contraceptive supplies and different programmatic and budgetary considerations.[17] For example, many clinics still experience stock-outs in their contraceptive supplies due to lack or inconsistent funding, restrictive policies, or weak logistical systems.

C. Health outcomes

ICPD emphasizes that reproductive health services, including voluntary family planning, can help couples avert high-risk pregnancies, prevent unwanted childbearing and abortion, and avoid diseases such as HIV/AIDS and other sexually transmitted infections that can lead to death, disability and infertility. Over the past decade, great efforts have been made to decrease these adverse health outcomes, while at the same time increasing positive ones. The five indicators on health outcomes we included in the Index are (1) Maternal mortality ratio, (2) Adolescent fertility rate, (3) Infant mortality rate, (4) Level of HIV/AIDS in men aged 15-24, and (5) Level of HIV/AIDS in women aged 15-24.

Maternal mortality

Each year, more than 525,000 women worldwide die from pregnancy or childbirth-related causes. The risk per birth is highest for women in sub-Saharan Africa and Afghanistan. The lifetime risk of death from pregnancy and childbirth is 1 in 60 in the developing world compared to 1 in 4000 in the industrialized world. We used maternal mortality ratio (MMR) for measuring status only and not to measure progress. Trends in maternal mortality are difficult to measure in the short term because of the large margins of error associated with the estimation of MMR. In many countries, a better measurement of maternal mortality hinges on reassessing and strengthening the completeness and adequacy of the vital registration and health information systems.

Adolescent fertility

Physiological and socioeconomic factors increase reproductive health risks for young women. Despite the risks associated with early pregnancy, levels of adolescent fertility, among both married and unmarried women, have remained practically the same in many countries over the past decade. Teen birthrates are highest in the Democratic Republic of the Congo, Angola, Liberia, Niger, Somalia, and Sierra Leone where more than one in five girls aged 15 to 19 give birth each year. In countries like Ghana where reducing the level of early childbearing has been a priority, adolescent childbearing declined dramatically; the Ghanaian government adopted a national Adolescent Reproductive Health Policy, and information on family planning, reproductive and sexual health was provided to adolescents at youth centers. The lowest rates of adolescent pregnancy are in the Democratic People's Republic of Korea, Republic of Korea, Japan, China and the Netherlands, where fewer than 1 in 200 girls give birth annually. The United States of America, New Zealand, and the United Kingdom have the highest rates among wealthy industrialized countries; 1 in 19, 1 in 32, and 1 in 40 adolescent girls give birth annually in the United States of America, New Zealand and the United Kingdom respectively.

Infant mortality

At least 4 million infants die each year, two thirds of them dying within one week of birth. Infant mortality rates have been declining in most countries since the mid-1980s and throughout the 1990s. However in some countries, especially those in sub-Saharan Africa, the decline in infant mortality rates has gradually slowed and in some cases reversed. Myriad factors may be responsible for changes in mortality including fertility, nutritional status, infant feeding, health services utilization by mothers and for children, environmental health conditions, and socioeconomic status.[18] Increasing mortality may also be due to factors including increasing resistance of malaria to drug treatment and increasing rates of HIV/AIDS infection prevalence among parents.

Level of HIV/AIDS in men and women aged 15-24

Over 95 percent of new HIV infections and AIDS deaths occur in the developing world, with most countries in sub-Saharan Africa having generalized epidemics while Asian countries have low-level or concentrated HIV/AIDS epidemics. HIV infection disproportionately affects young people, especially as girls and young women become sexually involved with older infected males. In sub-Saharan Africa young girls aged 15-24 are up to 2.5 times more likely to be infected with HIV than boys their age.[19]

The dynamics of HIV infection are best depicted by HIV incidence but measures of it are often not available; HIV prevalence thus remains the best available indicator for evaluation purposes. Because a significant proportion of new HIV infections are occurring among young people, HIV prevalence among boys and girls aged 15-24 is used as a rough approximation of actual incidence of HIV. UNAIDS presents data on HIV prevalence among young people 15 to 24 years old as an interval with a minimum and a maximum; for a summary measure of the interval we took the average of the interval -- recognizing that this is not the best representation of already weak data. In the hardest hit countries, the differences in HIV prevalence between men and women are most pronounced at this age interval.

D. Data and measurement issues

The new set of goals set at ICPD posed the challenge of measuring the qualitative gender-based goals. These obstacles to measuring ICPD progress include locating representative and quantifiable indicators of gender equality and female empowerment and standardizing definitions. Data sets for indicators related to gender were scarce and even those available were quite weak. In many cases such data may not reflect real opportunities for women in society. Also, because of varying contexts, different countries need different strategies to promote gender equality and empower women, adding to the complexity of standardizing measurement. More research is needed on the relationship between poverty and women's empowerment and reproductive health, especially at the household-level.

An additional need is for a systematic country-level review of women's legal rights, including an evaluation of inheritance laws, property rights, employment restrictions, and any other laws that may hamper or promote gender equality and women's empowerment.

