

THE MILLENNIUM SERIES



II Women and Population

BY ERLA ZWINGLE PHOTOGRAPHS BY KAREN KASMAUSKI



"Don't look at people like an ant heap,"

ON A CERTAIN NOVEMBER DAY an obscure woman in Iowa gives birth to seven babies; we marvel and rejoice. On the same day an obscure woman in Nigeria gives birth to her seventh child in a row; we are distressed and appalled.

In Brazil a mayor sees his town shrink by two-thirds. Determined not to lose subsidies tied to population, he bans all contraceptives. In Bangladesh the government, determined to stem the tide of births, offers to sterilize women for free and throws in a new sari as a gift.

In Kenya a woman keeps trying for a son because her husband asks, "Who will hold my head for me when I die?" In the United States an unmarried teenager looks at her infant daughter and says, "I don't really know what I was doing. I thought I was in love. I thought it was this great thing, but it was stupid."

Population: We know it's a problem. In fact most of the problems facing individuals, families, communities, and nations are affected by the quantity of humans sharing the planet. But if the problem were only numbers, these stories would have no power to touch or perplex us. Nor would we race to bring food to famine-stricken countries, or blanch to read of newborn babies being thrown into trash bins, or fall silent upon hearing of the pregnant mother who refused cancer treatments that could damage her baby, gave birth, and died. Even as some fear for our species' survival, we instinctively sense mysteries that transcend statistics. "Don't look at people like an ant heap," one expert urged. "These are individuals."

Two hundred years ago Thomas Malthus predicted mass catastrophe as a result of overpopulation. So far, events have not turned out quite as he supposed they would, yet the brutal probabilities he described continue to darken some views of the future. Today 98 percent of population growth is in the developing world. "The world is going to hell," as one observer

bluntly paraphrased the common fear, "if those people don't stop breeding."

True, the numbers give pause. Today there are almost six billion people in the world. For the next 15 years annual increases will probably remain just over 80 million (or one billion every 12 to 13 years). The United Nations estimates that by the year 2050 there could be from 7.7 billion to 11.2 billion people in the world.

Will this be too many? It is difficult to predict, as even Malthus would have seen by now. Predictions often impel changes in the very behavior that inspired the prediction. Providing enough food, of course, is paramount. But what about fresh water? Forty percent of the world population faces water shortages at



Freelance writer ERLA ZWINGLE lives in Venice, Italy, a country in which the falling birthrate is a serious concern. Photographer KAREN KASMAUSKI, a mother of two children and a veteran of 16 GEOGRAPHIC assignments, also focused on human migration for this issue.

heap,"

one expert urged. "These are individuals."

n fear, "if those

e. Today there
the world. For
ses will proba-
(or one billion
d Nations esti-
could be from
e in the world.
lifficult to pre-
e seen by now.
es in the very
iction. Provid-
is paramount.
erty percent of
er shortages at

some time during the year. What about jobs? There is already an increasing shortage of those too, and according to the Population Reference Bureau masses of unemployed people form "a social and political time bomb."

But there has been dramatic progress over the past 30 years. Birthrates have dropped in many developing countries (including China and India), and the number of children born to each woman has fallen on average from six to three. This is the result of remarkable changes on three fronts: contraception, health care, and

culture, the strongbox in which our sense of what we can do is locked.

Contraception has been the key. The number of women in some developing countries using contraceptives has risen to more than 50 percent. "There isn't any place where women have had the choice that they haven't chosen to have fewer children," says Beverly Winikoff at the Population Council in New York City. "Governments don't need to resort to force."

Yet some 200 million women become pregnant each year. Half of these pregnancies are

Soon to have a sibling, an only child nestles in her mother's sari at a clinic in Bangladesh. Nurses provide checkups and offer advice—starting with "space your children." Longer gaps between births mean healthier mothers and babies and slower population growth.





unplanned, and a quarter are unwanted. Unwanted children are often neglected, abused, or abandoned. They receive less food, medical care, and education than wanted children.

More than half a million women die each year from causes related to pregnancy, often the result of poor health, lack of medical care, and having babies too close together. Seven million infants die each year because their mothers were not physiologically ready for pregnancy or lacked obstetric care. Millions of women and men resign themselves to this reality. But with the chance to plan their families, they are beginning to see a way to re-imagine their future. "People are desperate," one woman said, "to control their own destiny."

IN BANGLADESH dawn rises over banana groves and palm trees, the emerald expanse of rice fields, and pools where women in vivid saris immerse themselves, drenched in the golden light. Here the problem of overwhelming numbers seems

obvious. Bangladesh is the ninth most populous nation on Earth, and, with only 52,000 square miles of land, it is one of the densest. It is also one of the poorest.

Today Bangladesh is praised as a population success story. In 1990 its birthrate was an unbridled 4.9 children per woman (which, if unchanged, would have doubled its population by the year 2015). The rate is now 3.3, a fact that has astonished those who believed the country's population would drop only after chronic poverty and illiteracy were overcome.

Much of the credit goes to two of the many organizations that help the poor: the Dhaka-based Grameen Bank, with its innovative program of "microcredit," or small loans, and the Bangladesh Rural Advancement Committee (BRAC), with its nationwide network of village clinics. The work of BRAC and Grameen has made it possible for millions of women and children who once could hope only for survival to begin to dream of progress. Mosammat Anowara Begum is one of them.

Chamurk from the 68 an assortment with corrug matting, clu of beaten e. to spread tl a baby give Someone n phone rings

Anowara village; it's: it with a lo she makes milk or egg sells telepl cents) a m phone bill keep some

"Every v the phone, three year: parts of B

Woman to woman

Pledged to bear no more children, a volunteer with the Bangladesh Rural Advancement Committee counsels a pregnant woman in Shoal village (left) and dispenses antibiotics for a mother's sick baby (below). She also discusses family planning. Contraceptives distributed by such workers helped lower Bangladesh's birthrate from seven children per woman in 1975 to fewer than four in 1995.



ninth most popu-
with only 52,000
e of the densest. It

ed as a population
birthrate was an
woman (which, if
led its population
is now 3.3, a fact
who believed the
l drop only after
y were overcome.
two of the many
poor: the Dhaka-
ts innovative pro-
all loans, and the
ment Committee
network of village
and Grameen has
is of women and
ope only for sur-
gress. Mosammat
em.

Chamurkhan village isn't very different from the 68,000 other villages in Bangladesh: an assortment of one- or two-room houses with corrugated metal roofs and walls of palm matting, clustered around small common areas of beaten earth. As the morning light begins to spread through the trees, a rooster crows; a baby gives a small, fretful cry; a dog barks. Someone nearby hawks and spits. Then the phone rings.

Anowara Begum has the only phone in the village; it's a Nokia cellular phone. She bought it with a loan from the Grameen Bank, and she makes money with it. Instead of selling milk or eggs, as many of her neighbors do, she sells telephone calls at 4.6 taka (about ten cents) a minute. At this rate, she can pay the phone bill and weekly loan installment and keep some profit too.

"Every week I make 300 taka [\$6.50] from the phone," she says, "and I repay 160 taka. In three years the loan will be repaid." In some parts of Bangladesh an illiterate widow with

several children could be destined to beg or even turn to prostitution. But once the loan is paid off, Anowara Begum stands to net an average of \$2 a day—more than \$700 a year—in a country with an average annual per capita income of about \$250.

Since its launching in 1976, the Grameen program has loaned more than two billion dollars, in amounts averaging only \$180, to more than 2.1 million destitute women.

"We find that when women start borrowing, it benefits the whole family," Mohammed Abul Hossain, a senior officer at Grameen, tells me. "Her children become important, the family's welfare becomes important." One recent study in Brazil showed that income controlled by the mother had a benefit on her children's health that was almost 20 times greater than income controlled by the father.

Sharifa Akhtar Shikha, Anowara's 20-year-old daughter, studies Islamic history at Dhaka's Jagannath University. "If my mother hadn't gotten the loan," Shikha says, "it would have

been impossible for me to go to the university. But she wanted me to have a higher education."

Why? Anowara smiles. "For the future," she answers. "She will be independent and have more income. And she'll be happy also."

When people can start making decisions about their lives, they also start making decisions about the size of their families and vice versa; family planning within Grameen families is twice as common as the national average. Surveys have also found a strong link between education and family planning.

But Bangladesh still has a high death rate of babies and mothers. Here females die earlier than males (the opposite of the biological norm), due in part to severe malnutrition and risky pregnancies, often too close together.

To help improve health care, BRAC has founded clinics throughout the country. "Many more women want contraceptives now," said Mergina Khatun, a village health worker in Mymensingh district. "They see that if a mother has fewer children, she can give them better care. And her health will be better."

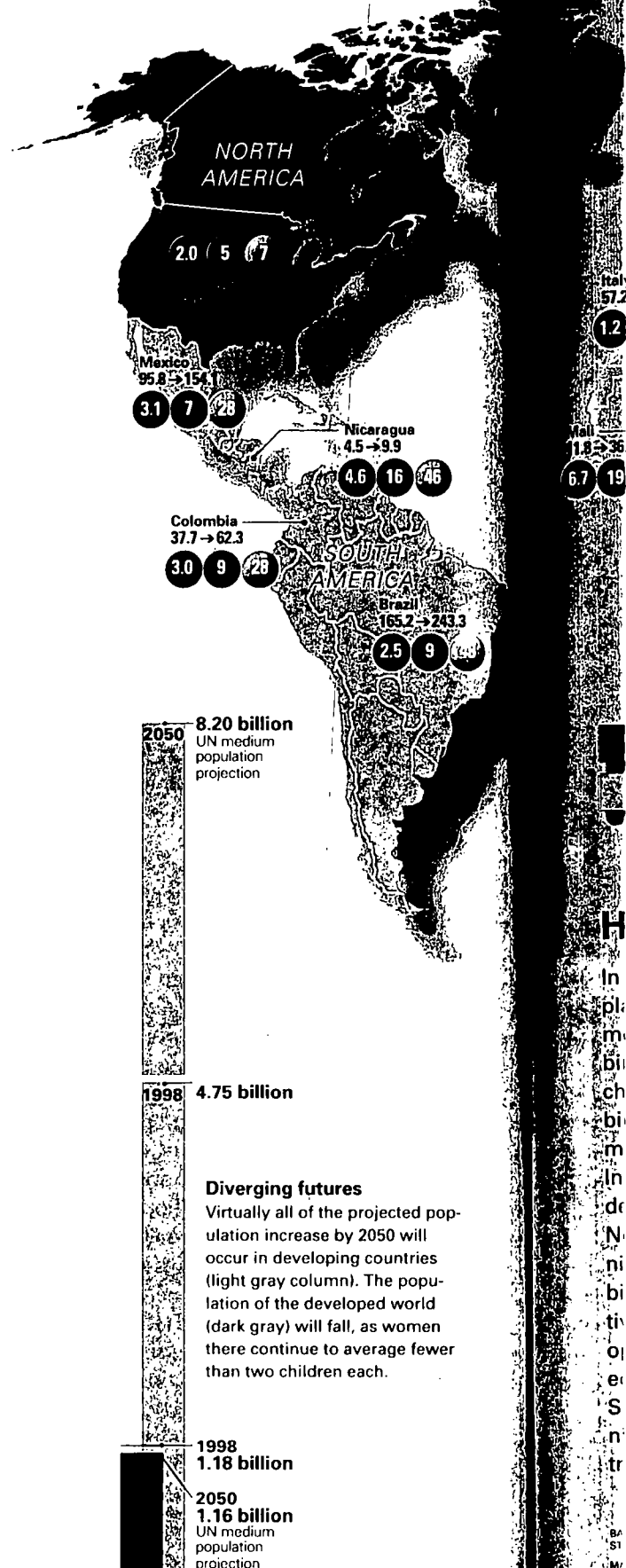
What if a conservative Muslim leader tells Mergina that contraception is against the will of God? "I say that God also told us to be responsible for our families."

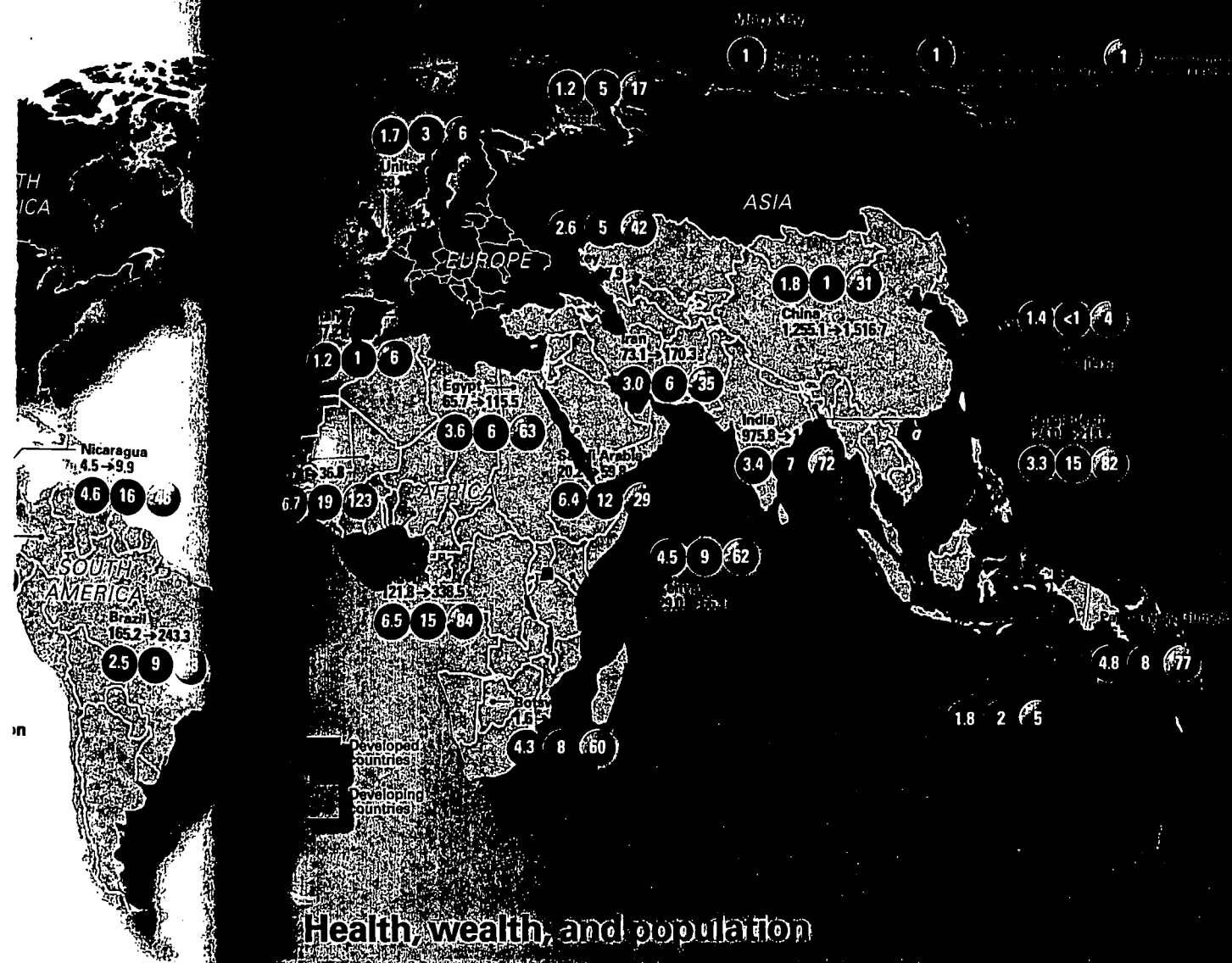
In the BRAC health center in the town of Mymensingh, the nurse is counseling a few of the 800 women who visit every month. A thin young woman, three months pregnant, sits listlessly by the desk. She tells the nurse that she has been suffering from morning sickness and has an intermittent fever. She is 20 years old and has been married three and a half years. This is her third pregnancy; she has already suffered one stillbirth and one miscarriage. Contraceptives could have helped her delay these pregnancies until her health improved.

The nurse advises her to take full bed rest, eat extra food, and do no heavy work. None of this will be possible for her. The nurse prescribes an antihistamine spray and an analgesic for the pain and fever. The girl's gray-haired mother-in-law crouches on the floor, leaning against the wall, waiting silently.

Loans and contraceptives continue to improve the lives of Bangladeshi women and their children. But sadness still infects the lives of even healthy families.

"I have three daughters; the youngest is just a year and three months old," says Firoza in



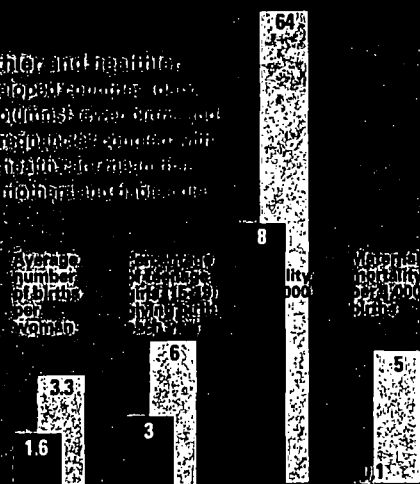


Health, wealth, and population

In what experts call a "virtuous cycle," family planning leads to healthier women, since mothers avoid early, late, or closely spaced births. Healthier women have healthier children. And fewer child deaths lead to fewer births, as women stop believing that they must have many babies for a few to survive. In the past, many concluded that economic development was the best contraceptive. Now, backed by studies showing family planning is the most effective means of lowering births worldwide, experts say, "Contraceptives are the best contraceptive." Yet development and its benefits, especially better education and health care, remain essential. Such advances raise demand for family planning, persuade young couples in poor countries to postpone childbearing, and encourage

the treatment of women as equals. According to the demographic projections compiled in New York City, this can promote a smaller world by promoting a more just world.

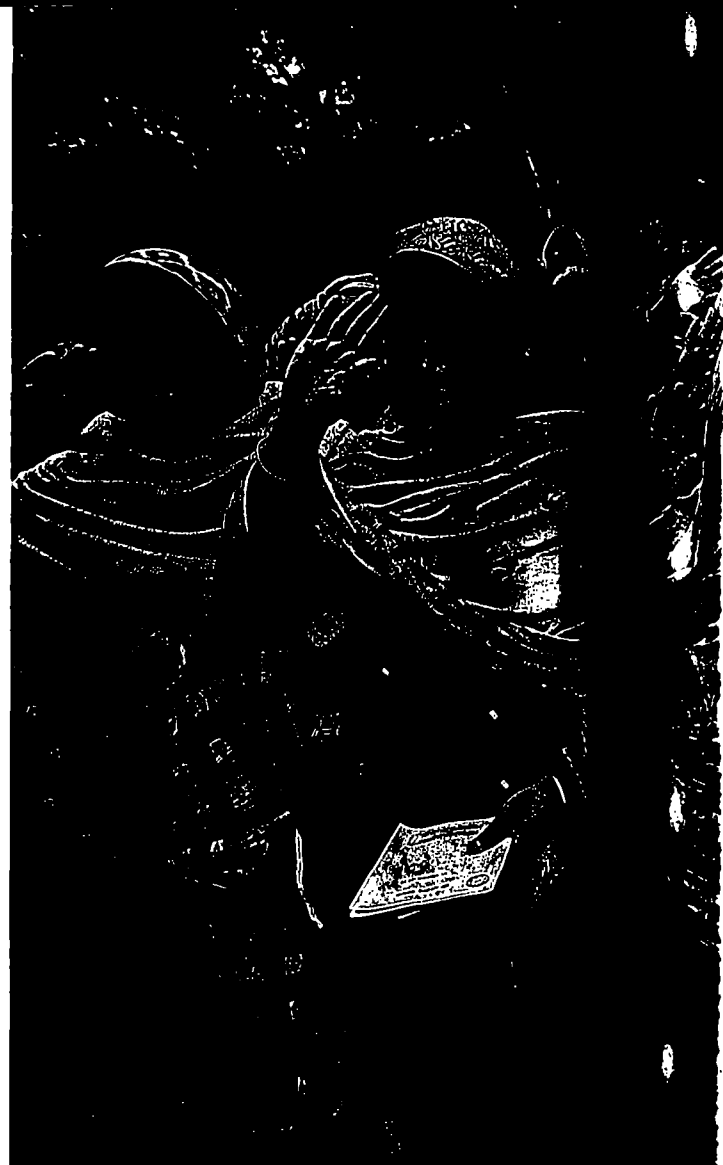
Worldwide, and nationally, in developing countries, the average number of children born to women has declined since 1960. This is due to a number of factors, including better health care, education, and family planning.



BASE MAP AND POPULATION DATA: UNITED NATIONS POPULATION DIVISION; UNITED STATES CENSUS BUREAU; HEALTH ISSUES DATA: POPULATION REFERENCE BUREAU. MAP AND GRAPHS BY STEPHEN ROUNTREE.

Army of entrepreneurs

Saluting the future, women meeting near Dhaka to repay loans acknowledge the loan officer from Grameen Bank, who freed them from lives of powerlessness and isolation. "We shall plan to keep our families small. We shall keep free from the curse of dowry. We shall not practice child marriage"—so runs the creed Grameen clients, who are 95 percent female and 100 percent poor, recite as a promise to break from traditions of poverty. Launched into business with a small loan, a woman travels from door to door selling cookware (below). Anowara Begum (below right) used a loan of \$390 to buy a cellular phone, which fellow villagers pay to use. Soon after the death of her husband, Anowara hears from her brother in Malaysia while their mother weeps. For birthrates to keep falling, experts say women must be offered opportunities beyond motherhood and given the authority to choose whether to bear children.







Taldighi village. "My husband is disappointed. Now he is saying he didn't want any more children. Two would have been better, he says, since the third one was a girl."

"I had twin baby boys," her neighbor, Alefjan, tells me. "They died of a respiratory infection, one when he was seven days old and the other when he was 14 days old. My husband told me, 'We don't need to go to the hospital—they don't have drugs for children this small.' And I believed him."

"**W**OMEN AND POPULATION," repeated Beverly Winikoff at the Population Council when I told her my topic. "It sounds like you're treating women as the disease vector." What about men?

The sun rises over Nairobi, gilding the dusty parks, the battered streets, the chaotic, make-shift markets. Kenya used to have one of the highest birthrates in the world, but in the past 20 years it has shown one of the steepest declines in all Africa. As in Bangladesh this is due

in large part to massive education campaigns, more clinics, and inexpensive contraceptives. But Africa, which still has the highest birthrates in the world, remains profoundly child centered. "A person who doesn't have children is looked down on," a woman explained, "because that person is incomplete in the society."

In much of the world men have often been the major objectors to family planning. Some do so on the basis of religious beliefs; others want to demonstrate their virility. Many believe that only the fear of becoming pregnant will keep their wives faithful. And there are misunderstandings: "I used to hate family planning," a man told me, "because I thought it meant that people shouldn't have children."

Yet as men struggle to provide for their families, some admit that smaller families are better. To help them become more involved in family planning, male-only clinics have begun to appear in Kenya, Ghana, and some South American countries. And a few pioneers, overcoming the common fear that sterilization will

make the Philip vary Ten neighbor man wit first me Marie St

The n children azines. The yell. "Plan yo depends world h

"My me. "It v for 13 c cup of t

"Whi was th: raise," l and she my wif

Early parenthood

Seven months a mother, Jill Crisler, 16, fixes a bottle for her son, Trenton, before leaving for Northeast High in Lincoln, Nebraska. Like many teenage births, this one was unplanned. "It's not a mistake," says Jill. "I call it a surprise." Unlike most unwed fathers, Luke Smith stays in his son's life, hurrying from his job to his new role as Trenton's playmate at the school day care (below).



on campaigns, contraceptives. highest birth- foundly child have children is ined, "because ociety."

n have often nily planning. igious beliefs; virility. Many coming preg- ul. And there o hate family use I thought ave children." ide for their r families are re involved in s have begun some South oneers, over- rilization will

make them impotent, are choosing vasectomy.

Philip Njuguna is pastor of the Nairobi Calvary Temple, a Pentecostal church in a poor neighborhood. At 37 he is a small, compact man with a friendly, intelligent expression. I first meet him in the male-only suite of the Marie Stopes Clinic downtown.

The main waiting room is full of women and children watching television and reading magazines. The rooms next door are for men only. The yellowish walls bear a few modest posters: "Plan your family now—your children's future depends on you." "45 million men around the world have had a vasectomy."

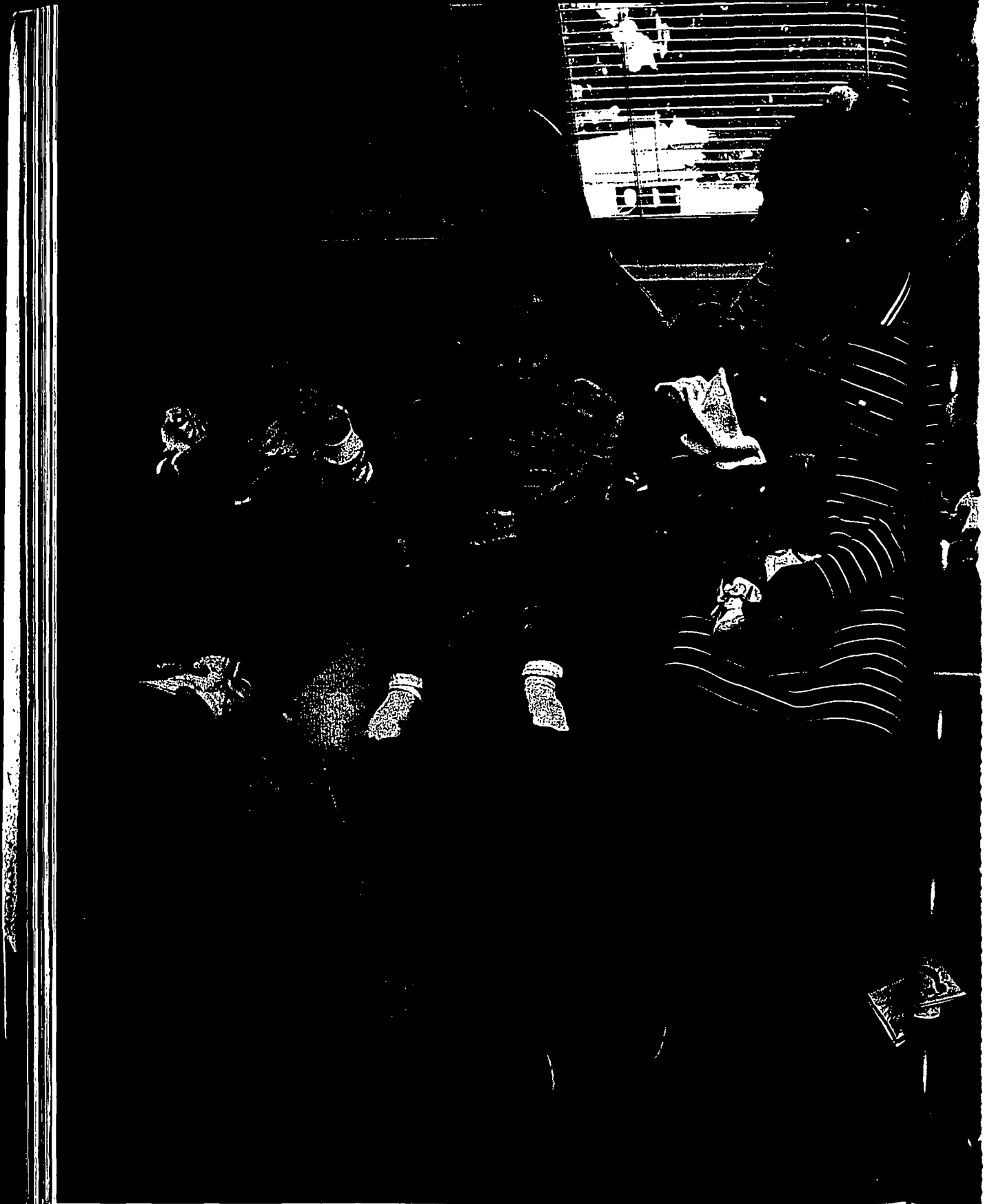
"My father had just eight acres," Philip tells me. "It was an average-size farm but not enough for 13 children. In the morning there was just a cup of tea. No lunch. Poverty eats you every day.

"What made me decide to have a vasectomy was that I wanted to have a family I could raise," he continues. "My wife was taking pills, and she had high blood pressure. Who am I to my wife? I'm her partner. I'm there to help her.

That's what the Bible says. So I read about vasectomy. The only side effect is that you can't have children anymore"—he smiles—"and that's the side effect I wanted."

To their credit many men worry about the possible side effects some contraceptive methods may have on their wives. Then again, studies show that men are generally reluctant to use methods that directly involve them—withdrawal, abstinence, condoms, and the rhythm method. As for vasectomy, says clinic counselor Patrick Musyoka in his gentle voice, "The stigma is still there."

Men are the point at which family planning leaves the realm of mechanics and enters the mysterious territory of behavior. Contraceptives themselves are simple—it's the users that are complicated, caught up in the volatile dynamics of human relationships. "Family planning came to Kenya through health programs for women," Godwin Mzenge, a program director, tells me. "The assumption was that women would discuss with their husbands



Premature parents, mothers at Lincoln High School gather at lunch as part of a student-child program that helps them graduate. The U.S. has the highest teenage birthrate in the industrialized world. Adolescent births endanger mothers and their babies while accelerating population

growth
program
birth c.



ident-child
ne industrial-
g population

growth. Rather than stressing either abstinence or contraceptives alone, successful prevention programs also emphasize setting and achieving goals. "Hope is the most important method of birth control," says Susan Powers-Alexander, of Lincoln's Planned Parenthood.



what they learned. But now we know that communication between them isn't that common."

"We encourage the women to keep discussing," says Rose Ngahu, a nurse. "It takes a lot of force of character to resist the husband."

IN LINCOLN, NEBRASKA, a crisp autumn morning spreads across the prairie, over the flags snapping in front of the state capitol, over the football fields ready for marching-band practice after school. In the half-light students are arriving for class at Lincoln High School. They carry the usual teenage stuff: books, musical instruments, backpacks. Some of the girls are also carrying their babies.

The U.S. has the highest teenage birthrate of any industrialized nation. Since 1960 the rate has tripled among unmarried females age 15 to 19. According to the Alan Guttmacher Institute, four in ten American girls become pregnant at least once before they reach 20; most of these pregnancies are unintended.

We think of Lincoln as the real America. And

it is, but not always in the way we mean. "I'd like to have a baby," said Tonya, a pert 12th grader, "but not now. Too many of my friends have babies: Mindy, Janet, Penny, Becky, Sue Ann, April. . . ."

This is bad news, for a number of reasons. First, there is sheer quantity: By the year 2000 there will be more adolescent girls in the world than there have ever been: 400 million poised to begin having children. If they were to delay their first baby by five years, it would mean 1.2 billion fewer people by the year 2100.

Second, there is the quality of those lives. Of the nearly four million babies born each year in the U.S., nearly one out of eight is born to a teenage mother. When a girl under 20 has a baby, problems mount for everyone. She may well drop out of school, in which case she is likely to go on welfare. (In 1995 the government spent 37 billion dollars on welfare, food stamps, and Medicaid for families begun by a teenage mother.) Emotional immaturity can lead her to abuse her baby; it can be hard to

overcome
on a bod
a myth
healthier
you know

Her b
Infants b
risk of lo
birth tha
24. They
and high
problem:
likely to s
found th
mother:
social co
many of
whelmed
said. "I fe

In 199
opened a
school. T
east High

Smaller is b

Dressed in school uniforms their mothers struggled to buy, Masai children drink a breakfast of tea in the doorway of a house in rural Kenya. In Nairobi, Philip Njuguna, a pastor, watches his third child and only son (below). Njuguna underwent a vasectomy after the boy was born. "When the family is small, whatever little they have they are able to share," he says. "There is peace."



we mean. "I'd
a, a pert 12th
of my friends
ny, Becky, Sue

ber of reasons.
the year 2000
ls in the world
million poised
y were to delay
ould mean 1.2
2100.

those lives. Of
born each year
eight is born
girl under 20
for everyone.
in which case
1995 the gov-
rs on welfare,
families begun
al immaturity
can be hard to

overcome the stresses of pregnancy and labor on a body that hasn't finished developing. "It's a myth that because they're younger, they're healthier," one woman told me. "What teen do you know who eats right?"

