The Cairo approach: Making reproductive health and family planning programmes more acceptable or embracing too much?

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INTRODUCTION

The International Conference on Population and Development (ICPD), held in Cairo in September 1994, was the third decennial conference convened under the auspices of the United Nations to address broad issues of and interrelationships between population and development. It resulted in the adoption of a Programme of Action (United Nations, 1995a), approved by consensus on 13 September 1994. The ICPD Programme of Action is a comprehensive document that identified a range of demographic and social goals to be achieved over the next 20 years as well as 243 actions to be taken to achieve these goals (United Nations, 1995b). Unlike the recommendations of the World Population Conference, held in Bucharest in 1974 (United Nations, 1975), and the International Conference on Population, held in Mexico City in 1984 (United Nations, 1984a), which emphasized a macro concern with rapid population growth, the resolutions and recommendations of the ICPD Programme of Action shifted emphasis to individual rights and needs in sexuality and reproduction. Thus, a "new paradigm" in international population policy giving prominence to women's reproductive health, rights and empowerment, rather than to the achievement of demographic targets that characterized the two previous conferences, emerged from Cairo (DeJong, 2000; McIntosh and Finkle, 1995).

While the Programme of Action does not quantify goals for population growth, structure and distribution, it still reflects the view that early stabilization of the world population would make a crucial contribution to realizing sustainable development (United Nations, 2000a). However, the corresponding slower population growth is not assumed to be primarily the result of population policies and family planning programmes. Instead, the assumption is that fertility would not fall until maternal and child mortality fall, men take responsibility for contraception, and women have the right to control their own fertility as well as the legal and political power that enable them to secure this right (McIntosh and Finkle, 1995). In sum, fertility decline is assumed to come from the effects of general social and development programmes, and from an integrated approach to reproductive health that embraces all aspects of reproduction and sexuality. As such, reproductive health describes an approach which sees women's health and well-being as important in their own right, not as a means towards the ends of fertility reduction (DeJong, 2000). Therefore, reproductive health is not limited to family planning but also includes maternal and child health, sexually transmitted diseases and HIV/AIDS, infertility, post-abortion care, reproductive cancers, gender-based violence, and reproductive and sexual rights (Luke and Watkins, 2002).

Even if many of the recommendations of the Programme of Action can be traced back to the Bucharest and Mexico City conferences, Cairo was considered a landmark because for the first time, women's interests in population matters had been broadly and seriously considered, non-governmental organizations (NGOs) were allowed unprecedented participation (both in formulating national policy statements and in drafting the Programme of Action), and policy was linked to implementation in terms of estimated financial resources required to achieve all population, family planning and reproductive health objectives and goals (McIntosh and Finkle, 1995). For the first time too, as a result of its integrated approach to population matters, the Cairo Programme of Action drew a wide consensus and 179 nations agreed upon it. Even if, like other documents that emerge from United Nations conferences, the implementation of the recommendations contained in the Programme of Action is the sovereign right of each country (United Nations, 2000a), the fact that it drew a clear agreement among so many countries let the international community believe that it would exert a significant pressure on the countries and donors to conform to its recommendations.

Our main objective in this study is to assess the extent to which the ICPD recommendations have been implemented and actually contributed towards the achievement of a better reproductive health in the developing world over the past ten years, halfway through the 20 years set up for the Programme of Action. In order to get a global picture, we first present an overview of the levels and trends of fertility and contraceptive use in developing countries with available data over the past 20 to 30 years. We try in particular to document the varying achievements between countries and explain these variations with such factors as implementation of population programmes and level of support and involvement from the public authorities. We then focus on the assessment of the population policies and programmes implemented after Cairo as well as of the effects of these policies and programmes on selected reproductive health indicators since Cairo. We give a particular attention to least developed countries where we think the Programme of Action should have had the most impact given that, in most of these countries, fertility transition had not started yet and the socio-economic and demographic context was still unfavourable in the early 1990s. We conclude by first arguing that the Programme of Action was probably better suited for countries already well engaged in their fertility transition and with fairly successful family planning programmes since it did not have the expected impact in the least developed countries where high fertility and low contraceptive use are currently still prevalent for a variety of reasons that we discuss in the paper. We then identify four major issues to be addressed urgently in order to accelerate the implementation of the Programme of Action in the least developed countries.

FERTILITY TRANSITION AND CONTRACEPTIVE REVOLUTION IN THE DEVELOPING WORLD: AN OVERVIEW

Fertility trends

Over the past four decades, tremendous changes took place in the demographic regimes of developing countries. Rapid mortality declines occurred in all countries until the early 1990s. In the majority of the countries, the decline has continued to the present except, unfortunately, in a number of countries, located mainly in sub-Saharan Africa, where stagnations and even increases in mortality levels have been observed due to the AIDS pandemic, and also, in several instances, to major deteriorations affecting the public health services (United Nations, 2005a).

Rapid fertility transitions have also been observed in the majority of developing countries. Between 1960-1965 and 2000-2005, the total fertility rate (TFR) of the less developed regions as a whole dropped from 6.0 to 2.9 children per woman, an estimated 52 per cent decline (United Nations, 2005a). Fertility declines have been impressive in virtually all major areas of the world, but Africa. TFR declined the most in Latin America and the Caribbean (from 6.0 to 2.6 children per woman, or a 57 per cent decline) and then in Asia (from 5.6 to 2.5 children per woman, or a 55 per cent decline). By contrast, TFR declined only from 6.9 to 5.0 children per woman, or a 28 per cent decrease, in Africa. This slow decline in Africa is due mainly to the sluggish decline in sub-Saharan Africa, where fertility decreased from 6.8 to 5.5 children per woman, or a 19 per cent decline (table 1 and figures 1a to 1d).

These averages mask important regional and even country differences though. In Asia, the decline has been particularly rapid in Eastern Asia where TFR declined by an estimated 67 per cent between 1960-1965 and 2000-2005. For 2000-2005, TFR is estimated at 1.7 children per woman in Eastern Asia compared to 3.2, 2.5, and 3.4 children per woman in South-central Asia, South-eastern Asia and Western Asia, respectively. The weights of China (in Eastern Asia), India (in South-central Asia) and Indonesia (in South-eastern Asia) in the fast fertility decline of Asia

are worth noting. These three countries are not only the most populous developing countries of Asia but also where national population policies are among the strongest (Hong Kong, Republic of Korea and Singapore also had fast fertility declines but they have much smaller populations). In Latin America and the Caribbean, fertility decline has been faster in continental America than in the Caribbean. TFR declined by 55 per cent, 60 per cent and 57 per cent, respectively, in the Caribbean, Central America and South America. In Africa, TFR in 2000-2005 is much higher in sub-Saharan Africa (5.1 children per woman) than in Northern Africa (2.9 children per woman). Within sub-Saharan Africa, though, TFR is not uniformly high. TFR is highest in Middle Africa (6.1 children per woman), followed by Western Africa and Eastern Africa (5.4 and 5.2 children per woman, respectively). By contrast, Southern Africa has a very low TFR of 2.7 children per woman, which is comparable to that of Northern Africa and South-eastern Asia.

Contraceptive use trends

Parallel to these fertility transitions, contraceptive prevalence (the proportion of married women of reproductive age, including those in consensual unions, who are using a method of contraception) is estimated to have increased steadily from 9 per cent in 1960-1965 to 38 per cent in 1980-1981, 53 per cent in 1990 and 62 per cent in 2000-2005 in the developing countries (table 1 and figures 1a to 1d). The increase in contraceptive use has been impressive in virtually all major areas and regions of the world, but sub-Saharan Africa. As a result, contraceptive prevalence is estimated to have reached 67 per cent in Asia and 75 per cent in Latin America and the Caribbean in 2005. It is worth noting that the figure for Asia is very close to the 71 per cent prevalence estimated for the more developed regions, and that the figure for Latin America and the Caribbean exceeds it. There are certainly variations among regions; however contraceptive prevalence is exceeding 50 per cent everywhere. Within Asia, the proportion of married women who are currently using a contraceptive method is estimated to have reached 84 per cent in Eastern Asia, 54 per cent in South-central Asia, 63 per cent in South-eastern Asia and 52 per cent in Western Asia. Within Latin America and the Caribbean, it is estimated that 62 per cent of married women are currently using a contraceptive method in the Caribbean, 73 per cent in Central America and 79 per cent in South America. By contrast, the situation is much less favourable in Africa. Only two out of the five regions of the continent have contraceptive prevalence in the 50 per cent range: Northern Africa and Southern Africa with 56 and 58 per cent prevalence levels respectively. In the other three regions, contraceptive prevalence remains low: 32 per cent in Eastern Africa, 25 percent in Middle Africa and 22 per cent in Western Africa (United Nations, forthcoming).

These levels of contraceptive use are the direct outcomes of the differing paces and schedules of contraceptive prevalence growth among the major areas and regions of the world since the 1960s. We measure growth in contraceptive prevalence in terms of annual percentage point increase, which is defined as the absolute difference between two estimates of contraceptive prevalence, pertaining to two different time points, divided by the number of years separating the two time points. We consider a growth in contraceptive prevalence of less than 1.0 per year as slow, a growth of at least 1.0 percentage point per year as fast, and one that is at least 1.5 percentage point per year as very fast. According to the available estimates, most of the growth in contraceptive use occurred in Eastern Asia in the 1960s and the 1970s where prevalence grew at an astounding average of 3.1 percentage points per year between 1960-1965 and 1980-1981 (table 1). Thereafter, contraceptive prevalence growth fell substantially to 1.1 percentage point per year during the 1980s and 0.5 percentage point per year during the 1990s. Given the very high level of contraceptive use reached in Eastern Asia by 2000, increase in prevalence is estimated to be negligible in 2000-2005. In the rest of Asia, most of the uptake took place mainly in South-central Asia and South-eastern Asia in the 1980s when contraceptive prevalence

increased at a very rapid pace of 2.0 percentage points per year. Before and after that period, contraceptive use increased at a less rapid pace of nearly 1.0 percentage point per year. In Latin America and the Caribbean, the pattern of growth was similar to that of South-central Asia and South-eastern Asia until 2000; most of the growth in contraceptive use happened in the 1980s (at a pace of 1.9 percentage points per year). In 2000-2005 though, Latin America and the Caribbean is estimated to behave similarly to Eastern Asia, that is, with a negligible amount of growth because of the very high level already achieved by 2000. In most of Africa, contraceptive use did not start to really grow until the 1990s and at a much lower pace (1.0 percentage point per year) than in Asia and Latin America and the Caribbean.

The fact that fertility transition was well under way in most developing regions, and even close to completion in some regions, was already evident in 1994 when the ICPD was held as the estimates of total fertility rates and contraceptive use given for 1990 in table 1 prove. It is worth noting that Bongaarts and Watkins in their comments on the state of fertility transitions in the 1990s said that: *"Over the past three decades, rapid fertility transitions have been observed in a majority of developing countries ... Declines have been most rapid in Asia and Latin America ..., less rapid in the Middle East and North Africa..., and almost non existent in sub-Saharan Africa..."* (Bongaarts and Watkins, 1996). Although, they cautioned that regional averages concealed wide variations among countries in the timing of the onset of transitions and subsequent pace, the feeling among many professionals and activists in the population and related fields in the 1990s was that the global demographic picture was encouraging. This certainly helped persuade many ICPD participants to think that rapid population growth had ceased to be a major problem and that promoting "birth control" or strong family planning programmes was no longer a top priority, which was indeed true for many countries. This feeling was reinforced by some evidence that fertility transition had started in sub-Saharan Africa, at least in certain countries and several urban areas (Locoh and Hertrich, 1994; Locoh and Makdessi, 1995). This led to a largely shared optimism in the 1990s and to the idea that Africa would soon experience a rapid fertility decline and rapid contraceptive growth similar to what had already happened in the other developing major areas of the world (United Nations, 1989).

