Women's Empowerment and Reproductive Health:
Links throughout the Life Cycle

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Introduction

The Rights Agenda

A series of international agreements reached in the past decade has affirmed that national development and global health depend on fostering the full capacity of all citizens. Essential to this is the empowerment of women.

The empowerment of women has been recognized through many international, regional and national conferences as a basic human right—and also as imperative for national development, population stabilization and global well-being. Reproductive and sexual health and rights are essential for the empowerment of women and to all quality of life issues concerning social, economic, political and cultural participation by women.

Empowerment of women was a central policy goal of both the International Conference on Population and Development (ICPD) in Cairo in 1994 and the Fourth World Conference on Women (FWCW) in Beijing in 1995. Both conferences recognized and reaffirmed that reproductive health is an indispensable part of women's empowerment.

Women's empowerment has also been underscored in agreements of other important international, regional and national conferences during the past decade, including the World Summit for Children in 1990, the World Conference on Human Rights in 1993, the World Summit for Social Development in 1995, the World Food Summit in 1996, Habitat II in 1996, and the fifth-year review of ICPD implementation (ICPD+5) in 1999.

Women's empowerment is the process by which unequal power relations are transformed and women gain greater equality with men. At the government level, this includes the extension of all fundamental social, economic and political rights to women. On the individual level, this includes processes by which women gain inner power to express and defend their rights and gain greater self-esteem and control over their own lives and personal and social relationships. Male participation and acceptance of changed roles are essential for women's empowerment.

This report, a contribution to the "Beijing+5" review of progress since the FWCW, focuses on reproductive and sexual health and rights as necessary and vital components of women's empowerment throughout the life cycle.

What Are Sexual and Reproductive Rights?

International understanding about sexual and reproductive rights has broadened considerably in recent years. The ICPD Programme of Action[1] and the Beijing Platform for Action[2] recognize sexual and reproductive rights as *inalienable, integral and indivisible parts of universal human rights.*

Sexual and reproductive rights are also a cornerstone of development. Attaining the goals of sustainable, equitable development requires that people are able to exercise control over their sexual and reproductive lives. The most important sexual and reproductive rights include[3]:

- *Reproductive and sexual health* as a component of overall health, throughout the life cycle, for both men and women;
- *Reproductive decision-making,* including voluntary choice in marriage, family formation and determination of the number, timing and spacing of one's children; and the right to have access to the information and means needed to exercise voluntary choice;
- *Equality and equity for men and women,* to enable individuals to make free and informed choices in all spheres of life, free from discrimination based on gender;
- *Sexual and reproductive security,* including freedom from sexual violence and coercion, and the right to privacy.

The neglect of sexual and reproductive health and rights lies at the root of many problems the international community has identified as in need of urgent action. These include gender-based violence, HIV/AIDS, maternal mortality, teenage pregnancy, abandoned children and rapid population growth. This massive denial of human rights causes the death of millions of people every year; many more are permanently injured or infected. Most are in developing countries—and most are women. Sexual rights and health are not just an individual concern. Rather, they can have direct impact on the economy of a country—as clearly evidenced in the African countries hardest hit by the AIDS pandemic.

Defining Concepts and Rights

The United Nations conferences of the 1990s reached agreement on the following key concepts and definitions:

- **Reproductive health** is a state of complete physical, mental and social well-being (not merely the absence of disease or infirmity) in all matters related to the reproductive system and to its functions and processes. (FWCW Platform for Action, paragraph 94; ICPD Programme of Action, paragraph 7.2)
- **Sexual health** means that people should be able to have safe and satisfying sex lives. Gender relations should be equal, responsible and mutually respectful. Sexual health encompasses behaviours essential to countering sexually transmitted diseases (STDs), including HIV/AIDS. Sexual health aims at the enhancement of life and personal relations, and sexual health services should not consist merely of counselling and care related to reproduction and sexually transmitted diseases. (FWCW Platform for Action, paragraph 94; ICPD Programme of Action, paragraph 7.2)
- **Reproductive rights** include "the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents". (FWCW Platform for Action, paragraph 95)
- **Sexual rights** include "the human right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence". (FWCW Platform for Action, paragraph 96)

Reproductive Health and the Life Cycle

Reproductive health is not just a concern during a woman's so-called "reproductive years", customarily defined as ages 15 to 45. Rather, reproductive health is a lifetime concern for both women and men, from infancy to old age.

In many cultures, discrimination against girls and women begins in infancy and determines their life course. Issues of education and appropriate health care arise in childhood and adolescence. These continue to be issues in the reproductive years, along with family planning, STDs and reproductive tract infections, adequate nutrition and care in pregnancy, and the social status of women. Issues in old age include chronic infection and increasing concerns about cervical and breast cancer.

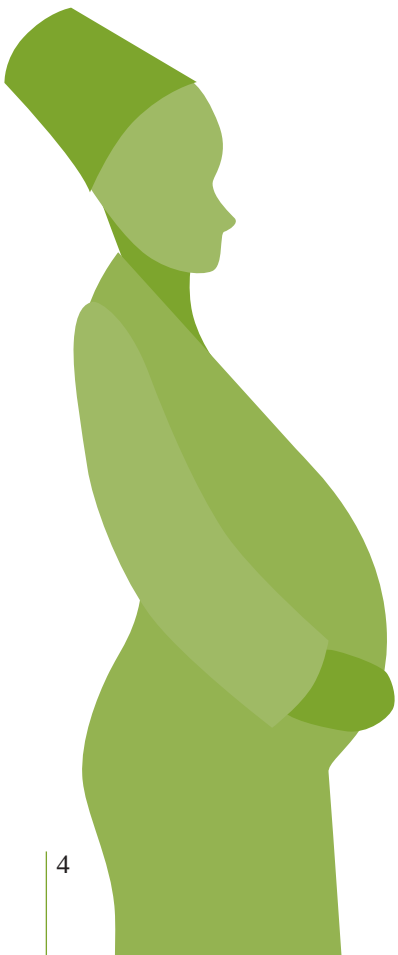
Male attitudes towards gender and sexual relations arise in boyhood, when they are often set for life. Men need early socialization in concepts of sexual responsibility and ongoing education and support for healthy sexual and family formation behaviour.

Women and men both need reproductive health care appropriate to their situation in the life cycle.[4]

Reproductive Health and Early Life Chances

A baby is born. Is it wanted? Who is its mother? Is she married? Does she have a partner or family able to provide support to her and her infant? How old is the mother? Is she educated? Literate? Is she prepared emotionally and otherwise mature enough to give the child the care and foundation it needs for a good start in life in an increasingly complex world?