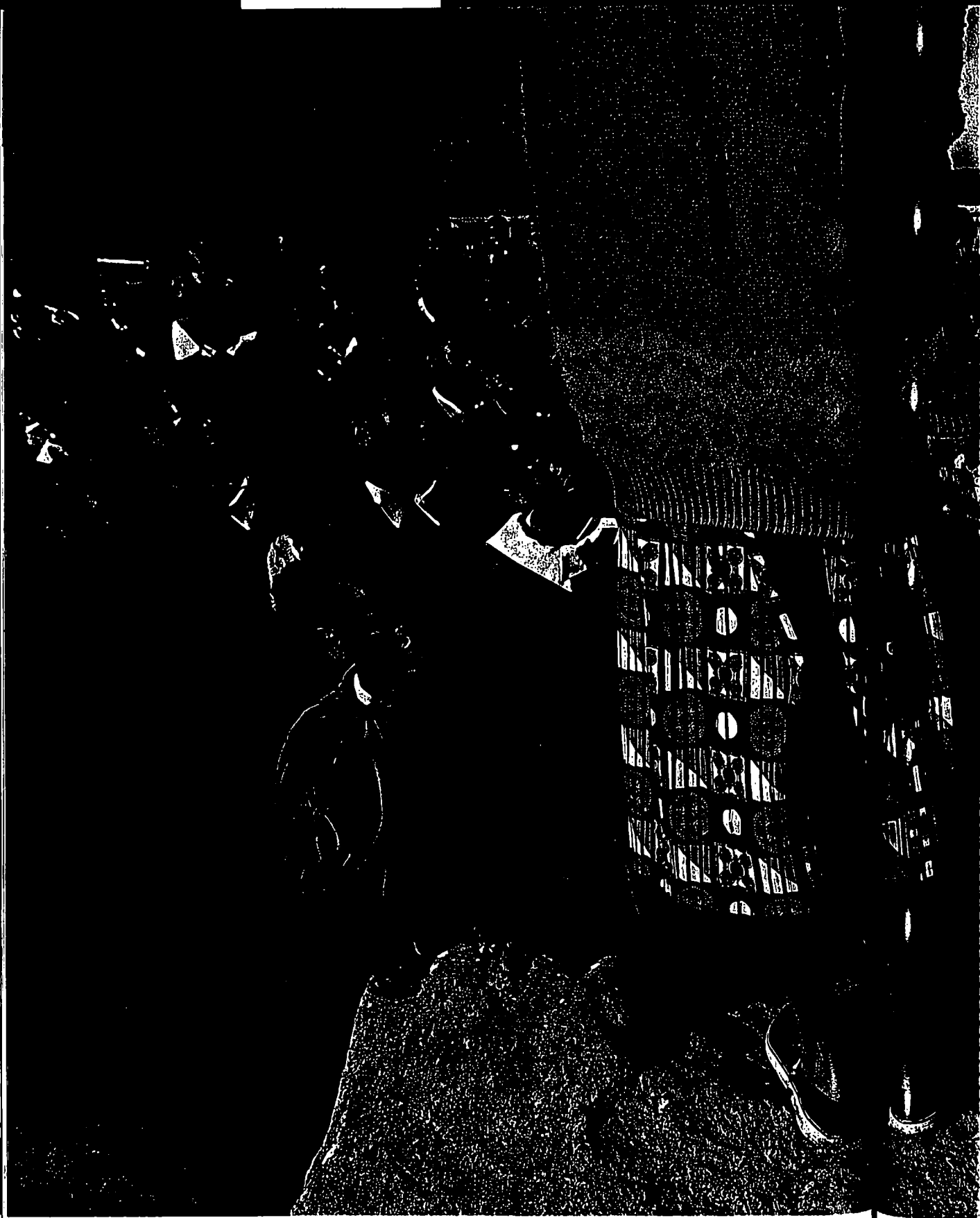
Her baby also may very well have difficulty: Infants born to teenage mothers are at higher risk of low birth weight, prematurity, and still-birth than children born to women age 20 to 24. They also tend to have lower test scores and higher rates of physical and psychological problems. Sons of teenage mothers are more likely to serve time in prison. The state of Utah found that every \$400 spent on a teenage mother saved the state \$400,000 in various social costs over the lifetime of her child. But many of the girls only know that they are overwhelmed. "I didn't feel shame," one of them said. "I felt fear."

In 1993 some of the staff at Lincoln High opened a child-care and learning center at the school. They—and their colleagues at North-east High—avow that their first priority is to

make sure the girls graduate. "We want the girls to be successful," says Karen Poore, a teacher at Northeast. "Whatever will help them complete their education, we advocate."

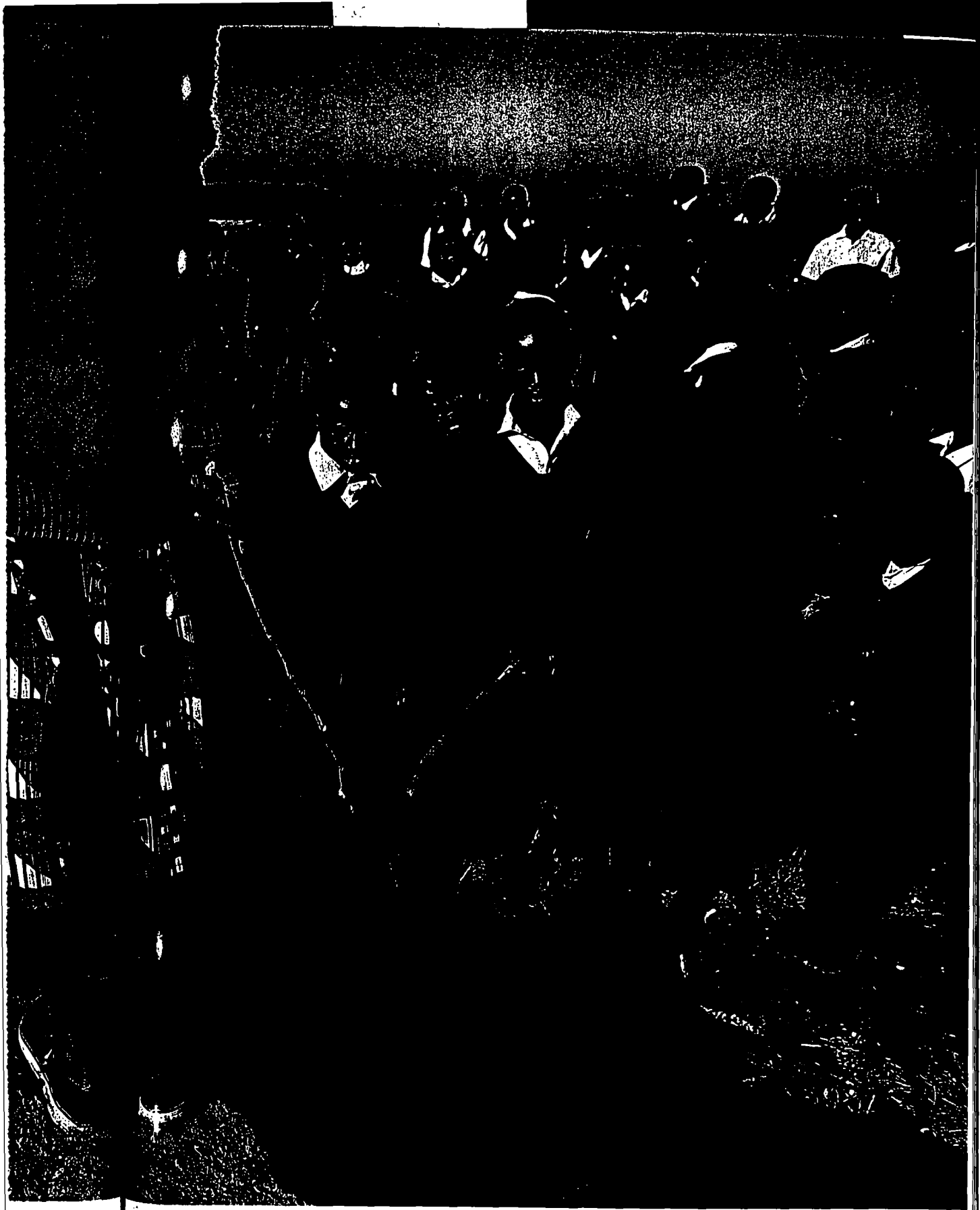
There was resistance. "Some people didn't want Lincoln High to be known as 'the pregnant school,'" says Ann Irvine at the public school district office. "There was still the shame factor. We had to get over that." And objections came from those who were convinced that a day-care center would be seen as encouragement to be promiscuous. "The girls just laugh," says JoAnn Bartek, who teaches family and consumer sciences. "They say, 'Oh yeah, that's really what we were thinking: They've got this really neat day-care center; I think I'll go get pregnant.'"

As for those who maintain that the girls shouldn't be in school, according to Bartek, the girls say, "Well, where should we be? If we don't get our high school diplomas, we're going to be on welfare. We're going to be homeless." One study found that almost 60 percent of



Masai children gather for opening ceremonies at Kimuka Primary School in Kenya's Rift Valley. Adapting to a shrinking supply of cattle land, Masai herders are bearing fewer children in hopes of sending all their sons and daughters to school. Africa has the world's highest

birthrate
planning
provide



t Valley.
in

birthrates, but they are starting to fall with better health care and education, stronger family-planning programs, and—in countries such as Kenya—weak economies that make it hard to provide for many children. Even so, the continent's human numbers will double in 30 years.

teens who became pregnant dropped out of high school. At Northeast and Lincoln High 80 percent of pregnant teens are graduating.

I meet some of these teens at the child-care center at Lincoln High. The room is spacious and cheerful, full of toys and cots and intensely clean. Several girls are here on their lunch break, crouched on the floor playing with their babies or talking with the assistants and each other. A few sit quietly, nursing. The mothers look more like older sisters.

At 3 p.m. Mandy Brehm comes to pick up her eight-month-old daughter, Juliana. Mandy is 16; she has long brown hair, green eyes, and a pretty, round face. She's named in *Who's Who Among American High School Students*. When we get home, her mother, Diane, and her younger brother, Jared, are there.

There is pizza for dinner. As we eat, Diane recalls the day she learned her daughter was pregnant. Mandy couldn't find the courage to tell her; instead she left a note on her mother's bed. "It said, 'I'll never be the daughter you wanted. This is the worst day of my life. But I don't want to kill the baby.' I cried for about two hours. Then I called her at school and asked if she wanted to come home."

Many girls do not have the support or the determination that Mandy did. Fifty percent of abortions in the U.S. are sought by women younger than 25.

"My own thought," says Beverly Winikoff at the Population Council, "is that most people wouldn't use abortion as a first choice. But they're pregnant, and they need not be."

What will Mandy tell Juliana when she grows up? "Not to have sex," she replies. "'Cause it's not worth it."

Mandy will probably be the only person telling her that. "We bombard kids with sexual messages, but we don't teach them how to process them," says Susan Powers-Alexander, a director at Planned Parenthood in Lincoln. "We don't teach kids to decipher that they're using sex to sell cars, perfume, pineapple."

The influences on adolescents are powerful and pervasive: movies, advertising, music, peer pressure. The girls face life with a wild assortment of mismatched traits: ignorance, bravado, curiosity, delusions of invulnerability. The reasons for teen pregnancy go on. Many teen mothers are children of teen mothers. Alcohol and drugs undermine the ability to

make clear decisions. Older boys can dazzle or dominate: Over half the males responsible for teen births are 20 or older. Early sexual abuse cripples the capacity to say no; one study reported that 48 percent of high school students who had been pregnant were once sexually abused. And there is fear of losing love.

"Part of the reason I was so reckless was I didn't like myself at all," Mindy Latzel, 18, tells me. "He was 22 at the time. He made me feel good about myself, telling me how pretty I was. But I guess it was a bunch of lies."

"**H**OW MANY CHILDREN should we have? How far apart?" Stan Bernstein, senior research adviser at the UN Population Fund, asks rhetorically. "How should we educate them—concentrate on a few and hope they'll take care of us?" These

Married
While m
choices.

discussio

The V
that sexu
lion time
the past
want to
to it. Ma
economy
shrinking
program
back on :

In Ken
want to
mother t
In Ban



Married but without children, a Masai teenage bride looks forward to her first pregnancy. While many women's lives are still dictated by circumstance, more and more now enjoy choices. In their hopes, fed by new possibilities, the future is born.

discussions are happening more and more.

The World Health Organization estimates that sexual intercourse occurs a hundred million times a day. Yet despite the great strides of the past three decades, millions of couples who want to use contraception don't have access to it. Many developing countries, faced with economic crisis and political uncertainty, are shrinking their financing of family-planning programs. Some foreign donors have also cut back on aid—the U.S. by one-third.

In Kenya a man says, "When my wife didn't want to have more than three children, my mother told her, 'You're just lazy.'"

In Bangladesh a woman says, "Two children

are enough. Because if you have more, you can't raise them as human beings."

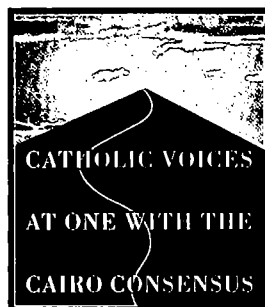
In the U.S. a 16-year-old father looks at his infant son and says, "I'd probably be locked up in some juvenile hall if he wasn't here. He's changed me for the better."

The sun rises every morning on more than a quarter of a million newborn babies. A few of them may change the world; all of them will change their mothers and fathers. They don't belong to the ant heap. They belong, for better or for worse, to us all. □

Erla Zwingle reports further on teenagers and pregnancy at www.nationalgeographic.com/features/2000/population/women.

ys can dazzle or
responsible for
rly sexual abuse
no; one study
high school stu-
were once sex-
r of losing love.
so reckless was
indy Latzel, 18,
ie. He made me
me how pretty
h of lies."

ould we have?
itan Bernstein,
iser at the UN
ks rhetorically.
—concentrate on
e of us?" These



Catholics and Cairo: A Common Language

One of the most daunting tasks in international discourse is the discovery and crafting of a common language. This imperative becomes all the more difficult and demanding when the issues seeking expression are charged with intense feelings, emotions, and differences in worldview.

The United Nations 1994 International Conference on Population and Development and its Programme of Action adopted in Cairo constitute a pivotal moment in the articulation of a common language of conscience. Furthermore, Cairo provided the Catholic church with an unprecedented opportunity to enter the world dialogue in terms not unfamiliar to its own traditions and mission.

THE CAIRO CONFERENCE AND THE PROGRAMME OF ACTION

Every ten years since 1974, the United Nations has convened an international conference on population and development. Past conferences have been held in Bucharest (1974) and Mexico City (1984). In 1994, 180 governments came to Cairo, Egypt, to attend the third United Nations International Conference on Population and Development (hereafter, Cairo or the Cairo Conference).

At Cairo, the governments of the world agreed to a list of proposed actions for the future – these are contained in a Programme of Action, which spans over 100 pages and comprises sixteen chapters. Chapters three through sixteen develop the qualitative and quantitative goals agreed to at Cairo. Of particular interest to Catholics and other people of faith are the principles in chapter two that provide the ethical framework for the Cairo approach to population and development.

Earlier population conferences were rightly criticized for focusing solely on limiting family size and reaching demographic targets, often using

inflammatory language, such as “population explosion” and “zero population growth.” This demographic approach emphasized reduction of population and neglected women’s human rights.

The Programme of Action represents a refreshing step forward. It recognized the importance of ethics, values, interrelationships, sustainability, poverty eradication, and especially the connection between the empowerment of women and lower fertility rates. The document articulates a broad vision that puts human dignity above demographic goals; women’s equality and men’s responsibility over mandated family planning. It crafted language on reproductive and sexual health and rights.

This year, the five-year assessment of Cairo will be conducted through a series of regional, national, and international meetings. This assessment is enhanced considerably by religious voices reflecting on the principles and goals of Cairo and its Programme of Action. Among these religious groups, a Catholic reflection is especially crucial because of the strong and sometimes controversial role played by the Vatican and the Holy See during the Cairo process.

THE VATICAN AT CAIRO

Cairo sought to deal with some of the most volatile issues in our personal, political, and religious lives: reproduction, sexuality, development, and women’s human rights. Remarkably, it chose to link these themes together and to deal with them in the overarching categories of rights and responsibilities.

Rights emerge from the individual, innate, and inviolable core of each person. Responsibilities are grounded, for the most part, in the community, in the demand to treat others with equal dignity and rights, and in the insistence that the consequences of

all our actions be measured by more than our own advantage and identity. The dialogue and tension between rights and responsibilities, between individual and community, between belief and conscience, between wealth and poverty, indeed between men and women were addressed in Cairo to an unheard-of level of agreement. To find the words and consensus to express the world's conscience on such controversial matters is extraordinary. One might have supposed that the Holy See would be gratified by the serious purpose, religious resonance, Catholic language, and moral tone with which Cairo went about its work.

The field of agreement between the Catholic church and the Programme of Action is large and impressive. Nonetheless, sharp differences emerged (these are dealt with in part 2 of this paper).

Unique among religious bodies of the world, the Catholic church enjoys a privileged status as a Non-Member State Permanent Observer at the United Nations through its governmental entity, the Holy See. In this capacity, the Holy See takes part in United Nations conferences and can exercise, as it did at Cairo, voting rights.

However, any government will not necessarily reflect the beliefs and practices of the people it purports to represent. There is a distinction between the Catholic church and its tradition as a whole (i.e. the entire body of believers) and the administration of that church as it is represented by the Holy See at the United Nations. This distinction is especially important to keep in mind because the laity, theologians, and the bishops at large have no meaningful voice or vote on the selection of the pope and the policies of the Holy See. Therefore, a truly Catholic position on a particular issue must take into account not only the official position of the Holy See, but also the way this position is received and lived out in the body of believers. This widely accepted approach insists that Catholic teaching is made up of two entities: the teaching hierarchy (pope, cardinals, and bishops) and the teaching of the laity -- the *sensus fidelium*.

For all these reasons, the strong Vatican rejection of major items in the Cairo document was puzzling and disappointing. The Vatican has every right to state its reservations. The difficulty many experienced with the Vatican's position derived from its unwillingness to enter the process of discussion

or to propose language that could win the support of the world. This difficulty was compounded by the Vatican's reluctance to affirm the revolutionary character of the Cairo Conference as it put issues of population in an overall ethical framework fortified by insistence on women's rights and health.

Furthermore, the Vatican's actions at Cairo weakened Cairo's message, particularly for the Catholic observer. While there are many Catholics who do not agree with the positions taken by the Vatican at Cairo, more still do not realize how consistent the Programme of Action is with Catholic teachings. In reality, Cairo and the Vatican had more areas of concurrence than disagreement. The Vatican came to Cairo with deep suspicions and an apparent unwillingness to trust the global process of reaching agreement on ethical issues, and, therefore, its message at Cairo was often inconsistent with church teachings. In particular, the Vatican's actions distorted what Cairo actually said on women's human rights, health, and family.

Reproductive rights are dealt with in the Programme of Action under the larger rubric of human rights for women. The same strategy is followed in addressing reproductive health through the more expansive issue of a right to health. This is one of the great contributions of Cairo. It constantly seeks a larger context, one in which there is universal agreement, before it deals with controversial specifics. Thus, all of the world agree on human rights for women even if they may disagree on reproductive rights. The same is true of a right to health and the more difficult issues of reproductive health, safe motherhood, abortion, and sexual health.

One of these difficult issues turned on the definition of "family." As Cairo sought a comprehensive definition, the Vatican feared that a consequence of so broad a definition would be the validation of homosexual unions.

The Vatican became most adamant over the issue of abortion. It finds abortion and contraception immoral in every circumstance. It rightly opposes coercive use of these methods. Delegates at Cairo agreed with the need to end coercion but also believed that people should be informed of all these choices. The Programme of Action leaves to religions and conscience the dialogue about whether particular individuals or traditions should choose among the options they are

given. In a world climate in which choices seen as moral by one side are branded as immoral by the other, the Cairo Conference had no other way to proceed.

The articulation of moral choices should never be so absolute that they have no reference to the real situations in which people live. Catholic theology and teaching have always affirmed the right of conscience and contextualized moral choices. Cairo did insist that where reproductive health is concerned, all legal options open to the individual should be safe and people should be informed fully about the consequences of deciding one way or the other.

CATHOLICS AND CAIRO

Cairo, in many ways, is a universal declaration of human rights applied to population, sexuality, and women's lives. Had the document been cast in the narrow terms the Vatican demanded, it would have divided and splintered the world community. A new language of shared values needed to be formulated, a language of universal rights and responsibilities. The agency to speak that language, the United Nations, gained the world's confidence more readily than the respected but sometimes ideological voice of the Vatican.

The debates at Cairo made it clear that in many moments, the Vatican and the global community frequently spoke with the same voice. The Vatican, however, often declared its position on the more controversial issues as definitive, neither inviting nor allowing participation or nuance in order to achieve consensus. The United Nations cannot adopt a language of ethics and values that the human family at large neither understands nor accepts. If people are fundamentally reliable, then open debate, accommodation, and global consensus may offer us our best hope for choices that are moral, profoundly human, and irresistibly fair.

For the purposes of this article and to help clarify the distinction between the official and the living church, the terms "Holy See," "Vatican," and "delegation" are used to represent church governance. The terms "church," "church teachings," and "church tradition" are used to represent a broader definition of Catholicism, to include the laity, theologians, and the hierarchy.

While it is written from a Catholic perspective, we hope this article will be of use and interest to readers from other religious, ethical, or philosophical traditions. And by no means does our analysis pretend to be exclusive: Cairo's vision reflects the values of many belief systems.

PART 1 AREAS OF AGREEMENT: SHARED PRINCIPLES

The Vatican claimed that the Programme of Action lacked an ethical framework and was the work of aggressive Western feminists: "One of the principal concerns of the Delegation of the Holy See regarding the Draft Final Document is its lack of a clear ethical vision."¹ The document that the Vatican so soundly excoriated, however, is actually remarkable for its principles and values -- values forged and agreed to by over 180 nations from around the world and clearly articulated in chapter two of the Programme of Action.

The principles, the foundation for the Programme of Action, are consistent with Catholic values -- especially as they relate to population and development -- reflecting how much the Catholic church has in common with the global community. These principles are the legacy of Cairo. Regardless of what happens with regard to proposed actions or financial commitments, the principles are critical to the development of a common language of values. And despite initial appearances to the contrary, the Vatican and those supporting reproductive rights do agree on these values.

PRINCIPLE 1: UNIVERSALITY OF HUMAN RIGHTS

Following the United Nations tradition of support for human rights, the Programme of Action includes strong support for individual rights. Catholic endorsement of the fundamental vocabulary of human rights moved forward dramatically as social justice documents and the *Declaration on Religious Freedom* from Vatican II were adopted in the 1960s. Since then, the church has become an international advocate for human rights, even though, like many other political and religious bodies, it has a mixed record in this area.

Catholic support for human rights -- such as bodily integrity, right to life, and right to health -- is linked to the value placed on human dignity by the church, biblically grounded in the creation of human

beings in the image of God (Gn 1:26) and the spirit of Christ (Jn 1). These rights are human, therefore universal, and transcend boundaries of gender, race, religion, and nations. However, while the church upholds the universality of human rights, its record on women's rights is varied.

Within the international community there is a debate over the universality of human rights. In this debate, the Vatican agrees with human rights organizations that a core group of human rights are universal because of our common human dignity and should be freely exercised independent of the current political, cultural, or economic atmosphere of a particular location. The other side of the debate argues that human rights are not necessarily universal and indeed are culturally conditioned. In this way "culture" has often been used to defend human rights abuses and to prevent the implementation of development programs.

While the church teaches that preservation of culture is an important consideration in any global mandate, it insists that culture is not an absolute value that justifies everything from the oppression of women to the bondage of children and genocide. The Jewish prophets and Jesus himself exemplified the Christian belief that people of good will often resist aspects of their own cultural heritage.

PRINCIPLE 2: PEOPLE AS CENTRAL CONCERN OF DEVELOPMENT

The true measure of development, according to both the Programme of Action and the church, is whether it meets people's human needs and aspirations and whether it does so in accord with their human dignity.

Development policies have at times been the subject of serious criticism by faith-based organizations, including both official and independent Catholic groups. Development policy has often been focused solely on economic rather than human development. In contrast, delegates at Cairo reaffirmed the emerging global consensus that people's lives, not markets or production, should be the central concern of all development policies.

PRINCIPLE 3: RIGHT TO DEVELOPMENT

The United States President's Council on Sustainable Development notes that people in developed countries -- only 20 percent of the world's population -- consume 85 percent of the world's resources.ⁱⁱ In light of this observation, we are made aware that we can do better and that the human cost

of resisting development is incalculable and unconscionable.

The Catholic social justice tradition and preferential option for the poor provide a basis for the church's teaching on development. The church maintains that industrialized nations should assist, through technology transfer and debt forgiveness, the developing world's ability to use its resources for its own development. In particular, John Paul II has criticized both capitalism and socialism for neglecting to put human needs and the common good above material profit.

PRINCIPLE 5: POPULATION-RELATED GOALS

Although often perceived as unwilling to acknowledge problems caused by rates of population growth, the church does consider hunger and other developmental problems to be exacerbated by population growth. Indeed, the Second Vatican Council insisted that parenthood be exercised responsibly. Parents who bring children into the world recklessly and thoughtlessly are censured. At issue is not limiting births or determining family size, which the Vatican accepts, but the means by which this limitation is achieved.

PRINCIPLE 6: SUSTAINABLE DEVELOPMENT

Because developing countries were able to voice their concerns over sustainable development at Cairo, a larger recognition of the overconsumption of developed countries was written into the Programme of Action. This principle is also seen in the church belief that developed countries must eliminate their overconsumption as a way to maintain sustainability and to achieve responsible stewardship.

The Catholic church supports consideration of environmental concerns in development policy. For many centuries, the church, prompted by Scripture, principally Genesis, believed that domination of the earth by people was God's will. To its credit, the church has begun to appreciate the vital interrelationship among human beings, other forms of life on the planet, and the planet itself. Now the church sees the world itself as a sacrament, namely a reality endowed with the presence of God and with grace. There remain those in the Catholic community who fear that ecological spirituality may lead to pantheism. This hesitancy has not prevented popes from speaking bravely about an ecological crisis, our common environmental responsibility,

and the need to impose limits on human domination and overconsumption of natural resources.

PRINCIPLE 7: ERADICATING POVERTY

The Programme of Action's focus on eradicating poverty and the special attention it gives to the neediest of poor countries is an important aspect of the Cairo consensus for Catholics. Cairo is consistent with church teachings on the preferential option for the poor and economic justice for all in insisting that "special priority" be given to the least developed nations of the world.

It has been observed that poverty imposes imperatives on the affluent. Jesus makes it quite clear that neglect of the poor is neglect of God. The Catholic tradition resonates with this teaching, from the medieval legends of the poor as saints and of God disguised in poverty to modern proclamations of a preferential option for the poor. Indeed, the Catholic church is often seen as the church of the masses, the poor, and the workers.

There are different ways of addressing poverty; sometimes the least effective, but by no means inconsequential, is charity and alms giving. On a deeper level, however, the church calls for the transformation of structures that create poverty. On the deepest level of all, the poor must be addressed as equal in dignity to those who are affluent. On this, the church and Cairo agree.

PRINCIPLE 10: RIGHT TO EDUCATION

In Cairo, education was emphasized as the means to the full development of human resources. Traditionally, girls and women have not been given equal access to educational opportunities. Investment in education is critical to the empowerment of women and the achievement of their human rights.

Catholic teachings support the importance of education. From monasteries to universities, the church has been a pioneer in educating people in their spiritual and social responsibilities.

PRINCIPLE 11: CHILDREN AS A PRIORITY

Cairo maintained children's rights to standards of living and adequate health care, as well as the right to be protected from injury and exploitation. The church protects children as innocents. The church was so concerned with the injustices perpetrated against children that the Pontifical Council for the Family organized three international meetings of

experts prior to Cairo to address this subject: prostitution of children in Bangkok, Thailand (1992); child labor in Manila, Philippines (1993); and street children in Rio de Janeiro, Brazil (1994).

However, it is important not to overstate the hierarchy's support of children's rights. While the church often speaks and acts on behalf of the well-being of children, it defines children's rights as almost exclusively derivative of parental rights. Furthermore, the Vatican is more likely to support parental rights over children's rights, as further recognition of the patriarchal family unit. Parents have a primary right to educate and raise their children, but it is not an absolute or exclusive right, such as prevails in some cultures where children are defined as property. Society at large and the church must establish and affirm children's rights when parents violate or neglect them.

PRINCIPLE 12: MIGRANT RIGHTS

The Programme of Action acknowledges that migrants often have the least access to resources and services provided in development plans and calls on countries to guarantee fundamental human rights to all migrants. The church's record here has been impressive and effective. The church has organized and spoken on behalf of migrants. It has often demanded that nations support immigrant and migrant populations by not only considering them as workers, but also respecting their cultural identity. The church has offered migrants pastoral service, and through the pope and national conferences of bishops has acted as their advocate before the world community. In fact, on the issue of migrant rights, the church and United Nations are more in agreement with each other than with developed nations.

PRINCIPLE 13: RIGHT TO ASYLUM

Cairo explicitly calls on nations to grant protection for refugees escaping persecution. This stance is well in line with church tradition, which condemns political and religious persecution and urges nations to provide asylum for those in exile as a duty of the common good. In fact, church buildings have traditionally been sanctuaries for the persecuted. The church at large, sometimes selectively, has offered protection to the vulnerable.

PRINCIPLE 14: INDIGENOUS RIGHTS

In the past, the church has in many instances favored evangelization and cultural transformation over the preservation of indigenous identities.

History tells how colonization of indigenous people by Western powers was often accompanied by the imposition of Christianity. The church, however, has recently been more sensitive to indigenous traditions. Nonetheless, it is disappointing that national church leaders, speaking on behalf of their own people, have not been sufficiently heard by the Vatican. Indigenous rights are not only the rights of indigenous minorities. The church cannot be truly incarnated in a culture unless it takes on the character of that culture. If the church appears as an alien presence in the culture, it will not reach the people there on a profound level or in an authentic way.

PRINCIPLE 15:

DEVELOPMENT RESPONSIBILITIES

The final principle agreed to in Cairo addresses the need for all nations to take responsibility in assisting global development while acknowledging that each nation has its own needs, capabilities, and responsibilities. It also states a special obligation of more developed countries to advance set agendas and to maintain sustainable levels of growth. The church has historically been sensitive to the diversity of nations in regard to population and development strategy, and it has put pressure on the North to contribute to the equitable development of the South.

PART 2

AREAS OF DEBATE: WOMEN, HEALTH, AND FAMILY

When the United Nations produces an international document such as Cairo's Programme of Action, its goal is to secure the support of as many nations as possible. Thus, it provides an extensive drafting process aimed at achieving consensus, with many versions of a document and numerous preparatory meetings -- with considerable input by nongovernmental organizations -- to discuss objectives. A government delegation objecting to any part of the document may have a section, phrase, or word placed in brackets for further debate and possible deletion. During the Cairo process the Holy See and a handful of other nations—including Argentina, Benin, Guatemala, Honduras, Malta, Morocco, and Nicaragua—bracketed most language referring to reproductive rights, sexuality education, abortion, contraception, the definition of family, and safe motherhood. In fact, the Vatican focused most of its energy at Cairo on objecting to the existing consensus on reproduction and sexuality rather than

proposing language or lending force to the many other issues discussed at the Cairo Conference and important to Catholics.

In the end the Vatican joined the global consensus on the Programme of Action as a whole, but placed reservations on the following list of specific phrases:

- contraception
- couples and individuals
- family planning
- reproductive health
- reproductive rights
- sexual health
- sexual rights
- widest range of family-planning services
- women's ability to control their own fertility

The Holy See also placed general reservations on eight of the sixteen chapters: "Reproductive Rights and Reproductive Health"; "Health, Morbidity, and Mortality"; "Population, Development, and Education"; "Technology, Research, and Development"; "National Action"; "International Cooperation"; "Partnership with the Non-Governmental Sector"; and "Follow-up to the Conference."