In reality, when current contraceptive prevalence is examined at the country level, it can be seen that the global encouraging picture that was the background against which the ICPD took place concealed major differences across countries and that significant progress remained and still remains to be done. The latest survey data pertaining to 1990 or later[1] collected among 116 developing countries (United Nations, 2005d) show that half of the countries still had a contraceptive prevalence of less than 40 per cent (for any type of method, excluding the lactational amenorrhoea method) at the time of the survey (table 2 and figures 2a and 2b). The vast majority of the low prevalence countries are located in Africa and are least developed countries (annex table 1). Indeed, about half (47 per cent) of the African countries have a prevalence level that is lower than 20 per cent, compared to 11 per cent of the Asian countries and none of the countries of Latin America and the Caribbean. Similarly, more than three-quarters (78 per cent) of the African countries have a prevalence level that is lower than 40 per cent, compared to only a third of the Asian countries and 14 per cent of the countries of Latin America and the Caribbean. It is worth noting that the majority of the countries whose most recent contraceptive prevalence estimate is lower than 20 per cent are countries that have experienced war or civil strife over the past 20 years. This is clearly the case for at least four of the five low prevalence countries of Asia—Afghanistan, Bhutan, the Democratic Republic of Timor-Leste, Iraq and Yemen—and for about half of the 23 low prevalence countries of sub-Saharan Africa.

[1] Except for Iraq and Liberia whose latest data refer to 1986 and 1989 respectively.

For countries that have had several surveys providing contraceptive prevalence estimates since the 1970s or early 1980s, it is possible to estimate the pace of contraceptive prevalence increase over a rather long period of time. We divided these countries into two categories depending on whether the surveys that collected their oldest and most recent data were separated by at least 15 years or by less than 15 years. We then calculated the average annual percentage point increase in contraceptive prevalence between the oldest and most recent data (table 3 and figure 3). For the 56 countries in the first group, the number of years covered ranges from 35 years for Bangladesh (1969-2004) to 15 years for Iraq (1974-1989). In most cases, the calculated average growths in prevalence refer to at least a whole 20-year period between the mid/late 1970s and the early 2000s. For the 38 countries in the second group, the average growths refer mainly to the 1990s.

Contraception revolution in Asia and Latin America and the Caribbean

The majority of the developing countries have had a substantial growth in contraceptive use over the past several decades. This is particularly evident among the group of countries with two surveys separated by at least 15 years, where two-thirds of the countries (36 countries out of 56) had annual growths in contraceptive prevalence of at least 1.0 percentage point per year. Over three-quarters of the latter (28 countries out of 36) are in Asia and Latin America and the Caribbean. It should be kept in mind that if these countries have an average growth of 1.5 percentage points per year, and if they had a prevalence of around 10 per cent in the 1960s or the 1970s, they would achieve their contraceptive revolution in about 40 years. Indeed, 13 of the 18 countries with an annual growth of at least 1.5 percentage points now have a prevalence level above 60 per cent. Among the remaining five countries, contraceptive prevalence is now close to 60 per cent in Bangladesh, around 50 per cent in Morocco and Zimbabwe, and below 50 per cent in Malawi and Nepal only (a reflection of a later start of the uptake of contraceptive use).

Interestingly enough, the rapid increases in contraceptive prevalence observed in these countries have been achieved through diverse institutional arrangements and often through a very limited choice of contraceptive methods (United Nations, 2000c). In Asia, a strong governmental commitment to family planning programmes is the main reason behind the success of many countries in achieving high levels of contraception. Explicit population policies, aimed at reducing population growth, were implemented by governmental organizations through public service programmes alone as in China, Indonesia and the Islamic Republic of Iran, or with the help of community and private organizations as in Bangladesh and Thailand. In Latin America and the Caribbean, the high contraceptive prevalence achieved by the majority of the countries is the result of a different situation, one where family planning services are available through a mix of private and public service programmes, as well as pharmacies. Organized family planning associations, mainly members of the International Planned Parenthood Federation, have started providing family services in their own clinics since the 1960s or 1970s, often in a context of strong opposition from the Catholic Church as well as opposition or passive attitude towards the provision of contraception from the Governments, as, for instance, in Brazil, Columbia and Ecuador. Many Latin American and Caribbean Governments did not start incorporating family planning into their public health services until much later. Thus, family planning services are mainly provided by the private sector in Latin America and a large number of women obtain contraceptive supplies from pharmacies where they are widely available (United Nations, forthcoming).

In sum, despite the diversity of the types of family planning programmes implemented in the developing countries over the past 40 years, it appears that their successes have been largely

dependent on a strong commitment from either the national political leadership or from committed groups within the civil society (organised noticeably through family planning associations) or both, with the support in all cases from external donors.

Slow pace of contraceptive use growth in Africa

Besides the super achievers, many countries continue to experience a slow pace of contraceptive use growth. Among the 56 countries with two surveys at least 15 years apart, 20 countries, half of which are in Africa, have experienced average contraceptive prevalence increase of less than 1.0 percentage point per year. In the group of 38 countries with two surveys less than 15 years apart, 20 countries, including 15 countries in Africa, have experienced annual prevalence growth of less than 1.0 percentage point increase in recent years (mainly in the 1990s). Although the latter data refer to a short period of time, they suggest that, in total, contraceptive use continues to grow only very slowly in 25 African countries (table 3 and figure 3).

The low levels of contraceptive use still common in Africa in general, and in sub-Saharan Africa in particular, are related to the context in which family planning programmes have been operating in the region. Factors such as weak governmental support, relatively recent programme implementation, inadequate resources and weak absorptive capacity are among the main reasons for the slow uptake of family planning (Caldwell and Caldwell, 2002). The weak governmental support is particularly true in Francophone Africa where the majority of the countries did not adopt a national family planning policy or a national population policy that promotes family planning until the late 1980s or 1990s. Moreover, despite the adopted policies, many legal barriers to the provision of family planning services still exist in these countries (United Nations, forthcoming). The weak governmental support is further worsened by a low degree of participation in population programmes, particularly in that of family planning, from the organized groups of the civil society and which translates into weak family planning programmes (Guengant and May, 2001).

Since 1972, indices reflecting effort by national family planning programmes have been measured periodically for developing countries and translated into scores. These indices score 30 key programme elements, grouped into the following categories: 1) policies and stage-setting activities; 2) service and service-related activities; 3) record-keeping and evaluation; and 4) availability of contraceptive methods. The programme effort scores have so far been calculated for most developing countries for 1972, 1982, 1989, 1994, and 1999 (Ross and Mauldin, 1996; Ross, Stover and Willard, 1999; Ross and Stover, 2000). According to the 1994 evaluation, sub-Saharan African countries scored very low in their family planning programme effort at the time of the ICPD. Indeed, the overall programme effort score, expressed as a percentage of the maximum attainable, was below 50 per cent for 22 of the 30 countries surveyed, reflecting less than acceptable efforts geared at family planning programmes. Sub-Saharan African countries scored particularly low for the "service and service-related activities", "record-keeping and evaluation", and "availability of contraceptive methods" components for which only seven, eleven and six countries, respectively, had scores above 50 per cent. The six countries with a score above 50 per cent for the "availability of contraceptive methods" component are all located in Eastern Africa (Kenya, Mauritius and Zimbabwe) and Southern Africa (Botswana, Namibia and South Africa). By contrast, the countries of sub-Saharan Africa scored rather well for the "policies and stage-setting activities" component, probably as a result of an increased awareness of the importance of population issues since the 1974 Bucharest World Population Conference. Twenty-two of the 30 countries surveyed scored above 50 per cent for this component. These results indicate that, while some degree of governmental commitment to family planning did exist in most sub-Saharan African

countries in 1994 (through political statements and enactment of population policies), the provision of family planning services and contraceptive methods, as well as the adequate monitoring of programmes, did not actually follow except in a handful of countries.

With this background in mind, what progress has been made since the ICPD? To what extent has reproductive health gained importance in population policies and programmes? As a result, have levels and trends of child mortality, fertility and contraceptive use been modified since Cairo, especially in the least developed countries and sub-Saharan Africa? These are the questions that we try to answer in the following section.

ACHIEVEMENTS IN REPRODUCTIVE HEALTH SINCE CAIRO

International population policy

At the international level, there are reasons for both optimism and concern regarding the ICPD's influence on agreements reached at subsequent international conferences on development. One of the most recent of such conferences is the United Nations Millennium Summit, held in New York in September 2000. At this conference, representatives of 189 nations reached a global consensus and adopted a set of eight goals referred to as the Millennium Development Goals (MDGs), as well as 18 targets, in order to combat poverty, hunger, disease, discrimination against women, degradation of land, and illiteracy (United Nations, 2000b). These goals and targets were set up to be reached by 2015. Similarly to other United Nations international conferences, the Millennium Summit follows and builds upon other important international activities, including a series of international conferences held in the 1990s on the environment, human rights and social development.

On the positive side, the recommendations of the ICPD Programme of Action doubtlessly contributed to the MDGs because the latter contain specific targets related to components of reproductive health, including gender equity and equality (MDG No. 3. Promote gender equality and empower women), maternal health (MDG No. 5. Improve maternal health) and HIV/AIDS (MDG No. 6. Combat HIV/AIDS, malaria and other diseases). Moreover, a recent series of evaluation of the implementation of the MDGs have reached the main conclusion that the full implementation of the ICPD Programme of Action is central to the achievement of several MDGs, particularly those related to the reduction of poverty and hunger, the achievement of gender equality, the reduction of child and maternal mortality, and the control of the HIV/AIDS epidemic (United Nations, 2005b).

On the negative side though, the MDGs do not contain any specific goal or target on reproductive health. In addition, the set of 48 indicators adopted by a consensus of experts from the United Nations Secretariat, the International Monetary Fund, the Organisation for Economic Cooperation and Development and the World Bank (United Nations, 2001) to measure progress towards the MDGs do not contain any on family planning. Yet, the Programme of Action stated clearly that all countries should take steps to meet the family planning needs of their populations and should in all cases seek to provide, by the year 2015, universal access to a full range of safe and reliable family planning methods (para 7.16). The only Millennium Development indicator that is remotely related to family planning is the one labelled "condom use rate of the contraceptive prevalence rate" used to monitor HIV/AIDS progress (indicator No. 19). Contraceptive prevalence is included but just as a sub-indicator (No. 19c) of this condom use indicator (see the Millennium Indicators Database maintained by the United Nations Statistics Division at http://millenniumindicators.un.org/unsd/mi/mi_goals.asp).

According to a study based on in-depth interviews and focus group discussions (Blanc and Tsui, 2005) carried out in 2003 among 27 key observers and actors in the field of family planning (including developing country programme managers, developing and developed country researchers, and staff of national and international non-governmental and donor organizations), the fact that family planning was left out of the MDGs is a matter of great concern because it is now competing directly for attention and funding with poverty reduction and HIV/AIDS, issues that are given the highest priorities in the MDGs framework. These competing priorities were seen by the key informants as contributing to the declining interest in and loss of visibility of family planning on the international scene, and ultimately the demise of the international family planning movement. To the key informants, the implicit assumption of this shift of focus (towards poverty reduction and HIV/AIDS) is that policy and programme efforts to develop the world are most effective if directed at reducing poverty whereas programmes to provide specific services, such as family planning, are unnecessary.

National population policies

Since 1976, the Population Division of the United Nations has been conducting periodical reviews of national population policies as part of its activities on global monitoring of the implementation of the World Population Plan of Action (United Nations, 1975) and that of the Programme of Action. These reviews are based on enquiries sent to the Governments of the Member States and non-member States of the United Nations. The most recent of such reviews (United Nations, 2004a) was conducted in 2003 and is based on answers provided by 194 countries, including 146 developing countries among which 49 are least developed countries. It shows not only the situation on Government views and policies in 2003 but also the trends in these views and policies (for 1976, 1986 and 1996) based on previous review cycles. The review reveals that continued high rates of population growth and high fertility remain issues of policy concern among many developing countries and the great majority of the 49 least developed countries that participated in the enquiry. In 2003, 54 per cent of the developing countries considered their rate of population growth to be too high. In the group of least developed countries, the great majority of which are sub-Saharan African countries, the corresponding proportion is much higher: 76 per cent, up from 73 per cent in 1996. As a consequence of these views, 51 per cent of the developing countries and 67 per cent of the least developed countries reported that they have implemented policies aimed at lowering their rate of population growth in 2003. The corresponding proportions were much lower in 1996: 48 per cent and 55 per cent.

In 2003, the proportion of countries that viewed their fertility level as too high was also fairly important among the developing countries (58 per cent) and very important among the least developed countries (78 per cent). Between 1996 and 2003, the proportions of countries that reported to have consequently implemented policies aimed at lowering their fertility level increased from 56 per cent to 57 per cent among the developing countries and from 65 per cent to 69 per cent among the least developed countries.