The circumstances into which a child is born determine to a great extent not only whether it survives but the entire course of its life. The reproductive choices of women significantly affect both their life prospects and those of their children. The age of the mother, the spacing of births, and care during pregnancy and delivery are important determinants of infant survival and progress through childhood.



Children born outside a formal union, and those born after their parents already have the number of children they want, are at risk of inadequate attention and support from their parents.

The Burden of Being Born to a Young Mother[5]

The impact of reproductive health on the newborn is immediate and can be dramatic. Children born to adolescent mothers are usually at a disadvantage, given the mother's physical and emotional immaturity and the fact that having a child usually puts a stop to her schooling. The risks are especially great for the child if its mother is a young teen (12-16), if she is unmarried, if she is poor, or if the child is unwanted. The burden of being born to an adolescent mother is greatest when all of these conditions prevail.

About half of all deaths among children under age five occur in their first month of life. In developing countries, an infant's risk of death during the first year is 30 per cent greater if born to a young mother than to an adult woman.[6] Even if they survive, infants born to adolescent mothers are more likely to be premature and low birth-weight. Such survival risks are far greater in developing countries, given conditions of poverty, poor nutrition and poor availability of medical care.

Infants born to adolescent mothers are also at risk due to adverse socioeconomic conditions that are typically more severe when the mother is a teen. Adolescent mothers are generally less able to provide the compensatory care for a premature or low birth-weight infant. In poor families, other adults are less likely to be available or able to provide the needed support.

- Data from Nigeria show a striking contrast in infant mortality for adolescent versus slightly older mothers. For mothers under 20, infant mortality was 121 deaths per 1,000 live births, compared to 79 deaths for the mothers aged 20-29.

- In many African countries, girls who become pregnant are forced to leave school and are also likely to face moral persecution. Data from Rwanda, for example, show about 10 per cent of pregnant schoolgirls being disowned by their families. This, in turn, can result in child abandonment ("baby dumping") and entry of the young mother into prostitution.

Whatever the reason a baby is unwanted, he or she is likely to start life at a disadvantage. Abandonment is common, a reason for the swelling numbers of street children in large cities from Manila to Rio de Janeiro. If the child is kept in the family, the mother still may not be psychologically prepared for the responsibility of child rearing, or family resources may not be adequate to meet the baby's needs. The child is also more likely to be subjected to abuse.

Short Birth Intervals and Infant Mortality

Spacing births offers important benefits for both infants and mothers. Infants born less than one year after the end of their mothers' last pregnancy are much more likely to be malnourished and die than infants born after a longer interval. The risk of death posed by short birth intervals continues even after the first year of life.

Furthermore, when two children are born very close together, the health of the older child may also be in jeopardy. The word "kwashiorkor" is used in Ghana to describe the kind of malnutrition often seen when a child is weaned from the breast too early because the mother is pregnant again. Children weaned too early are much more susceptible to malnutrition and infection.

The higher death rates among closely-spaced infants may be due, in part, to the lack of time for the mother's body to fully recover after the last pregnancy—sometimes called the "maternal depletion syndrome". This may be especially true among women who breastfeed their children for long periods and among women who are malnourished and perform heavy physical work.

Son Preference and Sex Selection

In many countries girls suffer from deep-seated cultural preference for sons. In many poor communities, little girls are often neglected and denied education and medical care. Parents on all continents are more likely to send their sons to school and keep them there longer than their daughters.

Strong preference for male children has led in some countries to sex-selective abortion of female foetuses and even female infanticide. Increased availability of reproductive technology such as amniocentesis and ultrasound has made possible this particular form of gender-based discrimination, resulting in higher-than-normal male-to-female sex ratios, as in China, the Republic of Korea and India. Laws in India and China now ban sex-determination testing. Nevertheless, in Asia alone, at least 60 million girls are "missing" due to these phenomena.[7]

The Impact of Maternal Mortality

Unfortunately, maternal mortality remains all too common in developing countries where more than half a million women die each year from pregnancy-related causes, including unsafe abortion. This is equivalent to about 1 in 50 women dying in developing countries from complications of pregnancy and unsafe abortion, about 35 times more than in developed countries.

The death of a mother has extremely serious consequences, especially for an infant or young child. In developing countries, if the mother dies, there is a high risk that her children under age 5 will also die—a probability as high as 50 per cent in some places.[8] Many families are able to provide adequate care for the children whose mother has died, but many cannot.

Mother-to-Child Transmission of HIV/AIDS and Other STDs[9]

For children whose mothers are infected by HIV, early life chances are even grimmer. Mother-to-child transmission is by far the largest source of HIV infection in children below age 15. In a growing number of countries, AIDS is now the biggest single cause of child death. In urban centres in southern Africa, HIV rates of 20-30 per cent among pregnant women tested at antenatal clinics are common.[10]

In 1998, 10 per cent of all those newly infected were children, the vast majority of whom acquired the virus from their infected mothers. (The virus may be transmitted during pregnancy, childbirth or breastfeeding.) Africa is home to 90 per cent of the world's HIV-infected children, largely due to very high levels of HIV infection among women combined with high fertility rates. However, the number of HIV-infected children in India and South-east Asia appears to be rising rapidly.

- Where no preventive measures are taken, the risk of a baby acquiring the virus from an infected mother ranges from 15 to 25 per cent in industrialized countries and from 25 to 45 per cent in developing countries.
- Nearly 4.5 million children below age 15 have been infected by HIV and more than 3 million of them have already died of AIDS.
- AIDS threatens to reverse years of steady progress in child survival achieved through such measures as the promotion of breastfeeding, immunization and oral rehydration. The Joint United Nations Programme on HIV/AIDS (UNAIDS) projects that by the year 2010, AIDS may have increased mortality of children under 5 years of age by more than 100 per cent in regions most affected by the virus.[11]
- There are also serious long-term consequences of congenital and perinatal sexually transmitted infections. For example, syphilis contributes to blindness, deafness, paralysis and bone disease, and gonorrhoea to blindness.

A new drug called nevirapine (Viramune) offers hope to resource-poor countries. An anti-retroviral that slows the reproduction of HIV, nevirapine has been reported to cut infection in half—and is far less expensive than other drugs. Used to treat HIV-positive pregnant women in Uganda (now a leader in HIV/AIDS control efforts), nevirapine has also received clearance from the U.S. Food and Drug Administration for treatment of paediatric HIV/AIDS.[12]

Orphans

Wars, civil strife and AIDS are leaving behind huge numbers of orphans, many severely traumatized. The impact has been most extreme in Africa. The 1994 massacres in Rwanda, for example, left an estimated 200,000 children orphaned or separated from their parents.

