vehicle accidents, rape, and muggings combined (*3*, p. 12).

Women are also subject to particular health risks because of inadequate services to meet health needs related to sexuality and reproduction. Reproductive tract infections are common diseases with profound social and health consequences, especially for women living in the Third World. Yet, in allocating scarce human and financial health care resources to developing countries, policymakers, program planners, and international donor agencies have generally given low priority to these reproductive diseases (*5*).

The acquired immunodeficiency syndrome (AIDS) pandemic is a case in point. At present, almost half of the adults newly infected by the human immunodeficiency virus (HIV) are women. Every minute of the day, every day of the year, two women become infected by HIV, and every 2 minutes a woman dies from AIDS. Women are biologically more vulnerable to infection with HIV. Transmission of HIV from male to female is 2 to 10 times more effective than from female to male (*6*). WHO estimates that by the year 2000, over 13 million women will have been infected with HIV, several million of whom will already have progressed to the disease state. Prevalence rates of other sexually transmitted diseases are higher among females than among males in those aged 20 years and younger (*7*).

At first, monitors of HIV and AIDS did not consider AIDS a serious health threat to women. More recently, concern over the growing pandemic has recast the image of women as merely vectors of virus transmission (*8*). Furthermore, much research on pediatric AIDS has focused on perinatal transmission in HIV-infected women. There is a serious lack of research focusing on the consequences of HIV infection in nonpregnant women (*9*).

Cancers of all types are another major health threat to women. Cervical cancer is the most common form of cancer in women in most developing countries and overall is the second most common form of cancer in women. There are an estimated 450,000 new cases each year (a realistic figure that includes undiagnosed early cases would be high as 900,000), of whom 300,000 will die from the disease (*10*). The most common form of cancer in North America, Latin America, and Europe is breast cancer. As in cervical cancer, early detection of breast cancer plays a major role in the reduction of mortality among women suffering from the disease (*10*).

On average, women live longer than men, yet little attention has been paid to gender differences in the quality of life among the elderly or to the illnesses from which they may suffer. One consequence of women's longer life-span is a longer period of overall morbidity (*11*). In the years to come, the number of women over the age of 65, in both industrialized and developing countries, will increase from 330 million in 1990 to 600 million in 2015 (*6*, p. 21). Of these elderly women, many will suffer from the chronic diseases associated with aging, such as osteoporosis and dementia, or from the consequences of neglect, such as malnutrition, alienation, and loneliness (*10*, p. 13).

Strategies for Health Promotion

Recognizing the current global state of women's health and health care research, the FWCW's Platform for Action proposes several actions that should be taken by governments, nongovernmental organizations, international organizations, and others in the field of health services delivery. The reaffirmation by the Conference of women's right to the enjoyment of the highest attainable standards of physical and mental health will enable governments to promote the attainment of this right by incorporating it into national legislation and by reviewing existing legislation (including health legislation) and policies to reflect a commitment to women's health (*2*, p. 38). This would be an important first step toward a more equitable health care system.

The Platform further proposes the design and implementation of gender-sensitive health programs. These might include decentralized health services that take into account women's multiple roles and responsibilities, and the diversity of women's needs across age and socioeconomic and cultural boundaries (*2*, p. 38).

The promotion of women-centered health research is also recommended through linking traditional knowledge with modern medicine and making information available to women that would enable them to make responsible decisions regarding their health (*2*, p. 45). Women will enjoy the right to make these decisions only when progress is made in overcoming age-old barriers to equality and choice. When this goal is achieved, all human beings—women and men—will be able to seek and receive health care that is accessible and reasonable. The Platform for Action provides a blueprint for realizing this goal. Governments, in particular, will be encouraged to make the commitment, not only to carry forward agreements reached in Beijing, but also to provide the resources to implement them.