Adolescent fertility was particularly recognized as a problem. In 2003, 61 per cent of the developing countries and 63 per cent of the least developed countries declared that it was a major concern, up from 53 per cent and 48 per cent, respectively, in 1996. As a consequence of these views, the great majority of the developing countries and the least developed countries (85 per cent in both groups) reported that they had, in 2003, programmes in place to address adolescent fertility. This proportion is much higher than the proportion in 1996 (around 60 per cent).

The views and policies of the Governments of developing countries regarding the use and provision of contraceptive methods were very favourable in 2003. Of the developing countries that answered the enquiry, 95 per cent declared that they supported family planning programmes and the provision of contraceptive methods to their population, up from 90 per cent in 1996. In 2003, 85 per cent of the developing countries supported directly through government facilities while 10 per cent supported indirectly by facilitating the activities of non-governmental organizations and associations dealing with family planning. In the least developed countries, the proportion of countries that supported family planning was even higher: 98 per cent in 2003, up from 94 per cent in 1996.

To summarize, the number of Governments that have espoused views favourable to, and implemented policies aimed at, stabilizing their high population growth, lowering their high fertility level, and facilitating the provision of family planning services and methods to their populations has increased in the developing countries in general, and the least developed countries in particular, since 1996. Despite these promising changes in views and policies, high population growth and high fertility were not considered by the countries of the less developed regions as the most significant issues they were facing in 2003. On the contrary, over 80 per cent of the developing countries cited infant and child mortality, maternal mortality, and HIV/AIDS as their most pressing population and development issues. Issues related to high fertility and high population growth were only ranked sixth to ninth in terms of importance. This situation can be a reason for concern since many of the least developed countries still have high fertility and low contraceptive prevalence today.

National population programmes

A United Nations review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the ICPD (United Nations, 2004b) shows that, over the past ten years, substantial advances have been made. A large majority of 165 developing countries surveyed by the United Nations Population Fund (UNFPA) in 2003 reported that they have implemented programmes on reproductive health, gender equity and women's empowerment, as well as integration of population and development linkages. In particular, close to 87 per cent of the countries said they have intensified their efforts to implement a more comprehensive approach to reproductive health (for example integrating family planning services, safe motherhood, adolescent reproductive health and sexually transmitted infections/HIV prevention into reproductive health programmes). At the same time, many countries have integrated reproductive health into their primary health-care package. With regards to family planning, many countries reported that they have greatly improved the availability of contraceptive supplies and services, with the result of providing individuals with greater opportunities for choice and decision-making.

However, the review also highlights several major constraints to the implementation of the Programme of Action, especially in the least developed countries. Among these constraints are social and cultural factors which prevent women from accessing services, limited access to quality reproductive health services, poor linkages between service delivery and information, education and communication (IEC) programmes, and weak advocacy campaigns. Another important constraint is the lack of financial and adequate human resources to make services affordable, accessible and available to the population. These constraints are such that many countries still have considerable unmet needs, in both normal and emergency situations, for reproductive health, including family planning, services. The review shows clearly that stronger political will and commitment, both at the national level (by the Governments, non-governmental organizations and civil society) and at the international level (by the donors and all partners of

development), appear necessary to accelerate progress towards the full implementation of the ICPD 20-year Programme of Action.

As regards more specifically the implementation of reproductive health and family planning programmes, the review acknowledges the bottlenecks faced by many countries, especially in their attempt to integrate reproductive health services into primary health care, so that services are accessible to and affordable by all who need them. At the institutional level, the vertical organizational structure of their health-care systems continues to be the main barrier to a more integrated approach in many countries. At the practical level, the obstacles include management arrangements, financial constraints, training of service providers and logistic systems. For many least developed countries, particularly in sub-Saharan Africa, only less than half of the population has adequate access to health facilities (defined as living less than five kilometres from a health centre), according to Demographic and Health Surveys data. Moreover, recent anthropological surveys conducted in several capitals of Western Africa, showed that the quality of the care provided in public facilities has deteriorated markedly in recent years. The functioning of these facilities is hampered by many factors such as low morale among the staff, lack of drugs and corruption, which leave no incentive to the staff to provide even the most basic information on family planning to women coming for pre-natal or post-natal visits (Jaffré and Olivier de Sardan, 2003).

Issues of competing priorities between service components to be integrated within reproductive health care were also mentioned by the countries that participated in the UNFPA field survey. For example, in many least developed countries, where fertility is still very high, implicit or explicit priority is often given to safe motherhood and child health care—the most urgent immediate needs indeed—at the expense of family planning. These countries recognized that their programmes were not ready for integration not only because of the institutional and operational bottlenecks mentioned earlier but also because the move towards a reproductive approach has diluted family planning efforts (United Nations, 2004b).

Beyond the statements made by Governments and the programmes implemented, what results have been achieved since Cairo? We try to answer this question in the following section by examining recent levels and trends of child mortality, population growth, fertility and contraceptive use in developing countries, particularly the least developed ones.

Selected demographic and health achievements since Cairo

Little improvement in child mortality

Over the past decade, child survival has improved very little in the least developed countries. According to the latest estimates of the United Nations, 31 of 48 least developed countries had a high under-five mortality rate of 150 per thousand or more during the 1990-1995 period (United Nations, 2005a). In seven of these high child mortality countries, the rate was above 200 per thousand, with Niger and Sierra Leone having the highest rates (307 per thousand and 331 per thousand, respectively). Although child mortality fell in all the countries but one—the Democratic Republic of the Congo—the percentage decrease in under-five mortality rates between 1990-1995 and 2000-2005 averaged only 14 per cent. As a result, all the 48 least developed countries still have a rate of under-five mortality above 100 per thousand in 2000-2005, with 23 of them having a rate above 150 per thousand. The eight countries where under-five mortality rate is now below 150 per thousand include Cambodia, Djibouti, Gambia, the Lao People's Republic, Madagascar, Sudan, Timor-Leste and Uganda. Their lower child mortality levels were achieved through decreases of more than 15 per cent in the under-five mortality rates.

Slow decrease in population growth

Population growth has decreased only slowly in the countries where population growth was high in the early 1990s. We consider a rate of population growth of 2.0 per cent per year or higher as being high and we include developing countries with a population of at least 100,000 in 2005. Before presenting the pace of decrease of the population growth rate, we remind that this indicator includes not only natural growth due to the difference between fertility and mortality rates but also growth due to migratory flows. Therefore, it can become very high in the case of massive migratory returns after a war (such as in Afghanistan) for instance.

It is estimated that 67 countries had a population growth rate of 2.0 per cent per year or higher during the 1990-1995 period (United Nations, 2005a), including 31 in Africa, 25 in Asia and 11 in Latin America and the Caribbean. The range of population growth rates was much wider in Asia (2.0 per cent in Viet Nam to 6.9 per cent in Afghanistan) than in Africa (2.1 per cent in the Libyan Arab Jamahiriya to 3.8 per cent in Guinea) and Latin America and the Caribbean (2.0 per cent in Panama to 2.9 per cent in Honduras).

Although the rate of population growth fell in all these countries, the decrease has in general been slow so that the countries with the highest rates of population growth in 1990-1995 remain those with the highest rates of population growth in 2000-2005. The decrease has been particularly slow among the countries of Africa. Every two out of three African countries (20 out of 31) still have a rate of population growth of at least 2.0 per cent per year in 2000-2005 compared to every one out of two countries in Asia (14 out of 25) and Latin America and the Caribbean (5 out of 10).

The percentage changes in population growth rate between 1990-1995 and 2000-2005 confirm the slow decrease generally experienced by African countries. In as many as eight countries (Cape Verde, Equatorial Guinea, Guinea-Bissau, Madagascar, Libyan Arab Jamahiriya, Congo, Comoros, and Angola), annual population growth rate fell by less than 10 per cent. By contrast, only two countries of Asia—Saudi Arabia and Lao People's Democratic Republic—saw their annual rate of population growth decrease by less than 10 per cent between the two periods. There are however variations across countries in both Africa and Asia. A few countries have seen their annual rates of population growth decrease by as much as 50 per cent or more between the two periods in Botswana, Namibia, South Africa and Zimbabwe (Africa) and in Bahrain, Jordan, Lebanon, Macao SAR of China and Oman (Asia). These countries have all also started their fertility transition before Cairo. Finally, in Latin America and the Caribbean, the decrease in the rate of population growth is generally more uniform across countries (when compared to Africa and Asia). The percentage decrease in the annual population growth rate between the two periods varies from 10.9 per cent in Panama to 30.4 per cent in Ecuador.

In sum, the majority of the countries with a high population growth rate (2.0 per cent per year or over) in 1990-1995 remained with a high population growth rate in 2000-2005. The exceptions are countries that have started their fertility transition much before Cairo. Therefore, Cairo does not seem to have contributed to slower population growth among countries where population growth was still very high around the time of Cairo.

Rapid and slow fertility declines

In countries where fertility was at a high level in the early 1990s, the subsequent pace of fertility decline varied substantially across major areas. We consider a TFR of at 5.0 children per woman or higher as high and we include countries with a population of at least 100,000 in 2005.

The latest estimates of the United Nations list 56 countries as having a TFR of 5.0 children per woman or higher in 1990-1995 (United Nations, 2005a). Every three out of four of these countries are located in sub-Saharan Africa (42 countries) and the rest in Asia, with the exception of Guatemala. The range of TFR values is very wide across countries within both Africa and Asia: from 5.0 in Cape Verde, Sao Tome and Principe and Nepal to 8.0 or higher in Afghanistan and Niger.

Between 1990-1995 and 2000-2005, TFR decreased faster among the countries of Asia than among the countries of Africa. In 2000-2005, every three out of four of the African countries (32 out of 42) still have a TFR of 5.0 or higher, including 14 countries with a TFR of 6.0 or higher. By comparison, less than one out of four Asian countries (3 out of 13) still have a TFR of 5.0 or higher in 2000-2005 but two of them (Afghanistan and Yemen) have a TFR of 6.0 or higher. In fact, TFR decreased in all the Asian countries whereas it is estimated to have stalled in eight African countries including Burundi, Chad, Congo, the Democratic Republic of the Congo, Equatorial Guinea, Guinea-Bissau, Sierra Leone and Uganda. The amount of decrease in TFR in Asia is quite substantial because in only two countries (Afghanistan and Occupied Palestinian Territory) did the TFR decrease by less than 15 per cent. By contrast, as many as 28 African countries experienced the latter small decrease in TFR. Moreover, TFR decreased by more than 25 per cent in as many as six of the Asian countries compared to only two among the African countries. In Guatemala, the only country with a TFR still above 5.0 children per woman in Latin America and the Caribbean, TFR decreased by a fairly high amount, 16 per cent, between 1990-1995 and 2000-2005.

In sum, fertility has decreased significantly since Cairo in the great majority of the high fertility countries of Asia and Latin America and the Caribbean so that over three-quarters of them are estimated to have a TFR of less than 5.0 children per woman in 2000-2005. On the contrary, fertility has decreased very little or not at all in three-thirds of the high fertility countries of Africa. As a result, only less than a quarter of the latter are estimated to have a TFR of less than 5.0 children per woman in 2000-2005. Therefore, Cairo does not seem to have contributed to lower fertility among the high-fertility countries of sub-Saharan Africa.

Slower growth in contraceptive prevalence

Table 4 shows contraceptive prevalence data pertaining to a year around 1994 for 49 developing countries (19 in Africa, 16 in Asia and 14 in Latin America and the Caribbean) that had data for at least three time points, with the middle time point being around 1994. The first time point is in most cases a year in the late 1970s or the 1980s. The third time point is the most recent date (mostly in the 1990s or the early 2000s) for which data are available. These data are taken from United Nations (2005d). The table also shows the annual percentage points of growth in contraceptive prevalence for both the period preceding Cairo (11 years on average) and the period following Cairo (6 years on average).

During the decade before Cairo, contraceptive prevalence increased fairly rapidly in the developing countries. The countries of Asia experienced the highest annual growths (1.5 percentage points on average) and only a very small number of them (2 out of 16) had slow growths in contraceptive prevalence, that is, less than 1.0 percentage point per year. By contrast, as much as a half (8 out of 19) of the countries of Africa were in the slow growth category even

though, on average, the African countries experienced annual growths (1.2 percentage points) that were not far from that of the Asian countries. In Latin America and the Caribbean, the annual growth was 1.3 percentage points on average, and only one third of the countries (4 out of 14) were in the slow growth category.