In this assessment, measuring progress toward meeting ICPD objectives proved extremely difficult, given the lack of data for multiple indicators for many countries, especially poorer ones and those in conflict. Of those countries in which data had been collected for the range of indicators used, many had only one measurement for an indicator over the past 10 years, rendering an analysis of progress impossible. For those 62 countries which at least had data points for multiple points in time, the data points were seldom from the same reference year for the various countries, therefore compromising the accuracy of comparisons across countries. As a result, we accepted measurements from a range of years, so long as they maintained a five year difference. More systematic national-level surveying and data collection must be implemented to enable better trend analyses.

However, national level data have some limitation, despite the fact that they are of use for policy-setting, fund-raising, resource allocation and public education/advocacy purposes. They capture only average tendencies and mask inequalities within the country -- between urban and rural areas, rich and poor, young and old, and men and women. Inequality could exist in access to services, in improvement in health, or in gender relations. National averages also mask differences in the factors at play. Improving national averages is a good goal indeed but having a clear picture of what is going on at the sub-national level and among those in the most need is crucial for reaching them. Therefore, sub-national and disaggregated data is needed for evidence-based programming, effective service delivery, targeting and prioritizing of interventions, monitoring of progress, evaluation of programmes, and for budgetary considerations.[20]

V. Conclusion

Data from these 62 countries show highly variable progress since 1990, with some countries making little or no progress in meeting the goals outlined by the ICPD and others recording significant progress. The two areas in which progress has been considerable are contraceptive use and school enrolment. Wide and easy access to contraceptive supplies remains a challenge that needs to be addressed. Progress was also made in closing the gap between boys and girls school enrolment rates as well as in improving child survival rates. To a lesser extent, there has been progress in access to care during pregnancy and delivery. There was also some increase in representation for women in their countries' governments as well as in the formal work force. Fertility rates among adolescents have not changed since 1994 and remain high, and AIDS remains one of the main causes of death.

Measuring the expanded definition of reproductive health involves going beyond an analysis of a set of relevant demographic and health indicators, into more qualitative goals such as achievement of gender equality and women's empowerment and "the provision of universal access to reproductive health services, including family planning and sexual health"[21]. This deserves an overdue evaluation of the adequacy of available data sets and measurement techniques.

Reproductive health remains difficult to measure at the national level. Even more difficult to measure is the concept of access to reproductive health services. There is a lack of uniform definition; definitions vary from one country to another and within a country. Statistical measures of access do not necessarily reflect real life opportunities, especially for women. Information and vital registration systems remain weak and fragile in many countries, and data is scarce and out of date especially in countries experiencing violent conflict. The micro- and macro-economic aspects of reproductive health, including HIV/AIDS, need to be better reconciled.

Also, progress remains difficult to determine because time series data are lacking for many indicators. Further, data systems do not ensure a standard time reference for most indicators, complicating comparisons across countries.

Better measurement of reproductive health status, at both national and local levels, is crucial for evidence-based programming, better monitoring of progress, evaluation of programmes, and policy-setting. However, monitoring and evaluation has to be adequately resourced in order to assure that actual service delivery does not suffer.

Further progress towards meeting the goals set at ICPD in 1994 depends on a supportive policy environment, commitment of sufficient human and financial resources, attention to quality issues, partnerships among the various sectors, capacity building at the local level, and improvement of health care infrastructures and of logistical systems including health information systems.

For the dataset please visit www.countdown2015.org and access the "Report Card: ICPD at 10" under "Resources"

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Annex

Share of women in non-agricultural wage employment	Score
High = Share of women is 50 percent or above	25
Medium = Share of women is between 25 and 49.99 percent	50
Low = Share of women is between 0 and 24.9 percent	75

Abortion policy	Score
I = To save the woman's life or prohibited altogether	80
II = To preserve physical health	70
III = To preserve mental health	50
IV = Socioeconomic grounds	10
V = Without restriction as to reason	0

Maternal Mortality Ratio (MMR)	Score
Highest = MMR 1000 deaths per 100,000 live-births or more	100
Very high = MMR 600 < MMR < 999	80
High = 300 < MMR < 599	60
Moderate = 100 < MMR < 299	30
Low = 30 < MMR < 99	10
Very low = MMR < 30	0

Infant Mortality Rate (IMR)	Score
Very High = IMR 100 deaths per 1,000 live-births or more	100
High = 50 < IMR < 99	80
Medium high = 30 < IMR < 49	50
Medium low = 15 < IMR < 29	20
Low = IMR <15	0

HIV prevalence among boys or girls 15-24	Score
Very High = HIV/AIDS prevalence > 10 percent	100
High = 5 < HIV/AIDS prevalence < 9.99 percent	80
Medium = 1 < HIV/AIDS prevalence < 4.99 percent	30
Low = HIV/AIDS prevalence < 1 percent	0

Average annual percent change
Decline = -1 percent to -0.1 percent change
Little or progress = 0 percent to 0.9 percent change
Moderate progress = 1 percent to 2.9 percent
Significant change = 3 percent or above

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