> Bernadette Nakayima, 70, lives in Uganda's Masaka district where one third of all children are orphans. Nakayima lost all her 11 children to AIDS. "All those left me with 35 grandchildren to look after," she says. One of every four families in Uganda is now caring for an AIDS orphan, according to a local women's group.[13]

But nothing compares with the devastation inflicted by AIDS. More than 10 million African children under age 15 have lost a mother or both parents to AIDS. The number of "AIDS orphans"

in the 23 most afflicted countries is projected to reach 40 million by 2010. Huge anticipated increases in infant and child mortality due to AIDS are projected to reduce life expectancy to 40 years or less in nine countries by 2010.

In countries where AIDS has claimed the lives of many adults, more than 10 per cent of children lose one or both parents during their childhood. Children orphaned by AIDS are more likely to stop going to school than others their age. They are more likely to have to support themselves and to take on adult responsibilities. They are more likely to leave home or lose their homes and join the growing numbers of street children.

Orphaned girls may feel increased pressure to marry, turn to "sugar daddies", or turn to prostitution for survival—which, for many, will be only short-term survival. A large burden of supporting AIDS orphans falls on grandparents and other extended family members. Family systems in high-prevalence countries are undergoing tremendous stress.

The key messages:

- *Inform and empower girls to delay pregnancy until they are physically and emotionally mature.*
- *Inspire and motivate boys and men to be sexually responsible partners and value daughters equally as sons.*
- *Educate the public to understand that, if a woman with HIV or AIDS becomes pregnant, her baby is very likely to get HIV from her—and also die.*
- *Governments must take responsibility for the human catastrophe of orphans and other children who live in the streets, by creating programmes to rehabilitate them as human beings able to contribute to the society, and increasing efforts to prevent unwanted pregnancies that result in more street children.*

Reproductive Health and Education: The Mutual Relationship

The girl reaches age 5. Will she go to school like her brother? Or will she stay home to help her mother fetch water and take care of the new baby? If she starts school, will her father pull her out when they need additional labour in the field? Will her brother stay in school? When she becomes older, will she know how to resist the sexual advances of boys who find her attractive? What happens if she becomes pregnant? Will she be forced to leave school?

Around the world, education of boys is more highly valued than of girls.[14] The benefit of education for girls is indisputable, but not all parents perceive this. There are tremendous gaps in both school enrolment and the length of time boys and girls stay in school. While nearly all boys begin primary school, only three out of four girls do so. In many developing countries, fewer than half of all children continue on to secondary school, and girls are far less likely than boys to do so. In Bangladesh, for instance, secondary enrolment is 25 per cent for boys but only 13 per cent for girls. This neglect has critical consequences for women's empowerment as well as for their reproductive decisions.

The link between education and reproductive health is two-directional. Education of girls is closely related to improvements in family health and to falling fertility rates. In turn, girls born into smaller families are more likely to be sent to school and to complete more years of schooling.

Educating women benefits the whole of society. It has a more significant impact on poverty and development than men's education. It is also the most influential factor in improving child health and reducing infant mortality.

The ICPD and FWCW affirmed everyone's right to education and gave special attention to women and girls, recognizing that education is a cornerstone of women's empowerment because it enables them to respond to opportunities, to challenge their traditional roles and to change their lives. Paragraph 4.2 of the ICPD Programme of Action states, "Education is one of the most important means of empowering women with the knowledge, skills and self-confidence necessary to participate fully in the development process."

The two conferences also emphasized eradication of illiteracy as a prerequisite for human development. Globally, nearly 600 million women remain illiterate today, compared with about 320 million men.

The Gender Gap

Around the world are many social, cultural and economic barriers to girls' schooling, both for enrolling and staying in school. Among the barriers:

- *In many societies, parents see limited economic benefits to educating girls.* Daughters attending school are less available to help with household chores and childcare for younger siblings. Cultural norms are that sons support parents in old age while girls marry out and leave their parents.
- *Poverty is a major hindrance.* Schooling usually involves substantial sums for fees, books, uniforms and transportation. When family resources are limited, parents usually give higher priority to sons.
- *Decisions about schooling for girls are often influenced by social norms related to sexuality and marriage.* In traditional societies where chastity is highly valued, parents may be reluctant to allow girls to travel to school, be taught by male teachers and have close contact with boys. Parents often expect girls will marry at an early age, not needing education.

Disparities between initial enrolment rates for girls and boys are much greater than differences in drop-out rates. This suggests that the major challenge is to get girls into school.[15]

Parents increasingly recognize the need for education to improve their children's chances in life—but this understanding is slower to come in the case of girls. Increasingly many parents also understand that the family's long-term economic needs will be best served by providing better health care and education for fewer children, rather than relying on larger numbers. Parents who hope for better education for their female children tend to want smaller families, perhaps so that they can provide more fully for the offspring they have.

Education Delays Marriage, Improves Health and Lowers Fertility

In almost every setting—regardless of region, culture, or level of development—better-educated women are more likely:

- To marry later, use contraception, bear fewer children and raise healthier children;
- To make better decisions for themselves and their children;
- To make greater economic contributions to the household.

One of the strongest statistical correlations in developing countries is between mothers' education and infant mortality: the children of women with more years of schooling are much more likely to survive infancy. Better-educated women are also likely to have a greater say in decisions such as when and whom they marry and to use family planning to bear only the children they can provide for.

Early Sexual Activity, Pregnancy and Curtailment of Education

While schooling clearly delays marriage, whether or not schooling delays sexual activity is much

less clear. Most cultural norms say that girls should not be sexually active before marriage, but the fact is that, the world over, many are. The increase in school attendance in developing countries often intensifies contact between boys and girls, even where single-sex schools are the norm. These trends, together with the declining average age at menarche, mean that increasing numbers of girls are exposed to opportunity for sexual activity before marriage.[16] Without access to sexuality education and contraceptive information and services, many girls become pregnant.

For many girls, becoming pregnant means the end of formal education. In many countries, pregnant girls are forced to drop out of school; in Kenya alone, an estimated 10,000 a year do so. Many others drop out to care for their newborns—and, if they marry, to meet the demands of their new husbands.

Sexual and Reproductive Health Education

Young children and adolescents learn about sexual matters and reproduction by observing adult behaviour, from peers and older siblings, increasingly from the media, and, in some families, from their parents. Such information, however, is typically limited, frequently erroneous and, in the case of the media, often unduly glamourized.[17]

UNFPA has funded the development and inclusion of family life education (FLE) in school curricula in 79 countries over the past three decades, with technical assistance from UNESCO. In contrast to earlier curricula that focused on the population-development linkage, today's curricula are more likely to add reproductive health and physiology, family planning information and training for responsible parenthood (including planning and decision-making skills), encouragement of sexual abstinence, STD/HIV prevention, and training in gender equality.