During the decade after Cairo, contraceptive use increased at a much slower pace in Africa and Asia, as compared to the increase experienced before Cairo. In Africa, contraceptive prevalence increased slowly, at 0.7 percentage point per year on average. Only 5 countries out of 19—Egypt, Malawi, the United Republic of Tanzania, Zambia and Zimbabwe—experienced fast growth, that is, above 1.0 percentage point per year. Malawi is worth singling out with its very rapid growth in contraceptive prevalence of 2.2 percentage points per year. In Asia, contraceptive prevalence increased faster than in Africa, at 1.0 percentage point per year on average. More than half the countries of Asia (9 out of 16) experienced rapid growth. Among them, the Islamic Republic of Iran, Nepal and Viet Nam particularly had very fast growths in contraceptive prevalence of 1.7, 2.2, and 1.7 percentage points per year, respectively.

In Latin America and the Caribbean, contraceptive use after Cairo increased as fast as or faster than before Cairo. In general, countries whose contraceptive prevalence levels were below 60 per cent around Cairo experienced the most rapid growths after Cairo (of at least 1.5 percentage points per year). By contrast, countries whose contraceptive prevalence levels were already high around Cairo (60 per cent or higher) experienced fairly slow growths (1.0 percentage point per year or less) after Cairo, which is expected. The exception to these general patterns is Bolivia where contraceptive prevalence around Cairo was low and yet was followed by a slow growth afterwards.

In fact, Figures 4a, 4b, 5a and 5b show clearly that the growth in contraceptive prevalence after Cairo (both in absolute term and relative to the growth before Cairo) varies across major areas and by the level of prevalence attained around Cairo. Although the trend lines for the data in the figures should be interpreted with caution given the small number of observations, the clear inverse U-shaped of the trend lines for the data in Figures 4a and 4b suggest that the absolute post-Cairo growth first increases with the level of prevalence and then decreases after a certain threshold in prevalence is reached. This pattern holds particularly true for modern methods than for any method of contraception, and for Asia and Latin America and the Caribbean than for Africa. The thresholds at which the post-Cairo growth in modern methods prevalence starts to decrease is around 20 per cent of prevalence in Africa, around 30 per cent of prevalence in Asia, and around 45 per cent of prevalence in Latin America and the Caribbean. For any method of contraception, the thresholds are slightly higher, at around 25 per cent in Africa, 30 per cent in Asia and 40 per cent Latin America and the Caribbean.

When the post-Cairo growth is compared to the pre-Cairo growth, it can be seen from the trend lines for the data in Figures 5a and 5b that, first, the difference between the two varies by major area. The difference in growth is in general highest and positive (meaning that there was an increase in the pace of contraceptive use growth after Cairo) in Latin America and the Caribbean and lowest and negative (meaning that there a decrease in the pace of contraceptive use growth after Cairo) in Africa and, to a lesser extent, in Asia too. Second, the difference between the post-Cairo and pre-Cairo annual growths tends to be positive (increase in the pace of contraceptive use growth after Cairo) for countries with a lower contraceptive prevalence around Cairo and negative (decrease in the pace of contraceptive use growth after Cairo) for countries with a higher prevalence around Cairo. This pattern is particularly true for modern methods of contraception. In Africa, the fact that the post-Cairo growth is slower than the pre-Cairo growth when the contraceptive prevalence around Cairo is still at a fairly low level—around 20 per cent

for any method—is a matter of concern. However, the situation is more promising when we look at the growths in modern methods because it is in countries where the prevalence of the latter methods reaches around 40 per cent that growth slowed down after Cairo. In Asia, growth slowed down after Cairo when the contraceptive prevalence (for any method) reached about 40 per cent around Cairo. Finally, in Latin America and the Caribbean, growth after Cairo slowed down as compared to growth before Cairo in countries where contraceptive prevalence was already at least 50 per cent around Cairo.

In sum, contraceptive prevalence increased after Cairo in most of the developing countries. However, the pace of increase after Cairo was in general slower in comparison to that before Cairo, especially in Africa and Asia. In Asia and Latin America and the Caribbean, the slowing down is more or less expected as it is related to the fact that the countries had already attained a fairly high level of prevalence around Cairo (at least 50 per cent. In Africa, the slowing down occurred among almost all the countries, even those whose prevalence was still very low (around 20 per cent) which suggests that Cairo had very little or no positive impact at all on the contraceptive prevalence of the African countries.

CONCLUSIONS AND DISCUSSION

There is no doubt that the Cairo Conference represented a major step forward for better approaching population and reproductive health problems, hence the expression of "new paradigm" attached to the ICPD (McIntosh and Finkle, 1995). The emphasis put on reproductive health and reproductive rights intended not only to satisfy the various groups (Governments as well as non-governmental and women organizations) that were very active before and during the Conference, but also to promote humane and client-sensitive programmes. In this sense, it can be said that the Cairo approach tried to get family planning programmes more acceptable, especially in those countries where in the 1990s, fertility transition and contraceptive revolution were still under way, as well as in the countries, mainly the least developed ones, where fertility was still high and contraceptive prevalence still low.

As shown in this paper, family planning programmes are now more acceptable (United Nations, 2004a), and indeed they are better accepted today by the populations of the least developed countries than in 1994. However, the results of the various analyses presented in the paper tend to indicate that progresses in fertility decline and contraceptive prevalence increase have remained very slow in these countries, and that the pace of changes has not really accelerated (as expected) after Cairo. Whether or not this unchanged pace of progress is the result of the fact that the Programme of Action was embracing too many issues at once depends on each one's personal view. Certainly, the ICPD Programme of Action covers a wide range of demographic and social issues. As it has been said, the formal purpose of the conference was to arrive at a consensus (McIntosh and Finkle, 1995). To arrive at a consensus between so many countries and groups with different interests and agendas required that all of them find to a certain extent an expression of their views in the final recommendations which were to be universally endorsed.

In our view, one of the major challenges of implementing the Cairo recommendations is not necessarily the high number of these recommendations. Today, the developing world is characterized by a great diversity in demographic regimes. In particular, the least developed countries, most of them located in sub-Saharan Africa, continue to experience the least favourable demographic trends, that is, high fertility and mortality levels coupled with low levels of contraceptive use. To us, the challenge is to take account of this demographic diversity when

setting priorities, designing population and reproductive health programmes, and implementing them, so as to better answer the various individual reproductive health needs of the overall population as agreed at the ICPD in 1994. This means, trying to satisfy not only the needs of the sexually active population and the population of reproductive age, but also the needs of the whole population, as well all as that of specific groups. Although the Programme of Action adopted in Cairo is a comprehensive document which can be adapted to various conditions, the poor results obtained in most of the sub-Saharan African countries concerning altogether child mortality reduction, fertility decline and contraceptive use (as we showed in this study) call for an acceleration of the progresses to be made towards the implementation of the ICPD Programme of Action. This acceleration itself calls for a complete reappraisal of the ways and means to implement the Programme of Action. Certainly, the poor performance of sub-Saharan African countries cannot be attributed to the "new paradigm" adopted in Cairo, since it is clear that the implementation of the recommendations contained in the Programme of Action is the responsibility and the sovereign right of each country. In fact the reappraisal of population and reproductive health programmes in the broad framework of social development which is direly needed for sub-Saharan African countries should be based upon the principles adopted in Cairo. But, this reappraisal should also be based upon a realistic, non complacent, assessment of the constraints faced by these countries.

In this respect, it is not realistic to expect most sub-Saharan African countries and other least developed countries to meet the family planning needs of their populations and provide, by the year 2015, universal access to a full range of safe and reliable family planning methods as stated in the Programme of Action. According to the latest DHS data, unmet need for family planning in sub-Saharan African countries varies generally from about 20 per cent to 40 per cent of the women in union. Therefore, meeting these needs by year 2015 would require in most cases a contraceptive prevalence increase between 2.0 and 4.0 percentage points per year on average in the next ten years. Such a tremendous increase seems out of reach given that very few countries in the world have succeeded to have contraceptive prevalence growths over 2.0 percentage points increase per year according to the data presented in this paper.

It is also worth noting that in most sub-Saharan African countries, the total demand for family planning services is much lower than in other regions of the world. Indeed, when current contraceptive use and unmet need for family planning are summed up, the estimated total demand for family planning rarely exceeds 50 percent of women in union (Guengant and May, 2001). By contrast, in other parts of the world, the total demand generally reaches 70 to 80 per cent. The lower demand for family planning in sub-Saharan Africa is probably the consequence of the fact that the need for family planning there is more for spacing than for limiting births, which is associated with high numbers of desired children as expressed by African women in many surveys (Feyisetan and Casterline, 2000). Various cultural, social, and economic factors lie behind these preferences. One may argue, as this has been sometimes observed, that the demand for limiting will grow as the use of contraception rises and will eventually exceed the demand for spacing (Moreland and Guengant, 1994). However, for a variety of reasons such as the desire to conform to traditional values, the fear of being criticized by religious leaders and other opponents of family planning, Governments officials as well as population policy leaders, health personnel, and the media continue to put an exclusive emphasis on spacing and sometimes even condemn family planning for limiting purposes. To avoid unwanted or ill-timed pregnancies, women must not only have access to effective methods of contraception but also be comfortable with the idea of being able to control their reproductive lives. In this respect, a better understanding of the factors leading to a modification of social norms and individual choices favouring a low fertility regime is needed. This subject should constitute an important research issue for the coming years so that

local actors can be better equipped for designing culturally sensitive, innovative, more efficient and results-oriented population and reproductive health programmes.

Finally, to get closer to the achievement of the most important recommendations of the ICPD Programme of Action, and accelerate progress towards the implementation of the most relevant actions in the least developed countries, four important issues must be discussed widely, openly, without any dogmatism and prejudice, by all the actors in the population, reproductive health and related fields, both at the national level (by the Governments, non-governmental organizations and civil society) and at the international level (by the donors and all partners of development. These issues relate to competing priorities, integration of services, genuine commitment of the actors, and effective accessibility of services.

As regards the issue of competing priorities, it is obvious that in the least developed countries where resources, both public and private, are limited, and the basic needs of the population are massive, it is more difficult than elsewhere to set priorities so as to achieve measurable results in relatively short periods of time such as 10 or 20 years. To improve the performance of the various development efforts undertaken in these countries, it is necessary, as indicated in the ICPD document, to take into consideration the various linkages between population and development. In this respect, the fact that family planning was left out of the MDGs is a matter of great concern because in most sub-Saharan African and other least developed countries the achievement of the majority of the MDGs (education for all, empowerment of women, and reduction in maternal and infant mortality) is presently seriously constrained by continued high population growth and numerous unwanted and ill-timed pregnancies. Thus, in addition to competing for resources with the other numerous components of reproductive health (maternal and child health, sexually transmitted diseases and HIV/AIDS, infertility, post-abortion care, reproductive cancers, gender-based violence, reproductive and sexual rights) family planning is today competing directly for resources with the MDGs. We think that it is necessary to evaluate what can be realistically done, in given time frames, for each component of reproductive health, and reallocate the human and financial resources accordingly.

As regards the issue of integration of reproductive health and family planning and services, the ICPD document recognized the importance of the involvement of the private sector and even encourages the partnership between Governments, NGOs and the private sector. Yet, the integration of reproductive health and family planning services with the public health remains for the many countries the desired model. It is true that in the review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the ICPD (United Nations, 2004b) many countries reported to have successfully integrated reproductive health into their primary health-care package, and indicated that with regards to family planning, such integration has greatly improved the availability of contraceptive supplies and services. However, the review also indicates that several developing countries recognized that their programmes were not ready for integration, not only because various institutional and operational bottlenecks, but also because the move towards a reproductive approach has diluted family planning efforts (United Nations, 2004b). The question of integration of family planning services in the public health system is not a simple one. Obviously its feasibility and efficiency vary from one country to another. This issue should be dealt with pragmatically, with the view that all actors—the Government, NGOs and the private sector—are welcome to contribute to the expansion of quality services in reproductive health and family planning, but duplication should be avoided.