REFERENCES

1. Proposals for Consideration in the Preparation of a Draft Declaration and the Draft Platform for Action: Following Consideration by the Commission on the Status of Women at its 39th Session, 15 March 1995.
2. Draft Platform for Action, p. 42.
3. R. J. Cook, *Women's Health and Human Rights* (World Health Organization, Geneva, 1994), p. 7.
4. World Health Organization, Geneva, *Women's Health: Towards a Better World* (Issues Paper for the Global Commission on Women's Health, 1994), p. 12.
5. R. Dixon-Mueller and J. Wasserheit, *The Culture of Silence: Reproductive Tract Infections Among Women in the Third World* (International Women's Health Coalition, 1991), p. 1.
6. World Health Organization, Geneva, *Women's Health* (1994), p. 18.
7. United Nations Economic and Social Council, *Second Review of the Nairobi Forward-Looking Strategies* (1995), p. 11.
8. J. L. Mitchell, *AIDS Publ. Policy J.* **3** (no. 2), 50 (1988).
9. J. L. Mitchell *et al.*, *J. Women's Health* **1**, 35 (1992).
10. United Nations Economic and Social Council, *Second Review of the Implementation of Nairobi Forward-Looking Strategies* (1995), p. 11.
11. R. J. Cook, *Women's Health and Human Rights* (World Health Organization, Geneva, 1995), p. 12.

International Perspectives on Women's Reproductive Health

Claudia García-Moreno and Tomris Türmen

Women all over the world have long been advocating for health services that view and address their needs in a holistic manner and not in fragments, and that take into account the context of their lives. The International Conference on Population and Development (ICPD), held in Cairo in September 1994, went a long way toward recognizing women's concerns in the area of reproductive health. The Cairo conference made several important conceptual shifts:

- from a single-minded concern with population growth and the need for population control to a framework for approaching population-related issues that considers the interactions of population, poverty, and patterns of consumption and production;
- from narrowly defined family planning programs that aim to reduce fertility to an emphasis on health, empowerment, and the right of individuals to determine the number, spacing, and timing of children;
- from a technological approach to fertility control to comprehensive reproductive

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health services joined with broader social action in other areas, including education for women, legislation to prohibit discrimination against women and girls, and the recognition of unsafe abortion as a major public health problem; and

- from seeing women as objects of family planning policies to endorsing gender equity, equality, and women's empowerment as important aims and as essential conditions for the promotion of reproductive health and rights.

Although some proponents of the old population control approach argue that the ICPD agenda in general, and reproductive health promotion and services in particular, are unmanageable, diffuse, and expensive, the weight of opinion is now in favor of the ICPD approach. How this approach can be applied in terms of national and international programs and activities is still the subject of discussion.

The New Vision and the Rationale for Change

Reproductive health is an aspect of general health, which has been defined by the World Health Organization (WHO) as "physical, mental and social well-being and not merely the absence of disease" (*1*). Reproductive health is the health and well-being of individuals "in all matters relating to the reproductive system and to its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. . . . [It implies] the right of access to appropriate information and services. . . . It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases" (*2*).

Reproductive health promotion strategies should consider the needs of women at different times in their life-span and should give special attention to adolescents and women in their reproductive years as well as to gaps in existing service provision. Reproductive health services should ensure the establishment of functional linkages or integration among programs that address the various components of reproductive health and aim to improve both access to services and quality of care, including the attitudes of service providers to the women they serve. Most important, strategies adopted should ensure that women and other users are involved in the planning and evaluation of these services. An approach to reproductive health that empowers women must be based on respect for women's autonomy and on the recognition that women will make appropriate decisions if they are given the necessary information and the means to do so. Such an approach should respect their human rights and support them in making choices free from coercion or discrimination. Another essential element is equality with men, which needs to be fostered in both sexes from an early age.

This new paradigm for reproductive health care arises from a recognition of the shortcomings of existing services and the limitations of vertical maternal and child health and family planning programs, as well as from new epidemiological data on reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) including acquired immunodeficiency syndrome (AIDS). Existing programs have until recently focused on reducing fertility and have ignored closely related reproductive health problems. In many cases family planning is still provided only to married women or couples; the needs of unmarried people in general, and adolescents in particular, have been neglected. Policies and programs should help young people to develop interpersonal relations of mutual respect and to avoid sexual relations they do not want or for which they are not ready, and should provide them with the information, skills, and services that enable them to protect themselves against unwanted pregnancy and STDs.