Cairo, of course, did not detail ethical values as a religious tradition would detail them. It could not do this, given the diversity of its constituency. It did, however, search for a common, global ethic based on human rights and responsibilities. Cairo afforded an opportunity for the Holy See to make its points regarding the importance of human dignity in population policy. The Holy See might have done this more convincingly by affirming more forcefully the many positive features in this document and by engaging in a constructive dialogue with the world on the complex issues of reproduction and sexuality.

The Holy See delegation's concerns over three principles in the Programme of Action -- women's human rights, the right to health, and the definition of family -- led to reservations on a number of Cairo objectives. Disagreement was over application, as the church has historically supported all three of these principles. However, a gap exists between what the Vatican said at Cairo and what Catholic tradition allowed the Vatican to say. In reality, official church statements could have been brought

to bear to support the United Nations positions on women, health, and family.

PRINCIPLE 4: WOMEN'S HUMAN RIGHTS

As part of the new development paradigm created at Cairo, women's human rights were supported as a principal goal. Prior to Cairo, women's lives were not always treated with dignity and respect in population policies; women were often considered only in terms of their reproductive capacity, and their aspirations and needs were made secondary to demographic outcomes.

While the church has a strong record of speaking in support of human dignity and objecting to human rights abuses, its record on women's human rights is ambiguous. It is not that church teachings do not support gender equity or the dignity of women, but that the Vatican has shown itself to hold a limited understanding of women's human rights, and in particular, the ability of women to control their own fertility.

The Holy See is careful never to assert women's equality with men without a qualifier, usually the notion of "women's special dignity." In the Vatican's worldview, men are the normative human beings and women are understood primarily in terms of their reproductive and mothering capacities. What seems to be a laudable principle -- women's dignity -- actually circumscribes women's options and equality. No such assumption is ever made with regard to men, whose dignity is presumed simply to stem from their humanity.ⁱⁱⁱ

When the Vatican addresses rights for women, they are more often rights to be protected through the agency of others. They are not political, social, or economic rights through which women themselves exercise power as autonomous moral agents. And while the Vatican does support the universality of human rights, a division exists between the Vatican and women's human rights advocates over the question of what a human right is. In the case of human rights dealing with reproductive health, sexuality, and women's empowerment, the Vatican holds that Western feminists, among others, are attempting to establish "new" rights. In reality, Cairo sought not so much an expansion of human rights but an expansion of what the global community means when it says human rights.

Catholic support for women's rights comes from the biblical tradition of gender equality. Theologians, men and women, working within the Catholic tradition have rediscovered the role of women in Scripture and early tradition and have found it to be more open, creative, and decisive than current Vatican policy. Scripture begins, in the first chapter of Genesis, with the grand theme of gender equality in the creation account. Not only is there no subordination of women, there is indeed a radical gender equality. The Christian Scriptures present to us the startling ease that Jesus has in bringing women into a discipleship of equals. The greatest of all messages about Christ, the Easter experience, is borne by a woman who becomes the apostle to the apostles and, indeed, their teacher. Paul readily speaks of the prominent role women play in the creation of the early church: Women are appointed as deacons, coworkers, and even apostles (Romans 16).

This discrepancy between the statements of the Holy See delegation at Cairo and church teachings is illuminated by the delegation's criticism of two areas of the Programme of Action: empowerment of women and reproductive rights.

EMPOWERMENT Of Women

Cairo's focus on the empowerment of women is a culmination of decades of progress in the field of population and development, accelerated as women entered the international dialogue and research showed that women's status was a factor in family size and efficacy of development programs. The Programme of Action was the first United Nations document on population that explicitly recognized the importance of women's rights as a crucial factor in development and indeed, as a worthy goal in itself. Cairo declared that development policies should not center on controlling women's fertility, but on empowering women to make decisions about their own reproduction. This empowerment could be advanced by ensuring access to information and resources and providing social, political, and economic conditions that favor autonomous decision making.

The Vatican and even Pope John Paul II himself have spoken of women's empowerment and call for the support of women in their dual roles as mother and part of the labor force. But this very positive view of women in the public sphere is presented with an emphasis on the woman's role as mother: "The true advancement of women requires

that labour should be structured in such a way that women do not have to pay for their advancement by abandoning what is specific to them and at the expense of the family, in which women as mothers have an irreplaceable role.”^{iv}

Vatican support of the economic empowerment of women demurs when this empowerment leads women to a sense of their sexual and reproductive options. As the Catholic tradition developed, men were made the norm for human experience, and women far too readily were defined in church teachings in terms of their reproductive and maternal capacities. In this scenario, little accrues to women simply because they are human. More often, women are praised when they are submissive, when they are mothers, and when they serve the needs of men or their children. Within this framework, the Vatican sees the exercise of women’s human rights as threatening the traditional family unit.

And although the church has spoken of the contributions women can make in the public forum, this belief does not extend to the role of women in the church. Actions speak more clearly than words. No woman is ordained in the Catholic church. The governing structure of the Holy See includes no women in decision- or policy-making roles and no women in the church’s pivotal electoral body, the College of Cardinals. There is no requirement that women be consulted regarding the development or content of Vatican documents and no indication that such consultation occurs voluntarily except in very limited and rare examples. Official church policies prohibiting important forms of women’s participation in the church make it difficult for people to believe that the church is committed to gender equality. The fact that these policies of exclusion are difficult, if not impossible, to derive from Scripture or tradition further weakens the Vatican’s position.

We cannot expect an all-too-human church to be centuries ahead of the cultural development of gender equality. It is unpardonable, however, when the church seems to be behind, or worse, when it resists such development.

REPRODUCTIVE Rights

The Vatican has recently been supportive of rights of women in society, but it continues to try to deny women reproductive rights. Cairo went beyond defining reproductive health to affirm reproductive

rights as an integral aspect of human rights. According to the Programme of Action, reproductive rights are grounded in previously recognized human rights, such as the right to bodily integrity and nondiscrimination, and specifically the right to decide freely the number and spacing of children and reproductive autonomy – a right first recognized in 1968 at the International Conference on Human Rights in Teheran, Iran.^v

The Vatican objected at Cairo to the Programme of Action’s treatment of reproductive rights, choosing this moment to invoke the preservation of culture and tradition and proclaiming the danger of establishing “new fundamental human rights.”^{vi} However, Catholic teachings supply many elements that support reproductive rights, primarily the church tradition advocating for the universality of human rights. The Vatican recognizes that human dignity is tied to the ability to exercise free will and individual conscience. In the contemporary world, religions gain credibility and become persuasive when they recognize the importance of free will, allow alternatives, and then guide or persuade people by appealing to their highest motives.

There is something demeaning and morally offensive about putting burdens on women without allowing them a voice and a vote about their own lives and the consequences they may be asked to endure. Women at large must be trusted to be concerned about life issues and to make responsible decisions. Political participation, equality in the workplace, protection from violence – all rights supported by the Vatican -- cannot be addressed without first affirming women’s moral capacity and integrity. Women cannot be expected to make decisions freely outside the home if society or the church preempts their personal decision making concerning the reproductive activity of their bodies.

Church teachings on the common good and justice show us that we cannot achieve moral order if individuals are coerced or repressed. Because women in the church have been excluded from defining elements of the common good, reproductive rights have not been adequately addressed in the Catholic church. Women, indeed all people, do best in dialogue, not when they are asked only to take dictation.

It is telling that the Vatican chose this moment in the Cairo negotiations to argue for cultural preservation. It argued, for example, that access to

contraception and legal abortion are staunchly opposed in other cultures and that democracy does not suit the culture of the Vatican. This may be true, but it raises the question of who defines this culture. Such "sensitivity" to culture is not evident when the culture of women, for example, is at issue or when cultures that strongly support contraception and legal abortion are denied these options because they do not adhere to the Vatican view of acceptable public policy.

There is a tendency to criticize Western culture as too feminist and to favor more traditional alternatives. However, when African and Asian bishops ask for different attitudes on the position of the Vatican, as they did in recent synods at Rome, they are not heard. When women of the South and East spoke to delegates on the importance of reproductive rights and health, their positions were dismissed. Culture has been invoked to silence the voices of women in the dialogue on reproductive rights. Surely those who have most at stake in every pregnancy should be allowed a decisive voice and choice on their own behalf.

PRINCIPLE 8: RIGHT TO HEALTH

The church's support of the right to health has biblical grounding in the healing tradition of Christ. A "right to medical care" is established in the 1963 encyclical *Pacem in Terris*, and the *Catechism of the Catholic Church* places the burden of respecting health on all of society. Pope John Paul II often calls upon nations to provide health care to all citizens as a basic economic right necessary for human dignity. By acknowledging the universality of the right to health care, the Catholic church is acknowledging the need for health care to be independent of geography, language, ethnicity, gender, or religion.

While the church asserts the right to health as a fundamental right, absolutely necessary for human dignity, the Vatican does not support health when applied to reproduction and sexuality, as clearly demonstrated in the Holy See's objections to the sections on reproductive health, safe motherhood, abortion, sexual health, and sexuality education for adolescents as agreed to at Cairo. At issue was how to specify and define health.

REPRODUCTIVE HEALTH

Cairo's Programme of Action was the first United Nations document to explicitly define reproductive health. Much of the language included in the recommended actions for obtaining reproductive

and sexual health is noncontroversial, such as prenatal, postnatal, and maternal health care and treatment for those affected with HIV. However, even this section of the Programme of Action provoked numerous objections on the part of the Vatican.

In addition to the church's strong support of health as a fundamental human right, Catholic health care is guided by the tradition of treating the whole person, recognizing that separating the body from the soul or treating only one aspect is not the best method of promoting overall health. Yet church leadership over and again singles out reproductive health and attempts to limit services and information available for this aspect of health. For women, reproductive health is central to overall health. At some point, women are placed in bondage to reproduction and biology if only periodic abstinence ("natural family planning") is tolerated.

To tell the world that "natural family planning" is the only means by which pregnancies may be avoided -- as the Vatican does -- is to speak with an ineffective voice. The world knows that such teaching is rejected by a virtual unanimity of Catholic couples and by the vast majority of Catholic theologians. The historical record shows that all the cardinalatial and episcopal committees formed by the popes to deal with this issue recommended a change in church teaching and the acceptance of artificial contraception as a moral option. The prohibition of artificial contraception is not so much church teaching as it is papal teaching.

Furthermore, Catholic teaching on responsible parenthood strongly rejects coercion by any group or individual attempting to restrain couples from making responsible decisions about procreation. Denying access to information about certain options was perceived by many in the global community as morally and practically coercive, especially when access and information are denied to those who are not Catholic or those whose consciences tell them that contraception is a moral choice. In any case, even according to church teachings, without options one cannot act morally. The Vatican remains free to address and influence the consciences of people by moral suasion. The world community objects, however, to efforts to eliminate access to artificial contraception, sterilization, and abortion completely with legal force and punishment.

SAFE MOTHERHOOD

The Vatican bracketed the term "safe motherhood" in the Draft Programme of Action and objected to its use at the Cairo Conference. Its opposition to the term, the Vatican delegation said, was based on a fear that inclusion of the term would open the door for abortion.^{vii} But "safe motherhood," by definition, covers many services and programs that the church unequivocally supports, including efforts to improve women's health in pregnancy through prenatal care and nutrition.

All women face risks in pregnancy and childbearing. Poor women face especially high risks. For example, Bolivia, the poorest country in South America, has a maternal mortality rate of 600 per 100,000 live births,^{viii} compared with 12 per 100,000 in the United States.^{ix}

The Vatican delegation's decision to reject the term "safe motherhood" outright, without any attempt to make a distinction between its acceptance of the components it supports and its resistance to abortion without exception, led to an inconsistent position on motherhood. All women's lives are defensible, and it is disingenuous for the church to claim to defend life while simultaneously opposing measures necessary to save women's lives. The Vatican's refusal to support safe motherhood at Cairo gave the impression that a woman's health is secondary to her reproductive functions.

ABORTION

Despite much talk about the issue, the Programme of Action principally deals with abortion in one paragraph, which makes four major statements:

- abortion should not be promoted as a method of family planning;
 - incidence of abortion should be reduced through access to family planning services;
 - abortion should be safe where legal; and
 - where illegal, the consequences of illegal/unsafe abortions should be addressed.
- During Cairo, the Vatican objected to all but the first.

Abortion is a complex moral and social issue — potential mothers know this best. However, the Vatican's position on abortion is compromised by its unwillingness to accept contraceptive services and devices even though they reduce abortions by diminishing the number of unwanted pregnancies. For example, according to the Alan Guttmacher Institute, data from Hungary show that as

contraceptives became more available over a thirty-year period, abortion rates fell from over 60 per 1,000 women aged 15 to 44 in the 1950s to under 40 per 1,000 in the 1980s.^x One of the best ways to reduce recourse to abortion is through access to a range of effective contraceptive options.

Even taking into account Vatican opposition to abortion, we remain puzzled about why the Vatican objects to abortion being safe where legal. "There is no such thing as a 'safe' abortion: Whether legal or not, abortion is lethal for the child and destructive of the mother and society," declared the US cardinals before the Cairo Conference.^{xi} This dismissal of safe abortion by the hierarchy is insensitive to the realities women face and to the number of women who die from unsafe abortions every day.

Because women everywhere resort to abortion, the alternative to safe abortion, of course, is unsafe abortion. Again, it is the hierarchy's preoccupation with eliminating abortion from the world that prevents the real issues of justice and health for women from being addressed. Such an absolutist position fails to acknowledge the ambiguity and doubt regarding fetal life and ignores the moral complexities surrounding each situation.

While the legal status of abortion appears to have relatively little connection to its overall pervasiveness in a country, it does influence the safety of conditions under which the procedure must be performed. Illegal abortion is associated with a high incidence of maternal death and disability. For example, while Mexico and United States have similar abortion rates, maternal deaths per 100,000 live births are almost ten times higher in Mexico, where abortion is illegal.^{xii}

In countries where abortion is illegal, it is the poor who are left to face abortions under the worst types of conditions. And in countries where abortion is legal, but safe abortions are costly, it is again poor women who shoulder the burden. The church tradition of a preferential option for the poor has been interpreted by many Catholics to support the safety of abortion and to oppose unsafe abortions when safe options are available. It is possible to be opposed to abortion without supporting unsafe procedures; concern for public safety is not the same as moral endorsement.

Despite Vatican disapproval, the Cairo Conference was right to address the catastrophic

health consequences for women of unsafe abortion. Mercy requires that we eliminate pain whenever possible; justice demands that we do not abandon poor women or women in need of help.

SEXUAL HEALTH

Cairo acknowledged the link between sexuality and gender relations, affirming that relationships between partners have profound consequences for sexual health and behavior. The Vatican, in response, accused the Programme of Action of "promoting a self-centered and casual view of human sexuality, an approach so destructive of family life and the moral fiber of society."^{xiii} In Catholicism, a long tradition of aversion to sexuality is the root of current Vatican conservatism on reproduction and women. Despite recent attempts to expunge this historical antipathy, church teachings often continue to reflect its influence.

Until Vatican II, pleasure was rarely, if ever, linked to sex in a positive way by the church. Sex was often presented as a necessary evil and is termed such by church teachers such as St. Augustine. The purpose of sex was procreation, not pleasure or even relationship. For more than a thousand years, the church taught the superiority of sexless marriages and urged all married priests to reject sex with their wives and to refuse to conceive children.

Today, the Vatican's suspicion of sexuality persists. Part of this mistrust is based on amnesia concerning biblical references to sexual pleasure as a value in its own right. A preeminent example of this tradition is the Song of Songs. In this most frank and erotic of all biblical books, sexual pleasure between lovers and spouses is celebrated. In addition, one of the overriding images of God's love for the human family in both testaments is the relationship between the bridegroom and bride. Jesus has been misinterpreted by some as hostile to pleasure. In reality, Jesus says little about sex but is deeply troubled by power and authoritarianism. The church's suspicions of sexual pleasure and its negative judgment about it do not derive from the Bible. They emerge from second- and third-century Greco-Roman ideas about pleasure and pain, ideas that the mind needs to control the body and that pleasure or emotions are less human or less acceptable than cognitive life.

Female sexuality, in particular, was and is often viewed negatively by the church. Women are blamed for men's sexual desires and presented as

temptresses. Celibacy is protected, admired, and rewarded by special privileges in the church. Holiness is equated with abstinence. In the Council of Trent (1545-1563), the church at its highest level of authority condemned and censured anyone who dared to say celibacy is not superior to marriage.

The Vatican's views on sexuality translate into an isolation in church policy of sexual health from other forms of mental and physical health, which has real impact on human lives. This impact is most conspicuous in the Vatican's treatment of HIV/AIDS. Forbidding the use of condoms when one partner is already infected is an irresponsible application of church teachings on contraception.

Realizing the impracticality of the Vatican's position on condoms, the French bishops in 1996 presented a 235-page document on AIDS acknowledging the usefulness of condoms in preventing the spread of HIV. The use of a condom, the bishops said, "can be understood in the case of people for whom sexual activity is an ingrained part of their lifestyle and for whom [that activity] represents a serious risk."^{xiv}

An escalating chorus of voices from recent official church teachings, theologians, and laity supports positive views of human sexuality. Spirituality and sexuality are seen today as linked. The celebration of our bodies and sexuality brings us spiritual awareness and even love itself. Human sexuality is seen as committing each person to concern for the other or else it forfeits its human and virtuous content. Sexuality, like love, should be sensitive, considerate, generous, compassionate, and concerned. Christianity insists that we love our neighbors as ourselves. This principle is expected to govern our sexual relationships.

Furthermore, in the sometimes less-than-ideal lives people must live, differing levels of tolerance, compassion, and resiliency matter. By denying the sexual or reproductive realities and needs of people, the church cannot effectively heal lives.

ADOLESCENTS AND SEXUALITY EDUCATION

During the Cairo Conference, the Vatican accused the Programme of Action of accepting "almost as an unrestricted right, that each individual including adolescents from an early age, may be 'sexually active.'"^{xv} In reality, the Programme of Action balances the needs of adolescents for access to services and information on sexuality and

reproduction with the rights and duties of parents and other adults to provide needed guidance and direction to maturing young people, calling on societies to promote mutually respectful and equitable gender relations and to provide education and services in order to deal with sexuality positively and responsibly.

Instruction in sexuality must, of course, fit with the age and condition of the person to be instructed. The intent should not be information only but formation of a responsible conscience and sensitivity to the lives of others.

Paralleling the Vatican's difficulty in affirming women as moral agents, there is only limited support of adolescent sexuality in Catholic teaching. When it is mentioned, the duty of educating adolescents on the issue of sexuality rests with the parents.

The Vatican is concerned that too much knowledge too soon, sexual information offered with no value orientation, and contraceptives made too readily available will be seen as tacit endorsement for irresponsible sexual behavior. These points could be made without discouraging the benefits of sexuality education. Adolescents deal with issues of sexuality every day. The church's policy of abstinence before marriage does not address the realities of adolescent lives or respect their capacity to make meaningful decisions about their sexuality. Abstinence should be encouraged, but not without information about alternatives, even if they are less than ideal.

While Cairo was concerned with the possible and the practical, the Vatican insisted on abstract moral imperatives, which led it once again to become an obstacle to the global community's consensus.

PRINCIPLE 9: DEFINING FAMILY

During the Cairo drafting process, John Paul II told pilgrims in Vatican City that the United Nations was attempting to destroy families: "I am going back to the Vatican to combat a project prepared by the United Nations, which want to destroy the family."^{xvi} Despite the pope's early characterization of the Cairo Conference, the Programme of Action clearly supports families in significant ways.

Principle 9 names the family as the basic unit of society and calls for its protection on these grounds. The *Catechism of the Catholic Church* refers to the family

as a "domestic church," a "privileged community," and "the original cell of social life."^{xvii} Indeed, society is always most stable when families are secure and when governments invest resources in them. But while both the Vatican and the Programme of Action concur that family is important, their definitions of what constitutes a family differ.

Cairo acknowledged a wide spectrum of families, reflecting the global reality of diverse family structures. In contrast, the Vatican objected to the diverse characterization of families in the Programme of Action out of fear that this diversity would threaten the patriarchal system that the church has supported and encouraged throughout the twentieth century. By using "families" instead of "family," the Holy See delegation believed Cairo would establish "a formula which would recognize all free unions, homosexual couples, etc. as equiparated with the family."^{xviii} Envisioning a "real family"^{xix} as only a husband, a wife, and children, the Vatican lobbied to include language giving special protection to this configuration of a family and in the end officially entered a reservation to the use of "couples and individuals."

In reality, family diversity has existed throughout human and biblical history. In biblical times, there were several perspectives on the family, none of which readily corresponds to the modern nuclear family. In the Hebrew Scriptures, patriarchy prevailed as well as polygamy, men were allowed concubines, and wives could be dismissed for even trivial reasons. In Matthew 19, Jesus objects strongly to this patriarchal model, especially when it allows a man to divorce a woman because she is property and forbids a woman to divorce a man on the same grounds.

Family structure is not set by nature but reflects the culture and economy in which it is embedded. A male-dominated nuclear family, consisting of a working husband, a wife who works in the home, and several completely dependent children, is a relatively recent development in history. Cairo, in suggesting that diversity reflects current realities and aspirations, is making a statement that has always been true. Out of fear that the Programme of Action would be interpreted as endorsing same-sex marriage, the Vatican failed to acknowledge that Catholic tradition supports and affirms diverse family forms such as extended families, multigenerational families, families without children,

and other constructs of family that embody love and acceptance.

There are some who observe that the Holy See has not always matched its performance on family life with its rhetoric. Marriages were dissolved in the past so that one partner might enter formal religious life. Annulments are granted today to one spouse or parent over the staunch objections of the other. And although the Holy See speaks beautifully of marriage, it continues to insist that celibacy is a superior state of life. It punishes priests who marry with exclusion from ministry; it does not, as a matter of course, allow married people to be ordained.

REFLECTION: CONSCIENCE AND CONSENSUS

Catholicism, despite appearances to the contrary, has a profound sense that rules are not rigid. Some of this sense comes from the New Testament resistance to law; some comes from the dynamics of canon law, which readily builds exceptions into the system; and some comes from a strong investment in forgiveness and reconciliation. All this protects church teaching and practice from many of the rigidities of fundamentalism and biblical literalism.

One of the hallmarks of Catholic moral teaching has been its capacity for nuance. Catholic tradition speaks with vigor about principles in the public forum but encourages latitude in pastoral practice. To appreciate the full range of Catholic teaching one must take into account not only the articulation of the principle but also the way the principle is lived out in practice.

For Catholics, conscience is always the court of last appeal in moral decisions. According to the *Catechism of the Catholic Church*, “a human being must always obey the certain judgement of his conscience.”^{xx} Even though the official church seeks to qualify conscience with such words as “informed” or “right,” it nonetheless allows that an objectively wrong action is a virtue if those who perform it are convinced in conscience they are doing good. One of the most influential church thinkers, St. Thomas Aquinas, said that it would be better to be excommunicated than to act in a way that contradicted conscience.^{xxi}

Given this tradition, why does the official church so often become rigid and ideological? More specifically, why were resiliency and consensus so difficult for the Vatican during Cairo?

We are amazed at how impressive church rhetoric is and how often it resonates with the global consensus. There is no reason not to conclude that the rhetoric is genuine and that it springs from a profound belief in what is being said.

Nonetheless, the consequences and practice that the world community expect to flow from such rhetoric do not follow in the Catholic church. The strong statements on the equality of women are difficult to reconcile with the marginalization of women in decision-making structures in the Catholic church and their absence from key Vatican offices and, of course, from the priesthood. The ringing words about parents rather than the state determining the number of their children and the appeal that parents should follow their consciences in doing so do not fit in easily with the rejection by the official church of the overwhelming number of Catholic parents who believe in conscience that artificial contraception can be a moral choice in structuring their families. The statements about the sacredness and sacramental character of sexual love are inconsistent with the denial of sexual love to church leaders.

This inconsistency happens, we believe, because the Vatican has been unwilling to admit that it sometimes makes mistakes, that it has sometimes misled, and that substantive change is possible in the system. The Vatican and the Catholic church have impressive power and resources. An admission of errors made in good faith in the past cannot destabilize the credibility of such an institution. A willingness to state, furthermore, that the world has impressive moral wisdom of its own in no way makes the Catholic church a less welcome participant in the global dialogue.

Morality can at times become the tool of a political program rather than a principle of rights and truth. Sexual norms are sometimes formulated not to illuminate the ethical content of the choices people make but to legitimate the denial or restriction of personhood for those who defy a convention. To sanction torture in the rooting out of heresy is to establish the overriding claims of orthodoxy. To forbid all sexual activity to homosexuals is to promote the exclusive claims and value of heterosexuality. To deny all contraception is to insist that pleasure and relationship must always be subordinate to reproduction. All these have been taught by the Vatican.

The Vatican declares that access to abortion, contraception, or the use of condoms is never

permissible. These positions are rigidly held and admit no exceptions. Thus abortion is not permitted even in cases of incest, rape, a seriously deformed fetus, or risk to the life of the mother. Contraception is prohibited even for women who have had so many births that another would imperil their health or lives. Condom use is condemned even to save one's partner from AIDS. Assisted reproduction is rejected even if done to correct a biological defect. At Cairo, such positions dominated the Vatican's diplomacy and eclipsed all other manner of church teaching and discourse.

The Catholic community at large and indeed the pastoral and theological communities take different positions on all these issues. One finds substantial latitude in the behavior and beliefs of Catholics, in the pastoral practice of priests, and in the teachings and analysis of Catholic theologians.

The Vatican position at Cairo reflected papal rather than necessarily Catholic thinking and tradition. Its position was narrowly focused rather than comprehensive, diplomatic rather than magisterial, political rather than morally conscientious. The Holy See delegation sought to bring the Cairo document as close as possible to the pope's thinking without expecting full concurrence from the world community, and yet the Vatican was at the same time convinced that it would withhold endorsement of the document if it did not receive complete concurrence. This stance did not reflect the flexibility that exists in the Catholic tradition.

The Vatican repeatedly expressed its concern at Cairo that the rest of the world does not affirm an impressive ethic on life, reproduction, sexuality, and family. The global community is aware that it faces life and death decisions regarding abortion, contraception, HIV/AIDS, and sexuality education. The Vatican, despite being a sovereign state, is immune from these concerns because of the character of its population and the purpose of its existence. Aware of this dilemma, the Vatican might have been resilient and flexible at Cairo on how its moral principles are applied to the world's governments as they confront concrete realities and diverse belief and ethical systems.

Yet there is reason for hope. History contains examples of church flexibility and growth, as well as Catholic teachings informed by global values. Substantive changes have occurred.

For example, the Universal Declaration of Human Rights declared, in 1948, that adult men and women had a right to marry and to found a family and, indeed, that they had equal rights in entering and dissolving a marriage. There was tension between the world community and the Catholic church on the question of divorce. Yet then, as now, there was a basis for dialogue. Article 16 of the Declaration goes on to use language echoing Catholic documents that the "family is the natural and fundamental" basis of society and that it is "entitled to protection by society and the State."

In the past fifty years, Catholics and sometimes the official church as well have moved closer to the United Nations' position. In 1948, for example, the church taught that celibacy was superior to marriage and asked many of its members to give up their right to marry and found a family. In 1948, Catholics responded favorably; now, they do not. Fifty years ago, virtually no Catholic marriages were officially dissolved; now, annulments are frequent, and many Catholics divorce and remarry without annulments.

An openness to sexual and reproductive ethics and rights is gaining ground in the Catholic church. Despite the vehement opposition of the Vatican, Catholics in many countries favor access to legal abortion and contraception and civil rights for homosexuals -- unthinkable even fifty years ago. Catholics support legal options even when they are not convinced that people have the moral authority to exercise them well.

At Cairo, it is relevant to note that, although the Vatican was a fully active and engaged participant, its sexual and reproductive agenda did not prevail. This fact was instructive for the both Vatican and the world. In the grand human dialogue, the church sometimes teaches the world (as the Vatican has done brilliantly on the evils of coercion and self-indulgence and on the sacred character of sexual experience and marital commitments), and sometimes the world teaches the church (as Cairo and the United Nations may be doing on human rights, women's human rights, and reproductive and sexual rights)

The church is always less than the truth it proclaims. It does not control this truth but serves it and searches for it. The church sometimes advances because of a reflection on its own traditions; very often it grows, however, because it hears and learns from the world. The Reformation and the

Enlightenment not only benefited the global community, they also enriched the church.

One of the more encouraging results of Cairo is an awareness of how the United Nations heard the church and respected its voice. It is now time for the church to hear the world community as it speaks with responsibility and consensus. When the church possesses truth, it is always a truth the world possesses in some way. The Creator does not love and enlighten only a few and leave all the others to their own devices. And so humility is always in order and hope is always justified.

NOTES

ⁱ Msgr. Diarmuid Martin, *Statement at the Beginning of the III Session of the PrepCom*, April 4, 1994: para. 7.

ⁱⁱ The President's Council on Sustainable Development, *Population and Consumption Task Force Report*, US GPO, Washington, DC: 1996: p. 33.

ⁱⁱⁱ Women-Church Convergence, *Equal is as Equal Does: Challenging Vatican Views on Women*, Washington, DC: Women-Church Convergence, 1995: p. 2-3.

^{iv} Pope John Paul II, *Laborem Exercens*, 1981: para. 19.

^v The Proclamation of Teheran said the following about reproductive rights: "Parents have a basic human right to determine freely and responsibly the number and the spacing of their children." United Nations International Conference on Human Rights, Proclamation of Teheran (Teheran, Iran), May 13, 1968.

^{vi} *Statement at the Beginning of the III Session of the PrepCom*: para. 12.

^{vii} Dennis Poust, "No Consensus," *Catholic New York*, April 28, 1994.

^{viii} United Nations Population Fund, *The State of World Population 1997* New York: UNFPA 1996, p. 86.

^{ix} Alan Guttmacher Institute, "The Role of Contraception in Reducing Abortion," *Issues in Brief*, 1997: p. 4.

^x "The Role of Contraception in Reducing Abortion": pp. 2-3.

^{xi} US Cardinals Conference, *Concerns Expressed to Clinton on Cairo Conference*, May 29, 1994.

^{xii} "The Role of Contraception in Reducing Abortion": p. 4.

^{xiii} US Cardinals Conference, *Concerns Expressed to Clinton on Cairo Conference*, May 29, 1994.

^{xiv} French Bishops Council, *AIDS: Society in Question*, February 12, 1996.

^{xv} *Statement at the Beginning of the III Session of the PrepCom*: para. 7.

^{xvi} Philip William, *UPI*, April 17, 1994.

^{xvii} *Catechism of the Catholic Church*: 2204-2207.

^{xviii} *Notes on the Draft Final Document of the ICPD*: p. 2.

^{xix} *Gravissimum Educationis Momentum*: para. 3.

^{xx} *Catechism of the Catholic Church*: 1800.

^{xxi} As quoted in T. O'Connell, *Principles for a Catholic Morality*, Crossroad, 1978/1990, chapter 8.

**The Rome Declaration
On the International Conference
On Population and Development
January 5, 1999**

Religion Counts

Religion Counts representatives met in Rome in January 1999 to draft and issue this statement, articulating religious support for ethical approaches to population and development, and specifically demonstrating solidarity with groundbreaking agreements made at the 1994 International Conference on Population and Development.

THE ROME DECLARATION
ON THE INTERNATIONAL CONFERENCE
ON POPULATION AND DEVELOPMENT
January 5, 1999

RELIGION COUNTS

Religion counts. Religious values and thought have helped to build the foundation for human well-being and they continue to inspire and guide billions of the world's people. Religions have maintained a sense of the sacred and sustained humanity in times of trial. They have nurtured spiritual growth, spurred intellectual inquiry, and provided moral guidance.

The world's faiths have developed in different cultures and historical contexts. They nonetheless share common moral sensibilities. The different traditions highlight complimentary values. In many indigenous faiths there is a comprehensive understanding of the relationship of human beings to the earth; in Hinduism a great appreciation of diversity and tolerance; in Buddhism a deep understanding of suffering and compassion; in Confucianism a powerful awareness of reciprocity and duty in human relationships; in Taoism an enduring emphasis on harmony and balance; in Judaism a profound regard for the sanctity of life; in Christianity a rich understanding of charity and mercy; in Islam a boundless devotion to equality and justice. These attributions have not been exclusive but are embraced across religious boundaries. They are religion's shared gifts to the world community.