The third issue to be addressed urgently is the issue of genuine commitment of the actors. In several sub-Saharan African countries, the present situation can be described as a situation of reciprocal, self-sustained low commitment of the Government, the civil society and the donors.

As the highest priority is given to poverty reduction by the MDGs and the international donors, Governments and national poverty reduction strategy documents rarely mention actions to be taken, or programmes to be implemented, in the population and reproductive health fields, except for the reduction of maternal and child mortality and HIV/AIDS. As a result, donors give a low priority to reproductive health and family planning activities, and, as national and international support for these activities is deemed weak, few groups of the civil society engage themselves in these activities. It appears clearly again in the review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the ICPD (United Nations, 2004b) that a stronger political will and commitment, both at the national level (by the Governments, non-governmental organizations and civil society) and at the international level (by the donors and all partners of development) is needed to accelerate progress towards the implementation of the ICPD 20-year Programme of Action.

The fourth and last issue to be addressed is the one of effective accessibility of services which includes information as well as counselling services, accessibility of supplies and medical advice and follow-up. Obviously, this issue is related to the three previous ones, and indeed the four major issues examined here must be addressed simultaneously. In most of sub-Saharan African countries and other least developed countries, an inventory of all constrains to effective accessibility of reproductive health and family panning services should be done or updated. Some of these constraints have already been identified in the review and appraisal of the progress made in achieving the goals and objectives of the Programme of Action of the ICPD (United Nations, 2004b). They include the limited access to quality reproductive health services, the poor linkages between service delivery and information, education and communication (IEC) programmes, the weakness of advocacy campaigns, as well as the lack of financial and adequate human resources to make services affordable, accessible and available to the population. These constraints are such that in many countries, they call for a critical evaluation or even a full reassessment of existing family planning programmes and activities, with special attention given to the number and type of contraceptive methods to be offered, and the different channels through which these methods should be made available to the various segments of the population.

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TABLE 1. TRENDS IN TOTAL FERTILITY RATE AND CONTRACEPTIVE PREVALENCE[a], BY MAJOR AREA AND REGION

	Year or period				
Major area and region	*1960-1965*	*1980-1981*	*1990*	*2000*	*2005*
			A. Total fertility rate (children per woman)		
World	5.0	3.8	3.2	2.7	2.6
More developed regions	2.7	1.9	1.8	1.6	1.6
Less developed regions	6.0	4.5	3.6	3.0	2.8
Africa	6.9	6.5	5.9	5.1	4.8
Sub-Saharan Africa	6.8	6.7	6.3	5.6	5.3
Asia	5.6	4.0	3.2	2.6	2.4
Eastern Asia	5.2	2.9	2.1	1.7	1.7
Other Asia	6.0	4.9	4.1	3.2	2.9
Latin America and the Caribbean	6.0	4.3	3.2	2.6	2.5
			B. Contraceptive prevalence[a] (percentage)		
World	--	--	57.0	62.6	63.8
More developed regions	--	--	72.0	70.1	71.0
Less developed regions	9.0	38.0	53.0	61.3	63.1
Africa	5.0	11.0	18.0	27.9	32.4
Sub-Saharan Africa	--	--	12.0	21.6[d]	26.8[d]
Asia[b]	--	42.0	58.0	65.2	66.9
Eastern Asia[b]	13.0	69.0	79.0	83.6	84.0
Other Asia[b]	7.0	24.0[c]	43.0	51.4	55.8
Latin America and the Caribbean	14.0	43.0	61.0	74.1	75.4
			C. Annual percentage point increase in contraceptive prevalence		
		1960-1965 / 1980-1981	1980-1981 / 1990	1990 / 2000	2000 / 2005
World		--	--	0.6	0.2
More developed regions		--	--	-0.2	0.2
Less developed regions		1.6	1.6	0.8	0.4
Africa		0.3	0.7	1.0	0.9
Sub-Saharan Africa		--	--	1.0	1.0
Asia[b]		--	1.7	0.7	0.3
Eastern Asia[b]		3.1	1.1	0.5	0.1
Other Asia[b]		0.9	2.0	0.8	0.9
Latin America and the Caribbean		1.6	1.9	1.3	0.3

Sources: Total fertility rates are linearly interpolated from United Nations (2005a). *World Population Prospects: The 2004 Revision. Highlights*. ESA/P/WP.193. Contraceptive prevalence figures are taken from United Nations (1996). *Levels and Trends of Contraceptive Use as Assessed in 1994 (*United Nations publication, Sales No. E.96.XIII.13) for 1960-1965 and 1990; from United Nations (1984). *Levels and Trends of Contraceptive Use as Assessed in 1983* (United Nations publication, Sales No. E.84.XIII.5) for 1980-1981; and from United Nations (forthcoming). *Levels and Trends of Contraceptive Use as Assessed in 2002* for 2000 and 2005.

NOTES: -- not available.

[a] Proportion of married women of reproductive age, including those in consensual unions, who are using a method of contraception.

[b] Excluding Japan.

[c] Figure shown is for South Asia.

[d] Figure shown is the weighted average of the figures for Eastern Africa, Middle Africa, Southern Africa, Western Africa and Sudan, with the numbers of married women of reproductive age in 2000 as weights.

TABLE 2. DISTRIBUTION OF 116 DEVELOPING COUNTRIES, BY MOST RECENT CONTRACEPTIVE PREVALENCE[a] AND MAJOR AREA

	Africa		*Asia*		*Latin America and the Caribbean*		*Less developed regions*	
Contraceptive prevalence[a]	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Less than 20 per cent	23	47%	5	11%	0	0%	28	24%
20 to less than 40 per cent	15	31%	10	22%	3	14%	28	24%
40 to less than 60 per cent	8	16%	13	29%	5	23%	26	22%
60 per cent or over	3	6%	17	38%	14	64%	34	29%
Total	49	100%	45	100%	22	100%	116	100%

Source: United Nations (2005d). *World Contraceptive Use 2005*. Database maintained by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

NOTES: The most recent contraceptive prevalence estimate for a country pertains to a year between 1990 and 2004.

[a] Proportion of married women of reproductive age, including those in consensual unions, who are using a method of contraception.

TABLE 3. DISTRIBUTION OF 94 DEVELOPING COUNTRIES, BY ANNUAL GROWTH IN CONTRACEPTIVE PREVALENCE[a] AND MAJOR AREA

Annual percentage point increase in contraceptive prevalence[a]	*Africa*		*Asia*		*Latin America and the Caribbean*		*Less developed regions*	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
				A. Countries with two surveys at least 15 years apart				
2.0 percentage points or more	2	11%	1	5%	1	6%	4	7%
1.5 to less than 2.0 percentage points	2	11%	6	30%	6	33%	14	25%
1.0 to less than 1.5 percentage points	4	22%	8	40%	6	33%	18	32%
0.5 to less than 1.0 percentage point	6	33%	1	5%	2	11%	9	16%
Less that 0.5 percentage point	4	22%	4	20%	3	17%	11	20%
Total	18	100%	20	100%	18	100%	56	100%
				B. Countries with two surveys less than 15 years apart				
2.0 percentage points or more	0	0%	4	31%	0	0%	4	11%
1.5 to less than 2.0 percentage points	5	24%	4	31%	0	0%	9	24%
1.0 to less than 1.5 percentage points	1	5%	2	15%	2	50%	5	13%
0.5 to less than 1.0 percentage point	6	29%	2	15%	1	25%	9	24%
Less that 0.5 percentage point	9	43%	1	8%	1	25%	11	29%
Total	21	100%	13	100%	4	100%	38	100%

Source: United Nations (2005d). *World Contraceptive Use 2005*. Database maintained by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

NOTE: [a] Proportion of married women of reproductive age, including those in consensual unions, who are using a method of contraception.

TABLE 4. TRENDS IN CONTRACEPTIVE PREVALENCE[a] BEFORE AND AFTER CAIRO, SELECTED DEVELOPING COUNTRIES

	Post-Cairo period				*Pre-Cairo period*								
			Annual percentage point of change in contraceptive prevalence				*Annual percentage point of change in contraceptive prevalence*		*Difference in contraceptive prevalence growth[b] between post- & pre-Cairo periods*		*Contraceptive prevalence around Cairo (per cent)*		
Country	*Period*	*Number of years*	*Any method*	*Modern methods*	*Period*	*Number of years*	*Any method*	*Modern methods*	*Any method*	*Modern methods*	*Year*	*Any method*	*Modern methods*
AFRICA													
Mali	1996-2001	5	0.0	0.2	1987-1996	9	0.2	0.4	-0.2	-0.1	1996	6.7	4.5
Mauritania	1991-2001	10	0.4	0.4	1981-1991	10	0.3	0.1	0.0	0.3	1991	4.1	1.2
Senegal	1993-1999	6	0.5	0.6	1978-1993	15	0.2	0.3	0.3	0.3	1993	7.4	4.8
Benin	1996-2001	5	0.4	0.7	1982-1996	14	0.5	0.2	-0.2	0.5	1996	16.4	3.4
Ghana	1993-2003	10	0.5	0.8	1980-1993	13	0.8	0.4	-0.4	0.5	1993	20.3	10.1
Madagascar	1997-2004	7	0.9	1.0	1992-1997	5	0.5	0.9	0.3	0.1	1997	19.4	9.7
Côte d'Ivoire	1994-1999	5	0.7	0.6	1981-1994	13	0.7	0.3	0.1	0.3	1994	11.4	4.2
Zimbabwe	1994-1999	5	1.0	1.6	1984-1994	10	1.0	1.6	0.1	0.0	1994	48.1	42.2
Malawi	1992-2000	8	2.2	2.3	1984-1992	8	0.8	0.5	1.4	1.8	1992	13.0	7.4
Rwanda	1992-2000	8	-1.2	-1.1	1983-1992	9	1.2	1.3	-2.4	-2.4	1992	21.2	12.9
Cameroon	1991-1998	7	0.5	0.4	1978-1991	13	1.1	0.3	-0.6	0.1	1991	16.1	4.3
Lesotho	1992-2000	8	0.9	1.3	1977-1992	15	1.2	1.1	-0.3	0.2	1992	23.2	18.9
Tunisia	1994-2001	7	0.4	0.3	1983-1994	11	1.7	1.5	-1.3	-1.2	1994	60.0	51.0
Kenya	1993-2003	10	0.7	0.4	1978-1993	15	1.7	1.5	-1.1	-1.1	1993	32.7	27.3
Uganda	1995-2001	6	0.6	1.0	1989-1995	6	1.7	0.9	-1.0	0.2	1995	14.8	7.8
Egypt	1995-2003	8	1.4	1.4	1984-1995	11	1.6	1.5	-0.2	-0.1	1995	46.9	45.5
Algeria	1995-2000	5	0.4	0.1	1987-1995	8	2.7	2.3	-2.2	-2.1	1995	56.9	49.4
Zambia	1996-2002	6	1.4	1.4	1992-1996	4	2.1	1.4	-0.7	0.0	1996	23.4	14.4
United Rep. of Tanzania	1996-1999	3	1.7	1.2	1992-1996	4	2.0	1.7	-0.3	-0.5	1996	18.4	13.3
Average (unweighted)			***0.7***	***0.8***			***1.2***	***1.0***	***-0.5***	***-0.2***			
ASIA													
Yemen	1992-1997	5	1.1	0.7	1979-1992	13	0.5	0.4	0.7	0.4	1992	7.2	6.1
Philippines	1993-2003	10	0.9	0.8	1983-1993	10	1.0	0.7	-0.1	0.1	1993	40.0	24.9
India	1993-1999	6	1.3	1.1	1980-1993	13	0.5	0.7	0.8	0.4	1993	40.6	36.2
China	1992-1997	5	0.1	0.0	1982-1992	10	1.3	1.5	-1.2	-1.5	1992	83.4	83.2
Thailand	1993-1997	4	-0.4	-0.6	1984-1993	9	1.0	1.1	-1.5	-1.7	1993	73.9	72.2
Turkey	1993-1998	5	0.3	0.6	1983-1993	10	1.2	1.2	-0.9	-0.5	1993	62.6	34.5
Sri Lanka	1993-2000	7	0.6	0.9	1982-1993	11	1.0	1.2	-0.5	-0.3	1993	66.1	43.6
Pakistan	1995-2001	6	1.6	1.3	1985-1995	10	1.0	0.6	0.6	0.6	1995	17.8	12.6
Nepal	1996-2001	5	2.2	1.9	1986-1996	10	1.5	1.2	0.7	0.7	1996	28.5	26.0
Indonesia	1994-2003	9	0.6	0.5	1985-1994	9	1.8	1.7	-1.2	-1.2	1994	54.7	52.1
Jordan	1997-2002	5	0.6	0.2	1985-1997	12	2.0	1.3	-1.4	-1.1	1997	50.3	37.7
Republic of Korea	1994-1997	3	1.0	0.0	1982-1994	12	1.6	1.6	-0.6	-1.6	1994	77.4	66.8
Iran (Islamic Rep. of)	1992-1997	5	1.7	2.3	1977-1992	15	1.9	..	-0.3	..	1992	64.6	44.6
Viet Nam	1994-2002	8	1.7	1.6	1988-1994	6	2.0	1.0	-0.3	0.6	1994	65.0	43.8
Bangladesh	1994-2004	10	1.4	1.1	1983-1994	11	2.3	2.0	-1.0	-0.9	1994	44.6	36.2
Myanmar	1997-2001	4	1.1	1.1	1991-1997	6	2.7	2.5	-1.6	-1.4	1997	32.7	28.4
Average (unweighted)			***1.0***	***0.8***			***1.5***	***1.3***	***-0.5***	***-0.5***			
Jamaica	1993-1997	4	1.0	1.1	1979-1993	14	0.5	0.3	0.5	0.8	1993	62.0	58.3
Costa Rica	1993-1999	6	0.8	1.0	1981-1993	12	0.8	0.7	0.0	0.3	1993	75.0	64.6
Haiti	1995-2000	5	1.8	1.6	1983-1995	12	0.9	0.8	0.8	0.9	1995	18.0	13.2
Guatemala	1995-2002	7	1.7	1.1	1983-1995	12	0.5	0.5	1.2	0.5	1995	31.4	26.9
Dominican Republic	1996-2002	6	1.0	1.0	1986-1996	10	1.4	1.3	-0.4	-0.2	1996	63.7	59.2
Mexico	1995-1997	2	1.0	1.0	1982-1995	13	1.4	1.2	-0.5	-0.2	1995	66.5	57.5
El Salvador	1993-2003	10	1.4	1.3	1978-1993	15	1.3	1.1	0.1	0.2	1993	53.3	48.4
Ecuador	1994-1999	5	1.8	0.9	1982-1994	12	1.4	1.1	0.4	-0.2	1994	56.8	45.7
Honduras	1996-2001	5	2.4	2.0	1984-1996	12	1.3	0.9	1.1	1.1	1996	50.0	41.0
Paraguay	1996-2004	8	2.1	2.4	1987-1996	9	1.2	1.4	0.9	1.0	1996	56.0	41.3
Bolivia	1994-2000	6	0.8	1.6	1983-1994	11	1.8	0.5	-0.9	1.1	1994	45.3	17.7
Colombia	1995-2000	5	0.9	0.9	1980-1995	15	1.6	1.2	-0.6	-0.3	1995	72.2	59.3
Peru	1996-2000	4	1.0	2.1	1981-1992	11	1.6	1.4	-0.6	0.7	1996	64.2	41.3
Nicaragua	1993-2001	8	1.5	1.8	1981-1993	12	2.3	2.3	-0.8	-0.5	1993	54.5	49.9
Average (unweighted)			***1.4***	***1.4***			***1.3***	***1.0***	***0.1***	***0.4***			