Thus, formal instruction is an important source of accurate information. Formalized curricula for sexuality education are much less common in developing countries than in developed ones, and they are typically not implemented on a national level. In many cases, the average period of school attendance is so short as to preclude this possibility. Even in countries with nearly universal secondary education, many of the most disadvantaged adolescents drop out of school prematurely. Thus, important as school-based programmes might be, they need to be supplemented by various community-based educational programmes.

There is often strong religious and political opposition to sexuality education out of fear that it will encourage sexual activity. Data indicate, however, that sexuality education does not encourage young people to engage in sex. Most studies show that education about reproductive and sexual health contributes to the postponement of sexual activity and to the use of contraception among teens who are sexually active.[18]

Especially now, when adolescents are increasingly at risk of STDs and AIDS, it is crucial that governments, educators, parents and community leaders recognize these risks and the reality of premarital sexual activity among young people. It is imperative to work together to provide the sexuality education young people need to protect themselves. This includes, in addition to biological facts, information about dating, relationships, marriage and contraception. Programmes must help young people—boys and girls—recognize the merits of abstinence, develop the skills necessary to resist peer pressure and inappropriate sexual advances, and instil the confidence to negotiate the use of contraception with their partner.

The key messages:

Governments and programmes should:

- *Adopt policies and take all the necessary steps to provide equal access to education for girls. Provide universal primary education for both girls and boys by 2015.*
- *Encourage parents to have fewer children and send all children to school.*
- *Provide, strengthen and reorient health education to encourage young people to postpone sexual activity, but also recognize the inevitability of many becoming sexually active and provide the information they need to prevent pregnancy and STDs, including HIV/AIDS.*
- *Provide boys with a different model of masculinity, based on shared responsibility instead of domination.*

Parents:

- *Fathers and mothers must make sure that their daughters go to school, stay in school, and acquire skills they need for life.*

Adolescence and the Transition to Adulthood

She is now 14. Some of her friends who did not go to school are already married. She is lucky: still in school. Boys are finding her very attractive. Some older men with money offer to buy her nice things her parents cannot afford, but they are also interested in sex. So is her uncle who has attempted to molest her. Whom can she talk to besides her friends who are in similar situations?

About half of the world's population is under age 20.[19] Adolescents are at the highest risk of sexual and reproductive health problems. More than 15 million girls age 15 to 19 give birth every year. Many of their pregnancies are unwanted and many result in abortion, yet only 17 per cent of sexually active adolescents use any form of contraception.

Estimates are that 1 in 20 adolescents contracts a sexually transmitted disease each year. In many developing countries, more than half all new HIV infections are among young people 15 to 24; rates among girls 15 to 19 are five or six times higher than among boys the same age. About 5 million girls aged 15 to 19 have abortions every year, 40 per cent of which are performed under unsafe conditions that lead to high rates of mortality. Two million girls undergo female genital cutting every year, also with high rates of mortality. Girls and young women are especially vulnerable to rape, sexual abuse, harassment and sexual exploitation.[20]

Adolescence—a period between sexual maturity and the assumption of adult roles and responsibilities—is a recent innovation. In pre-industrial societies early marriage and childbearing were the norm. Typically, girls were married soon after menarche or even before. Husbands were

usually older than their brides, more experienced with the world outside their immediate family, and socialized to demand and expect deference from their mates. Girls were prepared early for their future roles as mothers.

Today, throughout the world, earlier sexual maturity, later marriage and emphasis on education have contributed to the acceptance of adolescence as a distinct phase of life. These same three factors also produce a much longer period of time between the onset of sexual maturity and marriage. The longer this period extends—no longer months but years—the more likely it is that unmarried adolescents will become sexually active and that unmarried girls will become pregnant.

Restrictions on Girls, Aggressive Behaviour among Boys

When children reach puberty, gender differences become increasingly important. Everywhere society continues to have different expectations about boys' and girls' sexual roles and relationships. Girls face double standards which boys do not. Both face risks, but for girls they are greater.

Once a young woman is capable of having children, her mobility and opportunities may be restricted as her family fears she may be sexually victimized or have sexual intercourse that would bring dishonour to the family. Some cultures believe that women have sexual powers that seduce and lead men astray; these cultures impose social restraints on girls and young women through seclusion or other limitations. Although nearly all societies subjugate women in some way, female genital cutting is the most drastic measure taken by any society to control women's sexuality and reproduction.

Early marriage is in part a response to parents' perceived responsibility of protecting sexually mature young women, either from others or from themselves. "If a girl doesn't marry at an early age, she will sleep with many men. Nobody would want to marry her later," a father in Côte d'Ivoire explained in defence of forced marriage when girls enter puberty.[21]

Most boys are socialized to believe that dominant behaviour towards girls and women is part of masculinity. More than just dominance, risk-taking and aggressive sexual behaviour on the part of young men are often applauded by peers and condoned by society.

Young People: Primary Victims of STDs and HIV/AIDS

In developing countries, HIV/AIDS is transmitted mainly through heterosexual sex. Young women are the primary victims.

Sexually transmitted diseases, including HIV/AIDS, are most common in the 15-24 age group. In all countries, young women face the highest risk of HIV infection through heterosexual contact. Women are more biologically susceptible to the transmission of infection than men—and adolescent girls are more susceptible than adult women.

In western Kenya, nearly one girl in four aged 15-19 is HIV-positive, compared with 1 in 25 boys of the same age. In Zambia, in the same age group, 16 times as many girls as boys are infected. In rural Uganda, among 20-24-year-olds, six young women are HIV-positive for every infected young man.[22]

The risk of infection is increased by the low social status of young women, who may be forced into sex or have little power to negotiate condom use with sexual partners. Sexually transmitted infections can lead to infertility and have a devastating impact on the life of an adolescent.

The risk of exposure to STDs and HIV/AIDS is especially great for:

- Young people who become sexually active early and are therefore more likely to change sexual partners;
- The millions of adolescents living or working on the streets, many of whom turn to selling sex to make a living;
- Married women whose husbands engage in extramarital affairs.