These values are splendidly expressed in the *Programme of Action* adopted in Cairo in 1994 at the International Conference on Population and Development (ICPD). The conference articulated a new approach to population and development issues in which development policies focus on people rather than markets and population policies treat women not as receptors of family planning but as directors of their own reproductive decisions. The *Programme's* positioning of health and education as central components of human development replace a prior concentration on fertility regulation and population control. Finally, the ICPD acknowledged over-consumption in the developed world as both socially unjust and ecologically damaging. These developments represent a fundamental transformation in the way the world community and its policy makers address concerns related to population and development.

The ICPD's PRINCIPLES

The ICPD grounded these advances in a set of principles put forth in the second chapter of its *Programme of Action*. These principles are consistent with four moral norms that reflect core affirmations of the world's religions:

Equality, evidenced in the ICPD's assertions that women and men, whatever their difference, are equal in dignity and rights, and that education and comprehensive physical and mental health services are prerequisites for full participation in human societies.

Justice, which the ICPD states is violated in poverty and great disparities of wealth, and which is at the foundation of its assertion that families, in their diverse expression and as a basic unit of society, deserve defense and support.

Freedom, embodied in the ICPD's rejection of coercion in reproductive decision-making and its recognition that all women and men are meant to be free moral agents.

Respect, embodied in its call for public policies that are sensitive to cultural identities, and its insistence that nations not marginalize migrants and refugees.

RELIGIOUS INSIGHTS INTO THE *PROGRAMME OF ACTION*

People of faith readily recognize many of the values and principles in the concepts and commitments in the *Programme of Action* because they resonate with moral convictions that are deeply rooted in the heart of religious traditions. These principles provide the foundation in the document for addressing the interrelated issues of population and development, including those that require fundamental social transformation.

The *Programme of Action* establishes the elimination of poverty as a crucial means for achieving full human rights and for meeting the objectives of humane population policies and sustainable development. The recommendations challenge economic systems that cause and perpetuate poverty, exacerbate disparities in wealth among people and nations, and recklessly degrade the environment. These recommendations reflect historic teachings of the world's religions, giving a clear mandate to people of faith to advance the *Programme of Action*.

At the heart of the document is a challenge to patriarchal societies. Male dominance bears significant responsibility for women's illiteracy, sexual and physical violence to women, and women's lack of educational and economic opportunity and inadequate access to health care. Religions through history and even today are complicit in sustaining male domination in the societies of which they are part. In recent decades, religious traditions have begun to recognize that their integrity compels them to advance towards full gender equality, including within the religious communities themselves. Both traditional sources and findings of modern religious scholarship are fully in keeping with the ICPD recommendations on women's rights and political participation, education, reproductive health and rights, and socio-economic opportunity in the public and private spheres. Eradication of male dominance is imperative for the sanctity of all creation.

Reciprocity and mutuality in relationships is the appropriate moral and ethical foundation for policies related to sexuality. Prompted by the personal articulation of people's experiences, a reexamination of traditional teaching on sexuality is taking place within most religious communities.

Sexual and reproductive health are of significant religious concern as integral components of human well-being. Both women and men must exercise responsibility in their sexual behavior. Most faith communities accept modern forms of contraception and family planning, and even where there is official religious condemnation the evidence suggests that a great many adherents make use of artificial contraception without a sense of being unfaithful to their traditions. Sexual and reproductive health care, including education and access to comprehensive health services, should be available to all women and men.

The challenge is to provide reproductive and sexual health services to those women and men for whom it is still inaccessible. Religious communities should be advocates for the recommendations for the *Programme of Action* in these areas.

People with HIV/AIDS have human dignity that must be respected. There is no justification for stigmatizing them. Religious leaders and teachers have a particular duty to dispel the myth that AIDS is a punishment from God. In many countries, this devastating disease is killing millions of people, leaving children orphans, partners bereft, and communities crippled. Those who value life should support access to services that prevent the transmission of HIV. The world's religions are compelled to assert their most fundamental teachings on the sanctity of life by advancing comprehensive sexuality education, assertive positions on the use of condoms, confidential HIV/AIDS testing, and support for those affected by the disease.

Abortion continues to be a divisive and complex issue. The *Programme of Action* addresses the question of abortion in a very limited way. It notes that abortion should not be a method of family planning; that abortion can and should be reduced through access to family planning services; it should be safe wherever it is legal, and, where illegal, the consequences of unsafe abortion should be addressed as a public health issue.

Certain realities should be made clear. Where there is a full range of family planning services, the incidence of abortion decreases. In the absence of provisions for safe abortions, even when legal, the rate of maternal death is increased. When abortion is illegal it is poor women who suffer the greatest consequences in the loss of life and health. Children who are the result of unwanted pregnancy can suffer abuse or abandonment. Those who oppose even the modest provisions of the ICPD language on abortion need to be accountable for these realities.

Reflection on these hard truths has caused many people of faith, even those personally opposed to abortion, to conclude that provisions for legal, safe, and accessible abortions are defensible on religious and moral grounds. While the religious traditions differ on the issue of abortion, the *Programme of Action's* limited statements on abortion do not violate the teachings of any of our traditions. Therefore religious leaders and communities can and should support the ICPD on this issue.

CALL FOR ACTION

As **Religion Counts** joins with others in the five-year review of the *Programme of Action*, the following considerations demand our commitment:

1. **Principles count.** The principles articulated in chapter two of the *Programme of Action* must serve as the benchmark against which implementation of specific actions laid out at the ICPD are evaluated. For example, a comprehensive review of family planning programs must not only address their efficacy, but also the extent to which they embody the ICPD's principles.
2. **Partnerships count.** Governments and non-governmental organizations have the opportunity to enlist the support and participation of religions as large and powerful allies for the implementation of the *Programme of Action*. It would be tragic for both religious communities and advocates of the ICPD consensus if this opportunity for collaboration and cooperation were not realized.

3. **Commitments count.** As a matter of moral integrity, nations must keep their financial and programmatic commitments as signatories to the *Programme of Action*. Religious communities and other non-governmental organizations must insist that their governments meet these obligations.

4. **Religions count.** Religions must commit themselves to the realization of the ICPD's goals and assume an active role in the implementation of the *Programme of Action*, including empowering women, eliminating poverty, making provisions for comprehensive health care, and promoting a sustainable environment.

Religion Counts affirms the powerful message of the *Programme of Action*. All nations, all peoples, and all religions share this world in relationships of interdependence. The immense challenges taken on in Cairo five years ago by the countries of the United Nations can only be addressed in an environment of mutual respect.

Religion counts. This is a moment to make it count for the common good of all humanity and the whole of creation.

RELIGION COUNTS MEMBERS

Rev. Rose Teteki Abbey

Ghanaian
Pastor
Presbyterian Church of Ghana
in Accra
Accra, Ghana
Protestant

Denise M. Ackermann

South African
Professor of Religion and
Theology, University of Western
Cape
Belleville, South Africa
Anglican

Michio Araki

Japanese
Professor of Religion,
University of Tsukuba
Tsukuba Ibaraki, Japan
Buddhist

Mehmet Aydin

Turkish
Philosophy Department Head,
Dokuz Eylul University
Turkey
Muslim

Sheila Briggs

USA
Professor, School of Religion,
University of Southern
California
Claremont, California, USA
Roman Catholic

Dina Cormick

South African
Leadership, Women's
Ordination of South
Africa/We Are Church
KwaZulu-Natal, Republic of
South Africa
Roman Catholic

Rev. Julian Cruzalta

Mexican
Lecturer, Universidad Colonia
Copilco
Mexico City, DF, Mexico
Roman Catholic

Musa W. Dube

Botswanan
Professor, University of
Botswana
Gaborone, Botswana
Protestant

Asghar Ali Engineer

Indian
Director, Institute of Islamic
Studies
Mumbai, India
Muslim

Rev. Walter Fauntroy

USA
Pastor, New Bethel Baptist
Church, Former Member,
United State Congress
Washington, DC, USA
Protestant

Rev. Larry Greenfield

USA
Research Scholar, The Park
Ridge Center for Health, Faith,
and Ethics
Chicago, Illinois, USA
Protestant

Sahar Hafez

Egyptian
General Secretary, Arab
Women's Solidarity
Association
Cairo, Egypt
Muslim

Beverly Harrison

USA
Professor of Christian Ethics,
Union Theological Seminary
New York, New York, USA
Protestant

Elfriede Harth

German, Colombian
Coordinator, International
Movement We Are Church
Member
Versailles, France
Roman Catholic

Riffat Hassan

USA
Professor of Religious Studies
and Humanities,
University of Louisville
Louisville, Kentucky, USA
Muslim

Teresia Hinga

Kenyan
Professor of Religion, DePaul
University
USA
Roman Catholic

Shamsul Islam

Indian
Senior Reader, Political Science
Department, University of
New Delhi
Delhi, India
Muslim

June Jacobs

British
President, International
Council of Jewish Women
London, England
Jewish

Sandha Jain

Indian
Columnist, the Times of India
and political/religious
commentator
New Delhi, India
Hindu

Madhu Khanna

Indian
Associate Professor, Indira
Ghandi National Centre
for the Arts
New Dehli, India
Hindu

Gabi Kienesberger

Austrian
Theologian, member,
European Women's Synod
Vienna, Austria
Roman Catholic

Frances Kissling

USA
President,
Catholics for a Free Choice
Washington, DC, USA
Roman Catholic

Manfred Kulesa

German
Leadership,
Association of Churches'
Development Service
Bonn, Germany
Protestant

Chung Hyun Kyung

Korean
Professor,
Union Theological Seminary
New York, New York, USA
Protestant

Rabbi Amy Levin

Israeli
Treasurer, Rabbinical Assembly
of Israel
Jerusalem, Israel
Jewish

Joanna Manning

Canadian
Founder, Coalition of
Concerned Canadian Catholics
Toronto, Ontario, Canada
Roman Catholic

Rev. James Martin-Schramm
USA

Assistant Professor,
Department of Religion and
Philosophy, Luther College
Decorah, Iowa, USA
Protestant

Maria Consuelo Mejia

Mexican
Director, Catolicas por el
Derecho a Decidir
Mexico D.F., Mexico
Roman Catholic

Rev. Myosei Midorikawa

Japanese
Chaplain, Jindai Temple
Tokyo, Japan
Buddhist

Philomena Mwaura

Kenyan
Lecturer, Department of
Religious Studies, Kenyatta
University
Nairobi, Kenya
Roman Catholic

Maria Jose Rosado Nunes

Brazilian
Coordinator, Catolicas pelo el
Direito de Decidir, Brazil,
Professor, Catholic University
of Sao Paulo
Sao Paulo, Brazil
Roman Catholic

Anthony Padovano

USA
Director, CORPUS, a national
association for married priests
Morris Plains, New Jersey,
USA
Roman Catholic

Rev. Gustavo A. Parajon

Nicaraguan
President, Nicaraguan Council
of Churches
Managua, Nicaragua
Protestant

Rosemary Radford Ruether
USA

Georgia Harkness Professor,
Garrett-Evangelical Seminary
Evanston, Illinois, USA
Roman Catholic

Arvind Sharma

Indian
Birks Professor of
Comparative Religion,
McGill University
Montreal, Quebec, Canada
Hindu

Sheikh Gamal Solaiman

British
Council Member, Institute of
Business Ethics
Ottawa, Ontario, Canada
Muslim

Rev. Gordon Sommers

USA
Former President, National
Council of Churches
Bethlehem, Pennsylvania, USA
Protestant

Ven. Haeju Sunim

Korean
Professor of Philosophy,
Dongguk University
Seoul, Republic of Korea
Buddhist

Ven. Karma Lekshe Tsomo

USA
Secretary, Sakyadhita:
International Association of
Buddhist Women
Honolulu, Hawaii, USA
Buddhist

Rev. Carlton Veazey

USA

Executive Director, Religious
Coalition for Reproductive
Choice

Washington, DC, USA

Protestant

Isaac Wüst

Dutch

Member, International

Movement We Are Church

Amsterdam, the Netherlands

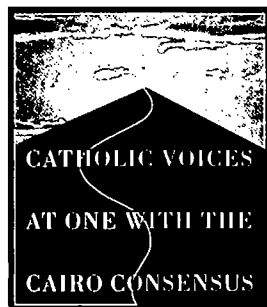
Roman Catholic

RELIGION COUNTS

Religion Counts is an inter-religious group of religious scholars, experts, and leaders from around the world. An initiative of the Park Ridge Center for Health, Faith, and Ethics and Catholics for a Free Choice, Religion Counts provides a positive, ethically sensitive religious contribution to discourse on issues surrounding population, reproductive health, and development policies.

The Park Ridge Center
211 East Ontario
Suite 800
Chicago, IL 60611
Attention: Larry Greenfield
(p) 312-266-2222
(f) 312-266-6086

Catholics for a Free Choice
1436 U Street, NW
Suite 301
Washington, DC 20009
Attention: Frances Kissling
(p) 202-986-6093
(f) 202-332-7995



Catholic Voices: Reflections from the Paseo de la Reforma Mexico City, December, 1998

INTRODUCTION

Over the past decade, the United Nations has, through a series of international conferences and plans of action, addressed a number of serious problems facing the world and its people: human rights, the environment, population and development, social development, housing, and women's rights. Few areas have been more contentious or difficult than the question of population and development, which embody differing deeply embedded political and religious views of women's rights, gender, sexuality, and reproduction.

At the UN International Conference on Population and Development, held in Cairo in 1994, these different perspectives collided. The Vatican and its Holy See delegation occupied substantial public space, serving as an obstacle to a growing international consensus on population. This consensus resulted in a remarkable, socially transformative document called the Programme of Action, which was adopted by the world's governments. The past five years have marked the beginning of realizing the world view represented in that document and implementing its outlined actions. These matters were the basis for discussion of Catholic Voices, a forum of Catholic leaders, theologians, activists, and scholars who came together in Mexico City in December 1998.

With Catholic Voices' work for women's rights, human development, and church reform, it was fitting that the meeting took place on Mexico City's *Paseo de la Reforma*, the Reform Promenade. This wide, grand boulevard with its stirring name became a symbol of our hopes for the human community's progress toward justice and the common good.

The gathering on the Paseo de la Reforma came just two months before the first of a series of

formal meetings sponsored by the United Nations, The Hague Forum in February, 1999. The Hague Forum will evaluate the progress in implementation of agreements made at the International Conference on Population and Development held in the Cairo Programme of Action since its completion in September 1994. One of the remarkable aspects of the Cairo conference was the partnership forged between governments and civil society in the crafting of international policies. In the spirit of that partnership and with an eye toward the five-year review, the United Nations invited non-governmental organizations to share their perspectives with the UN on the themes and actions outlined in the Cairo Programme of Action. Catholic Voices has taken up this invitation with enthusiasm, and thus we gathered in Mexico to reflect upon the issues of population and development.

We are not experts in service delivery or program evaluators. Rather, we review the Programme of Action from the perspective of values and principles enlightened by the Catholic social justice tradition. The agreements reached at the Cairo conference represented what has been called by many a "paradigm shift" in the world's approach to population and development. In this shift, an emphasis on demographic targets gives way to an emphasis on human needs and the common good. In the new paradigm, we see hope, a reverence for life, health, and well being, and an impulse toward respect for human dignity, social justice, and equality among all people. Especially evident in the Programme of Action is a new-found respect for the moral agency of women.

Particularly because the views of many Catholics were not represented by the Holy See at the Cairo Conference, we present this report of our reflections on issues related to population and development.

Reflection: Eradicating Poverty

We are rooted in the principle of the preferential option for the poor and economic justice for all in insisting that special priority be given to the least developed nations of the world and to the poorest individuals everywhere. Profound concern for the poor is a refrain throughout the Hebrew Scriptures, where the community is urged time and again to care for the widow, the orphan, and the stranger. In the Christian Scriptures, neglect of the poor leads to exclusion from the Reign of God (Mt. 25), which embraces not just life after death, but also the here and now, indeed, the totality of human experience.

Poverty imposes imperatives on the affluent. Neglect of the poor is neglect of God. We support ways of helping the poor such as charity, but we also call for the transformation of domestic and world structures that create and maintain poverty. On the deepest level, it must be recognized that the poor and the affluent are equal in dignity and rights. Furthermore, the privileged must acknowledge and reform their habits of over consumption. The world's resources belong to all of us, rich and poor alike.

As population and development policies are created and implemented, it is important to note that poverty cannot be blamed on population growth. Poverty arises from injustice, and slowing fertility rates is not a single or simple solution to poverty. We applaud Cairo's call for nations to cooperate to eradicate poverty "in order to decrease the disparities in standards of living and better meet the needs of the majority of the people of the world."

Reflection: People-Centered Development

People's lives, not markets or production, should be the central concern of development policies. The true measure of development is whether it meets people's human needs and aspirations and whether it does this in accord with their human dignity. In the past, the Catholic church as a whole has seriously criticized development policies for focusing solely on economic rather than human development. Ethical population and development policies must be focused on people, not numbers; on rights, not demographics; on serving human needs, not denying human desires.

Every person has the right to development. The cost of the world community's failure to support development is incalculable and unconscionable. Development policies should

enable people to "seek to do more, know more and have more in order to be more," as Pope Paul VI's 1967 encyclical *Populorum Progressio* (On the Development of Peoples) put it.

As part of development, Cairo specifically emphasized the right to education and noted that investment in education is critical to the empowerment of women and the achievement of their human rights. Cairo also underscored everyone's right to "the enjoyment of the highest attainable standard of physical and mental health." Cairo recognized development as an integral part of fundamental human rights and said it must be fulfilled so as to equitably meet the needs of present and future generations.

Reflection: Human Rights and the Poor and the Marginalized

Our Catholic tradition calls us to stand with the poor and the marginalized. Marginalization of the "other" leads to corruptions such as racism and nationalism. Common human dignity argues for the free exercise of rights by those who are marginalized, including the impoverished, migrants, threatened indigenous populations, the disabled, the elderly, the persecuted, homosexuals, and other disempowered groups. World history reveals an often repeated record of maltreatment of these groups. It also shows us that women and children are the world's poorest and most marginalized.

Cairo calls on countries to do better. For example, the Programme of Action acknowledges that migrants often have the least access to resources provided in development plans. It entreats countries to guarantee fundamental human rights to all migrants. It also explicitly calls on nations to grant protection for refugees escaping persecution and to recognize and support the identity, culture and interests of indigenous peoples, and to enable them to participate fully in the nation's life.

Reflection: Women's Human Rights

To put it concisely: women's rights *are* human rights. Women and men are entitled to the same rights and privileges; both also share the same responsibilities and duties. Universal acceptance of women's human rights remain unsettled. However, throughout the last several decades, women's rights have been increasingly recognized in the world, in both the secular and religious fields. Unfortunately, the Vatican's actions at Cairo did not reflect the richness

of the Catholic tradition in support of women's human rights.

Cairo's Programme of Action was the first United Nations document on population that explicitly recognized the importance of women's rights as a worthy goal in itself and as a crucial factor in development. Prior to Cairo, women's lives were not always treated with dignity and respect in population policies; women were often considered only in terms of their reproductive capacity, and their aspirations and needs were made secondary to demographic outcomes. Cairo noted the exceptional importance of the "empowerment and autonomy of women and the improvement of their political, social, economic and health status."

We stand with Cairo's groundbreaking calls for gender equality, the empowerment of women, and the recognition of women's moral agency. We endorse its outlined actions aimed at advancing women's status, including promoting education for women, eliminating economic and other discrimination against women, enhancing women's employment opportunities, and ending violence against women.

Reflection: Adolescents' Human Rights

Adolescence is a passage in the human journey toward maturity. It is an age in which people appropriately begin to explore and discover experiences related to adult life, including social, spiritual, and personal growth. Given this search, adolescents must have adequate reliable information to light their way. Adolescents must also be recognized as more than recipients of adult knowledge and advice. They have much to draw from and to offer as a result of their own insights and experience.

The intent of sexuality education for adolescents should not be information only; it should rather be aimed toward the formation of a responsible conscience and sensitivity to the lives of others. The responsibility for these kinds of messages are shared by many, including parents, schools, the media, and other social institutions. Sexuality education must respond to the expressed and unexpressed needs of young persons themselves.

One of Cairo's achievements was its recognition that the reproductive health needs of adolescents as a group have been largely ignored by existing

reproductive health services. Cairo called for adolescents to have information and services "to help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility." Cairo also correctly called on governments to safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent. It said countries should remove legal, regulatory and social barriers to reproductive health information and care for adolescents. The Programme of Action also acknowledged that adolescents must be fully involved in the planning and implementation of these educational programmes.

Reflection: Sexuality

Sexuality is a gift of God and is integral to our humanity. The celebration of our bodies through sexuality brings us spiritual awareness. Human sexuality commits each person to concern for the other or else it forfeits its human and virtuous content. Sexuality, like love, should be sensitive, considerate, generous, compassionate, and concerned. The same standards apply to men and women equally. The principle that insists that we love our neighbors as ourselves is expected to govern our sexual relationships. Ethical expressions of sexuality based on equality, mutual respect, and concern are found in many kinds of relationships and unions.

These perspectives reflect a broader understanding of sexuality than the ones put forth by the Vatican at Cairo. Indeed, a persistent tradition of aversion to sexuality within Catholicism is the root of current Vatican conservatism on reproduction and women. Sex has often been presented as a necessary evil by churchmen, reflecting a kind of amnesia concerning biblical references to sexual pleasure as a value in its own right.

Sexual expression is multi-faceted and serves many good purposes. It is a way of communicating intimately with another, of giving and receiving pleasure, and of creating new life. It is morally separable from its reproductive function. To its credit, Cairo addressed "sexual health" in the context of "enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases." The Cairo agenda should be informed by agreements made by nations at the 1995 Fourth World Conference on Women, which declared that "the

human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality ... free of coercion, discrimination and violence."

Reflection: Reproductive Health and Rights

Reproduction is one of the most important and profound aspects of human life and relationships. Through reproduction, we express our hope in the future of the human family. Reproduction is both private and public. It has undeniable consequences for the community and society at large. It is also a matter of public health, religious teachings, and government policy. It is an area in which women are the central protagonists, for it is women who bear the risks and consequences of childbearing and the greater responsibility for child rearing. In the just world we work toward, these risks and responsibilities will be equally shared by men and better supported by society.

An ethically based approach to reproductive health and rights has several underlying principles. First, it must be voluntary rather than coercive. Imposition of external limits on family size are unacceptable. Couples must have the right to decide when, whether, and how to bring new life into the world. Second, it must be comprehensive rather than focused on family planning alone. Women's reproductive health cannot be extricated from their health, and programs must provide a wide range of services. Third, it must be seen as an integral aspect of human rights. Reproductive rights are grounded in previously recognized human rights. This right was first recognized in 1968 at the International Conference on Human Rights in Teheran, Iran. Fourth, it must be tied irrevocably to respect for the rights of conscience and free will. Couples consider a range of concerns in making the decision whether to have a child. The community, family, religious teachings, social conventions will play a role in reproductive decisions, but in each decision, the individual conscience has the ultimate say.

Cairo's approach to reproductive health and rights is grounded in these principles. Its rejection of coercion and its support of comprehensive safe motherhood programs are to be commended.

Reflection: Contraception

Catholics around the world have come to believe that contraception is a moral option. Bringing children into the world is a sacred responsibility. Safe and effective contraception not only makes

responsible procreation more possible, it also allows for a satisfying, pleasurable sexual life with diminished fear of unintended pregnancy. Furthermore, the control over fertility that contraception offers has allowed women to develop aspects of their lives beyond motherhood.

The Vatican supports, in fact encourages, the practice of family planning, for it recognizes the moral imperative of responsible parenthood. However, only "natural family planning," a set of methods that involve periodic abstinence, is allowed. Making only one method available – and one that does nothing to protect against sexually transmitted diseases – cruelly ignores the reality of people's lives. Women and men must freely decide not only whether they wish to use contraception, but which method is best for them.

Couples worldwide have indicated that they need and want to use contraception. We endorse Cairo's commitment to voluntary family planning programs that include a full range of safe, effective, and affordable contraceptive choices.

Reflection: HIV/AIDS

Society's and individuals' responses to AIDS must be rooted in compassion, responsibility, and a commitment to life. These principles require that efforts to prevent the spread of HIV must include condoms and condom instruction. Couples should be encouraged to use them to prevent transmission of HIV. We reject the Vatican's opposition to condom use, and we stand with Cairo's approach to treating and preventing this tragic disease.

Reflection: Safe Abortion

Abortion is a complex moral and social issue – potential mothers know this best. The Vatican's position on abortion is compromised by its unwillingness to accept contraceptive services and devices even though they reduce the need for abortion. Even taking into account Vatican opposition to abortion, we remain puzzled by Vatican objections to abortion being safe where legal. This dismissal of safe abortion by the church hierarchy is insensitive to the realities women face and to the number of women who die from unsafe abortions every day. Because women everywhere resort to abortion, the alternative to safe abortion is, of course, unsafe abortion. Again, it is the hierarchy's preoccupation with eliminating abortion from the world that prevents the real issues of justice and health for women being addressed. Such an

absolutist position fails to acknowledge the ambiguity and doubt regarding fetal life and ignores the range of moral complexities surrounding each situation.

Despite charges that it did, Cairo did not call for universal legal abortion. In fact, it based a large measure of its support for comprehensive family planning programs on the imperative to reduce the need for abortion. It did call for abortions to be safe where legal and for the public health issues of unsafe abortion to be addressed. The Holy See opposed even these points.

In countries where abortion is illegal, it is the poor who are left to face abortions under the worst types of conditions. And in countries where abortion is legal, but safe abortions are costly, it is again poor women who shoulder the burden. The church tradition of a preferential option for the poor has been interpreted by many Catholics to support the safety of abortion and to oppose unsafe abortions. Within the Cairo context, concern for public safety is not the same as moral endorsement.

Despite Vatican disapproval, Cairo was right to address the catastrophic health consequences for women of unsafe abortion. Justice demands that we do not abandon poor women or women in need of help.

Reflection: Families

A broad, fluid vision of families is reflected by Jesus himself in the Gospel of Mark. As his mother and brothers one day approached Jesus and a group encircled around him, Jesus asked, "Who is my mother, or my brothers?" He gestured toward the circle and said, "Here are my mother and my brothers!" (Mk. 3:31-35)

We do not agree with the parsimonious view of family espoused by the Vatican.

In the fragile world in which we live, it seems to us that we do better as a human community to embrace extended and varied definitions of families. Why decry people's bonds of solidarity and willingness to take responsibility for another?

However, whatever structure the family has taken, it has often been the site of violence against women and children. As we look to a more generous vision of families, violence has no place.

Cairo honored families in the Programme of Action, saying, "The family is the basic unit of society and as such should be strengthened." And it recognized diversity. "In different cultural, political and social systems, various forms of the family exist."

Reflection: The Role of Religion

Religious thought has an important role to play within the civil society and its cultures. The values and principles at the core of all the major religious traditions – respect for human dignity, care for the poor and marginalized, a striving for the common good – are important touchstones for civil society. Where religion is rooted in community and experience, religious stories and traditions serve as important teaching tools. Religious insights often form the framework for the most fundamental and profound human inquiries.

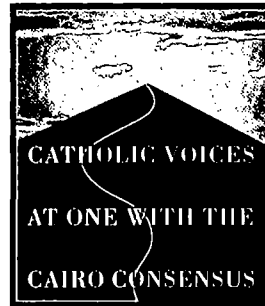
Many of the issues at the heart of population and development concerns— not least among them issues of sexuality and reproduction, women's rights, gender roles and responsibilities— call for massive social change. They center on transforming relationships, between men and women, between government and citizens, and between and among family members. This kind of social reform and reorganization will be difficult and will take a long time. Participation by religious institutions, organizations, and individuals can promote, enhance, and accelerate this transformation.

However, there is not one religious model that applies to the whole world. There must be constant dialogue among religious and spiritual movements so that we can become more aware of how to accommodate difference as well as reach shared values. As Catholics, we are called by the Second Vatican Council to "recognize the legitimacy of differing points of view," and show respect for our fellow citizens. (*Gaudium et Spes*, 75). Moreover, while religions have a place at the policy table, it is not a privileged place. Rather, they are equal voices among many.

EPILOGUE

As Catholics who support the ethical approach to population and development articulated in the Cairo Programme of Action, we call on nations to strengthen their commitment to the principles and actions outlined therein. We further call on people who gather themselves in religious communities to

dedicate themselves to addressing the challenges and problems related to these issues. We look forward with hope to a future in which poverty and its roots are eliminated, men and women enjoy equal rights, children have what they need to grow and develop, and the rights of conscience are protected.



Acting Against the Grain A Chronology of Church Action to Block Cairo's Implementation

At the September 1994 International Conference on Population and Development held in Cairo, Egypt, the overwhelming majority of nations agreed to a Programme of Action — a set of actions and policies intended to address “the critical challenges and interrelationships between population and sustained economic growth in the context of sustainable development.” The Holy See joined the consensus on all of the principles articulated in the conference Programme of Action, while expressing reservations on most of the document's other chapters, including those dealing with sexual and reproductive health and rights.

The Vatican's opposition to agreements reached in these areas did not end with the conference's conclusion. In the ensuing four and a half years, church officials, from the Vatican to bishops' conferences and beyond, have conducted a campaign of obstruction to implementation of these parts of the Cairo agenda. Many of these instances have taken the form of direct incursions into the formation of public policy; some are more oblique efforts to vilify those implementing the Cairo agreement, as when the pope maintained that international institutions providing voluntary contraceptives to couples who want them are involved in a “conspiracy against life.” All of their efforts, however, affect not only Catholics, but citizens of all faiths and no faith all across the world.

The Cairo Programme of Action stresses the “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,” and it called for expanded access to primary and reproductive health care. Cairo called for family planning programs to “ensure that women and men have information and access to the widest possible range of safe and effective family planning methods in order to enable them to exercise free and

informed choice. In fact, the agreement says that governments should remove “unnecessary legal, medical, clinical and regulatory barriers to information and to access to family-planning services and methods.” But church officials around the globe have acted as barriers themselves, taking steps to restrict access to any method of family planning officially banned by the church. (Official teaching forbids the use of any method except periodic abstinence.)

Since Cairo, church officials have obstructed efforts to implement many other Cairo agreements, including efforts to broaden sexuality education programs, to improve and expand prevention programs on HIV/AIDS and other sexually transmitted diseases, and even to end discrimination of disabled persons with regard to reproductive rights and family formation.

The following chronology enumerates incidents in this campaign of obstruction. It is by no means comprehensive, and in fact presents only a portion of what is likely a high number of such actions. The entries in this chronology have been gleaned principally from church documents that have been made public and from news reports of public actions by church officials. There is no way to identify or quantify nonpublic efforts of the Roman Catholic church as an institution in the crafting of public policy and the shaping of individual behavior. Appearing at the end of each chronology entry is a citation of the relevant section from the Cairo Programme of Action.

In chapter 11 of the Programme of Action, delegations at Cairo agreed that those in “influential positions,” including religious leaders, should “mobilize public opinion in support of the actions proposed” (11.17). Sadly, officials of the Roman Catholic church have tried to do just the opposite.

Chapter 11 was among those on which the Holy See did not join the consensus, and indeed, church representatives have worked, often in the public policy arena, to make it harder for the Cairo vision to be realized.