Source: United Nations (2005d). *World Contraceptive Use 2005* . Database maintained by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

NOTES: [a] Proportion of married women of reproductive age, including those in consensual unions, who are using a method of contraception.

[b] Annual percentage point of change in contraceptive prevalence for the post-Cairo period minus annual percentage point of change in contraceptive prevalence for the pre-Cairo period.

ANNEX TABLE 1. MOST RECENT CONTRACEPTIVE PREVALENCE[a] (INCREASING ORDER) BY MAJOR AREA, 116 DEVELOPING COUNTRIES

Africa			*Asia*			*Latin America and the Caribbbean*		
Country	*Year*	*Contrac-eptive prevalence[a]*	*Country*	*Year*	*Contrac-eptive prevalence[a]*	*Country*	*Year*	*Contrac-eptive prevalence[a]*
			A. Contraceptive prevalence below 20 per cent					
Chad	2000	3.6	Afghanistan	2000	4.8			
Sierra Leone	2000	4.3	Dem. Rep. of Timor-Leste	2003	8.4			
Mozambique	1997	5.6	Yemen	1997	12.8			
Angola	2001	5.9	Iraq	1989	13.7			
Eritrea	2002	5.9	Bhutan	1994	18.8			
Guinea	1999	6.2						
Liberia	1986	6.4						
Guinea-Bissau	2000	6.7						
Mali	2001	6.9						
Niger	2000	7.1						
Mauritania	2001	7.7						
Ethiopia	2000	8.1						
Sudan	1993	8.3						
Gambia	2000	9.6						
Senegal	1999	10.5						
Nigeria	2003	11.2						
Rwanda	2000	11.8						
Burundi	2000	13.5						
Burkina Faso	2003	13.7						
Côte d'Ivoire	1999	15.0						
Benin	2001	18.2						
Uganda	2001	18.6						
Cameroon	1998	19.3						
Number of countries		***23***	***Number of countries***		***5***	***Number of countries***		***0***
			B. Contraceptive prevalence between 20 per cent and less than 40 percent					
Togo	2000	21.7	Oman	1995	21.4	Haiti	2000	26.8
Central African Rep.	2000	23.1	Cambodia	2000	23.5	Guyana	2000	37.0
United Rep. of Tanzania	1999	23.5	United Arab Emirates	1995	27.5	Trinidad & Tobago	2000	38.1
Comoros	2000	24.1	Pakistan	2001	27.6			
Ghana	2003	24.9	Saudi Arabia	1996	30.6			
Madagascar	2004	25.5	Lao People's Dem. Rep.	2000	32.2			
Dem. Rep. of the Congo	2001	25.6	Tajikistan	2000	32.9			
Swaziland	2000	27.6	Syrian Arab Republic	1993	36.1			
Sao Tome & Principe	2000	28.7	Myanmar	2001	37.0			
Namibia	1992	28.9	Nepal	2001	39.3			
Malawi	2000	30.2						
Lesotho	2000	30.3						
Gabon	2000	31.1						
Zambia	2002	31.5						
Kenya	2003	39.3						
Number of countries		***15***	***Number of countries***		***10***	***Number of countries***		***3***

ANNEX TABLE 1. (*continued)*

C. Contraceptive prevalence between 40 per cent and less than 60 percent

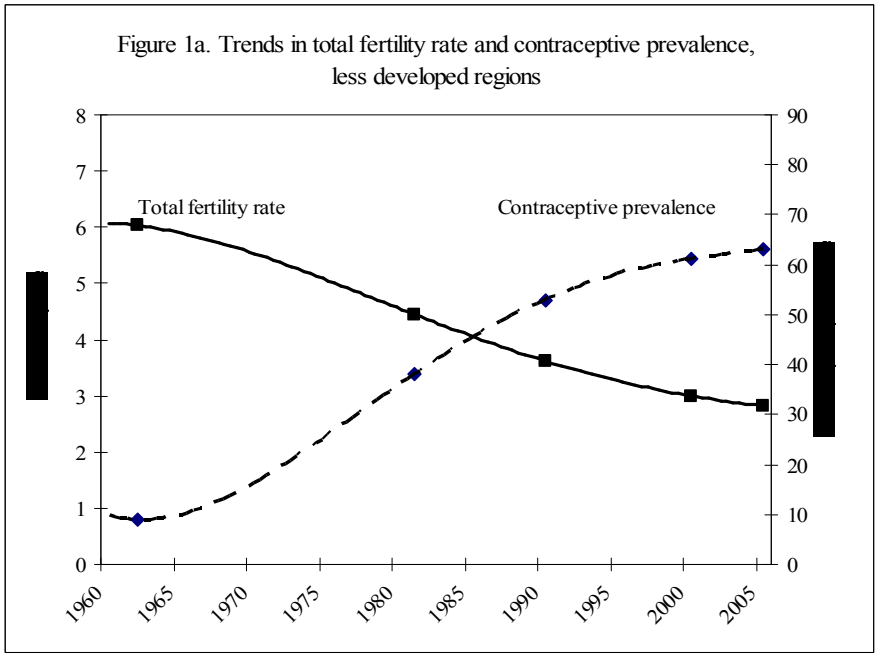
Botswana	2000	40.4	Georgia	2000	40.5	Suriname	2000	42.0
Libyan Arab Jamahiriya	1995	45.1	Qatar	1998	41.7	Guatemala	2002	43.2
Morocco	1995	50.3	Maldives	1999	42.0	Belize	1991	46.7
Cape Verde	1998	52.9	India	1999	48.2	Bolivia	2000	50.2
Zimbabwe	1999	53.3	Philippines	2003	48.6	Panama	1984	58.2
South Africa	1998	56.3	Kuwait	1996	48.7			
Egypt	2003	57.9	Jordan	2002	53.2			
Algeria	2000	59.1	Turkmenistan	2000	53.9			
			Malaysia	1994	54.5			
			Azerbaijan	2001	55.4			
			Bangladesh	2004	58.1			
			Armenia	2000	58.6			
			Kyrgyzstan	1997	59.5			
Number of countries		***8***	***Number of countries***		***13***	***Number of countries***		***5***

D. Contraceptive prevalence of 60 per cent and over

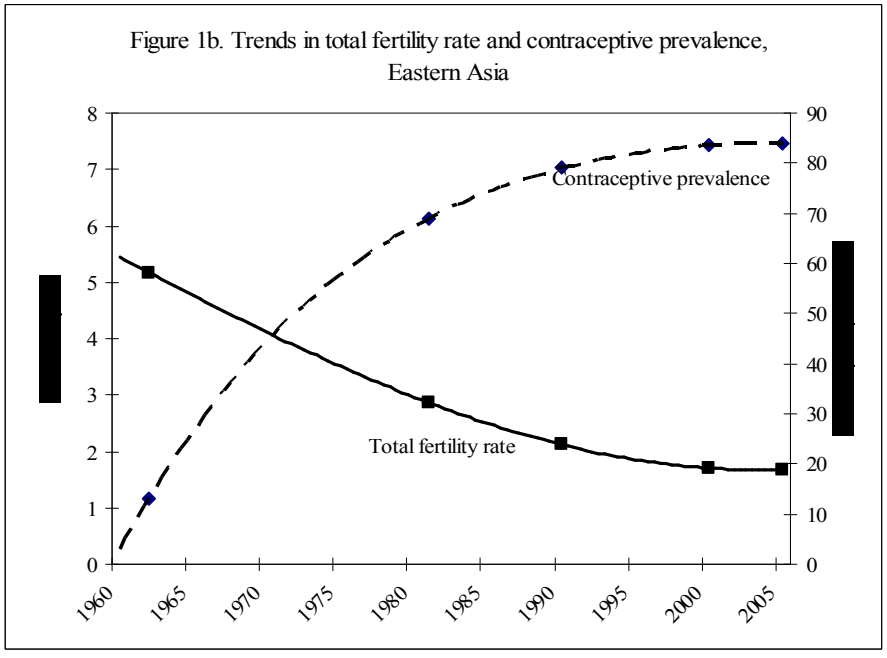
Tunisia	2001	63.0	Indonesia	2003	60.2	Honduras	2001	61.8
Réunion	1990	66.6	Bahrain	1995	60.5	Ecuador	1999	65.8
Mauritius	1991	74.7	Lebanon	1996	61.0	Jamaica	1997	65.9
			Dem People's Rep. of Korea	1992	61.8	Nicaragua	2001	66.8
			Singapore	1997	62.0	El Salvador	2003	67.3
			Mongolia	2000	62.7	Peru	2000	68.2
			Turkey	1998	63.9	Mexico	1997	68.4
			Kazakhstan	1999	64.5	Dominican Rep.	2002	69.4
			Uzbekistan	2002	64.9	Paraguay	2004	72.8
			Israel	1988	68.0	Cuba	2000	73.2
			Sri Lanka	2000	70.0	Brazil	1996	76.7
			Thailand	1997	72.2	Colombia	2000	76.9
			Iran (Islamic Rep. of)	1997	72.9	Puerto Rico	1996	77.7
			Viet Nam	2002	78.5	Costa Rica	1999	80.0
			Republic of Korea	1997	80.5			
			China	1997	83.8			
			Hong Kong (SAR of China)	1992	86.2			
Number of countries		***3***	***Number of countries***		***17***	***Number of countries***		***14***
Total number of countries		***49***	***Total number of countries***		***45***	***Total number of countries***		***22***

Source: United Nations (2005d). *World Contraceptive Use 2005*. Database maintained by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

NOTE: [a] Proportion of married women of reproductive age, including those in consensual unions, who are using a method of contraception.