In Africa, Asia and Latin America alike, the millions of street children in fast-growing cities are at significant risk of STDs and HIV. In Brazil, with some 7 million street children, girls as young as 9 and 10 are forced into prostitution to survive, and many have STDs and HIV.[23]

Sexual Abuse, Rape and Exploitation

For some young women, sexual relationships are not entered into willingly, but come about as the result of force, coercion or abuse, including incest. Although the young and powerless of either sex may fall victim, young women are most likely to encounter sexual exploitation and, with it, the risk of infection and unwanted pregnancy. Risk and exploitation take many forms:

- Poverty, migration, warfare, and other disruption caused by emergency situations increase the risk of exposure to exploitative relationships, including sexual abuse.
- Rapid urbanization, resulting in large numbers of unskilled young people on the economic margin and only tenuously connected to their families, along with a ready market for sex, has led to large numbers of adolescents entering prostitution.
- The phenomenon of "sugar daddies" in Africa is a variation of prostitution, although the young women do not necessarily view it as such. Poor girls are particularly vulnerable to the interests and lures of older men who trade economic and social favours for sex. Many female students in Kenya and Nigeria, for example, reportedly view sexual favours as the only currency they have to exchange for the small amounts they need to cover books, school clothes and bus fare.
- Fear of AIDS leads many men to prey on young girls, either in the belief that they will not be infected, or, more dangerously, in the hope that their own infection will be cured.
- In Bangladesh, Brazil, Nepal, the Philippines and Thailand, girls are lured into prostitution by recruiters who promise jobs in restaurants or as domestic workers. Instead the girls have been sold to brothel owners and treated as virtual slaves. In Nepal and Thailand, some poor parents sell their daughters into prostitution as a source of family income.
- Girls and young women are especially vulnerable to rape. A review of data from various countries found that 40 to 47 per cent of reported rapes were perpetrated against girls 15 and under, while 18 per cent involved girls 9 and under. An organization working with young mothers in Costa Rica reported that 95 per cent of the pregnant girls under 16 were victims of incest.[24]

Pregnancy and Abortion

The unmarried adolescent girl who becomes pregnant faces three alternatives. She may marry the father; if she is in school, she most likely will drop out. The marriage as well as the pregnancy may be unwanted and soon result in divorce or abandonment. A second and increasingly common alternative is that she may become a single mother, often experiencing societal disapproval

and economic hardship. Or she may have an abortion, typically illegal and unsafe.

If she goes through with the pregnancy, the risk of complications or of dying in childbirth are much greater than if she had delayed childbearing until physically mature. Girls aged 15-19 are five times more likely to die in pregnancy or childbirth than women aged 20 to 24; for younger girls the risk is even higher. Whether the girl marries the father or not, her life options will be severely curtailed.

In Chile, Mexico and the Caribbean, studies indicate that adolescent mothers will have more children than those who start childbearing later, and will live with parents or other family more often and for longer periods. Fewer of the children's fathers will head the household or provide financial and other support.[25]

Pregnancy has become the principal cause of death among girls 15 to 19 in the Dominican Republic. Nearly one in four girls in this age group is either pregnant or has already given birth. Using peer education and counselling, a UNFPA-supported project aims to reduce adolescent pregnancy and STD and AIDS infection rates by making young people more aware of the health risks of unprotected sex. Teens are encouraged to postpone their first sexual encounter or to maintain a faithful relationship with one partner.[26]

Many girls resort to abortion. Usually this is clandestine and unsafe, because in most countries abortion is not legal except under certain circumstances. Even where abortion is legal, many young women resort to unsafe abortion, due to social stigma and inaccessibility of health services. While reliable data are scarce, an estimated 70,000 deaths each year result from the 20 million or so unsafe abortions that occur every year. Many of these deaths occur among adolescent girls and young women.[27]

Female Genital Cutting and Mutilation

The effort to control young women's sexuality can impose physical harm. In particular, female genital cutting, or mutilation, can cause severe physical and psychological damage. Female genital cutting is deeply entrenched where it is practised and is perpetuated by strong cultural dictates that may bar "uncircumcized" women from marrying, preparing meals or being accepted in society. Fearing ostracism, it is often mothers—and even girls themselves—who request the procedure. In some countries (e.g., Yemen), the mutilation occurs in infancy. In most cultures, however, genital cutting is a ritual that occurs between 4 and 12 years of age, at a time when girls can be made aware of the social role expected of them as women.[28]

Each year an estimated 2 million girls are at risk of genital cutting or mutilation. The procedure is typically carried out with primitive, unsterilized instruments while the young girl is forcibly held down. Immediate complications, very common, include violent pain, shock, haemorrhage, injury to adjacent organs, infection and death. Later problems include scarring, painful and prolonged menses, recurrent urinary tract infection, sexual complications, psychological trauma and difficult childbirth (prolonged labour, lacerations and vesicovaginal and rectovaginal fistulas). Complications are most serious for girls who are also subjected to infibulation (removal of clitoris and labia followed by sewing together of the raw surfaces).

- In a woman who has been infibulated, intercourse usually involves some tearing and bleeding, especially in the early years, as the opening must always be forced. Because of this, infections are commonplace.
- Female genital cutting and infibulation may contribute to the spread of HIV, due to tearing of scarred vaginal tissue. In cases of infibulation, some husbands may turn to anal sex or other partners when faced with difficulty of vaginal penetration.

Dire Need for Information and Services

Despite their great need for accurate information, adolescents throughout the world have extremely limited access to reproductive health services. Teenagers have difficulty making use of the services even when they are available. In Zimbabwe, young people cite, as reasons for not using such services, the cost, not knowing where to go and perceived disapproval if they go to a clinic.[29] The widespread lack of knowledge about STDs among young people prevents many from using protection or seeking help from health services.

The ICPD Programme of Action called on countries, with the support of the international community, to protect and promote the rights of adolescents to reproductive health education, information and care, and strive to reduce sexually transmitted disease and pregnancy among adolescents. It also recognized the need to educate young men to respect women and their reproductive choices, and to share responsibility with them in matters of sexuality, contraceptive use and reproduction.

The key messages:

- *Reorient health education and services to meet the needs of adolescents. Integrated sexual education and services for young people should include family planning information, and counselling on gender relations, STDs and HIV/AIDS, sexual abuse and reproductive health.*
- *Ensure that health care programmes and providers' attitudes do not restrict adolescents' access to the services and information they need.*
- *Support efforts to eradicate female genital cutting, sexual abuse, and exploitation of adolescents.*
- *Socialize and motivate boys and young men to show respect and responsibility in sexual relations.*

Marriage and the Family

At age 21, she has been married now for three years to a young man she met just after finishing secondary school. He treats her well. She almost died during the birth of their first child, born a year after their marriage; the second child, born 18 months later, was also a girl. Lately she and her husband quarrel frequently. She wants to use contraception—and go to vocational school to gain skills to supplement the household income—but his mother insists on grandsons.

Health Risks of Early Marriage

Early marriage is still the norm in many parts of the world. Early marriage usually leads to early motherhood. In many developing countries, at least 20 per cent of women—in some countries about half of all women—give birth to their first child before age 18. Expectations from parents, in-laws and society are to produce a child as soon after marriage as possible. Many young wives feel pressure to bear sons. This typically results in pregnancies being spaced too closely together, in addition to occurring too soon in the young mother's life.

In developing countries, more than half a million women die every year from pregnancy-related causes. There are four important reasons for these deaths. Births are either "too soon, too close, too many, or too late". Statistically, it is young women who most often die during pregnancy.