December 1994

The US bishops approve updates and revisions to the *Ethical and Religious Directives for Catholic Health Care Services*. The *Directives* bar Catholic health care facilities from providing or condoning contraceptive practices, from providing condoms or condom counseling, even for disease protection, and from performing voluntary sterilizations for men and women.¹ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17

December 1994

US Archbishop Francis Schulte of New Orleans, Louisiana, issues a pastoral letter entitled "Pastoral Action for Families," in which he denounces the use of contraceptives. "To many," he writes, "the ability to control conception seems to be accompanied by the right to separate the procreative and unitive functions of marriage."² PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17

March 1995

Pope John Paul II issues his encyclical letter, *Evangelium Vitae* (The Gospel of Life), in which he condemns, among other things, contraception and treatment of infertility. The pope claims that international institutions are involved in a "conspiracy against life" because they are engaged in campaigns to make contraception available.³ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17

June 1995

The Catholic church in Kenya vows to fight a new program of Family Life Education in schools. The new program would give young people access to information to equip them with the ability to say "no" to sex and to help them avoid unwanted pregnancies and sexually transmitted diseases, including HIV/AIDS.⁴ PROGRAMME OF ACTION 7.46, 8.31, 8.35, 11.9

June 1995

Fifteen bishops from the Middle East and Asia meet at the Vatican to discuss goals in the pastoral care of families. In their statement, "Serving the Needs of the Family," the bishops call upon all men and women to reject "safe sex" programs, saying, "We

insist that the only reliable remedy to the spread of AIDS is fidelity within marriage and chastity outside marriage." In their statement, the bishops also insist that periodic abstinence is the only acceptable method of family planning.⁵ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.31, 8.35

August 1995

The Peruvian bishops' conference issues a news release upholding the pope's new encyclical, *Evangelium Vitae*, which condemns contraception and criticizes family planning programs. The bishops assert that the church's ban on contraception is not just an opinion, but is a truth, taught by the church, "in the name of God." Moreover, they assert, this church doctrine is not only directed at Catholics, but is directed to all people of good will.⁶ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.31, 8.35

September 1995

Brazilian Roman Catholic officials publicly criticize the government's new AIDS prevention campaign. The campaign advocates the use of condoms to prevent the spread of HIV and AIDS. Bishop Dadeus Grings states that "a sickness isn't fought by degrading morals and hurling people to hell. The church preaches chastity and is opposed to the use of prophylactics . . . The church is highly concerned about preserving human dignity and can't agree with the methods adopted to fight AIDS."⁷ PROGRAMME OF ACTION 7.23(b), 8.31, 8.35

September 1995

In its reservations and statements of interpretation of the UN World Conference on Women in Beijing, the Vatican says, "The Holy See in no way endorses contraception or the use of condoms, either as a family planning measure or in HIV/AIDS prevention programs."⁸ The Vatican also criticizes the platform of the Conference for the document's focus on sexual and reproductive health, and wants that all references to sexuality in the document be interpreted to mean sex within marriage. Joined by Latin American, Islamic countries, and conservative nongovernmental organizations (NGOs), the Vatican opposes language that it claims denigrates the two-parent (mother and father) family, belittles motherhood and diminishes the rights of parents to decide if their children should receive sex education and reproductive health care, including contraceptive services.⁹ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 7.37, 7.46, 8.31, 8.35, 11.9

September 1995

Catholic groups oppose Ireland's move to institute sex education programs in schools, accusing the Stay Safe program of "confusing moral judgments and personal feeling." Although there persists a debate among Catholics in Ireland over the sex education program, Stay Safe continues — but it is closely monitored by the church.¹⁰ PROGRAMME OF ACTION 7.23(b), 7.37, 7.46, 8.31, 8.35, 11.9

January 1996

Church leaders and Catholic conservatives fight against a New York City AIDS education curriculum that includes condom distribution and textbooks that teach respect and tolerance for diverse sexual orientations. Consequently, the Board of Education adopts a revised curriculum on AIDS education that no longer includes classroom demonstrations of condom use.¹¹ PROGRAMME OF ACTION 7.23(b), 7.37, 7.46, 8.31, 8.35, 11.9

February 1996

The Vatican advises parents to "reject the promotion of 'safe sex' or 'safer sex,' a dangerous and immoral policy based on the deluded theory that the condom can provide adequate protection against AIDS."¹² PROGRAMME OF ACTION 7.3, 7.23(b), 7.37, 7.46, 8.31, 8.35, 11.9

February 1996

The Peruvian bishops' conference releases a letter, "Building a Culture of Life," that criticizes the government's promotion of a sex education program geared toward adolescents. They claim the program is devoid of moral values and social responsibility. They assert that the program is limited to education on prophylactics and condoms, and thus encourages recreational sex that does not take into account responsibility for consequences.¹³ PROGRAMME OF ACTION 7.23(b), 7.37, 7.46, 8.31, 8.35, 11.9

March 1996

The Vatican orders Scottish Archbishop Keith O'Brien to remove his imprimatur (official permission to print) from an AIDS education package that includes information and advice on using condoms. The most important inadequacy of the package, according to one churchman involved, is the attitude towards condoms, "that if you have got HIV and you are having pre-marital sex, or sex in any situation, you should use a condom."¹⁴ PROGRAMME OF ACTION 7.23(b), 7.37, 7.46, 8.31, 8.35, 11.9

March 1996

A Brazilian Roman Catholic bishop rejects the marriage application of a Brazilian couple because the man is "paraplegic and therefore impotent," according to the bishops' letter to the couple. The man had applied to the Catholic church to marry a widow who had two children from a previous marriage. A couple "needs to be in perfect physical condition to be married," the bishop says.¹⁵ PROGRAMME OF ACTION 6.30

August 1996

As 250 people watch, Kenya's top Catholic bishop, Cardinal Maurice Otunga, ceremoniously burns several boxes of condoms and one hundred copies of pamphlets promoting safe sex. According to the World Health Organization, one million of Kenya's twenty-six million people are infected with the virus that causes AIDS.¹⁶ PROGRAMME OF ACTION 7.6, 7.23, 7.37, 8.31, 8.35

August 1996

Experiencing pressure from Catholic and other religious groups, Kenya's President Daniel Arap Moi rules out sex education in primary schools. Moi states that, "Our religions are against such immorality [sex education] and my government will reject calls for it to be debated in parliament." The Catholic church has persistently opposed the teaching of sex education because the proposed curriculum included information about contraception.¹⁷ PROGRAMME OF ACTION 7.23(b), 7.46, 8.31, 8.35, 11.9

August 1996

The Catholic bishops of Nicaragua release a statement saying the country is suffering under a campaign of "antireproductive colonialism." The bishops call for Catholics to not be confused by those who speak of "reproductive rights," "reproductive health," and "safe sex," arguing that these terms disguise "abortionists, promiscuity, and the arbitrary use of sex."¹⁸ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.23, 8.25

November 1996

The Holy See announces at the Pledging Conference for Development Activities, held at the United Nations in New York, that it will not offer its usual symbolic contribution to United Nations Children's Fund (UNICEF) for 1997 and calls on others, especially Catholic institutions and individuals, to reconsider their support for the agency. The attack is based on charges—unequivocally denied by

UNICEF — that the agency is engaged in distributing contraception and promoting abortion, and on UNICEF's endorsement of a UN manual dealing with women's needs in emergency situations and in refugee camps. Produced at the height of the Bosnian conflict, the manual states that women — including the victims of rape as an instrument of war — “have the same rights as others to have access, on the basis of free and voluntary choice, to comprehensive information and services for reproductive health,” including emergency post-coital contraception for raped women.¹⁹ PROGRAMME OF ACTION 4.17, 4.18, 4.19, 7.46, 11.8, 11.9

November 1996

The Roman Catholic church in Honduras uses its influence to prevent the distribution of condoms at polling stations during primary elections. The Honduran Ministry of Health had planned to distribute more than one million condoms at polling places where voters from the country's two major parties were choosing candidates for the presidency and other offices. Government officials say they cancelled the plans largely because of church objections.²⁰ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.31, 8.35

December 1996

Addressing participants in a course to prepare teachers of natural family planning, the pope reiterates that natural family planning is the only method permitted by the church for married couples to use to space pregnancies. A month prior to his statement, the pope urged doctors to adhere to the church's sanctioned method of family planning, and he condemned contraceptives as a form of “hedonism.”²¹ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.35

January 1997

In a letter to the US Congress, Cardinal Bernard Law of Boston, Massachusetts urges members of Congress to vote against the US Administration's proposal to spend an additional \$123 million for international family planning assistance.²² PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17, 8.25, 8.31

February 1997

In an address to members of the Philippine bishops' conference during their *ad limina* visit to Rome, Pope John Paul II instructs the bishops to defend the family by publicly opposing sterilization and

contraception. The pope asks that the bishops “support the teaching of natural methods of regulating fertility.”²³ PROGRAMME OF ACTION 7.6, 7.15, 7.23(b), 8.31, 8.35

February 1997

The US National Conference of Catholic Bishops decries the congressional approval of a bill providing additional international family planning assistance. The bishops claim that the money would support abortion activities, even though US law prohibits the use of US funds for any abortion-related activities overseas.²⁴ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17, 8.25, 8.31

March 1997

The Pontifical Council for the Family issues a reference document entitled, “*Vade Mecum* for Confessors Concerning Some Aspects of Morality of Conjugal Life,” in which contraception is referred to as an “evil.” The document states, “The church has always taught the intrinsic evil of contraception, that is, of every marital act intentionally rendered unfruitful. This teaching is to be held definitive and irreformable. Contraception is gravely opposed to marital chastity; it is contrary to the good of transmission of life . . . ; it harms true love”²⁵ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.35

April 1997

The Catholic bishops of the United States urge the US Congress to vote against aid for family planning programs overseas.²⁶ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17, 8.25, 8.31

June 1997

In a letter to US Bishop John McCarthy of Austin, Texas, the Vatican's Congregation for the Doctrine of the Faith instructs the bishop to terminate all access to contraception and sterilization at Brackenridge Hospital. The letter is part of a series of correspondence regarding the leasing arrangement between Seton (a Catholic health care system) and Brackenridge Hospital (a public medical facility) in Austin, Texas. “This Congregation,” the letter reads, “directs Your Excellency to ensure that direct sterilizations, as well as any other contraceptive programs, immediately and permanently cease at Brackenridge Hospital.”²⁷ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23

July 1997

L'Osservatore Romano, the Vatican newspaper, gives its support to a report which calls on people with mental and physical disabilities to abstain from sex. Dr. Maria Cristina Baldacci, a surgeon and consultant in bioethics, wrote an article for *Medical Morality*, saying the disabled should "collaborate with God to avoid creating further pain and sorrow" by expressing their sexual urges as "friendship or something more transcendental."²⁸ PROGRAMME OF ACTION 6.30

July 1997

Catholic and Muslim groups form Citizens for a Healthier Kenya to campaign against the government's sex education programs and distribution of contraceptives. The group seeks to gain support for "traditional family life" and in its literature states that the planned sex education will be dangerous "killing all sense of morality, opening the way to free sex, to contraception and abortion."²⁹ PROGRAMME OF ACTION 5.9, 5.13, 7.15, 7.23, 8.31, 8.25, 8.35, 11.9

August 1997

The archbishop of Mexico, Norberto Rivera Carrera, demands that all condoms distributed through Mexico's AIDS prevention program carry warning labels that state, "Use of this product is harmful to health." In his homily in Mexico City's cathedral, the archbishop praises the Mexican government officials for placing warning labels on alcoholic beverages that say, "this product is harmful to your health," and laments how the government does not do the same for contraceptives.³⁰ PROGRAMME OF ACTION 7.6, 7.15, 7.23, 8.31, 8.35

September 1997

With the support of PROVIDA, a conservative prolife group in Mexico, Mexico's Archbishop Norberto Rivera Carrera rejects the use of contraceptives in marriage. In his homily, Rivera Carrera instructs parishioners not to use intrauterine devices and condoms, arguing that they are methods that destroy the sexual unity between spouses.³¹ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17

October 1997

Fr. Jacques Suaudeau, a medical doctor who is a member of the Vatican Council for the Family claims that using condoms during sexual intercourse will not protect against transmission of the HIV virus.³² PROGRAMME OF ACTION 7.23(b), 8.31, 8.35

November 1997

The Vatican nuncio to the United Nations protests medical aid in refugee camps, saying it is "sometimes almost exclusively in the form of reproductive health measures."³³ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 10.25

January 1998

The German bishops' conference concedes to Pope John Paul II's "urgent request" that Catholic church-sponsored counseling centers stop issuing counseling certificates to pregnant women who need abortions. The bishops agree to withhold counseling certificates that are key in Germany's legal procedures for abortion.³⁴ PROGRAMME OF ACTION 7.6, 7.24, 8.19, 8.25

January 1998

The local Catholic church in Zambia opposes a proposed regulation that would allow unmarried pregnant girls to continue in school, claiming the regulation sanctions immorality. The church says that only students with potential should have the opportunity to continue their education, and argues that pregnant unmarried girls do not have potential.³⁵ PROGRAMME OF ACTION 4.17, 4.18, 4.19, 11.8

February 1998

On the thirtieth anniversary of *Humanae Vitae* — the 1968 encyclical letter issued by Paul VI that reiterates the church ban on the use of artificial contraception — Pope John Paul II tells Catholics that the church's ban on contraception is the law. In his letter addressed to Anna Cappella, director of the Center for Research and Study on the Natural Regulation of Fertility at Rome's Catholic University of the Sacred Heart, Pope John Paul states that "in the act that expresses their love, spouses are called to make a reciprocal gift to themselves to each other in the totality of their person. . . . This is the reason for the intrinsic unlawfulness of contraception: It introduces a substantial limitation into this reciprocal giving"³⁶ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 7.24

April 1998

The New York State Catholic Conference and the Connecticut Catholic Conference lobby against US legislation that would require health insurance policies to provide prescription drug coverage for contraceptive drugs and devices. Women of low-

incomes would especially benefit from the legislation.³⁷ PROGRAMME OF ACTION 7.2, 7.3, 7.15, 7.23, 7.24

April 1998

The archbishop of Lima, Peru, Cardinal Augusto Vargas Alzamora, protests sex education for eleven- and twelve-year-olds in secondary school, calling it a sacrilege and a crime. He criticizes the program for teaching students to prevent pregnancies by using artificial contraception. The minister of education, Domingo Palermo, explains the program addresses the country's problem of teen pregnancy and the aim is to bring information not only to the students, but also to parents and teachers.³⁸ PROGRAMME OF ACTION 7.23(b), 7.37, 7.46, 8.31, 8.35, 11.9

May 1998

Cardinal Augusto Vargas Alzamora of Lima, Peru, calls upon parishioners to boycott artificial methods of contraception. The archbishop states that, "the church condemns these methods because they compromise and affect health, dignity and the economy of families."³⁹ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23, 8.17

June 1998

In the process of instituting the International Criminal Court, the Vatican opposes the inclusion of "forced" or "enforced" pregnancy among the court's list of war crimes, in fear of women being able to use the ICC to obtain abortions in countries where abortions are illegal.⁴⁰ PROGRAMME OF ACTION 7.35, 7.39

July 1998

US residents of Enid, Oklahoma, face the loss of tubal ligation services. The city's two hospitals, one Catholic and the other Baptist, plan to build a Medical Plaza for Women and Infants. The new facility will not offer the choice of tubal ligations at delivery for women because it will operate under the *Ethical and Religious Directives for Catholic Health Care Services*, the Catholic church's national guidelines barring most reproductive services.⁴¹ PROGRAMME OF ACTION 7.2, 7.3, 7.6, 7.15, 7.23

August 1998

The US Catholic bishops lobby against the US Congress bill that would require federal employees' health insurance to cover prescription contraceptives. The bill passes, but the bishops succeed in securing exemptions for Catholic-

sponsored insurance plans.⁴² PROGRAMME OF ACTION 7.2, 7.3, 7.15, 7.23, 7.24

NOTES

- ¹ US Bishops, "Ethical and Religious Directives for Catholic Health Care Services." *Origins* 24:27 (December 15, 1994). 450-460.
- ² Archbishop Francis Schulte, "Pastoral Action for Families." *Origins* 24:30 (January 12, 1995), 506.
- ³ Pope John Paul II, *The Gospel of Life Evangelium Vitae* (New York: Random House, 1995), 23-30.
- ⁴ *Open File*, June 1995.
- ⁵ Asian, Middle Eastern Bishops, "Serving the Needs of the Family," *Origins* 25:6 (June 22, 1995), 100.
- ⁶ "Al Servicio del Evangelio de la Vida," comunicado de los Obispos de Perú, 4 de agosto de 1995.
- ⁷ UPI wire service, September 19, 1995.
- ⁸ Mary Ann Glendon, "Vatican Stance: Women's Conference Final Document," *Origins* 25:15 (September 28, 1995), 235.
- ⁹ "Vatican Criticizes Women's Platform," UPI, September 15, 1995.
- ¹⁰ *The Catholic World Report*, August-September 1995.
- ¹¹ "Best for Kids," *Catholic New York*, January 4, 1996.
- ¹² Pontifical Council for the Family, "The Truth and Meaning of Human Sexuality," *Origins* 25:32 (February 1, 1996).
- ¹³ Carta de los Obispos de Perú a los fieles creyentes. "Construyamos una Cultura de Fe," 2 de febrero de 1996; *The Catholic World Report*, March 1996.
- ¹⁴ *The Catholic World Report*, March 1996; PA News wire service, November 11, 1995.
- ¹⁵ "Brazil Bishop Bans Marriage Because of Impotence," Reuter wire service, March 26, 1996.
- ¹⁶ AP wire service, August 31, 1996.
- ¹⁷ *The Catholic World Report*, August-September 1996.
- ¹⁸ "Obispos Católicos condenan 'Colonialismo anticonceptivo'," *La Tribuna*, August 15, 1996.
- ¹⁹ "Vatican Shelves UNICEF Support," AP wire service, November 5, 1996; "The Holy See Suspends Its Annual Symbolic Contribution to UNICEF," Holy See press release, November 4, 1996.
- ²⁰ "Honduran Church Blasted For Halting Condom Giveaway," Reuter wire service, November 28, 1996.
- ²¹ "Pope—Birth Control," AP wire service, December 7, 1996.
- ²² Cardinal Law, letter to Members of Congress, January 30, 1997. See www.nccbuscc.org.
- ²³ "Filipino Families Are Seeking Sound Doctrine, Grace and Human Empathy," *L'Osservatore Romano*, February 19, 1997.
- ²⁴ "Official Expresses Dismay on Vote for Funds for Abortion Groups," National Conference of Catholic Bishops news release, February 13, 1997.
- ²⁵ Pontifical Council for the Family, "Vade Mecum for Confessors Concerning Some Aspects of Conjugal Life," *Origins* 26:38 (March 13, 1997), 621.
- ²⁶ Most Reverend Theodore E. McCarrick and Most Reverend John Ricard, letter to Senator/Representative, April 22, 1997.
- ²⁷ Congregation of the Doctrine of Faith, letter to the Most Reverend John McCarthy, June 9, 1997.
- ²⁸ "Disabled Protest to Vatican on 'Avoid Sex' Call," *Irish Times*, July 2, 1997.
- ²⁹ *The Wanderer*, July 17, 1997.
- ³⁰ "El condón no es totalmente seguro, dice el arzobispo Rivera Carrera," *Crónica*, 25 de agosto de 1997.

³¹ "Rivera Carrera rechaza los métodos anticonceptivos dentro del matrimonio." *Crónica*, 1 de septiembre de 1997.

³² *The Tablet*, October 18, 1997.

³³ *Catholic New York*, November 13, 1997.

³⁴ "Obeying Pope, German Bishops End Role in Abortion System," *New York Times*, January 28, 1998; "German Catholics to end abortion certificates," Reuter wire service, January 27, 1998.

³⁵ Von Zarina Geloo, "Zambia's Young Mothers Should be Allowed to go to School Again," DPA wire service, January 12, 1998.

³⁶ Pope John Paul II, "Why Natural Family Planning Differs from Contraception," *Origins* 27:40 (March 26, 1998), 680-681; "Pope Reminds Catholics Contraception Not Allowed," Reuter wire service, March 2, 1998.

³⁷ New York State Catholic Conference, letter to New York State Assembly, 3 April 1998; Connecticut Catholic Conference, letter to state legislators, 30 April 1998.

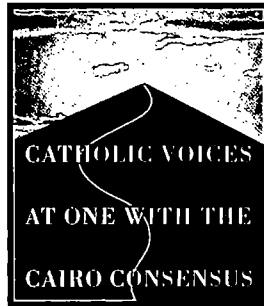
³⁸ "Cardenal Vargas Alzamora critica contenido de educación sexual," *El Comercio*, 10 de abril de 1998; "Ministerio de Educación no imparte planificación familiar a adolescentes," *El Comercio*, 15 de abril de 1998.

³⁹ "Cardenal pide a los feligreses boicotear métodos artificiales para control natal," *Expreso*, 12 de mayo de 1998.

⁴⁰ "New Struggle for Life," *The Catholic World Report*, August-September 1998; "The Holy See's Statement on Criminal Court," *L'Osservatore Romano*, July 22, 1998; "Semantics Stalls Pact Labeling Rape a War Crime," *New York Times*, July 9, 1998.

⁴¹ "Religion, Medicine, Collide on Birth Care," *Chicago Tribune*, July 7, 1998.

⁴² "Political and health issues dominate 'pill bill' debate," *Our Sunday Visitor*, August 30, 1998; "Women's Groups Eye Insurance Bill," AP wire service, August 31, 1998; "Federal Coverage for Birth Control Gives Pro-Abortion Forces a Boost," *National Catholic Register*, August 16-22, 1998.



The Holy See and Cairo

The 1994 International Conference on Population and Development gave rise to unprecedented attention by the Vatican to a United Nations meeting. "No issue has affected John Paul II in a more profound way throughout his fifteen-year papacy than the Cairo conference," observed Raymond Flynn, then US ambassador to the Vatican. Five months before the ICPD convened, Reuters reported that the pope had "pulled out all the stops in an attempt to influence the conference."

Throughout the year leading up to the conference, Pope John Paul II and other top Roman Catholic church officials campaigned with a vengeance against the consensus taking shape around the UN conference. John Paul met in March 1994 with Nafis Sadik, executive director of the United Nations Population fund and secretary general of the ICPD. Face to face, he upbraided Sadik and criticized the draft Programme of Action as formulating "population issues in terms of individual and 'sexual and reproductive rights,' or even in terms of 'women's rights'."

Then came his letter to every head of state, claiming that the document promotes a "lifestyle" that is "totally individualistic, to such an extent that marriage now appears as something outmoded." This lifestyle, the pope wrote, is "typical of certain fringes within developed societies, societies which are materially rich and secularized."

In late March, John Paul summoned all ambassadors assigned to the Vatican for a papal lesson on population. A month later, he spoke by telephone and in person with President Clinton on the matter.

Through the spring and summer, the pope took every opportunity in general audiences and other public appearances to attack the conference with fiery rhetoric. The conference aims to "destroy the

family," John Paul said. It is the "snare of the devil," promulgates a "culture of death," and represents a "serious setback for humanity." On one visit to a neighborhood church in Rome, the pope told parishioners, "I am going back to the Vatican to combat a project prepared by the United Nations, which want to destroy the family. I say simply no, no. Think again. Convert your hearts. If you are the United Nations, you must not destroy."

Other senior church officials joined in. Cardinal Alfonso Lopez Trujillo, president of the Pontifical Council for the Family, said the ICPD could cause "the most disastrous massacre in history." Trujillo accused the United States and other Western countries of "biological colonialism" for advocating family planning methods the Vatican opposes—that is, any methods other than those relying on periodic abstinence, or "natural family planning."

A gathering of 114 of the church's 139 cardinals in June endorsed the Vatican's fight with a statement charging that the Cairo document would legitimize "abortion on demand, sexual promiscuity and distorted notions of the family."

At the final preparatory meeting in April in New York, Holy See Delegate Diarmuid Martin infuriated participants when he accused conference leaders of flouting the "cultural, ethical, spiritual, and religious values" of people in developing nations and of indulging in "reticence towards a coherent moral vision." NGO representatives jeered his remarks, and in a curt response, the chairman of the session, Fred Sai of Ghana, turned the charge of ethical shortcomings back against the Holy See.

Unbowed, the Vatican attempted to secure allies for its crusade, but months of diplomatic efforts netted few recruits. After one staunch soldier, President Carlos Menem of Argentina, failed

to rally Latin American heads of state to adopt a joint "right to life" platform for the Cairo conference, it seemed that the pope began turning over stones to find comrades. In August the Vatican reached out to Islamic fundamentalists, paying calls on repressive regimes such as Libya. A Libyan news agency reported that, in return for Libya's support in condemning the Cairo conference, Vatican diplomats were supporting Libyan efforts to resolve differences with Western governments around the 1988 bombing of a Pan Am jet over Lockerbie, Scotland.

During their campaign against the conference, Roman Catholic church leaders were especially critical of the US government and its positions on issues related to the Cairo conference. The US bishops issued a statement calling on the US government to "reverse its efforts" on the conference.

Higher up the hierarchy, the US cardinals wrote a letter to President Clinton that distorted the emerging Programme of Action in order to attack it. They claimed, for example, that the document advocated increased use of sterilization, even though neither the draft document nor its final articulation promoted particular methods of regulating fertility and never used the words "sterilization," "ligation," "vasectomy," or "surgical contraception."

Meanwhile, the US administration, in the person of Vice President Al Gore, made extraordinary efforts not to offend the Vatican while defending the conference agenda. For Gore's trouble, a top Vatican official, papal spokesman Joaquin Navarro-Valls, publicly insulted him by name, suggesting that the Vice President was lying about US intentions.

The Vatican also courted US opinion with an op-ed article written by Navarro-Valls and published by the *Wall Street Journal* a few days before the ICPD opened. The conference, Navarro-Valls wrote, would be "a crucial challenge to Christianity's most fundamental doctrine on the sanctity of life as it has to come to be and exist in the family. The Holy Father is not merely defending a sort of odd Catholic view about life and family. He is in fact pointing to the key issue on which future humanity must make a choice. This issue of human life and population undergirds all others. A false step here leads to a general disorder of civilization itself."

Indeed, the Vatican's vision of civilization did seem to be at stake. The conference became a debate "between modernity and tradition, between dogma and reason," the Italian daily *La Repubblica* observed. What the Vatican decried, others acclaimed. The overwhelming majority of world governments, religious leaders, and a broad array of public interest organizations with historically diverse views on population issues had come to a consensus on humane population policies and sustainable development; the Vatican dug in its heels, crying that the new views of sexuality, reproduction, and families meant the end of civilization.

With the preponderance of governments in strong support of the plan—a sign that it was no manifesto of radical liberalism—the Vatican made efforts to cloak its disapproval in acceptable terms. But, crowded with straw men, Vatican criticisms often had a ring of absurdity: "The conference's themes," Navarro-Valls asserted in his op-ed, "include coerced family planning, abortion, homosexuality and versions of women's rights that are harmful to women." Readers would have to do their own research to learn that the document clearly and repeatedly condemned coercive measures, did not mention homosexuality, and enjoyed the support of women's advocates the world over.

When the conference began on September 5, Vatican diplomats were undeterred by their lack of success to date. As soon as delegates set to work on the document, of which 10 percent had been marked for continued debate at Cairo, the Holy See seized upon the paragraph on abortion and, for five days, would not let go. To some extent, the Holy See held the conference hostage to the high value the UN placed on achieving consensus. The Vatican also took advantage of its own vestigial aura of authority in international circles; with as little support as the Vatican had mustered, few countries would have been able to win such a long hearing for their particular agendas.

Even after delegates had reworded sections to appease the Holy See, the pope's envoys forced delay. So exasperated were delegates that at one session they booed a Holy See representative.

"Does the Vatican rule the world?" asked Egyptian population minister Maher Mahran. "If they are not going to negotiate, why did they come?"

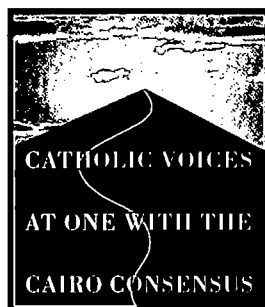
Delegates and NGO representatives grumbled about the Holy See's obstructionist behavior, and at least two petitions circulated calling for a change in the Vatican's status at the United Nations. While the movement to repeal the Holy See's status was limited, frustration with the delegation ran deep. It was exacerbated by the widespread understanding that the Pope's positions on reproductive matters do not reflect the attitudes and practices of Catholics around the world. "The bottom line is the credibility of the papacy," one government delegate told Reuters. "If no one follows him, for whom does he speak?"

The Holy See had refused to endorse the two previous UN population conference documents, in 1974 and 1984, and no one expected anything different in Cairo. But in the end, the Holy See surprised most observers by joining the consensus on about half the Programme of Action.

From news reports of the ICPD, many might have been led to believe that the single issue of abortion accounted for the conflict between the Holy See and the majority of the delegations in

Cairo. But in reality, Cairo's statements about abortion account for only a tiny portion of its remarkable 20-year plan for the world's future. To be sure, Cairo explicitly addressed the public health problem of unsafe abortion for the first time in a UN document. But the document also says "in no case should abortion be promoted as a method of family planning."

As evidenced by the Vatican's statements decrying the broad themes of the conference, the Holy See's conflicts centered not only on abortion, but on the notion that couples and individuals should have access to a range of contraception, including but not limited to natural family planning, on the prominence of women's rights and women's equality, and on the recognition of the centrality of reproductive and sexual health in ethical population policies. The Vatican's differences with the world consensus on these issues has not changed, and can be expected to arise again during the five-year review of the implementation of the ICPD.



The Church at the United Nations

Through an entity called the Holy See, the Roman Catholic church enjoys unique governmental status at the United Nations, where the Holy See is a Non-Member State Permanent Observer. While there are numerous UN observers (intergovernmental organizations, liberation movements, and specialized agencies of the UN system), the Holy See and Switzerland are the only two currently holding that status as “states.”

THE HOLY SEE, VATICAN CITY, THE ROMAN CATHOLIC CHURCH—ARE THERE DIFFERENCES AMONG THEM?

The Roman Catholic church is a religious society without a political identity under the law. Vatican City is an independent city-state within Rome that serves as the site of the church’s government and is itself governed by the head of the church, the pope. The Holy See is “the supreme organ [of government] of both the Catholic church and the Vatican City State,” according to the authoritative work on the Holy See’s international relations, written by Archbishop Hyginus Eugene Cardinale, who was a Vatican diplomat.¹ Vatican City is temporal and territorial; the Holy See, a more nebulous construct, is religious.

The term Holy See has multiple meanings. In one sense it is simply the pope’s “see,” or diocese (the authority and jurisdiction of a bishop), including not just Vatican City but also Rome. In another sense, as the “central government” of the church, it refers to the pope, the Roman Curia, and the College of Cardinals together.² Also called the Apostolic See, the Holy See refers to the pope’s “authority, jurisdiction, and sovereignty” in both the “spiritual and temporal governance and guidance” of the church, including Vatican City.³

Although the Holy See is not the same thing as the Roman Catholic church—which encompasses

the adherents as well—“it exists and operates within the international community as the juridical personification of the Church.”⁴

Legally, the Holy See and Vatican City are distinct entities with a relationship unique in international law. The Vatican city-state exists to administer the properties belonging to the Holy See and to insure the ecclesial independence of the Holy See. The Holy See holds sovereign authority over Vatican City and carries out international relations on the city-state’s behalf as well as on behalf of the Roman Catholic church.⁵ While Vatican City does not enter into diplomatic relations, the Holy See is active in the United Nations and maintains full diplomatic relations with 157 countries.⁶

IS THE HOLY SEE CONSIDERED A STATE?

No, despite its designation as a non-member “state” permanent observer, “the Holy See is not a state,” according to Cardinale.⁷ It is a religious entity without defined temporal territory.⁸ Diplomatically, however, many countries treat the Holy See “as being on the same footing as a state” because of the influence of the pope, as leader of Catholics worldwide.⁹ According to its Permanent Observer Mission, the Holy See can enter into treaties as the “juridical equal of a state.”¹⁰

In international law, statehood traditionally rests on four criteria: a permanent population; a defined territory; a government; and the capacity to enter into relations with other states.¹¹ The United Nations Charter, while requiring statehood for membership, does not define a “state.”

Unlike the Holy See, Vatican City is considered a state. At less than half a square kilometer and with fewer than 1000 residents—only about half of those being citizens—it is the smallest entity in the world

claiming statehood.¹² In order to administer and safeguard the property of the Holy See, the State of Vatican City was established by the 1929 Lateran Treaty, between the papacy and Italy, which had seized the Papal States during the Italian unification.

WHY IS THE HOLY SEE, A RELIGIOUS NON-STATE—AND NOT VATICAN CITY—ACTIVE IN THE UNITED NATIONS?

There was confusion over Vatican/Holy See terminology at the United Nations during the 1950s. Official UN documents referred to UN relations with the "State of the Vatican City," but in an exchange of letters with the UN secretary-general in 1957, the church sought and secured the agreement that it was the Holy See that maintained relations with the United Nations.¹³

The decision, according to Cardinale, was based on the church's desire to stress the pope's spiritual leadership rather than his temporal sovereignty.¹⁴ "This opportune classification immensely broadened the perimeter of the papacy's interest" in the United Nations' many activities.