Source: Table 1.



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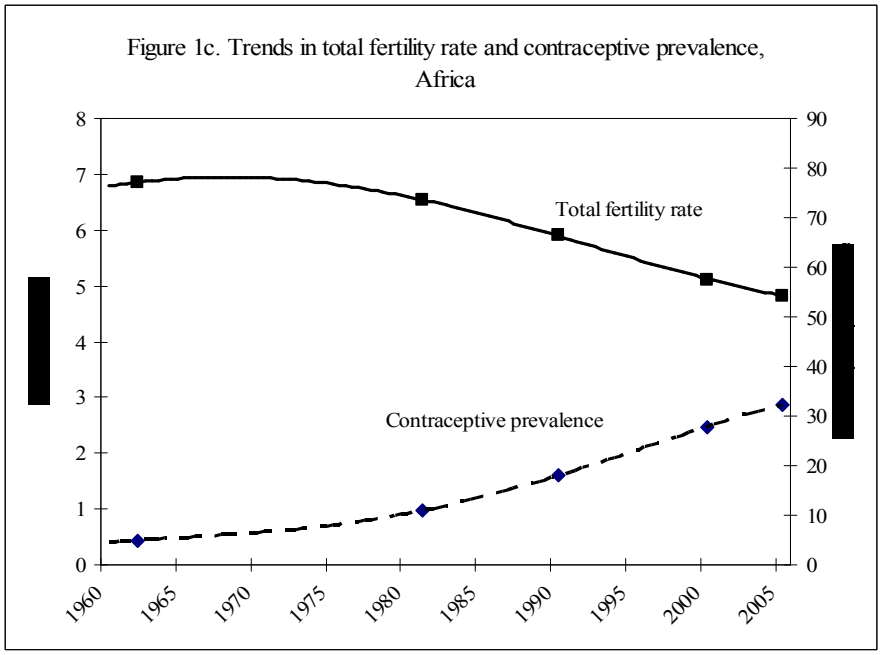

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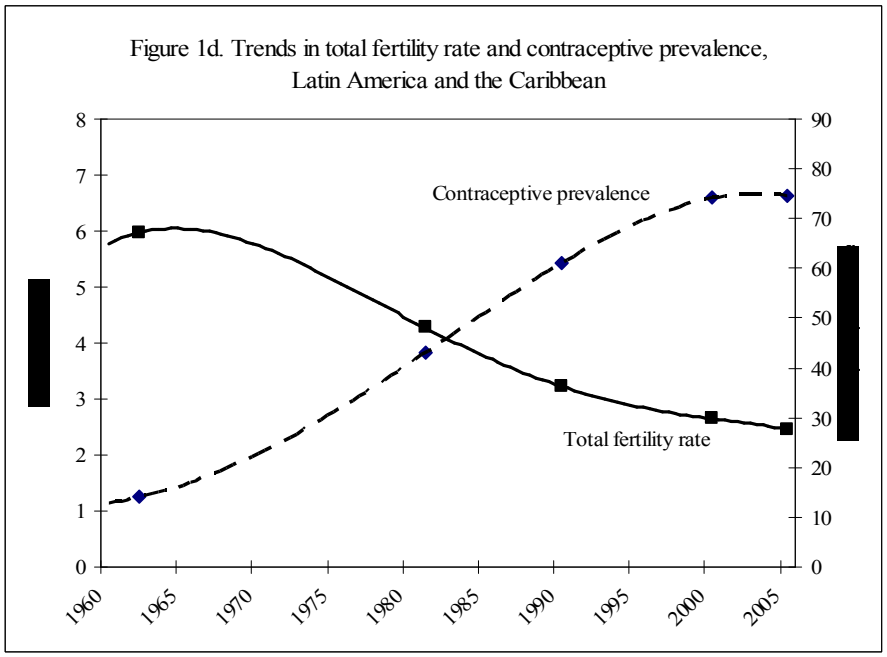
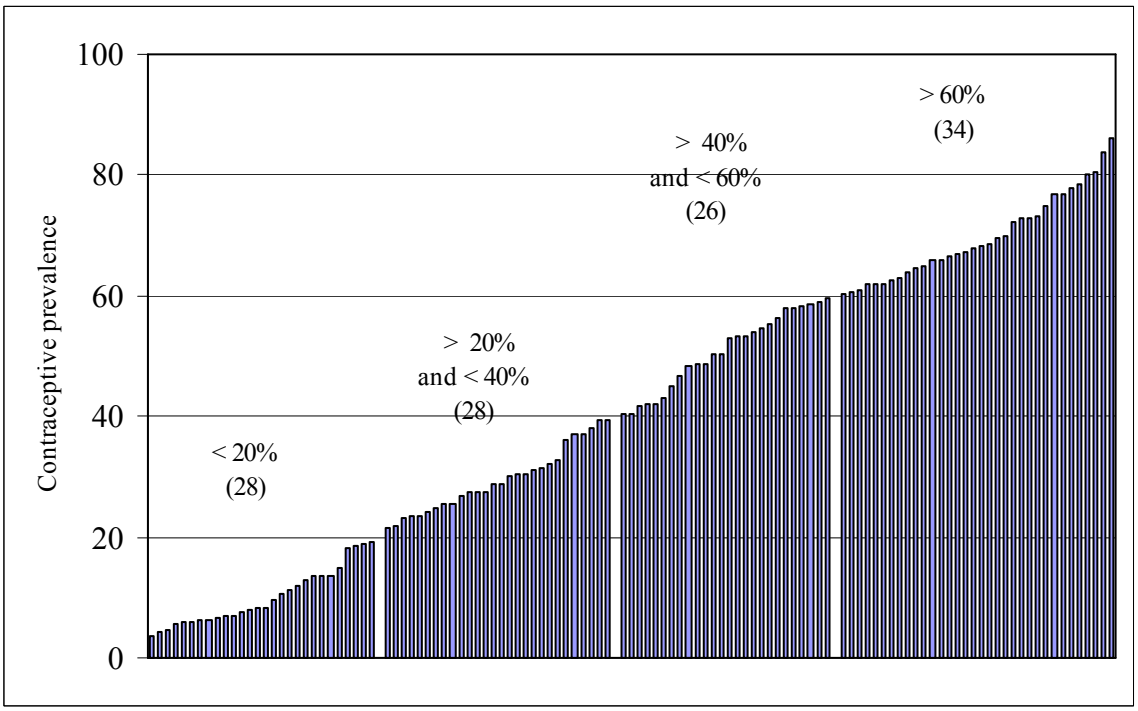


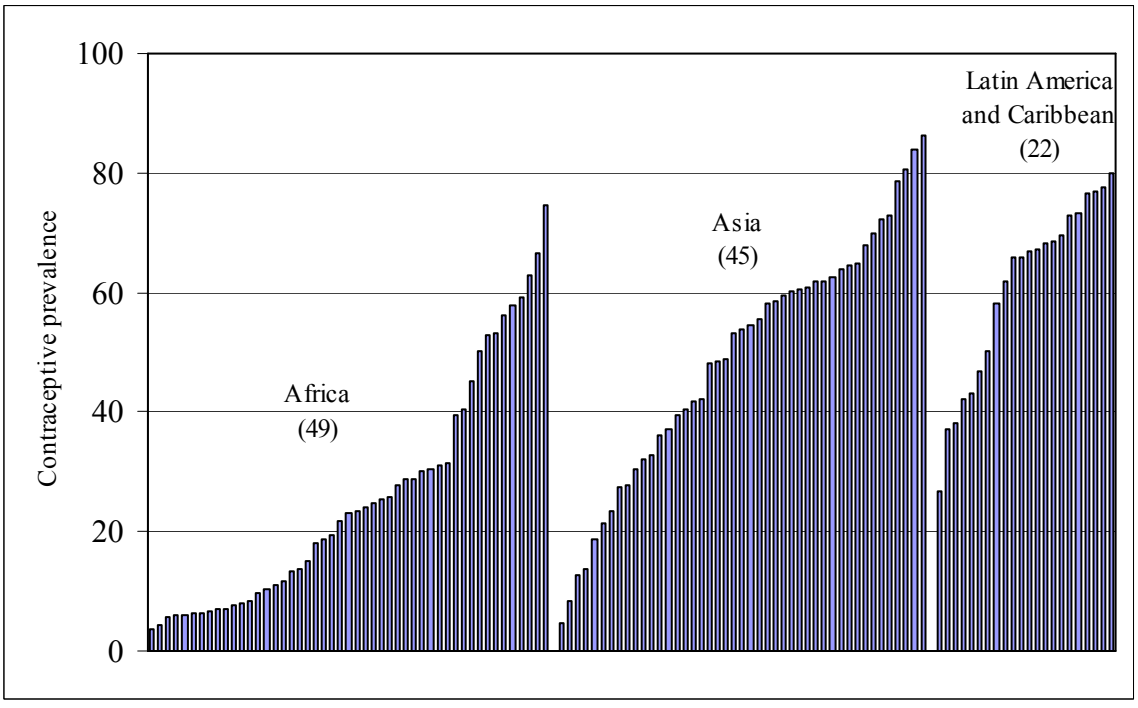
Source: Table 1.

Figure 2a. Most recent contraceptive prevalence pertaining to the year 1990 or later, 116 developing countries



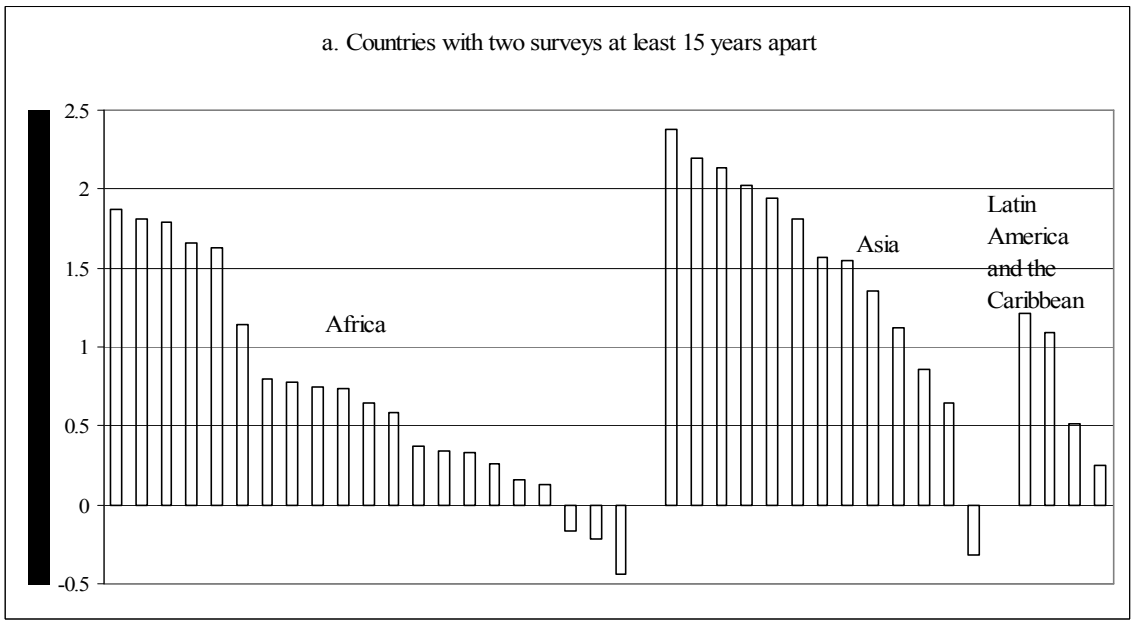
Source: Annex table 1.

Figure 2a. Most recent contraceptive prevalence pertaining to the year 1990 or later, by major area, 116 developing countries



Source: Annex table 1.