Reproductive health care requires a wide range of information and services at the primary care level, and it also must provide referrals for services at other levels of the system. This range includes family planning, safe delivery and postnatal care, safe abortion where legal, management of the consequences of unsafe abortion in all circumstances, treatment of RTIs including STDs, and active discouragement of harmful practices such as female genital mutilation.

Although policies and programs have been developed for many of the individual components of reproductive health care, the major challenge now is to design approaches that link them effectively. Potential solutions cannot involve health services alone; reproductive health affects and is affected by the broader context of people's lives, including their economic circumstances, their education and employment opportunities, the social relations between men and women, and the cultural and legal structures within which they live (*1*). In particular, the status of girls and women in a given society determines the degree of control they have over their lives, their sexuality, and their fertility.

Magnitude of the Problem

There is a lack of reliable information on many aspects of reproductive health, but the available data indicate that serious problems exist, particularly for women. An analysis by the World Bank and WHO (*1*) showed that reproductive ill health accounts for more than 30% of the overall burden of disease and disability among women of reproductive age, compared to 12% for men. STDs account for 8.9% of the burden of disease among women compared to 1.5% for men of the same age group (*1*). Also, STDs in women are more often not recognized and treated until major morbidity has occurred.

Worldwide estimates of reproductive ill health are given in Table 1. The total unmet need for family planning, estimated at 120 million people, does not include the unmet needs of adolescents or unmarried people, nor does it include the unmet need for care in cases of contraceptive failure. We are accumulating new data on the impact of RTIs, many of them caused by STDs, on the health and well-being of women (*3*). In developing countries STDs are among the leading causes of mortality and morbidity in women. If left untreated they can lead to pelvic inflammatory disease, infertility, ectopic pregnancy, and cancer.

The rapid spread of the human immunodeficiency virus (HIV) and AIDS among women (*4*), particularly young women (*5*), has highlighted the extent to which gender inequalities render women unable in many circumstances to make choices and to protect themselves even when they have the information and knowledge to do so. The need to develop women-controlled methods

that protect against STDs (including HIV) and to make them available at low cost has been raised frequently by women in recent years, and this need is now being addressed by researchers in various institutions. There is still a long way to go before women-controlled methods are available, and interventions to change sexual behavior—particularly among men—are still urgently needed.

Violence against women, which often occurs in the context of sexuality and reproduction, is another problem that is only now beginning to be recognized in its full dimensions. More than 35 well-designed studies (6) document that in many countries, from 20% to more than 50% of women have been beaten by an intimate male partner; other data show sexual assault to be a common event in the lives of many girls and women (6). Rape, sexual abuse, battery during pregnancy, forced prostitution, and incest all have serious consequences for women's physical and mental health. These include STDs, unwanted pregnancies, unsafe abortions, mental problems and, in some cases, death.

From Rhetoric to Reality

Undertaking an approach to reproductive health that addresses the wide range of women's needs and provides relevant services offers opportunities for improving overall program effectiveness and client satisfaction. For example, a recent review (7) identified lack of knowledge, fear of side effects, and social and familial disapproval as the principal causes of unmet need for contraception in developing countries. The authors concluded that programs can be "successful if they reach beyond the conventional boundaries of service." We know empirically that inclusion of diagnosis and treatment of RTIs in antenatal and family planning services would have beneficial effects (3). Improving the quality of care and responding to women's needs can enhance the effectiveness and increase the likelihood of continuity of contraceptive use.

As yet, however, little experience has been gained in the actual implementation of a more integrated approach. Although less than a year has passed since governments and international agencies agreed to a reproductive health agenda, some people have already begun to assert that its goals will be too difficult or too expensive to achieve. There are also those who deeply believe that family planning is the highest priority. In fact, better linkages across services and greater responsiveness to women's needs may prove to be less expensive in the long run by meeting needs earlier and preventing problems before they arise or become incurable.

Many questions and challenges remain, but the vision expressed at ICPD needs to be put into practice. Funding agencies should invest in alternative and innovative approaches to service delivery that incorporate nonmedical elements that also affect reproductive health. More resources need to be mobilized for women's health in general and for reproductive health in particular. Better coordination and collaboration between providers of funds and international agencies, with greater accountability, should improve the way these resources are allocated and used.

Table 1. Estimated global magnitude of major reproductive health concerns (*1*).