At the same time, the Permanent Observer Mission sees to the interests of Vatican City as well as those of the Holy See. "It is up to the Holy See to decide . . . whether, in actual fact, the representatives it sends to international organisations and meetings are to act in its own name, or in that of the State of the Vatican City, or even in both at once, according to the subject matter. In any event the sending authority is the Holy See and not the Vatican City State."¹⁵

WHAT DOES PERMANENT OBSERVER STATUS MEAN?

Permanent Observer status is a matter of custom; there is no provision for it in the United Nations Charter. The custom originated in 1946, when Switzerland named a "permanent observer" to the United Nations and the UN secretary-general accepted the designation.¹⁶ To become a Permanent Observer, a state must be a member of at least one specialized agency of the UN system (such as the International Atomic Energy Agency), must be "generally recognized" by UN member states, and

must apply to the UN secretary general for the status.¹⁷

Permanent Observers cannot vote in the General Assembly, but as a matter of custom they have full access to meetings and documents. Permanent Observers may address the General Assembly and participate in its debates.¹⁸ (The Vatican's observer status in the World Health Organization is similar—a voice but no vote.)

Observers can take part in UN conferences, such as the Fourth World Conference on Women. The UN agency organizing each meeting decides what level of participation to allow observers, and non-member states typically are granted the full status enjoyed by UN member states, including a vote on any question that is put to a vote. The United Nations works hard, especially in conferences, to avoid relying upon votes, preferring to operate by consensus in adopting documents such as the programs of action by which UN conferences address global issues. The practice of operating by consensus gives states with minority views—even lone dissenters—a stronger voice in proceedings than they would have otherwise.

Additionally, recent General Assembly resolutions have called for all "states" participating in conferences to be accorded "full voting rights."¹⁹

Taken together, these factors have enabled the Holy See to exercise a presence equal to that of any UN member state—including some power to block consensus—at recent conferences such as the 1992 Conference on the Environment and Development, in Rio de Janeiro; the 1994 International Conference on Population and Development, in Cairo; and the 1995 World Summit for Social Development, in Copenhagen. The same will be the case at the 1995 Fourth World Conference on Women, in Beijing.

HOW DID THE VATICAN GET INVOLVED IN THE UNITED NATIONS?

The Holy See owes its participation in the United Nations to the membership of Vatican City in the Universal Postal Union (UPU) and the International Telecommunication Union (ITU), which the city-state joined because of its operation of postal and radio services. The United Nations, soon after its

formation, invited these organizations and their members to attend UN sessions on an ad hoc basis.²⁰ The Holy See began attending the General Assembly, the World Health Organization, and the UN Educational, Scientific, and Cultural Organization in 1951 as an ad hoc observer.²¹ In 1956, the Holy See was elected a member of the UN Economic and Social Council and also became a full member of the International Atomic Energy Agency.²²

HOW DID THE VATICAN BECOME A NON-MEMBER STATE PERMANENT OBSERVER?

While the Holy See was an ad hoc observer, the pope's representative at UN meetings was an auxiliary bishop of New York, who also carried out other duties in the archdiocese. The relationship between the Vatican and the United Nations was one of "mutual experimentation," a Catholic periodical said at the time.²³ Pope John XXIII moved toward closer relations in 1963 when he endorsed the United Nations in his encyclical *Pacem in Terris* (Peace on Earth) and, as he was dying, sent Cardinal Leon-Joseph Suenens to summarize the encyclical in an address to the General Assembly.

In 1964, Pope Paul VI named a permanent observer, following Switzerland's precedent. UN Secretary-General U Thant accepted the designation and announced it within three weeks.²⁴

Paul VI did not pursue full membership. Under the UN Charter, membership entails a state's acceptance that it may be required to commit military power in collective measures to suppress acts of aggression "or other breaches of the peace."²⁵ By Lateran Treaty and by choice, the Holy See and Vatican City are committed to neutrality.²⁶

FOR WHOM DOES THE VATICAN SPEAK AT THE UNITED NATIONS?

Church officials describe their role in the United Nations as being unique:

As a full member of the international community, the Holy See finds itself in a very particular situation, because it is spiritual in nature. Its authority—which is religious and not political—

extends over one billion persons scattered throughout the world and belonging to the most diverse ethnic groups and geographic regions. Its strength . . . consists in the respect that its words, its teaching, and its policies enjoy in the conscience of the Catholic world—a respect that is widely shared by many people who do not belong to the Church. The real and only realm of the Holy See is the realm of conscience.²⁷

When Pope Paul VI arrived in New York in 1965 to address the United Nations, he told the crowd at Kennedy Airport that he offered "to your terrestrial city of peace the greetings and good wishes of our spiritual city of peace." Addressing the General Assembly, he presented the church as an "expert in humanity," and in asking nations to work together as equals, he referred to himself "as a representative of a religion that believes salvation is achieved through the humility of its divine Founder."²⁸

In a papal address to the General Assembly in 1979, John Paul II also claimed a special role. "The nature and aims of the spiritual mission of the Apostolic See and the church make their participation" in UN activities "very different from that of the states, which are communities in the political and temporal sense," he said.²⁹

Monsignor Diarmuid Martin, a leader of the Vatican delegations to Cairo and Copenhagen, referred to "the social teaching of the church" as "the principal inspiration of the positions taken by the Holy See at the conferences."³⁰

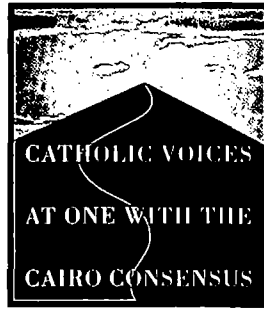
Archbishop Renato R. Martino, the Vatican's "Permanent Observer" to the United Nations—as the ambassador for a Permanent Observer state is called—also speaks of a religious mission. Asked about the Vatican role in the United Nations, when there is no "voice" for Protestant religion, Islam, or Judaism, Martino quoted a Moslem supporter: "The Vatican has a right to be present" partly because, "if you would ask the Moslem to come forward and speak, we would not know who would be the one to speak," whereas there is "one voice" for the Catholic church. Martino added that the Catholic church's "one voice is a message of salvation, found in the Scriptures and lived in the tradition of the Church over the centuries. It is an objective truth

that remains changeless. . . . During the month preceding the Cairo Conference, Pope John Paul II and the world episcopate have applied these eternal truths to the topics addressed by the conference."³¹

What place does a religious body—claiming to possess the universal “objective truth” and to speak infallibly on moral matters—have in an intergovernmental institution like the United Nations?

NOTES

1. Hyginus Eugene Cardinale, *The Holy See and the International Order* (Gerrards Cross, England: Colin Smythe, 1976), pp. 257-59.
2. *The Official Catholic Directory*, 1995 (New Providence, NJ: P.J. Kennedy & Sons with R.R. Bowker, 1995), p.xix.
3. *The Catholic Encyclopedia*, (New York: Thomas Nelson Publishers, 1987), p. 268; Cardinale.
4. Cardinale, pp 81-83.
5. Cardinale, pp. 82-85; Tiyanjana Maluwa, “The Holy See and the concept of international legal personality: some reflections,” *Comparative and International Law Journal of Southern Africa*, Mar. 1986, pp.24-25.
6. Permanent Observer Mission of the Holy See, “The Holy See and the United Nations,” undated article, in distribution, June 1995.
7. Cardinale, p. 259.
8. Cardinale, pp. 256-59, William Schabas, “Notes on the Legal Status of the Vatican City and the Holy See,” 1994; diplomatic sources; Center for Reproductive Law and Policy (CRLP) (New York), “Church or State? The Holy See at the United Nations,” July 3, 1994.
9. Cardinale, p. 259.
10. Permanent Observer Mission of the Holy See (above, note 6).
11. Cardinale, p. 81; CRLP, citing *Restatement (Third) of the Foreign Relations Law of the United States*, §201 (1986).
12. Schabas; Cardinale, p. 104.
13. Cardinale, pp. 256-57.
14. Cardinale, p. 256.
15. Cardinale, p. 257.
16. UN Public Inquiries Unit, “Information on the Status of Permanent Observer Missions to the United Nations,” Oct. 1994.
17. “Legal Opinions of the Secretariat of the United Nations,” *United Nations Juridical Yearbook*, 1962, pp. 236-37; United Nations Public Inquiries Unit “Image and Reality,” April 1993.
18. United Nations Public Inquiries Unit, *Image & Reality: Questions and Answers about the United Nations, How It Works, and Who Pays for It*, Apr. 30, 1993.
19. CRLP (above, note 8).
20. Cardinale, p. 256.
21. Schabas.
22. Cardinale, p. 233.
23. “Vatican UN Observer,” *America*, Apr. 25, 1964, pp. 560-61.
24. *Tablet* (London), Apr. 18, 1964, p. 447; *New York Times*, Apr. 7, 1964; Cardinale, p.232.
25. United Nations Charter, Articles 1, 4, 43, 45 & 49.
26. Schabas; Cardinale, pp. 259-60; Permanent Observer Mission of the Holy See (above, note 6).
27. Permanent Observer Mission of the Holy See (above, note 6).
28. Peter Hebblethwaite, *Paul VI: The First Modern Pope* (New York: Paulist Press, 1993), p. 437-39.
29. *Origins*, vol. 9 (1979-80), pp. 257-259.
30. Msgr. Diarmuid Martin, “What the Church Tries to Do at International Conferences,” *Origins*, vol. 25, no 6 (June 22, 1995), pp. 94-98.
31. Dialogue, *National Catholic Register*, Feb. 5, 1995.



Catholics and Contraception: A Struggle for Control

"If anyone says that it is not better and more godly to live in virginity or in the unmarried state than to marry, let him be anathema." (From a declaration of the church, Council of Trent, 1545-1563)

Sincere people worldwide are baffled by the Roman Catholic prohibition of all contraceptives from condoms to pills. The hierarchy's vehement and absolute opposition to abortion would seemingly lead it to champion contraception to reduce the need for abortion. The church also accepts that population pressures exacerbate poverty and contribute to human suffering; contraceptives could help alleviate those pressures as well. Instead, some church leaders, especially Pope John Paul II, have intensified the opposition to contraception.

The above quote exalting chastity points to the reason: in a church in which all officials are male and celibate, power and control is maintained when the sexual and reproductive functions are resisted. Throughout church history, fear of women and sexuality runs deep. Sexual intercourse, Catholics are told, is not a good if engaged in for pleasure or love alone—it must carry an openness to pregnancy and childbearing. These "goals" redeem sexuality from time honored notions of evil. More importantly, these limits serve to keep distance between the priestly elite and the ordinary Catholic. They serve as a form of control over the lives of all, but most tragically of women, who bear the brunt of avoidable mortality and morbidity.

St. Augustine (354-430): Sexual Pleasure = Sin
A zealous convert after a lustful youth, Augustine dominated moral theology for more than a millennium and has recently re-emerged as a principal influence on ultraconservative theology. Augustine linked original sin, lust, and sex: he asserted that sexual pleasure was the path by which original sin was transmitted from generation to generation. Sexual intercourse, inherently tainted, needed always to be salvaged by the pure motive of

procreation; contraception was implicitly evil. Augustine strongly opposed periodic abstinence, the method today's Vatican extols.

Medieval Years: Monks Put Their Stamp On Sexuality

From Augustine's death to the twelfth century, writings on sexuality were codified by monks and monk-bishops. They gave the prohibition of contraception more of a "corporate stamp. . . ."¹ Popes and bishops, in turn, promoted monasticism and clerical celibacy to prevent the clergy from having heirs with claims to church property.

1140: First Code Says Contraception a Sin

Gratian, a monk, compiled the first collection of canon law that was accepted as authoritative within the church. It declared contraception a sin, but not a grave one.

1230-34: A Pope Calls Contraception Murder

The first papal injunction against birth control came when Pope Gregory IX, the creator of the Inquisition, compiled existing authoritative decrees into the universally binding *Decretals*. The *Decretals* condemned contraception as murder.

1588: Pope Sixtus V Adopts a Population Policy

Pope Sixtus V issued the bull *Effraenatum* (Without Restraint), which used the rhetoric of birth control as murder; the bull applied to contraception the penalties designated for homicide. The bull was directed partly against the sexual activity of the clergy and served Sixtus's crusade to eradicate adultery and prostitution in Rome. Rome had also endured the plague in 1581 and famine in 1578 and 1583, providing additional reason for Sixtus's

condemnation of behavior that would restrain population growth.

Renaissance and the Counter-Reformation: Fresh Thinking

The Renaissance and Counter-Reformation brought fresh thinking and new influences to bear on Catholic ideas about marriage and sexuality. The theology of Thomas Aquinas was dominant. He had asserted that contraception violates nature's order because sex is clearly nature's way of propagating species. But he set the stage for moderate reform by saying that marital intercourse is good and therefore so is the pleasure in it. Theologians defended sex as legitimate when one used sex to pay the "marriage debt"—that is, to meet the sexual demands of one's partner.

Council of Trent (1545–1563):

Religious Rivalry Rules the Day

Catholic-Protestant rivalry fueled competition for strength in numbers and, therefore, support for the prohibition of contraception. Similarly, in reaction against the Protestant rejection of clerical celibacy, Catholicism insisted that celibacy is better than sexual marriage. The bishops declared at the Council of Trent: "If anyone says that it is not better and more godly to live in virginity or in the unmarried state than to marry, let him be anathema."

Yet the church's posture toward contraception eased in two ways during the Counter-Reformation. Confessors were told to respect penitents' good faith and not interrogate them so vigorously as to "disturb" those who were ignorant of the "natural law" and unlikely to mend their ways. Also, it was deemed lawful for a wife to go along with a husband who practiced coitus interruptus.

Seventeenth Century: Reasons to Limit Births

In 1679, Innocent XI renewed the condemnation of sex for pleasure, but the condemnation was not severe. Restricting intercourse to avoid having too many children won theological approval. Poverty and the need to provide for the education of existing children were accepted as grounds to limit sexual activity, marking new approval for the idea that "economic and educational reasons were valid moral reasons for not wanting more children."²

Nineteenth Century:

The Birth Control Movement

1853: The human ovum had been discovered, and with it, scientific support of the belief that women must be infertile on some days during their menstrual cycles. In this year, the Roman Penitentiary said couples who had sex only on days they believed the wife was infertile did not need to be disturbed by confessors, if the couple had sound reasons for abstaining from sex.

The birth control movement grew through the early twentieth century. The idea that overpopulation causes famine and war gained currency. But declining birthrates threatened to weaken the church, as well as individual nations, and nationalism became an instrument of propaganda in the churches fight against the birth control movement.

Bastille Day, 1872: Contraception and War

Catholic moralists blamed France's military defeat by Prussia on waning fertility and predicted the decline and fall of an underpopulated France. In a Bastille Day speech in 1872, a Swiss cardinal told a French audience. "You have rejected God, and God has struck you. You have, by hideous calculation, made tombs instead of filling cradles with children; therefore you have wanted for soldiers."³ World War I aggravated population related fears, and an alliance of churchmen and politicians enacted laws against contraception in many countries.

Late 1800s through 1940s:

Feminism First Seen as a Threat

The birth control movement was seen as part of a broader threat to the church: feminism. Many Catholic bishops and priests tried to exert influence against women's suffrage. In 1944, the chairman of the US bishops' conference lamented "a new wave of perverted feminism that is obviously bent on turning women still more away from the home and towards extradomestic occupation." Contraception was integral to the problem; the conference considered planned parenthood a threat to the "integrity" of the home.⁴

1930: Pope Attacks "Wicked Childless Parents"

Pope Pius XI's 1930 encyclical *Casti Connubii* denounced "those wicked parents, who seek to remain childless"⁵ or who avoid childbearing "not through virtuous continence. . . but by frustrating the marriage act."⁶ "Since. . . the conjugal act is destined primarily by nature for the begetting of children, those who in exercising it deliberately

frustrate its natural power and purpose sin against nature and commit a deed which is shameful and intrinsically vicious," the document said.⁷

1951: The Church Gets Rhythm

In 1951, Pope Pius XII declared the rhythm method was available to all couples who for serious motives—including economic and social ones—wish to avoid procreation "for a long time, perhaps even for the duration of the marriage." The overriding restriction on which Pius insisted (as does John Paul II) was that rhythm not be used "habitually" for less than "grave" reasons; in fact, if a woman's health demands that she not become pregnant, she must abstain, not simply use rhythm. Abstinence is possible, Pius XII said; otherwise God would not require it.

Earlier fears of inadequate population had been translated into directives against contraception; now population pressure seems to have contributed to a reserved acceptance of a contraceptive practice that St. Augustine had damned.

1953: The Appearance of the Pill

It fell to Pius XII to respond to "the pill," which emerged in 1953. In 1958, he forbade the use of the pill if the aim is contraception. But he confirmed that the pill can be used for therapeutic, noncontraceptive purposes—despite its contraceptive side-effect—under the principle of double effect. The pill was licit to clear up menstrual pain, but not prevent a pregnancy expected to kill the mother: to cure illness, but not to save lives.

1963-1966: The Papal Birth Control Commission

In 1963, Pope John XXIII convened a commission on population and birth control, handing the question to a panel that ultimately included bishops, theologians, physicians, demographers, and married couples.

July 29, 1968: Pope Paul VI

Reaffirms Prohibition, Inspires Dissent

In 1966, the birth control commission created by John XXIII and continued by his successor, Paul VI, issued a majority report in favor of permitting the use of contraception. A minority dissented, arguing that to change the teaching—admitting error—would undermine the authority and credibility of the Vatican. After two years of pondering, Paul categorically reaffirmed the prohibition of contraception in his encyclical *Humanae Vitae* (Of

Human Life), while glorifying the exception made for rhythm (or periodic abstinence).

Dissent loudly greeted the encyclical and continues more quietly to this day. Theologians note that the principle of probabilism gives Catholics the right to dissent from doctrine on a moral matter if there is a "solid probability" in favor of the dissenting opinion. "If . . . after appropriate study, reflection, and prayer, a person is convinced that his or her conscience is correct, in spite of a conflict with the moral teachings of the Church, the person not only may but *must* follow the dictates of conscience rather than the teachings of the Church," theologian Richard McBrien explains.⁸

1970s: Elements of Dissent

Scholars criticize *Humanae Vitae* because it reduces sexuality to biological or physical facts. Theologians point out that *Humanae Vitae* fails to see individual sexual acts in the context of the marriage as a whole and assesses marriage "exclusively in physical terms"—the production of children—without regard to its other results or products.⁹ Theologians criticize as hypocritical the assertion that one can enjoy sex during the infertile period, while fully intending to avoid conception by remaining abstinent on fertile days.

1980s: Eruptions and Reaffirmations

In large part, Catholics in the pews went their own way while priests looked the other way. In 1980, a synod of bishops spoke urgently of the prohibition's non-reception among the laity and called for new exploration of the issue. Bishop Patrick Iteka of Mahenge, Tanzania, said that for socioeconomic reasons, African families had to be planned. Indonesian bishop Sudartanto Hadisumatra said the church should help couples reduce the number of children they bore. Archbishop Angelo Fernandes of New Delhi asked for a pastoral statement on contraception that would respond to his people's situation.¹⁰

But the synod's closing statement reaffirmed *Humanae Vitae*, saying that "the transmission of life is inseparable from the conjugal union."¹¹ John Paul's closing sermon was even more severe. He said immediate compliance is expected.¹²

Ever since the 1960s:

The Challenge of Modern Feminism

Feminism has presented an enormous challenge for the church in the areas of sexual and marital ethics

and the exclusively male priesthood. Throughout this century, the church has linked contraception and feminism as intertwined evils. Members of the hierarchy continue to make statements that indicate that one root of the contraception prohibition is a restrictive view of women.

"I want to remind young women that motherhood is the vocation of women. . . . It is women's eternal vocation," Pope John Paul II said in his weekly general audience in January 1979.

"However, a radical feminism which seeks the rights of women by attacking and denying fundamental, clear and constant moral teaching does not reflect or promote the full reality and true dignity of women," the pope explained in a 1989 letter to US bishops.

1988: Motherhood First and Foremost

In his apostolic letter *Mulieris Dignitatem* (*On the Dignity and Vocation of Women*), John Paul again focused on maternity and virginity. Because men neither bear nor nurse children, "parenthood . . . is realized much more fully in the woman," the pope wrote. "In many ways [a man] has to learn his own 'fatherhood' from the mother."

The 1990s: Recent Dissent

A few brave souls continue to question and even disagree with *Humanae Vitae*. At a meeting of the US National Conference of Catholic Bishops, Bishop Kenneth Untener of Saginaw, Michigan, told the assembly that the logic of the birth control position is "not compelling" to Catholics, even priests and some bishops. If the church's positions were put to a blind vote, he speculated in a 1991 interview, most US bishops would opt to change it.

A statement on AIDS by France's bishops in 1989 suggested that using a condom may be better than death. "The whole population and especially the young should be informed of the risks," they said. "Prophylactic measures exist." And Cardinal Jean-Marie Lustiger, Archbishop of Paris, told a television audience, "Chastity is possible," but if AIDS-virus carriers fail to abstain from sex, they "should use all known means" to protect others from the disease.¹³

That contraception is an issue of power can be seen in *Humanae Vitae*. Historian Francis X. Murphy, C.S.S.R., writes, "Actually, what the document amounts to is an assertion by the Pope that, as the

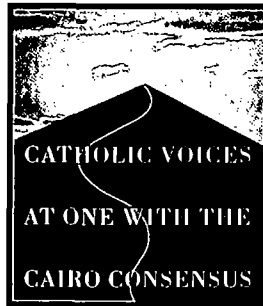
supreme interpreter of natural law, his fiat is final in expressing the Church's moral viewpoint.¹⁴

Journalist Robert Kaiser, who wrote the authoritative chronicle of the birth control commission and the aftermath of *Humanae Vitae*, makes the point compellingly that the issue is power. Referring to Jesuit John Ford, one of the four theologians behind the minority report of the birth control commission, Kaiser wrote this:

Unwittingly, Father Ford gave the game away when he said the encyclical reaffirmed "the power of the magisterium to bind consciences." For Ford, the point was not truth. It was power. The point was not to teach, but to rule.¹⁵

NOTES

1. John T. Noonan, Jr., *Contraception: A History of Its Treatment by the Catholic Theologians and Canonists*, enlarged edition (Cambridge, MA: Belknap Press/Harvard University Press, 1986; original edition, 1965), pp. 145 and 143.
2. Noonan, p. 336.
3. Noonan, p. 414, quoting Cardinal Gaspar Mermillod, via B. Deppe, "Théologie pastorale," *Nouvelle revue théologique* 31 (1899), 455-456.
4. Quoted in Earl Boyea, *The National Catholic Welfare Conference: An Experience in Episcopal Leadership, 1935-1945*, doctoral dissertation, Catholic University of America, 1987 pp. 359-65.
5. *Casti Connubii*, 65.
6. *Casti Connubii*, 53.
7. *Casti Connubii*, 54.
8. Richard P. McBrien, *Catholicism*, Study Edition (Minneapolis, MN: Winston Press, 1981), p. 1004.
9. Thomas Shannon, "Ethical Dilemmas in Population Policy," *Conscience*, vol. VII, no. 2 (March/April 1986): 1-6, p. 4.
10. Francis X. Murphy, "Of Sex and the Catholic Church," *Atlantic Monthly*, Feb. 1981, p. 44 ff.
11. *Origins* 10:323.
12. Francis X. Murphy, "Catholic Perspectives on Population Issues II," *Population Bulletin*, Population Reference Bureau, Vol. 35, No. 6 (Feb. 1981).
13. Peter Hebblethwaite, "What the French are not saying about condoms," *National Catholic Reporter*, Feb. 3, 1989, and *Origins* 18:446.
14. Murphy, *Population Bulletin*, p. 25.
15. Robert Blair Kaiser, *The Politics of Sex and Religion* (Kansas City, MO: Leaven Press, 1985), p. 219.



Abortion and Catholic Thought Through History

Most people believe that the Catholic church's position on abortion has remained unchanged for 2000 years. Not true. Church teaching on abortion has varied continually over the course of its history. There has been no *unanimous* opinion on abortion at any one time. While there has been constant and general agreement that abortion is almost always evil and sinful, the church has had difficulty in defining the nature of that evil. Church hierarchy has consistently opposed abortion as evidence of sexual sin, but they have not always seen early abortion as an act of homicide. Though not commonly known, the "right to life" argument is a relatively recent development in church teachings. The debate continues today.

Also contrary to popular belief, the prohibition of abortion is not governed by claims of papal infallibility. This fact leaves much more room for discussion on abortion than is usually thought, with opinion among theologians and the laity differing widely. In any case, Catholics may follow their own conscience on moral matters even when it is in conflict with hierarchical views. The current pope's attempt to make his position on abortion the defining one at the ICPD in Cairo is only one stop on a long journey of shifting majority and minority views within the Catholic church.

In 400 AD, St. Augustine expressed the mainstream view that early abortion required penance only for the sexual aspect of the sin. Eight hundred years later, St. Thomas Aquinas agreed, saying abortion was not homicide unless the fetus was "ensouled," which he was sure took place well after conception. Church teaching that abortion is a serious sin and grounds for excommunication only became established 150 years ago.

The following brief chronology cannot do full justice to the twists and turns of theological thinking over the centuries. However, it can put the debate

on abortion within the Catholic church in a historical perspective and show the importance of continued debate and open hearts and minds.

THE FIRST SIX CHRISTIAN CENTURIES: BEFORE 600 AD

Early Christianity: Moving Away from Paganism

Pagan religions had a calm acceptance of contraception and abortion, including the use of barrier methods, coitus interruptus, and various medicines that prevented conception or caused abortion.

Early Christian leaders, to distinguish Christianity from Pagan beliefs, developed ideas about contraception and abortion, marriage for procreation and the unity of body and soul. They taught that even sex for reproduction was bad and sex for pleasure was heinous. Chastity became a virtue in its own right.

100 AD: The Debate Begins

One of the earliest church documents, the *Didache*, condemns abortion, but asks two key questions: 1) Is abortion being used to conceal the sins of fornication and adultery? and 2) Does the fetus have a rational soul from the moment of conception or does it become an "ensouled human" at a later point? This idea of "hominization"—the point at which a developing embryo becomes a human being—would become one of the cornerstones of the debate about abortion and remains unsolved even today.

Early 400s: St. Augustine Says Abortion is Not Homicide

St. Augustine (354–430) condemns abortion because it breaks the connection between the conjugal act and procreation. However, in the *Enchiridion* he says, "But who is not rather disposed to think that

unformed fetuses perish like seeds which have not fructified," clearly seeing actual human life beginning at some point after the fetus has begun to grow. He held that abortion was not an act of homicide. Most theologians of his era agreed with him.¹

The general legislative agreement at this time said abortion was a sin requiring penance if it was intended to conceal fornication and adultery.

THE MIDDLE PERIOD: 600–1500

ca. 675: Illicit Intercourse is the Greater Sin

The *Irish Canons* place the penance for "destruction of the embryo of a child in the mother's womb [at] three and one half years" while the "penance of one who has intercourse with a woman, seven years on bread and water."²

ca. 8th Century: Recognizing Women's Circumstances

In the *Penitential Ascribed by Albers to Bede*, the ideal of delayed hominization is again supported, as well as acknowledgment of women's circumstances: "A mother who kills her child before the fortieth day shall do penance for one year. If it is after the child has become alive, [she shall do penance] as a murderess. But it makes a great difference whether a poor woman does it on account of the difficulty of supporting [the child] or a harlot for the sake of concealing her wickedness."³

1140: Gratian Code Holds Abortion Not Homicide when Fetus Unformed

In 1140, Gratian compiled the first collection of canon law—the Gratian code—that was accepted as authoritative within the church. In the canon *Aliquando*, Gratian concluded that, "abortion was homicide only when the fetus was formed.⁴ If the fetus was not yet a formed human being, abortion was not homicide.

1312: Council of Vienne Confirms Aquinas On "Delayed Hominization"

The position of this council, still very influential in Catholic hierarchical teaching, confirmed the conception of man put forth by St. Thomas Aquinas. He said that the fetus is first endowed with a vegetative soul, then an animal soul, and then when the body is developed, a rational soul. This theory of "delayed hominization" is the most consistent thread throughout church history on abortion.

While St. Thomas Aquinas opposed abortion as a form of contraception and a sin against marriage, he maintained that abortion was not a sin of homicide unless the fetus is ensouled, and thus, a human being.⁵

PRE-MODERN PERIOD: 1500–1750

1588: Making the Penalty for Abortion Excommunication

Concerned about prostitution in Rome, Pope Sixtus V issued the bull *Effraenatum* (Without Restraint) and applied to contraception and abortion, at any stage of pregnancy, the penalties designated for a homicide. The prescribed penance was now excommunication. There were no exceptions for therapeutic abortion.⁶

1591: Quickly Relaxing the Rules

Only three years after Pope Sixtus V issued his *Effraenatum*, he died and Gregory XIV succeeded him. Gregory felt Sixtus's stand was too harsh and in conflict with penitential practices and theological views on ensoulment. He issued *Sedes apostolica* recommending that, "where no homicide or no animated fetus is involved, not to punish more strictly than the sacred canons or civil legislation does." This papal pronouncement lasted until 1869.⁷

1679: Denying Abortion to Pregnant Girls Facing Murder by Their Families

Abortion had consistently been considered wrong if used to conceal sexual sins. Pope Innocent XI attempted to define the "outer limits of permissible teaching" when he rejected the idea that abortion is permissible even in situations in which the parents of a girl would murder her for becoming pregnant. The church was still teaching delayed hominization, but said hominization occurred some time before the moment of birth.

THE MODERN ERA: 1750–PRESENT

1869: Requiring Excommunication for All Abortions

Pope Pius IX's *Apostolicae sedis* completely ignores the question of hominization and requires excommunication for abortion at any stage of pregnancy.⁹ He said all abortion was homicide. His statement was the first implicit endorsement of immediate hominization by the church.

1917: Excommunicating Doctors and Nurses Performing Abortions

In the *Code of Canon Law*, the first new edition of canon law since Gratian's in 1140, excommunication was required for both the woman and any others, such as doctors and nurses, who take part in an abortion.¹⁰

1930: Condemning Therapeutic Abortions

Pope Pius XI issued the encyclical *Casti Connubii* (Of Chaste Spouses), condemning abortion in general, and specifically in three instances: in the case of therapeutic abortion, which it is killing an innocent; in marriage to prevent offspring; and on social and eugenic grounds as practiced by some governments.¹¹ Pius's stance on abortion continues as the hierarchical view. This document did not purport to be infallible teaching, but as an address by the pope to the bishops it carried great moral authority.

1965: Protecting the Embryo From the Moment of Conception

Vatican II, *Gaudium et Spes*, section 51 declared: "Life must be protected with the utmost care from the moment of conception; abortion and infanticide are abominable crimes." Here, abortion is now condemned on the basis of protecting life, not as a concealment of sexual sin.

1974: Arguing for the "Right to Life"

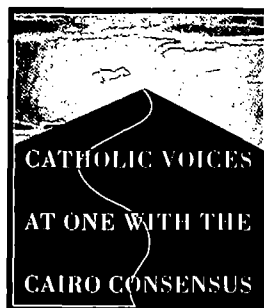
The Sacred Congregation for the Doctrine of Faith issued the "Declaration on Abortion," which argues against abortion on the grounds that "one can never claim freedom of opinion as a pretext for attacking the rights of others, most especially the right to life." The key to this position is that the fetus is human *life* from the moment of conception, if not necessarily a full human being. The church has now fully changed the terms of argument.

Today: Abortion Ban is Absolute

The Catholic church hierarchy of today does not permit abortion in any instance, not even in the case of rape or to save the life of a pregnant woman.