Women who marry or enter union at a young age are likely to have husbands who are much older than they are—up to 15 years older in some countries. This difference in age reduces the chance that the woman will be able to participate in decisions about childbearing or be able to negotiate the use of contraceptives.

Family Forms and Norms are Changing

Everywhere the family is in transition.[30] Marriage and unions increasingly take a great variety of forms:

- In many countries, the expectation of marriage leading to immediate childbearing is eroding and new types of relationships are becoming common.
- In Latin America and the Caribbean, many couples live in consensual unions without legally marrying.
- In developing countries, the proportions of young people who are unmarried into their thirties continues to increase.[31]
- Everywhere the proportion of female-headed households is increasing.[32]

Whatever form a particular family takes, the challenge remains for children born to be given the best possible chances for a good future.

Family Planning and Contraception

One of the most important choices a woman or couple can make is the decision to use contraception. Even if a couple wants a child as soon as possible after marriage, the use of contraception thereafter—for child "spacing"—is a sensible decision. Data show that optimal spacing between children is at least three to four years. Family planning allows parents to give the child the best chance possible for the nourishment and nurturing it needs—before another child is born. Spacing is also important for the health of the child's mother and the harmony and financial health of the family unit. Similarly, using contraception to limit the number of children to only those that the couple can truly care and provide for is also a wise decision. For many couples, use of contraception also contributes to a more satisfying sexual relationship by reducing or eliminating the fear of accidental unwanted pregnancy.

It is crucial for the well-being of children, families, and communities that family planning information and services be available to help women and men learn about and effectively use a method of contraception.

Husband-Wife Communication

The ideal situation is good communication between husband and wife about the spacing and number of children they will have. Some women are lucky and are able to make decisions about family planning and family size in collaboration with their husbands. Others, particularly newly married and younger women, have little or no decision-making power in the home, and husbands, parents or mothers-in-law decide for them. Still others use contraception clandestinely, fearing husbands or relatives will disapprove.

Women may be afraid out of a sense of modesty or shame to talk to their husbands about family planning. Some say they are too shy to begin discussions with their husbands; others fear their husband's response or worry that their knowledge of sexual issues could be interpreted as promiscuity or infidelity. Conflicts arise about when to have intercourse, whether to use contraception, which method to use, spacing of children, and when the children already born are enough. Many men say their role as financial provider gives them authority to decide how many children the family can afford. Contraceptive use, however, is usually considered the woman's responsibility.

In many cultures it is believed that men have rights to control their wives' childbearing. Thus in many countries the law requires a husband's consent when a woman wants to undergo sterilization.

With higher levels of education, couples are increasingly likely to communicate effectively on family planning and use of contraception to space their children and keep their families small. And increasingly men are adopting new models of masculinity that include being a responsible, caring husband and father.

Impacts of Unwanted Pregnancy

Many women in every country—more than half in some countries—say their last pregnancy or child was unwanted or mistimed. Unwanted pregnancies and births can have many negative consequences, for the children themselves, their siblings, their parents, and the society as a whole. Older women, and women who have already borne several children, face increased risk of complications and death in childbirth, especially in conditions of poverty and where health facilities are far away.

More than one in four pregnancies worldwide each year ends in abortion, many performed under clandestine and unsafe conditions. Unsafe abortion is a major cause of maternal death worldwide and has a devastating public health impact—as measured by deaths, illnesses, injuries and the costs of emergency care. More than half of women seeking abortions are married with children, although in many countries the proportion of young, unmarried women having abortions is increasing.

Expanding family planning services reduces the numbers of abortions—and the number of women who die as a consequence of unsafe abortion. This is especially true when greater access to contraception is combined with effective sexuality education.[33]

Safe Motherhood

Half a million women die each year due to complications of pregnancy and childbirth; 99 per cent of these deaths occur in developing countries. Increased access to family planning can reduce the maternal mortality rate by reducing the number of pregnancies among women of reproductive age.

The primary means of preventing maternal deaths is to provide rapid access to emergency obstetric care, including treatment of haemorrhage, infection, hypertension and obstructed labour. It is also important to ensure that someone with midwifery training is present at every delivery; in the developing countries, only 51 per cent of all births are professionally attended.[34] Life-saving interventions, such as transportation to medical centres, antibiotics and surgery, are unavailable to many women, especially in rural areas. These women may lack the money for health care or transport, or may simply lack the permission of their husbands to leave the village to seek care.

Sexual Health, STDs and HIV/AIDS

Sexual health and a healthy sexual relationship are important in a marriage and in holding a family together. Unfortunately, sexually transmitted diseases (STDs), including HIV/AIDS, are an increasingly common threat to a healthy marriage. A husband's extramarital relations now carry the risk that not only he may become infected but that he may bring home infection that could also kill his wife. The converse is also true, though less frequently so.

Today an estimated 33.6 million people are infected with HIV/AIDS. About 5.6 million people became newly infected in 1999.[35] More than 90 per cent of these live in developing countries where HIV is most commonly spread through heterosexual transmission.[36] HIV/AIDS has become a global pandemic, recognizing no national borders and posing threats that many

countries have yet to acknowledge. The pandemic is a profoundly destabilizing force, destroying families and communities, sowing misery and tragedy on a wide scale and retarding the development prospects of entire nations.

Men are twice as likely as women to infect their partners. Women are biologically more vulnerable to infection. In addition, many women do not understand the nature of STD/HIV transmission and many are in denial about their husband's extramarital sexual activity. Finally, most women do not have the power to deny intercourse to their husbands or partners, or to insist they use a condom.

The transmission of HIV is facilitated by the presence of other sexually transmitted infections, especially ulcerative infections. Each year there are 12 million new cases of syphilis, 89 million of chlamydia, 62 million of gonorrhoea, and 170 million of trichomoniasis. Here, too, women are at greater risk.[37]

The key messages:

- *Improve communication between men and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that they are equal partners in public and private life.*
- *Enable women to exercise their right to control their own fertility and their right to make decisions concerning reproduction, free of coercion, discrimination and violence.*
- *Improve the quality of reproductive health services, availability of those services, and eliminate barriers to access. Implement commitments to reducing the tragedy of maternal mortality.*
- *Encourage men's responsibility for sexual and reproductive behavior and increase male participation in family planning.*
- *Recognize unsafe abortion as a major public health concern, and frame policies and programmes based on a commitment to women's health.*

Labour Force Participation and Employment

She did not make it to vocational school, but went to work in a garment factory. Conditions were bad: long hours, dim lighting, blasting noise, fibre particles always in the air, supervisors promising longer breaks in exchange for sex. Having failed to persuade her husband about contraception, she became pregnant again—and was fired. It was actually a relief. After the birth of their third daughter, her husband finally agreed to have a vasectomy. He brought a cousin from the countryside to provide childcare, and she succeeded in going to vocational school where she acquired accounting skills that led to a job in a bank.