Category	Millions (worldwide)
Couples with unmet family planning needs	120
Infertile couples	60 to 80
Maternal deaths (cases per year)	0.5
Severe maternal morbidity (cases per year)	20
Perinatal mortality (cases per year)	7.2
Infants with low weight at birth (cases per year)	23
Unsafe abortions (cases per year)	20
HIV infections by 2000	30 to 40
AIDS cases by 2000	12 to 18
Curable STDs (cases per year)	315
Female genital mutilation	85 to 110

Many people who were involved in the Cairo process are working for change in their own countries. For example, in South Africa, a review of existing reproductive health services is under way in two provinces (8). The Women's Health Project of the University of the Witwatersrand has organized meetings with primary health care providers to identify their constraints and the difficulties they face in providing the best possible service. Meetings were also held with women who use the services to learn what they did not like about the current services. The experience gained from these initiatives will be brought together and analyzed to find mutually acceptable solutions that could improve services without incurring major additional expenditures. As another example, the Bangladesh Women's Health Coalition has expanded the range of services it provides in order to respond better to women's needs (9). This includes a weekly legal clinic that helps women to deal with violence, property rights, employment, and other issues. Higher priority should be given to operational research that can help to improve the quality of and access to reproductive health information and services, the safety and efficacy of available technologies, and our understanding of the many factors that affect sexual and reproductive behavior.

There is no blueprint for reproductive health; we should move away from the "technological fix" mentality toward an incremental approach that adapts and builds on what already exists in a number of countries. This approach may enhance both the efficiency and the local acceptability of programs. For example, what is feasible and appropriate in Bangladesh may be very different from what is relevant for Brazil, but in both places interventions should enable women to have control over their fertility and their lives, and to have choice and continuity of high-quality care. Barriers that impede women's access to health care should be attacked, including legal barriers. Funding agencies need to support new approaches to sexual and reproductive health—programs that are innovative and genuinely participatory, including education and information programs on sexuality. The retraining of health care providers and policy-makers is another important area where much support will be needed. We also need to improve our understanding of the nonbiomedical aspects of reproductive health by means of genuinely multidisciplinary research that takes into account women's own perceptions of reproductive health and of the sociocultural environment in which they live. More complete qualitative and quantitative information is essential to provide future guidance for policy and action. In addition to resources, achievement of women's reproductive health will require vision, perseverance, and imagination.

REFERENCES AND NOTES

1. *Achieving Reproductive Health for All, The Role of WHO* (WHO/FHE/95.6, World Health Organization, Geneva, 1995).
2. *Report of the International Conference on Population and Development*, International Conference on Population and Development, Cairo, Egypt, 5 to 13 September 1994 (A/CONF.171/13, United Nations, New York, 1994), paragraph 7.2.
3. See, for example, A. Althaus, *Int. Fam. Plann. Perspect.* **17**, 145 (1991); C. Elias, "Sexually transmitted diseases and the reproductive health of women in developing countries" (Working Pap. 5, Population Council, New York, 1991). In a recent study of rural women in Egypt, 52% of participants in the study were found to have an RTI [N. Younis *et al., Stud. Fam. Plann.* **24**, 175 (1993)].
4. *The HIV/AIDS Pandemic: 1994 Overview* (WHO/GPA/SEF/94.4, Global Programme on AIDS, World Health Organization, Geneva, 1994).
5. *Women and AIDS: Agenda for Action* (WHO/GPA/DIR/94.4, report prepared by WHO and UNDP in consultation with the United Nations Division for the Advancement of Women, New York, 1994).
6. L. Heise, J. Pitanguy, A. Germain, "Violence against women: the hidden health burden" (Discussion Pap. 255, World Bank, Washington, DC, 1994).
7. J. Bongaarts and J. Bruce, *Stud. Fam. Plann.* **26**, 57 (1995).
8. S. Fonn and B. Klugman, Women's Health Project, Centre for Health Policy, University of the Witwatersrand, Johannesburg, South Africa, personal communication.
9. B. Kay, A. Germain, M. Bangser, Bangladesh Women's Health Coalition, *Quality/Calidad/Qualité Series* no. 3 (Population Council, New York, 1991).