NOTES

1. St. Augustine, *De nuptiis et concupiscentia*, 15. 17. (CSEL 42.229-230).
2. John T. McNeill and Helena M. Garner, *Medieval Handbooks of Penance* (New York: Octagon books, 1974), pp. 119-120.
3. McNeill and Garner, *Medieval Handbooks of Penance*, p. 225.
4. John Noonan, ed., *The Morality of Abortion: Legal and Historical Perspectives*, (Cambridge, Mass.: Harvard University Press, 1970), p. 20.
5. Joseph F. Donceel, S.J. "Immediate Animation and Delayed Hominization," *Theological Studies*, Vols. 1 and 2, (New York and London: Columbia University Press, 1970), p. 86.
6. *Codex iuris fontes*, ed. P. Gasparri, vol. 1, (Rome, 1927), p. 308.
7. *Codex iuris fontes*, ed. P. Gasparri, pp. 330-331.
8. *Actae Sanctae Sedis*, 5. 298.
9. *Codex iuris canonici*, c. 2350.
10. (AAS 22.539-92).



Catholics For A Free Choice An Organizational Summary

Catholics for a Free Choice is the voice of Catholics worldwide who hold progressive views on women, reproduction and sexuality. CFFC's work deals with some of today's most debated cultural and moral issues in some of the most significant forums, including the United Nations conferences on women, the environment, and population and development. With a skillful and accomplished staff of researchers, writers, and analysts, CFFC has become an important source of information and analysis worldwide on a range of subjects, including reproductive health and ethics, religious fundamentalism, population policy, and Catholic church reform. CFFC carries out its work through policy analysis, outreach and advocacy, and education and communications. CFFC was established in 1973 and has headquarters in Washington, DC, four partner organizations in Latin America, and a US staff of twenty.

CFFC articulates sound ethical arguments – based on Catholic teachings – that support the right to follow an informed conscience in making moral decisions about sexual and reproductive matters. CFFC counters the efforts of the Roman Catholic hierarchy to see that public policies reflect Vatican positions. In one recent campaign, Catholics for Contraception, CFFC organized a leadership committee of more than 1,000 Catholics in the United States to voice support for international family planning assistance.

CFFC creates room in the dialogue on reproductive rights for progressive religious voices to present their views on an equal footing with religious institutions. A CFFC initiative, Catholic Voices, is aimed at lifting up Catholic support for the plan of action adopted by the

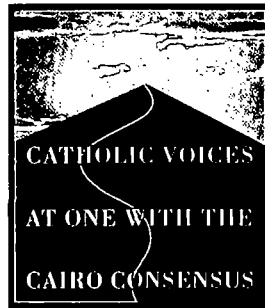
International Conference on Population and Development. In partnership with the Park Ridge Center for Health, Faith and Ethics, CFFC is also co-sponsor of Religion Counts, an inter-religious group of scholars, experts, and leaders providing a positive, ethically sensitive religious contribution to discourse on issues surrounding population, reproductive health, and development policies. Its Women, Religion, and Public Policy project is an effort to extend outreach across faith lines and across national borders to examine religion's influence on public policies related to women.

The organization has ECOSOC status at the United Nations, and was a prominent NGO participant in the activities surrounding the 1994 ICPD and the 1995 Fourth World Conference on Women.

CFFC's positions and activities are backed by original, accurate research and study of myriad resources, including church documents and references. Publications feature a quarterly magazine, *Conscience, A Newsjournal of Prochoice Catholic Opinion*, and a number of titles including *Catholics and Reproduction: A World View*, an unprecedented collection of opinion and behavior surveys from around the world; *When Catholic and Non-Catholic Hospitals Merge: Reproductive Health Care Compromised*, a groundbreaking study of the loss of reproductive health services in the United States as a result of consolidations in the health care industry; *Evolution of an Earthly Code*, a history of the changing church position on family planning and population; and *Catholic Options in the Abortion Debate: Reforming Irish Law*, a submission to the Irish government's Interdepartmental Working Group.

CFFC works nationally in the United States and internationally, particularly in Latin America and Europe, to provide materials to Catholics, policy makers, and the media. We work in close collaboration with four partner organizations in Latin America: Católicas por el Derecho a Decidir (Catholics for the Right to Decide) in Mexico, Argentina, and Bolivia, and Católicas pelo Direito de Decidir (Catholics for the Right to Decide) in Brazil. CFFC is a respected member of the international reform and renewal movement in the Catholic church.

CFFC has been led since 1982 by Frances Kissling, a leader in both the church reform and the women's rights and health movements internationally. CFFC's board of directors includes theologians, public health experts, and women's' rights leaders. The organization's funding comes from some of the world's most respected philanthropic foundations, such as the Ford Foundation and the MacArthur Foundation, as well as from individual Catholics.



Catholic Voices

Catholic Voices, an initiative of Catholics for a Free Choice, is an international forum on issues of population and development. The forum provides a space for progressive Catholic leaders to reflect, research, and participate in national and international discourse on women's human rights, sexuality, and reproductive health. With special attention to the values and ethics of the Catholic tradition, Catholic Voices supports public policies and agreements on these issues that promote social justice, respect human dignity, and honor the rights of individual conscience.

Begun in 1998, Catholics Voices is in formation. Membership is in the initial stages; to date, seventeen Catholic leaders, theologians, and activists from twelve countries have formed a leadership circle. In December, 1998, Catholic Voices issued its first declaration, "Catholic Voices: Reflections from the Paseo de la Reforma," from Mexico City. The declaration examines the Programme of Action of the International Conference on Population and Development through a Catholic lens.

Following are brief biographies of the leadership members of Catholic Voices. Each can be contacted through Catholics for a Free Choice in Washington, DC, at (country code 01) 202/986-6093, or email, cffc@igc.apc.org.



Sheila Briggs
United States

Sheila Briggs is Associate Professor in the School of Religion at the University of Southern California. Her feminist theology research interests are early

Christianity, nineteenth and twentieth century theology, and modern liberation movements. She has been a consultant to the Lily Foundation project "What's Left" on the Roman Catholic left in America. Prof. Briggs is a member of the steering committee of the Feminist Theology and Theory Group of the American Academy of Religion.



Dina Cormick
South Africa

Born in Nkana, Zambia, Dina Cormick is an artist, feminist, and political activist. She earned a Masters degree in Feminist Theological Ethics from the University of South Africa in 1993. An active participant in the reform movement in the Catholic church, Ms. Cormick is a member of the international steering committee of Women's Ordination Worldwide, a co-founder of Women's Ordination South Africa, and a member of the Circle of Concerned African Women Theologians.



Elfriede Harth
France

Elfriede Harth is a leader in the Roman Catholic church reform movement. She is spokesperson for the International Movement We Are Church, member of the steering committee of Women's Ordination Worldwide, and member of Maria von Magdala, an association working for women's equal rights in the Catholic church. Ms. Harth is currently working on her doctoral dissertation on women, Catholicism, and fertility from the Ecoles des Hautes Etudes en Sciences Sociales in Paris.

Teresia Hinga
Kenya

Teresia Mbari Hinga is Assistant Professor in the Department of Religious Studies at DePaul University in Chicago, Illinois. She has written extensively on issues surrounding women and religion in Africa. Book chapters have included "Christianity and Female Puberty Rites in Africa: The Agikuyu Case," "Between Colonization and Inculturation: Feminist Theologies in Africa," and "Gikuyu Theology of Land and Environmental Justice." Under a research grant from the Rockefeller Foundation, Dr. Hinga produced a research report, *The Role of Religious Networks in the Provision of Education to Women in Africa*.



Joanna Manning
Canada

Joanna Manning is an acclaimed teacher and writer; in the 1990s she won the Canadian Church Press award for theological reflection.

Her book, *Is the Pope Catholic?* will be published by Malcolm Lester Books in March 1999. An activist for justice, peace, and women's equality, Ms. Manning started the Rigoberta Menchu Centre for Justice, Peace, and Creation, and founded the Coalition of Concerned Canadian Catholics. She has a Masters in Theology from Regis College, University of Toronto.

Philomena Mwaura
Kenya

Philomena N. Mwaura is a lecturer in the Department of Religious Studies at Kenyatta University in Nairobi, Kenya. She has a Masters degree in Religious Studies from the University of Nairobi and is currently a Ph.D. candidate. She has taught courses on the church in Africa, women in religion and culture, and development of Christian doctrine.

Mrs. Mwaura is deeply involved in the ongoing constitutional review process through the Kenya Women Political Caucus. She has organized and facilitated workshops and conferences for the Ecumenical Association of Third World Theologians and the Circle of Concerned African Women Theologians.



Anthony Padovano
United States

A well known theologian, author, activist, and commentator on Catholic church issues, Anthony Padovano holds an S.T.D. from the Gregorian University in Rome and a Ph.D. from Fordham University. He was president of CORPUS, National Association for Married Priesthood from 1988 to 1998. He is vice-president of the International Federation of Married Catholic Priests, which has members in thirty countries. Dr. Padovano is Professor of American Literature and Religious Studies at Ramapo College of New Jersey. He has been a summer visiting professor at twenty-four American universities and has lectured throughout the Americas and in Asia, Europe, Australia, and New Zealand.



Rosemary Radford Ruether
United States

One of the world's leading Catholic feminist theologians, Rosemary Radford Ruether teaches courses on the relationship of Christian theology and social justice issues at Garrett Theological Seminary and Northwestern University. The author or editor of twenty-five books, among them, *Contemporary Catholicism: Crises and Challenges* (1987) and *Gaia and God: An Ecofeminist Theology of Earth Healing*, she has also contributed to eighty-five book symposia. She writes regularly for the *National Catholic Reporter*, *Christianity and Crisis*, and the Religion News Service. Dr. Ruether is a frequent lecturer at conferences and universities; she has lectured throughout the Americas and Europe, as well as Israel, Egypt, Japan, Korea, India, the Philippines and South Africa.



Valerie Stroud
United Kingdom

Valerie Stroud has served as a catechist and has been employed in parish administration and pastoral care. She served for several years as Secretary to the Deanery Pastoral Council, a worker for the Diocesan Liturgy Commission and is currently a member of the Diocesan Christian Unity

Commission. Mrs. Stroud represented her diocese at the 1996 Council of Churches of Britain and Ireland Assembly. A commissioned Eucharistic Minister, Mrs. Stroud now works full time in the reform/renewal movement in the Catholic church. She is the UK liaison for the International Movement We Are Church.



Isaac Wüst
The Netherlands

Isaac Wüst works full time in the renewal/reform movement in the Catholic church. He became a priest in 1956 in Amsterdam, where he was born. He studied Latin American political and social sciences at the Catholic University of Louvain, and subsequently lived and worked in Latin America for many years. Mr. Wüst was executive secretary of the education department of CELAM, the Latin American bishops' conference, for five years before leaving the priesthood. In the mid-1970s, he worked as an advisor to a UN project that introduced new methods for health education, mother and child care, and family planning in remote areas. During the next decade, he was involved in many development and education projects throughout Colombia. Since returning to The Netherlands in 1986, Mr. Wüst has worked at the service of parishes in Amstelveen and Amsterdam.

**REPRESENTATIVES OF CATHOLICS FOR A FREE CHOICE
AND CATHOLICS FOR THE RIGHT TO DECIDE IN THE
LEADERSHIP CIRCLE OF CATHOLIC VOICES:**

Marta Alanís
Argentina

Marta Alanís is coordinator of *Católicas por el Derecho a Decidir* (Catholics for the Right to Decide) in Córdoba, Argentina. Since 1989, Ms. Alanís has worked as a teacher in the Archdiocesan Charities of Córdoba. She has worked in human rights communities in Bolivia, France, and Nicaragua, focusing particularly on indigenous women's literacy. Committed to both liberation and feminist theologies, Ms. Alanís has studied with liberation theologian Leonardo Boff and feminist theologian Ivone Gebara.

Paloma Alfonso
Spain

Angeles Paloma Alfonso Aguirre earned her degree

in philosophy and letters from the Universidad Central de Barcelona. She has been involved for several years in a collective, *Mujeres y Teología* (Women and Theology), and in 1997 joined with four other women to form the group *Católicas por el Derecho a Decidir* (Catholics for the Right to Decide) in Spain. Both groups collaborate on projects with *Somos Iglesia de España* (We Are Church in Spain). For the past two decades, Ms. Alfonso has taught children and adults, and currently works in a literacy program with women *gitanas* (gypsies) in Madrid.



Frances Kissling
United States

Writer, advocate, and policy analyst, Frances Kissling has been President of Catholics for a Free Choice since 1982. An internationally recognized non-governmental organization, CFFC works to advance reproductive health, women's rights and the strengthening of civil society through research, education, and policy analysis. Ms. Kissling is a highly regarded speaker and thinker on issues of religion, reproductive health, women's rights, and population policy. Ms. Kissling's views on reproductive health issues combine a deep respect for the spiritual aspect of life-giving with a passionate commitment to the moral agency of women. Ms. Kissling has briefed parliamentarians and development professionals in a number of countries, including Brazil, the United Kingdom, Mexico, the Philippines, Germany, Ireland, Poland, and throughout the United States. A leading voice promoting international public policy that advances women's health and rights, Ms. Kissling was a prominent participant in the United Nations conferences on Population and Development (Cairo, 1994) and on Women (Beijing, 1995).

Teresa Lanza Monje
Bolivia

Teresa Lanza is coordinator of *Católicas por el Derecho a Decidir* (Catholics for the Right to Decide) in Brazil. A lawyer, Ms. Lanza graduated from the Universidad Mayor de San Andres in La Paz, where she conducted research for her thesis on sexual and reproductive rights and the problem of abortion in Bolivia. She is a founder

of *Género Y Teología* (Gender and Theology), an ecumenical collective of pastors and theologians. She has written several opinion columns on women's rights for major daily newspapers. Currently, Ms. Lanza is involved in providing information to legislators, opinion leaders, health providers, and the news media on the positions of CDD.



María Consuelo Mejía
Mexico

An anthropologist, feminist, and Catholic activist, María Consuelo Mejía directs *Católicas por el Derecho a Decidir* (Catholics for the Right to Decide) in Mexico. Ms. Mejía was named to Mexico's country delegation to the International Conference on Population and Development in 1994 and participated in the 1995 Fourth World Conference on Women. Born in Bogotá, Colombia, she became a naturalized Mexican citizen in 1984. She received her Masters degree in Latin American Studies from the National Autonomous University of Mexico (UNAM) in 1986. Since 1990, she has worked as a researcher in the Interdisciplinary Humanities Research Center and as a consultant for the University Program on Gender Studies at UNAM.



Marysa Navarro-Aranguren
United States

Marysa Navarro is Charles Collis Professor of History and Chair of the Latin American, Latino and Caribbean Studies Program of Dartmouth College, where she has taught for thirty years. She is an academic and also an activist. She has been a member of the board of directors of the Ms. Foundation for Women, the Global Fund for Women and Catholics for a Free Choice, which she presently chairs.



Maria José Rosado Nunes
Brazil

Maria José Nunes is coordinator of *Católicas pelo Direito de Decidir* (Catholics for the Right to Decide) in Brazil. She is a graduate Professor in Religious Studies at the Pontifical Catholic University in São Paulo and at the Methodist University of São Paulo. Ms. Nunes is a director and past vice-president of the Institute for Religious Studies in Rio de Janeiro. With a grant from the MacArthur Foundation, she managed a research project on the Catholic position on abortion. Ms. Nunes is an award winning author and frequent contributor to national and international magazines.

MILLENNIUM SUPPLEMENT: POPULATION

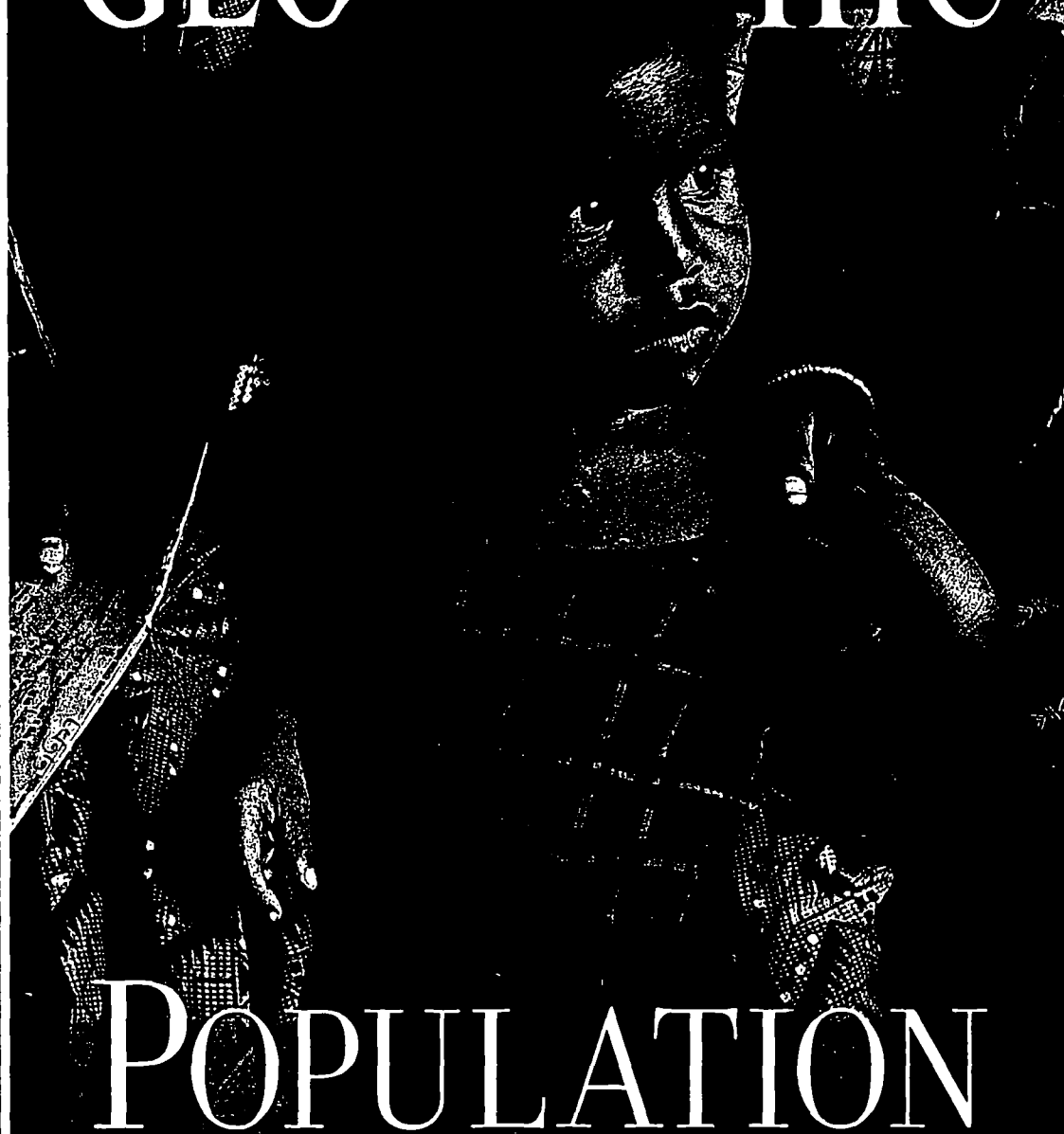
INSIDE
Sample
PERFUMES
from the PAST

NO. 4



OCTOBER 1998

NATIONAL GEOGRAPHIC



POPULATION

HUMAN MIGRATION 6 WOMEN AND POPULATION 36 FEEDING THE PLANET 56
LEWIS AND CLARK 76 PERFUME 94 ANTARCTIC DESERT 120

OFFICIAL JOURNAL OF THE NATIONAL GEOGRAPHIC SOCIETY WASHINGTON, D.C.



THE MILLENNIUM SERIES

Women and Population

BY ERLA ZWINGLE PHOTOGRAPHS BY KAREN KASMAUSKI



"Don't look at people like an ant heap,"

one exp

ON A CERTAIN NOVEMBER DAY an obscure woman in Iowa gives birth to seven babies; we marvel and rejoice. On the same day an obscure woman in Nigeria gives birth to her seventh child in a row; we are distressed and appalled.

In Brazil a mayor sees his town shrink by two-thirds. Determined not to lose subsidies tied to population, he bans all contraceptives. In Bangladesh the government, determined to stem the tide of births, offers to sterilize women for free and throws in a new sari as a gift.

In Kenya a woman keeps trying for a son because her husband asks, "Who will hold my head for me when I die?" In the United States an unmarried teenager looks at her infant daughter and says, "I don't really know what I was doing. I thought I was in love. I thought it was this great thing, but it was stupid."

Population: We know it's a problem. In fact most of the problems facing individuals, families, communities, and nations are affected by the quantity of humans sharing the planet. But if the problem were only numbers, these stories would have no power to touch or perplex us. Nor would we race to bring food to famine-stricken countries, or blanch to read of newborn babies being thrown into trash bins, or fall silent upon hearing of the pregnant mother who refused cancer treatments that could damage her baby, gave birth, and died. Even as some fear for our species' survival, we instinctively sense mysteries that transcend statistics. "Don't look at people like an ant heap," one expert urged. "These are individuals."

Two hundred years ago Thomas Malthus predicted mass catastrophe as a result of overpopulation. So far, events have not turned out quite as he supposed they would, yet the brutal probabilities he described continue to darken some views of the future. Today 98 percent of population growth is in the developing world. "The world is going to hell," as one observer

bluntly paraphrased the common fear, "if those people don't stop breeding."

True, the numbers give pause. Today there are almost six billion people in the world. For the next 15 years annual increases will probably remain just over 80 million (or one billion every 12 to 13 years). The United Nations estimates that by the year 2050 there could be from 7.7 billion to 11.2 billion people in the world.

Will this be too many? It is difficult to predict, as even Malthus would have seen by now. Predictions often impel changes in the very behavior that inspired the prediction. Providing enough food, of course, is paramount. But what about fresh water? Forty percent of the world population faces water shortages at

some time during the 21st century. There is already a shortage of water in too many places, and according to the World Bank, "a social and political crisis is likely to develop in many of the world's major cities by the year 2025." But there has been progress in the past 30 years (many developing countries, such as India), and the world is not as bleak as it once was. Each woman has the right to choose whether to have a child. This is the case on three fronts: c

Soon to have a si
Nurses provide ch
gaps between bir



Freelance writer ERLA ZWINGLE lives in Venice, Italy, a country in which the falling birthrate is a serious concern. Photographer KAREN KASMAUSKI, a mother of two children and a veteran of 16 GEOGRAPHIC assignments, also focused on human migration for this issue.

t heap,"

on fear, "if those
use. Today there
n the world. For
ases will proba-
n (or one billion
ted Nations esti-
re could be from
le in the world.
difficult to pre-
ve seen by now.
ges in the very
diction. Provid-
is paramount.
Forty percent of
ater shortages at

one expert urged. "These are individuals."

some time during the year. What about jobs? There is already an increasing shortage of those too, and according to the Population Reference Bureau masses of unemployed people form "a social and political time bomb."

But there has been dramatic progress over the past 30 years. Birthrates have dropped in many developing countries (including China and India), and the number of children born to each woman has fallen on average from six to three. This is the result of remarkable changes on three fronts: contraception, health care, and

culture, the strongbox in which our sense of what we can do is locked.

Contraception has been the key. The number of women in some developing countries using contraceptives has risen to more than 50 percent. "There isn't any place where women have had the choice that they haven't chosen to have fewer children," says Beverly Winikoff at the Population Council in New York City. "Governments don't need to resort to force."

Yet some 200 million women become pregnant each year. Half of these pregnancies are

Soon to have a sibling, an only child nestles in her mother's sari at a clinic in Bangladesh. Nurses provide checkups and offer advice—starting with "space your children." Longer gaps between births mean healthier mothers and babies and slower population growth.





unplanned, and a quarter are unwanted. Unwanted children are often neglected, abused, or abandoned. They receive less food, medical care, and education than wanted children.

More than half a million women die each year from causes related to pregnancy, often the result of poor health, lack of medical care, and having babies too close together. Seven million infants die each year because their mothers were not physiologically ready for pregnancy or lacked obstetric care. Millions of women and men resign themselves to this reality. But with the chance to plan their families, they are beginning to see a way to re-imagine their future. "People are desperate," one woman said, "to control their own destiny."

IN BANGLADESH dawn rises over banana groves and palm trees, the emerald expanse of rice fields, and pools where women in vivid saris immerse themselves, drenched in the golden light. Here the problem of overwhelming numbers seems

obvious. Bangladesh is the ninth most populous nation on Earth, and, with only 52,000 square miles of land, it is one of the densest. It is also one of the poorest.

Today Bangladesh is praised as a population success story. In 1990 its birthrate was an unbridled 4.9 children per woman (which, if unchanged, would have doubled its population by the year 2015). The rate is now 3.3, a fact that has astonished those who believed the country's population would drop only after chronic poverty and illiteracy were overcome.

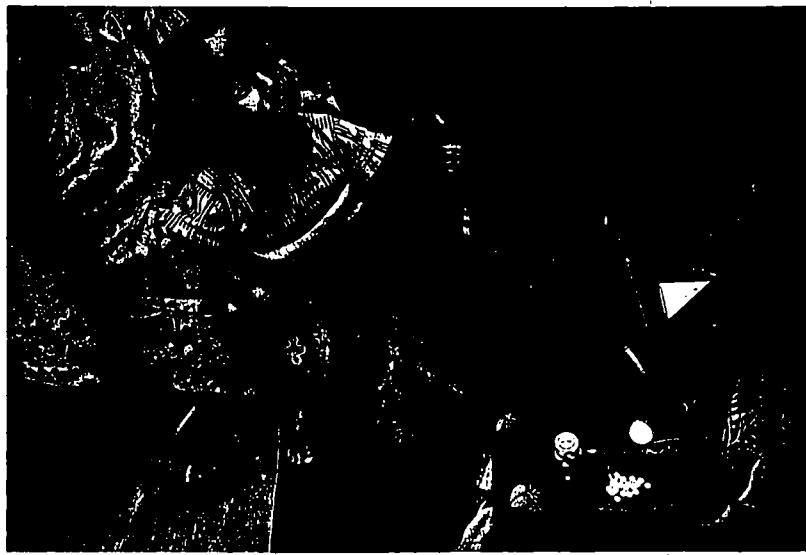
Much of the credit goes to two of the many organizations that help the poor: the Dhaka-based Grameen Bank, with its innovative program of "microcredit," or small loans, and the Bangladesh Rural Advancement Committee (BRAC), with its nationwide network of village clinics. The work of BRAC and Grameen has made it possible for millions of women and children who once could hope only for survival to begin to dream of progress. Mosammat Anowara Begum is one of them.

Cha
from t
an ass
with co
mattin
of bea
to spre
a baby
Someo
phone
Ano
village
it with
she ma
milk o
sells te
cents)
phone
keep so
"Eve
the ph
three y
parts o



Woman to woman

Pledged to bear no more children, a volunteer with the Bangladesh Rural Advancement Committee counsels a pregnant woman in Shoal village (left) and dispenses antibiotics for a mother's sick baby (below). She also discusses family planning. Contraceptives distributed by such workers helped lower Bangladesh's birthrate from seven children per woman in 1975 to fewer than four in 1995.



with most popu-
with only 52,000
of the densest. It

as a population
birthrate was an
woman (which, if
ed its population
s now 3.3, a fact
who believed the
drop only after
were overcome.
two of the many
oor: the Dhaka-
s innovative pro-
all loans, and the
ent Committee
network of village
and Grameen has
s of women and
pe only for sur-
gress. Mosammat
m.

Chamurkhan village isn't very different from the 68,000 other villages in Bangladesh: an assortment of one- or two-room houses with corrugated metal roofs and walls of palm matting, clustered around small common areas of beaten earth. As the morning light begins to spread through the trees, a rooster crows; a baby gives a small, fretful cry; a dog barks. Someone nearby hawks and spits. Then the phone rings.

Anowara Begum has the only phone in the village; it's a Nokia cellular phone. She bought it with a loan from the Grameen Bank, and she makes money with it. Instead of selling milk or eggs, as many of her neighbors do, she sells telephone calls at 4.6 taka (about ten cents) a minute. At this rate, she can pay the phone bill and weekly loan installment and keep some profit too.

"Every week I make 300 taka [\$6.50] from the phone," she says, "and I repay 160 taka. In three years the loan will be repaid." In some parts of Bangladesh an illiterate widow with

several children could be destined to beg or even turn to prostitution. But once the loan is paid off, Anowara Begum stands to net an average of \$2 a day—more than \$700 a year—in a country with an average annual per capita income of about \$250.

Since its launching in 1976, the Grameen program has loaned more than two billion dollars, in amounts averaging only \$180, to more than 2.1 million destitute women.

"We find that when women start borrowing, it benefits the whole family," Mohammed Abul Hossain, a senior officer at Grameen, tells me. "Her children become important, the family's welfare becomes important." One recent study in Brazil showed that income controlled by the mother had a benefit on her children's health that was almost 20 times greater than income controlled by the father.

Sharifa Akhtar Shikha, Anowara's 20-year-old daughter, studies Islamic history at Dhaka's Jagannath University. "If my mother hadn't gotten the loan," Shikha says, "it would have

been impossible for me to go to the university. But she wanted me to have a higher education."

Why? Anowara smiles. "For the future," she answers. "She will be independent and have more income. And she'll be happy also."

When people can start making decisions about their lives, they also start making decisions about the size of their families and vice versa; family planning within Grameen families is twice as common as the national average. Surveys have also found a strong link between education and family planning.

But Bangladesh still has a high death rate of babies and mothers. Here females die earlier than males (the opposite of the biological norm), due in part to severe malnutrition and risky pregnancies, often too close together.

To help improve health care, BRAC has founded clinics throughout the country. "Many more women want contraceptives now," said Mergina Khatun, a village health worker in Mymensingh district. "They see that if a mother has fewer children, she can give them better care. And her health will be better."

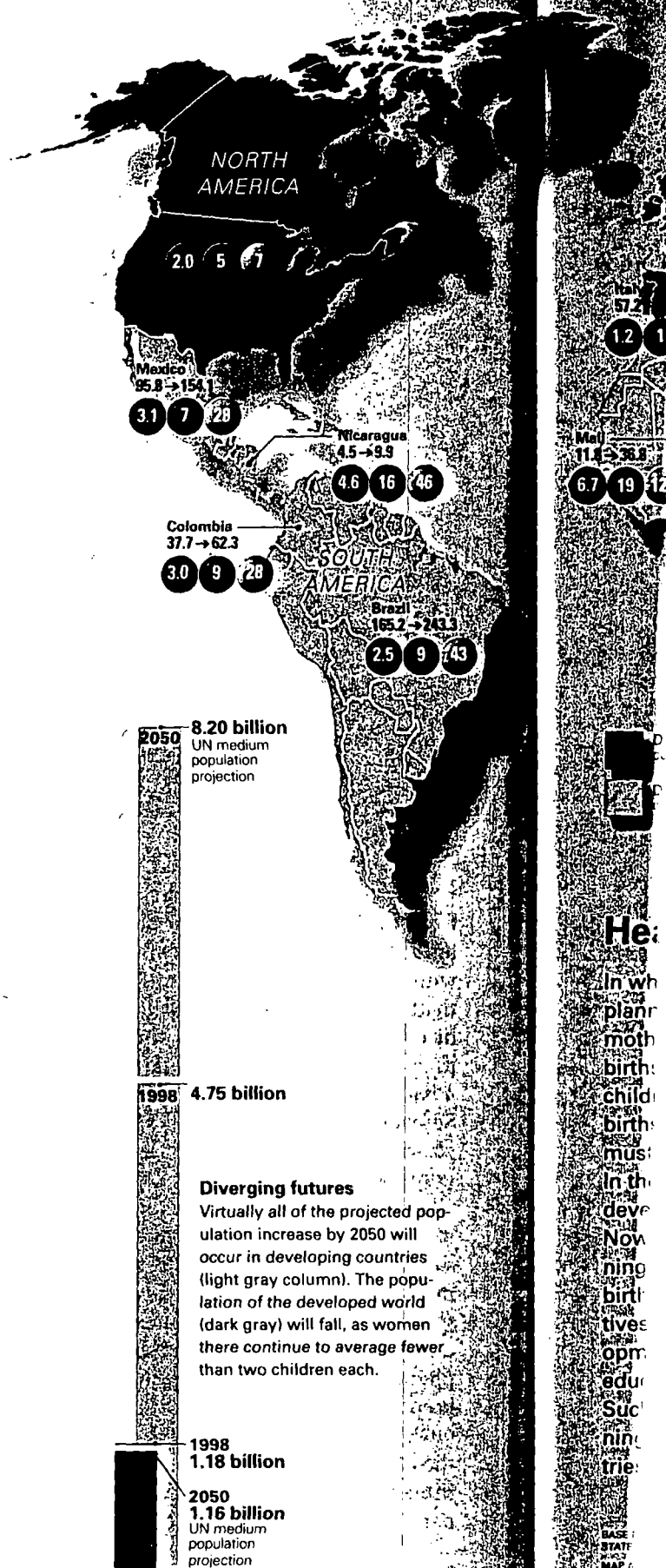
What if a conservative Muslim leader tells Mergina that contraception is against the will of God? "I say that God also told us to be responsible for our families."