Figure 3. Annual growth in contraceptive prevalence, by major area, 94 developing countries



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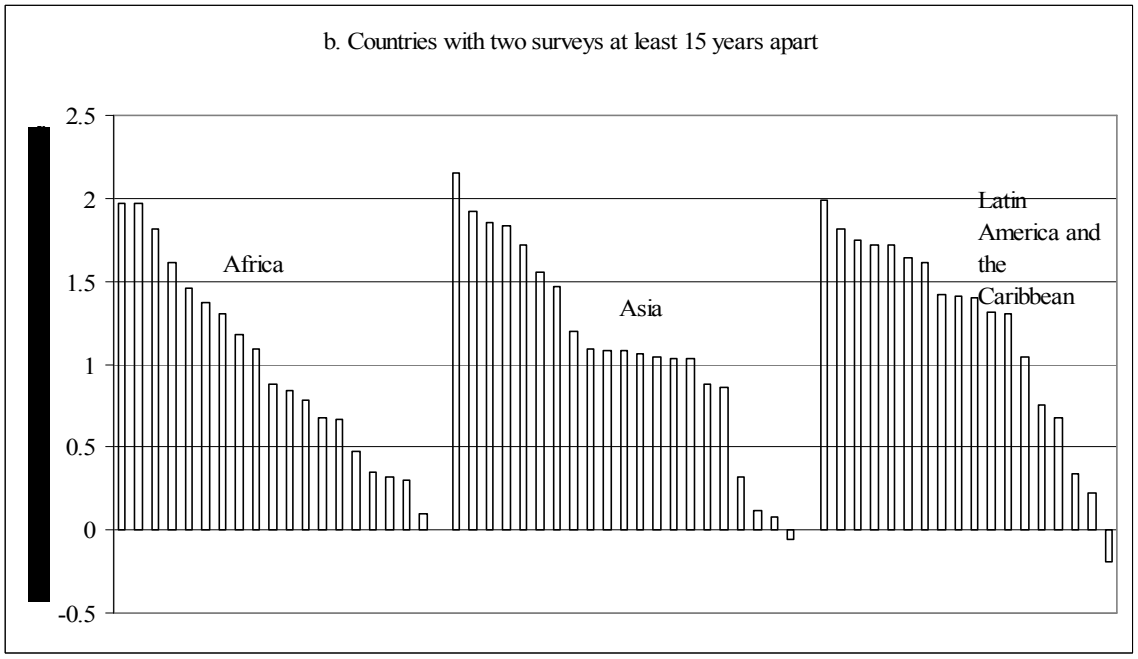

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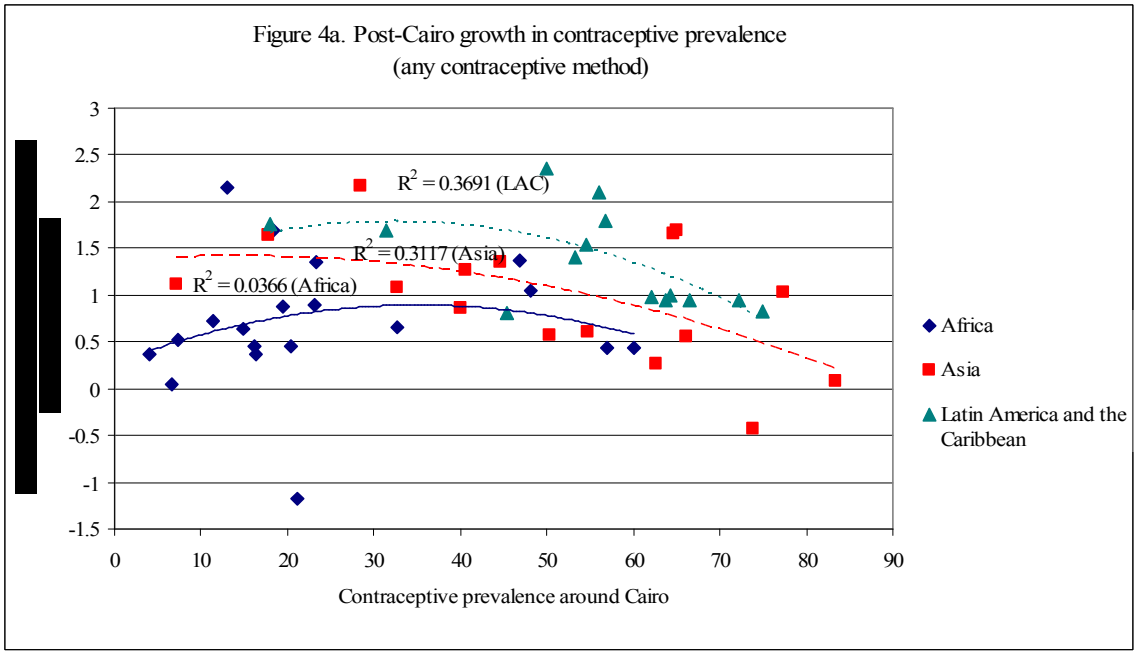

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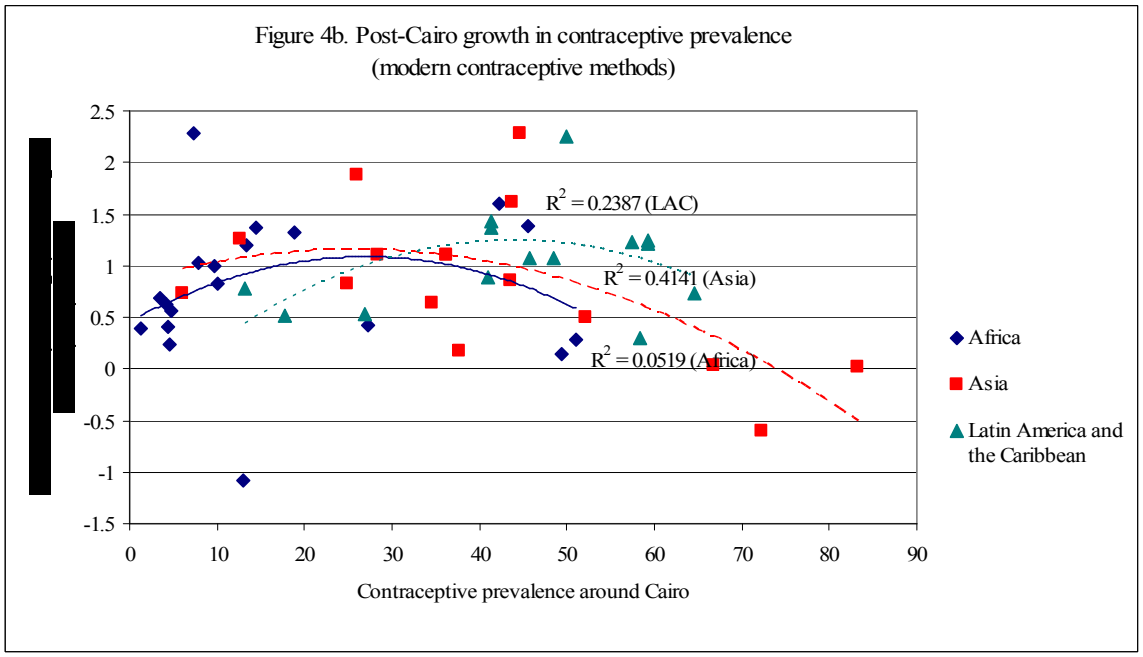

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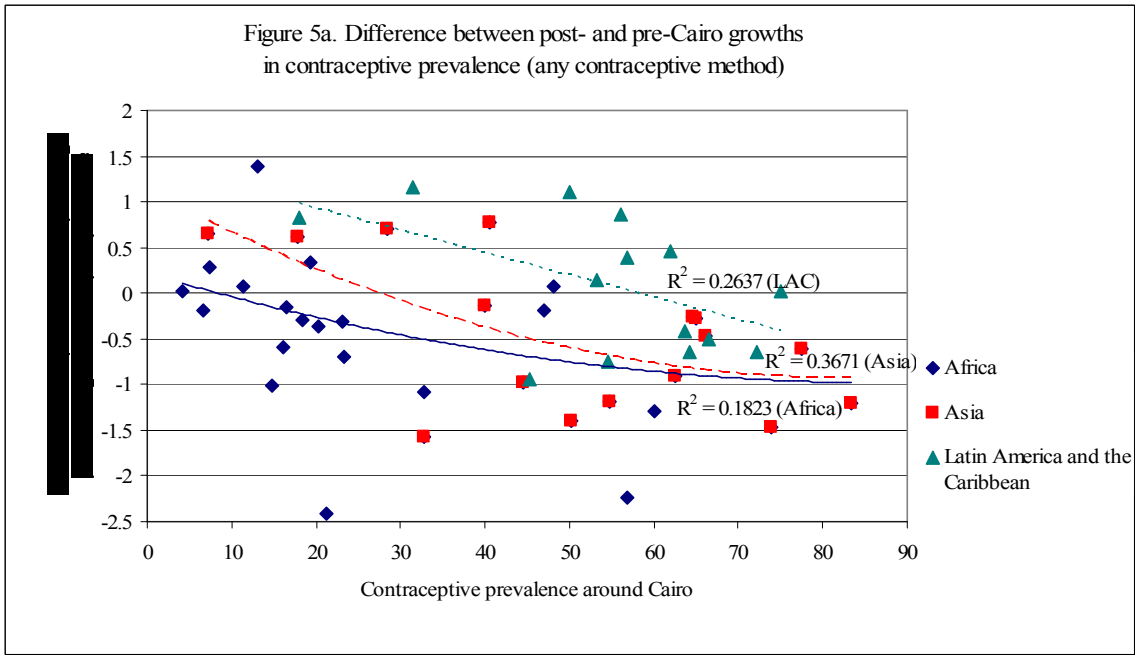

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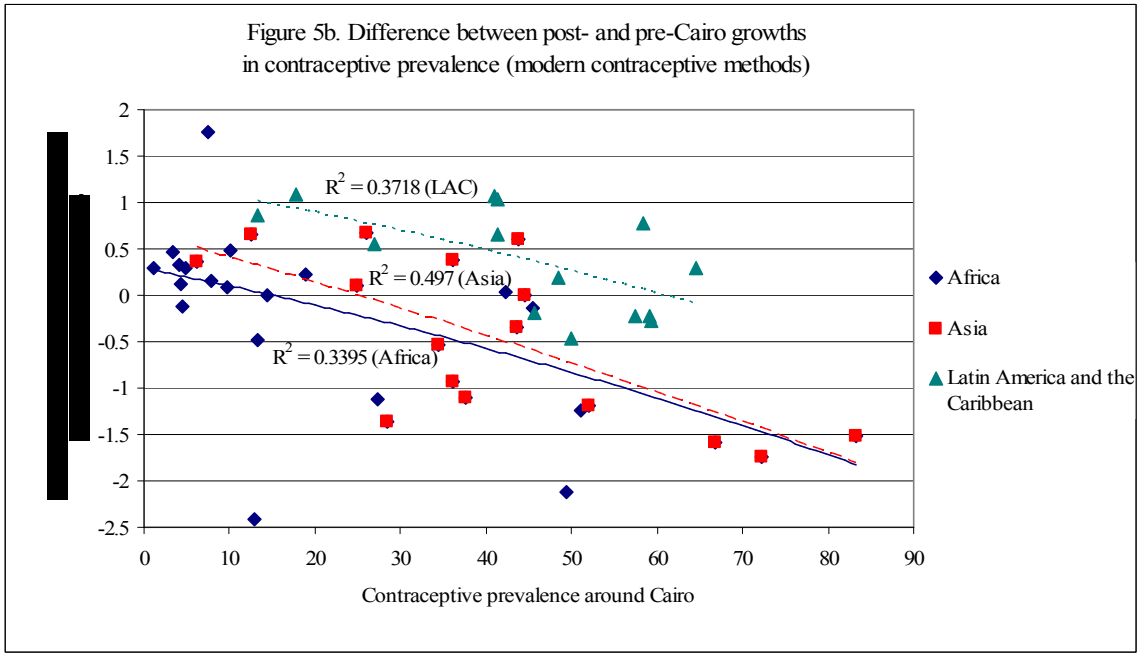

Source: Table 4.