In every society and every household, women provide critical economic support to their families, whether in agriculture or by earning income in the informal or formal labour market. Reproductive decisions and sexual health have a great impact on women's ability to engage in productive labour and contribute to family well-being and that of the nation.[38]

Housework and Care of Young Children

Throughout the world women continue to bear primary responsibility for childcare and housework. This unpaid work remains economically invisible, but creates a foundation for all other economic, political and social life.

At the same time, pregnancy and care for young children impede women's opportunities for employment. Women today increasingly lack the traditional support of the extended family, in which other family members participated in childcare and children helped with agricultural and domestic chores. Childcare is often a heavy burden on women who work outside the home to support the family. Poverty greatly exacerbates the problem.

A survey in Japan found that married women with paying jobs spent an average of two hours and 26 minutes daily on household chores, while married men spent an average of only seven minutes. Japan is not unique in this regard.[39]

Employment for Women and Reproductive Decisions

The vast majority of women in developing countries continue to be employed in agriculture, but most do not own the land on which they toil. For example, in South-east Asia and the Indian subcontinent at least 70 per cent of the female labour force works in agriculture. Yet fewer than 10 per cent of women farmers in India, Nepal and Thailand are landowners.

Traditionally, marriage norms, inheritance laws and social customs give men control over women's access to economic opportunities. In many countries in Africa and elsewhere, women are not allowed to inherit land; without land as collateral, they cannot gain access to credit. Enabling women to inherit land and have access to credit permits entrepreneurship and changes women's goals and status, and contributes to their having fewer children.

Where women work for pay, around the world, they work more and are paid less.

- In many developing countries, wage discrimination is severe. On average women earn only 60 to 70 per cent of what men are paid for similar work, in parts of Africa and Asia, only 50 per cent.[40]
- When all of women's work, paid and unpaid, is taken into account, their economic contribution is generally greater than that of men.
- Women work longer hours than men. In developing countries, women's work hours are estimated to exceed men's by about 30 per cent.[41]

Women's employment in formal-sector wage work is increasing. In developing countries, women now represent more than a third—in some Asian countries, almost a half—of the manufacturing labour force.[42]

For young women in particular, wage work may offer not just economic opportunities but also the chance to learn new skills, make wider social contacts and experience more of life's variety.

In Indonesia, Singapore, South Korea, Taiwan (Province of China) and Thailand—where modern contraception has been widely accepted, many girls are educated, and family sizes have declined dramatically—the numbers of women who have moved into professional, technical and

The key messages:

Governments should implement commitments made in Cairo, Beijing and Copenhagen to:

- *Increase gender equality and equal opportunities for women in all spheres of employment.*
- *Provide education and training that enable women to catch up and adapt to changing economic conditions and new technology.*
- *Create policies to harmonize employment and family responsibilities for women and men and to promote egalitarian sharing of domestic and community responsibilities.*
- *Eliminate discriminatory practices by employers and take appropriate measures in consideration of women's reproductive roles and functions.*
- *Undertake legislation and reforms to give women equal access to economic resources, including ownership and control over land and other forms of property, credit and inheritance.*

administrative positions have increased substantially in recent decades.

The same is true in many parts of Latin America and Africa as well, but overall the proportion of women who have moved into desirable jobs remains low. For those women closest to poverty who work in low-wage jobs, especially in the manufacturing sector, conditions are often poor and even gruesome.

Use of family planning increases a woman's prospects for employment, which can result in both economic benefits and better self-esteem. It also allows women to seek additional training and education, which enables them to get better employment. Earning an income improves marriage prospects for many unmarried women, and gives them a greater voice in the family when they do marry.

Increased family income may reduce tensions related to poverty and reduce domestic violence. Many women report gaining a sense of equality through wage-employment, are more able to communicate effectively with their partners, and feel less vulnerable to abuse.[43]

Women's groups and non-governmental organizations play important roles in providing opportunities for women to gain knowledge, confidence and skills to find better employment while also promoting sexual and reproductive health, including contraception.[44]

Risks in the Workplace

For the increasing numbers of women who take industrial jobs in rapidly developing economies, occupational health risks are many. Many are forced to work long hours at low pay under hazardous conditions and in unhealthy environments. Sex discrimination and sexual harassment are common, coinciding in many places with rising rates of crime and violence against women. Reproductive hazards are increasingly apparent; data indicate increases in spontaneous abortion, miscarriage, cancer, birth defects and serious teratogenic effects of toxic-chemical exposure.[45] Women who become pregnant are often fired without benefits.

Reproductive Health and Violence

Influenced by the plight of one of her daughters, she is now working with the local women's group to "shatter the silence" on domestic violence. That daughter is married to a man who beats her and who she fears will give her HIV; she wants to leave but cannot because she lacks economic means to support herself and her two children, and fears he may kill her.

Gender-based violence is universal, differing only in scope from one society to the next.[46] The negative impacts and horrors of violence inflicted upon women—in war, the streets and the home—include rape, unwanted pregnancy, physical injury, harm to a wanted pregnancy, HIV/AIDS, disfigurement, psychological misery and death. In developing countries, it is estimated that rape and domestic violence account for 5 per cent of the healthy years of life lost to women of reproductive age.

- In Bangladesh and parts of Latin America, acid throwing, a form of abuse increasingly perpetrated by vengeful lovers, leads to permanent disfigurement.[47]
- In the United States, battery is the greatest single cause of injury to women, accounting for more injury than auto accidents, muggings and rape combined.[48]
- In societies where virginity is emphasized, rape is sometimes used as a weapon of revenge to dishonour a young woman or her family.
- In Alexandria, Egypt, a study of female homicides revealed that nearly half the women and girls killed had been murdered by relatives seeking to rid themselves of the "dishonour" of a family member having been raped.[49]

Abuse-related injuries range from cuts to broken bones to death. In addition, battered women often suffer chronic headaches, abdominal pain, recurrent vaginal infections, and sleep and eating disorders. Battered women are four to five times more likely to require psychiatric treatment and five times more likely to attempt suicide than other women. About a third of battered women suffer major depressions, and some go on to abuse alcohol or drugs.[50]

Domestic Violence

Around the world, much of gender-based violence is inflicted on girls and women by husbands, fathers or other male relatives.

- In surveys from countries as diverse as Egypt, the United States and parts of Nicaragua and Zimbabwe, 20 to 50 per cent of ever-married women report being beaten or otherwise physically abused by their partners.[51]
- In Bangladesh, half of all murders are of wives by husbands. In Canada, 62 per cent of women murdered in 1987 died as a result of domestic violence. And in Papua New Guinea, almost three fourths of women murdered were killed by their husbands.
- In urban Maharashtra and greater Mumbai, one out of every five deaths among women 15-45 is due to "accidental" burns.
- Among Fijian Indian families, 41 per cent cite marital violence as the cause of their loved one's suicide.

Pregnant women are particularly vulnerable. Some husbands become more violent during the wife's pregnancy, even kicking or hitting their wives in the belly. These women run twice the risk of miscarriage and four times the risk of having a low-birth weight baby. Other complications that may result from abuse are pre-eclampsia and premature labour.[52]

- In a survey of 342 women near Mexico City, 20 per cent of those battered reported blows to the stomach during pregnancy.

Much of domestic violence relates to male sexual desire, jealousy and desire to exert authority over the woman. Everywhere, for women who live with violent or alcoholic partners, the possibility of coercive sex is great.

- In the United States, 10 to 14 per cent of married women report being physically forced to have sex against their will; among battered women the prevalence of coercive intercourse is at least 40 per cent.
- Studies in Guatemala, the Philippines, Peru and Sri Lanka reveal forced sex in marriage, especially when men arrive home drunk.

Women as Victims in War and Emergencies

In war, rape of women and girls—often in front of family members—can be an assault on both the individual and her family and community. In situations of ethnic conflict, rape can be both a military strategy and a nationalistic policy. Rape in war may be intended to disable an enemy by destroying the bonds of family and society.

Women who have been raped in war not only endure the physical and emotional horrors of sexual violation and a possible child by the enemy, but face exposure to STDs, including HIV/AIDS. Often women who have been raped seek to keep this secret, feeling shame and fearing rejection by their husbands or partners, families and the community.

Approximately 75 per cent of the world's 18 million refugees are women and girls. Repeated and often brutal rapes are a too-common aspect of the female refugee experience. Refugee women are subject to sexual violence and abduction at every step of their escape, from flight to border crossings to life in refugee camps.[53]

- Data on Vietnamese boat people indicate that 39 per cent of women were abducted and/or raped by gangsters while at sea.
- Refugee workers find a common link between rape and subsequent domestic violence, especially by men whose wives or daughters have been raped in their presence.

Refugee men often feel victimized by their experience and feel that they have failed in their obligation to protect their families. This vulnerability, compounded by the frustration of resettlement, often leads refugee men to resort to domestic violence to recover power and control.[54]

Additional Costs

In addition to personal costs, violence against women and girls puts a strain on the limited resources of most national public health care systems. The culture of silence about the causes of injury and pain suffered by too many women and girls results in an inefficient use of available services, since treatment provides only temporary reprieve if root causes are not addressed directly.

Children who witness violence experience many of the same emotional and behavioural problems that abused children do. These include depression, aggression, disobedience, nightmares, poor school performance and somatic health complaints. Children who witness or experience violence are more likely to be abusive as adults.

The key messages:

Governments should:

- *Develop or strengthen existing national plans of action, in collaboration with non-governmental organizations, to promote the protection of women, youth and children from any form of violence.*
- *Provide rehabilitation and support programmes for victims of violence, including confidential counselling and mental health care for girls and women of all ages who have experienced any form of violence, including sexual abuse, sexual exploitation, prostitution and trafficking.*
- *Develop programmes to educate, raise awareness of and prevent acts of violence against women, including by supporting non-governmental organizations and women's groups in this effort.*
- *Condemn violence against women and girls and refrain from invoking any custom, tradition, or religious consideration to avoid obligation with respect to elimination of violence.*
- *The international community should take leadership in breaking the norm of condoning war rape against girls and women. War crimes such as rape and violence against girls and women refugees should be condemned and punished.*

The Older Years

She's among the fortunate. Although widowed, her health is better than most, thanks to the extra income she brought into the household, to good nutrition, and to the support she had from her husband. She is active in the community and a local women's group, encouraging young parents to use family planning and send all their children to school. Her sisters have not been so lucky. Her younger sister is now HIV positive, the result of her husband's playing around. Her older sister died in childbirth during her seventh pregnancy.

The worldwide population of post-menopausal women is expected to increase by the year 2030 to a total of 1.2 billion. Of these, about 75 per cent will live in developing countries.

The health and circumstances of women in their older years are to a great extent the cumulative outcome of reproductive and sexual health during the earlier years. Women live longer than men and average more years of ill health late in life.[55] Two scenarios become apparent:

Most women who enjoy healthy older years, primarily in industrialized countries, are those who completed at least basic education, who have had few children, good access to reproductive and preventive health care, good nutrition, minimal exposure to work-related stress and injury, and a supportive husband or partner. Their older-age health concerns focus on issues such as hormone replacement and degenerative conditions such as arthritis and osteoporosis.

In developing countries, many older women suffer from chronic health problems caused by years of neglect, discrimination and hardship. Their health reflects inadequate access to basic services, food and nutrition throughout their lives, and the hardships of their childbearing years—including births too early and too closely spaced, poor nutrition and anaemia, and heavy physical labour. Lifelong exposure to smoky kitchens, polluted water, and pesticides may also have harmed their health.

Reproductive health problems after menopause are significantly influenced by the quality of care women receive when younger. Uterine prolapse, urine incontinence, and the debilitating outcome of living with vesicovaginal fistula are examples of post-menopausal health problems that have their origin in poor or no obstetrical care at an earlier age.

Leaving the reproductive years marks an important change for women in social status. In most traditional societies, women exercise more power in the household as mothers-in-law and grandmothers than they did as younger women. As older women, they have the authority to perpetuate injurious cultural norms such as early marriage and son preference, or to promote new norms for gender equality and women's empowerment.

The Bamilikes and others in north-western Cameroon believe that cessation of menstruation makes the woman as wise as a man and that her social status can therefore be elevated to a position of leadership.

The key messages:

- *Reorient and strengthen health care services to better meet the needs of older women.*
- *Support outreach by women's NGOs to help older women in the community to better understand the importance of girls' education and reproductive and sexual health and rights so that they may become effective transmitters of this knowledge.*
- *Develop strategies to better meet needs of the elderly for food, water, shelter, social and legal services and health care.*

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49. UNFPA 1998b, p. 11.
50. Koblinsky, Timyan, and Gay 1993, Ch. 8, p. 172.
51. Blaney 1998.
52. UNFPA 1998b, p.10.
53. Heise 1993, p.178.
54. Friedman 1991.
55. Sources: UNFPA 1998a; Segal, Sheldon. 1997. "Women's Health: Issues Beyond the Reproductive Years." *South-to-South Newsletter* 7: 4-5; and Shaaban, Mamdouh. 1997. "Menopause in the Context of Developing Countries." *South-to-South Newsletter* 7: 6-8.