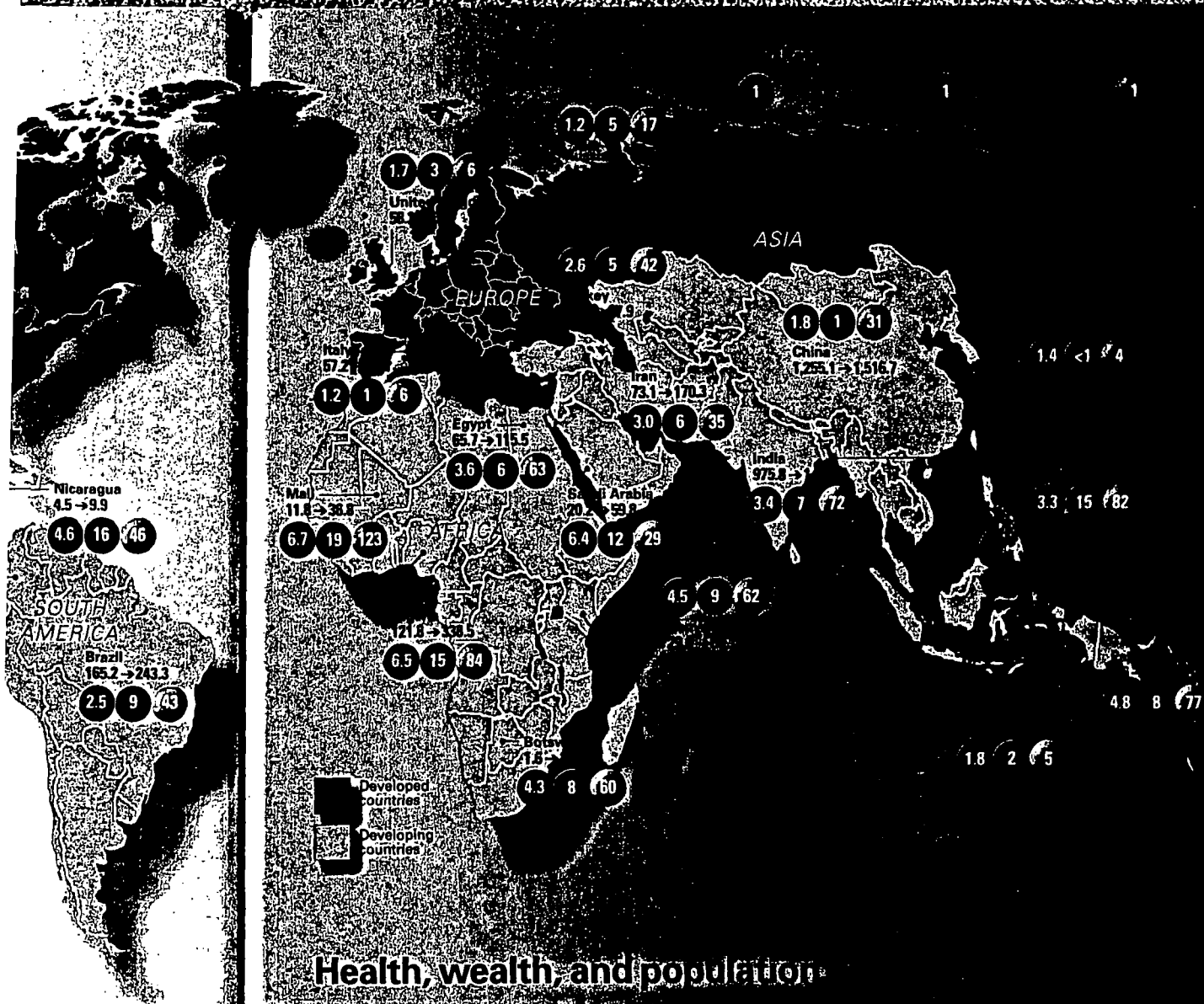
In the BRAC health center in the town of Mymensingh, the nurse is counseling a few of the 800 women who visit every month. A thin young woman, three months pregnant, sits listlessly by the desk. She tells the nurse that she has been suffering from morning sickness and has an intermittent fever. She is 20 years old and has been married three and a half years. This is her third pregnancy; she has already suffered one stillbirth and one miscarriage. Contraceptives could have helped her delay these pregnancies until her health improved.

The nurse advises her to take full bed rest, eat extra food, and do no heavy work. None of this will be possible for her. The nurse prescribes an antihistamine spray and an analgesic for the pain and fever. The girl's gray-haired mother-in-law crouches on the floor, leaning against the wall, waiting silently.

Loans and contraceptives continue to improve the lives of Bangladeshi women and their children. But sadness still inflects the lives of even healthy families.

"I have three daughters; the youngest is just a year and three months old," says Firoza in



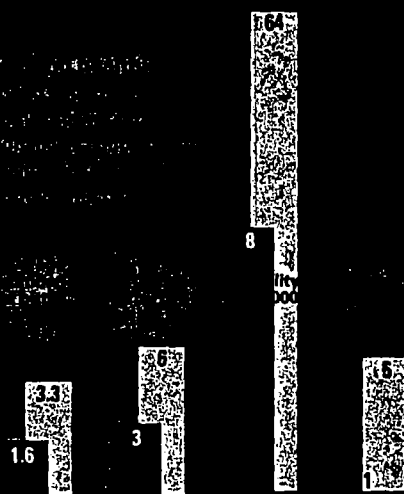


Health, wealth, and population

In what experts call a "virtuous cycle," family planning leads to healthier women, who then avoid early, late, or closely spaced births. Healthier women have healthier children. And fewer child deaths mean fewer births, as women stop believing their babies must have many babies for a healthy world. In the past many concluded that economic development was the best contraceptive. Now, backed by studies showing family planning is the most effective means of reducing births worldwide, experts say, "Contraceptives are the best contraceptive." As development and its benefits, especially better education and health care, remain elusive, such advances raise demand for family planning, persuade young couples in developing countries to postpone childbearing, and encourage

at least one child. The result is a smaller, healthier population of women who can then have fewer children, and so on.

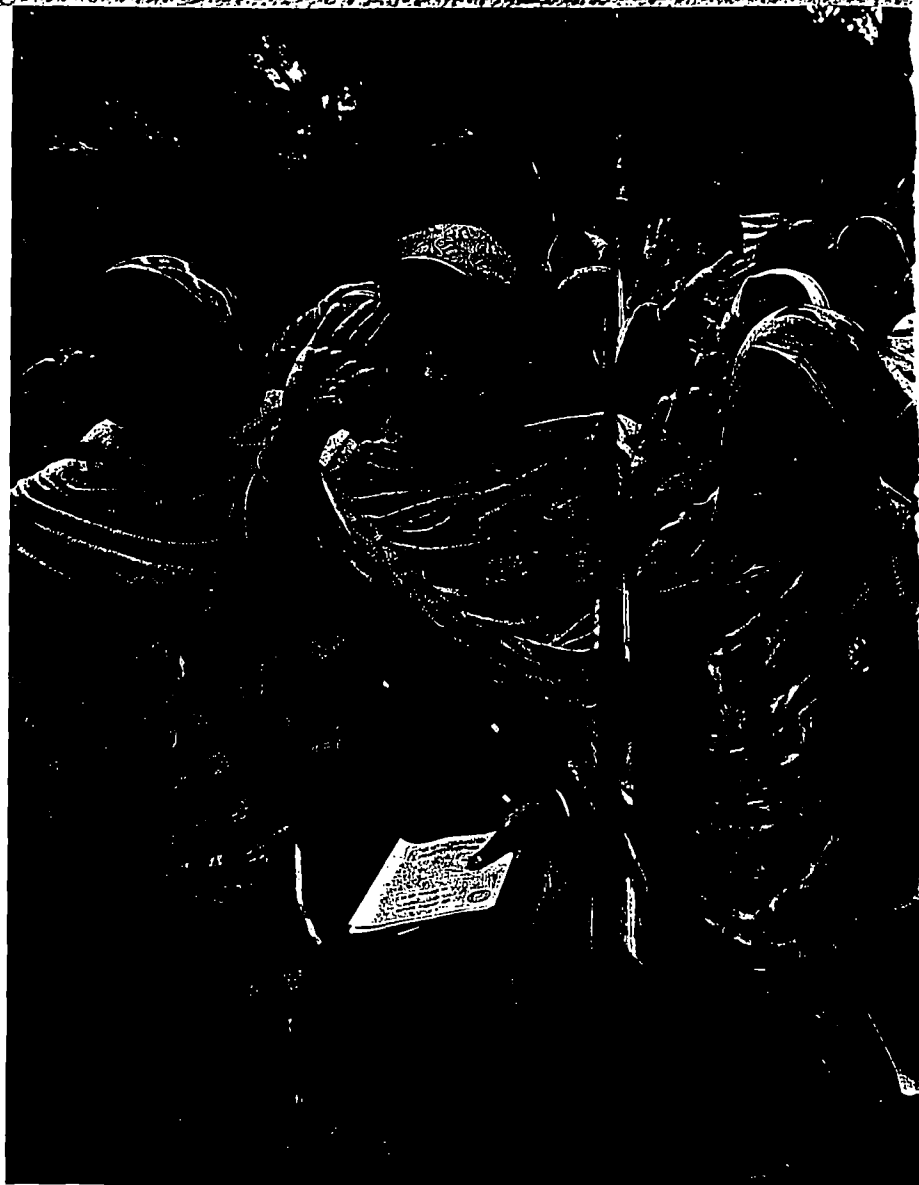
Family planning is the most effective means of reducing births worldwide, experts say. Contraceptives are the best contraceptive. As development and its benefits, especially better education and health care, remain elusive, such advances raise demand for family planning, persuade young couples in developing countries to postpone childbearing, and encourage

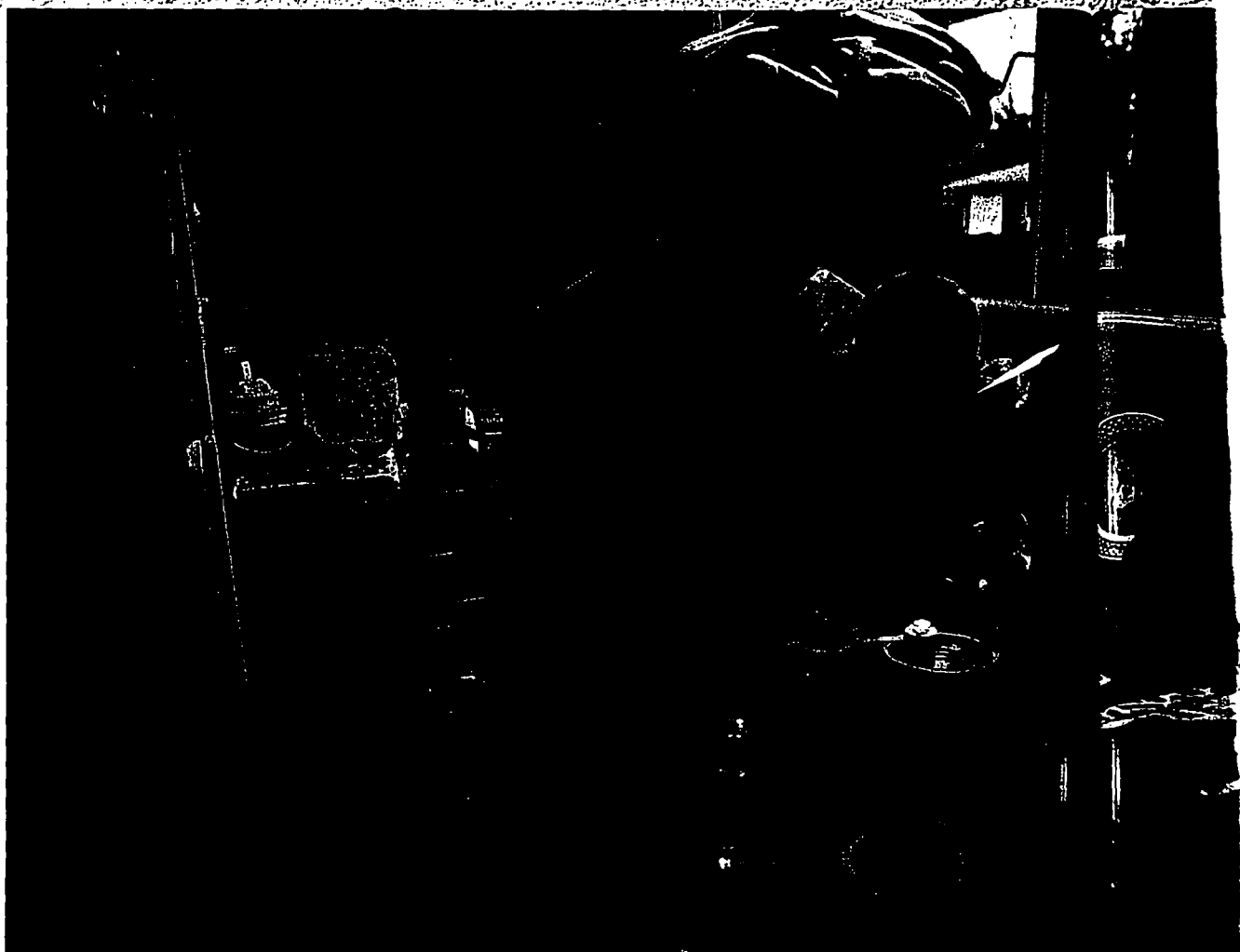


BASE MAP AND POPULATION DATA: UNITED NATIONS POPULATION DIVISION; 2000 STATES CENSUS BUREAU; HEALTH SERVICES DATA: POPULATION RESEARCH; 2000 MAP AND GRAPH BY STEPHEN ROBERTS

Army of entrepreneurs

Saluting the future, women meeting near Dhaka to repay loans acknowledge the loan officer from Grameen Bank, who freed them from lives of powerlessness and isolation. "We shall plan to keep our families small. We shall keep free from the curse of dowry. We shall not practice child marriage"—so runs the creed Grameen clients, who are 95 percent female and 100 percent poor, recite as a promise to break from traditions of poverty. Launched into business with a small loan, a woman travels from door to door selling cookware (below). Anowara Begum (below right) used a loan of \$390 to buy a cellular phone, which fellow villagers pay to use. Soon after the death of her husband, Anowara hears from her brother in Malaysia while their mother weeps. For birthrates to keep falling, experts say women must be offered opportunities beyond motherhood and given the authority to choose whether to bear children.





Taldighi village. "My husband is disappointed. Now he is saying he didn't want any more children. Two would have been better, he says, since the third one was a girl."

"I had twin baby boys," her neighbor, Alefjan, tells me. "They died of a respiratory infection, one when he was seven days old and the other when he was 14 days old. My husband told me, 'We don't need to go to the hospital—they don't have drugs for children this small.' And I believed him."

"**W**OMEN AND POPULATION," repeated Beverly Winikoff at the Population Council when I told her my topic. "It sounds like you're treating women as the disease vector." What about men?

The sun rises over Nairobi, gilding the dusty parks, the battered streets, the chaotic, makeshift markets. Kenya used to have one of the highest birthrates in the world, but in the past 20 years it has shown one of the steepest declines in all Africa. As in Bangladesh this is due

in large part to massive education campaigns, more clinics, and inexpensive contraceptives. But Africa, which still has the highest birthrates in the world, remains profoundly child centered. "A person who doesn't have children is looked down on," a woman explained, "because that person is incomplete in the society."

In much of the world men have often been the major objectors to family planning. Some do so on the basis of religious beliefs; others want to demonstrate their virility. Many believe that only the fear of becoming pregnant will keep their wives faithful. And there are misunderstandings: "I used to hate family planning," a man told me, "because I thought it meant that people shouldn't have children."

Yet as men struggle to provide for their families, some admit that smaller families are better. To help them become more involved in family planning, male-only clinics have begun to appear in Kenya, Ghana, and some South American countries. And a few pioneers, overcoming the common fear that sterilization will

make t
Phil
vary Te
neighb
man w
first m
Marie S

The
children
azines.
The yel
"Plan y
depend
world h

"My
me. "It
for 13 c
cup of t

"Wh
was tha
raise," h
and she
my wife

Early parenthood

Seven months a mother, Jill Crisler, 16, fixes a bottle for her son, Trenton, before leaving for Northeast High in Lincoln, Nebraska. Like many teenage births, this one was unplanned. "It's not a mistake," says Jill. "I call it a surprise." Unlike most unwed fathers, Luke Smith stays in his son's life, hurrying from his job to his new role as Trenton's playmate at the school day care (below).



, are choosing vasectomy. pastor of the Nairobi Cal- ecostal church in a poor 7 he is a small, compact , intelligent expression. I e male-only suite of the downtown.

room is full of women and evision and reading mag- xt door are for men only. ear a few modest posters: w—your children's future million men around the ectomy."

st eight acres," Philip tells -size farm but not enough e morning there was just a Poverty eats you every day. ecide to have a vasectomy o have a family I could 'My wife was taking pills, od pressure. Who am I to ner. I'm there to help her.

That's what the Bible says. So I read about vasectomy. The only side effect is that you can't have children anymore"—he smiles—"and that's the side effect I wanted."

To their credit many men worry about the possible side effects some contraceptive methods may have on their wives. Then again, studies show that men are generally reluctant to use methods that directly involve them—withdrawal, abstinence, condoms, and the rhythm method. As for vasectomy, says clinic counselor Patrick Musyoka in his gentle voice, "The stigma is still there."

Men are the point at which family planning leaves the realm of mechanics and enters the mysterious territory of behavior. Contraceptives themselves are simple—it's the users that are complicated, caught up in the volatile dynamics of human relationships. "Family planning came to Kenya through health programs for women," Godwin Mzenge, a program director, tells me. "The assumption was that women would discuss with their husbands



Premature parents, mothers at Lincoln High School gather at lunch as part of a student-child program that helps them graduate. The U.S. has the highest teenage birthrate in the industrialized world. Adolescent births endanger mothers and their babies while accelerating population

grow
pro
birth



a student-child
in the industrial-
izing population

growth. Rather than stressing either abstinence or contraceptives alone, successful prevention programs also emphasize setting and achieving goals. "Hope is the most important method of birth control," says Susan Powers-Alexander, of Lincoln's Planned Parenthood.



what they learned. But now we know that communication between them isn't that common."

"We encourage the women to keep discussing," says Rose Ngahu, a nurse. "It takes a lot of force of character to resist the husband."

IN LINCOLN, NEBRASKA, a crisp autumn morning spreads across the prairie, over the flags snapping in front of the state capitol, over the football fields ready for marching-band practice after school. In the half-light students are arriving for class at Lincoln High School. They carry the usual teenage stuff: books, musical instruments, backpacks. Some of the girls are also carrying their babies.

The U.S. has the highest teenage birthrate of any industrialized nation. Since 1960 the rate has tripled among unmarried females age 15 to 19. According to the Alan Guttmacher Institute, four in ten American girls become pregnant at least once before they reach 20; most of these pregnancies are unintended.

We think of Lincoln as the real America. And

it is, but not always in the way we mean. "I'd like to have a baby," said Tonya, a pert 12th grader, "but not now. Too many of my friends have babies: Mindy, Janet, Penny, Becky, Sue Ann, April. . . ."

This is bad news, for a number of reasons. First, there is sheer quantity: By the year 2000 there will be more adolescent girls in the world than there have ever been: 400 million poised to begin having children. If they were to delay their first baby by five years, it would mean 1.2 billion fewer people by the year 2100.

Second, there is the quality of those lives. Of the nearly four million babies born each year in the U.S., nearly one out of eight is born to a teenage mother. When a girl under 20 has a baby, problems mount for everyone. She may well drop out of school, in which case she is likely to go on welfare. (In 1995 the government spent 37 billion dollars on welfare, food stamps, and Medicaid for families begun by a teenage mother.) Emotional immaturity can lead her to abuse her baby; it can be hard to

overcome
on a body
a myth tha
healthier,"
you know v

Her baby
Infants bor
risk of low
birth than
24. They a
and higher
problems.
likely to ser
found that
mother sav
social costs
many of the
whelmed."
said. "I felt

In 1993
opened a cl
school. The
east High—

Smaller is better

Dressed in school uniforms their mothers struggled to buy, Masai children drink a breakfast of tea in the doorway of a house in rural Kenya. In Nairobi, Philip Njuguna, a pastor, watches his third child and only son (below). Njuguna underwent a vasectomy after the boy was born. "When the family is small, whatever little they have they are able to share," he says. "There is peace."



of pregnancy and labor finished developing. "It's they're younger, they're old me. "What teen do t?"

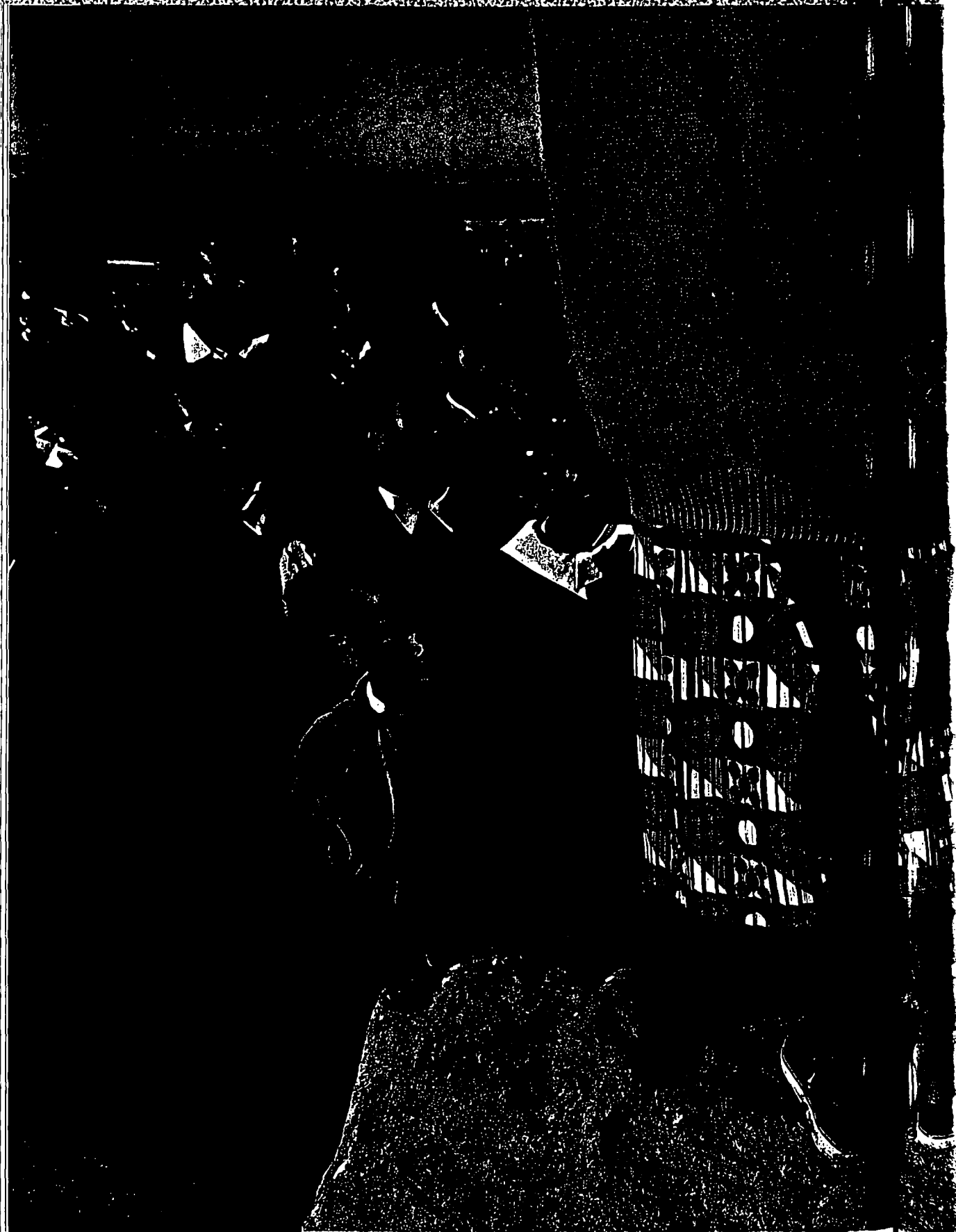
ery well have difficulty: mothers are at higher prematurity, and still- n to women age 20 to have lower test scores sical and psychological age mothers are more ison. The state of Utah spent on a teenage : \$400,000 in various time of her child. But now that they are over- shame," one of them

staff at Lincoln High learning center at the r colleagues at North- their first priority is to

make sure the girls graduate. "We *want* the girls to be successful," says Karen Poore, a teacher at Northeast. "Whatever will help them complete their education, we advocate."

There was resistance. "Some people didn't want Lincoln High to be known as 'the pregnant school,' " says Ann Irvine at the public school district office. "There was still the shame factor. We had to get over that." And objections came from those who were convinced that a day-care center would be seen as encouragement to be promiscuous. "The girls just laugh," says JoAnn Bartek, who teaches family and consumer sciences. "They say, 'Oh yeah, that's really what we were thinking: They've got this really neat day-care center; I think I'll go get pregnant.' "

As for those who maintain that the girls shouldn't be in school, according to Bartek, the girls say, "Well, where should we be? If we don't get our high school diplomas, we're going to be on welfare. We're going to be homeless." One study found that almost 60 percent of



Masai children gather for opening ceremonies at Kimuka Primary School in Kenya's Rift Valley. Adapting to a shrinking supply of cattle land, Masai herders are bearing fewer children in hopes of sending all their sons and daughters to school. Africa has the world's highest



s Rift Valley.
ren in
est

birthrates, but they are starting to fall with better health care and education, stronger family-planning programs, and—in countries such as Kenya—weak economies that make it hard to provide for many children. Even so, the continent's human numbers will double in 30 years.

teens who became pregnant dropped out of high school. At Northeast and Lincoln High 80 percent of pregnant teens are graduating.

I meet some of these teens at the child-care center at Lincoln High. The room is spacious and cheerful, full of toys and cots and intensely clean. Several girls are here on their lunch break, crouched on the floor playing with their babies or talking with the assistants and each other. A few sit quietly, nursing. The mothers look more like older sisters.

At 3 p.m. Mandy Brehm comes to pick up her eight-month-old daughter, Juliana. Mandy is 16; she has long brown hair, green eyes, and a pretty, round face. She's named in *Who's Who Among American High School Students*. When we get home, her mother, Diane, and her younger brother, Jared, are there.

There is pizza for dinner. As we eat, Diane recalls the day she learned her daughter was pregnant. Mandy couldn't find the courage to tell her; instead she left a note on her mother's bed. "It said, 'I'll never be the daughter you wanted. This is the worst day of my life. But I don't want to kill the baby.' I cried for about two hours. Then I called her at school and asked if she wanted to come home."

Many girls do not have the support or the determination that Mandy did. Fifty percent of abortions in the U.S. are sought by women younger than 25.

"My own thought," says Beverly Winikoff at the Population Council, "is that most people wouldn't use abortion as a first choice. But they're pregnant, and they need not be."

What will Mandy tell Juliana when she grows up? "Not to have sex," she replies. "'Cause it's not worth it."

Mandy will probably be the only person telling her that. "We bombard kids with sexual messages, but we don't teach them how to process them," says Susan Powers-Alexander, a director at Planned Parenthood in Lincoln. "We don't teach kids to decipher that they're using sex to sell cars, perfume, pineapple."

The influences on adolescents are powerful and pervasive: movies, advertising, music, peer pressure. The girls face life with a wild assortment of mismatched traits: ignorance, bravado, curiosity, delusions of invulnerability. The reasons for teen pregnancy go on. Many teen mothers are children of teen mothers. Alcohol and drugs undermine the ability to

make clear decisions. Older boys can dazzle or dominate: Over half the males responsible for teen births are 20 or older. Early sexual abuse cripples the capacity to say no; one study reported that 48 percent of high school students who had been pregnant were once sexually abused. And there is fear of losing love.

"Part of the reason I was so reckless was I didn't like myself at all," Mindy Latzel, 18, tells me. "He was 22 at the time. He made me feel good about myself, telling me how pretty I was. But I guess it was a bunch of lies."

HOW MANY CHILDREN should we have? How far apart? Stan Bernstein, senior research adviser at the UN Population Fund, asks rhetorically. "How should we educate them—concentrate on a few and hope they'll take care of us?" These



Married but without children, a Masai teenage bride looks forward to her first pregnancy. While many women's lives are still dictated by circumstance, more and more now enjoy choices. In their hopes, fed by new possibilities, the future is born.

discussions are happening more and more.

The World Health Organization estimates that sexual intercourse occurs a hundred million times a day. Yet despite the great strides of the past three decades, millions of couples who want to use contraception don't have access to it. Many developing countries, faced with economic crisis and political uncertainty, are shrinking their financing of family-planning programs. Some foreign donors have also cut back on aid—the U.S. by one-third.

In Kenya a man says, "When my wife didn't want to have more than three children, my mother told her, 'You're just lazy.'"

In Bangladesh a woman says, "Two children

are enough. Because if you have more, you can't raise them as human beings."

In the U.S. a 16-year-old father looks at his infant son and says, "I'd probably be locked up in some juvenile hall if he wasn't here. He's changed me for the better."

The sun rises every morning on more than a quarter of a million newborn babies. A few of them may change the world; all of them will change their mothers and fathers. They don't belong to the ant heap. They belong, for better or for worse, to us all. □

Erla Zwingle reports further on teenagers and pregnancy at www.nationalgeographic.com/features/2000/population/women.

boys can dazzle or
es responsible for
arly sexual abuse
y no; one study
high school stu-
nt were once sex-
ar of losing love.
s so reckless was
Mindy Latzel, 18,
me. He made me
g me how pretty
ch of lies."

should we have?
Stan Bernstein,
viser at the UN
asks rhetorically,
—concentrate on
are of us?" These

Issues in Brief

Risks and Realities of Early Childbearing Worldwide

Summary Points

Policy Implications

A 10-year-old girl works beside her mother in a remote, rural village. Miles away, in a bustling metropolis, a boy about the same age gets ready for school. Despite their differences, both are embarking on one of the most crucial periods in their lives—their adolescence.

Over the next 10 years, these young people will face vital decisions regarding education, work, sexual relationships, marriage and having children. Their decisions will be tempered by social and economic circumstances and influenced by family members and the members of their community.

The choices adolescents make will strongly affect their educational attainment and employment opportunities—in fact, the entire direction of their lives. Collectively, their choices will have significant consequences for the future of their communities, their countries and the rest of the world.

Terms Used

Adolescents are young people aged 10–19.

Marriage includes both legal marriage and cohabiting unions.

Adolescents, broadly defined as 10-19-year-olds, are a vital population segment, making up one-fifth of the world's people. The sheer size of the group commands attention: They numbered nearly 1.1 billion in 1995—913 million lived in developing countries and 160 million in developed countries. The world's two most populous countries, China and India, were each home to approximately 200 million young people (Table 1, column 1).

table 1
Adolescent Demographics Worldwide

Country and survey year	Number aged 10-19, 1996	% of population 10-19, 1996	% of women 15-19 in urban areas	% of women 15-19 with ≥ 7 years of schooling*	% of women 40-44 with ≥ 7 years of schooling*	% of women 20-24 who gave birth by age 20Y	% of women 40-44 who gave birth by age 20Y	% of births to women 15-19, 1996	% of births to women 15-19, 1996
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)

Sub-Saharan Africa

Botswana, 1988	362,000	24	31	75	21	55	50	14	71
Burkina Faso, 1992/1993	2,335,000	22	26	11	2	62	57	18	23
Burundi, 1987	1,485,000	23	4	1	2	27	39	6	36
Cameroon, 1991	3,163,000	23	42	40	8	67	64	19	24
Cen. African Rep., 1994/1995	752,000	22	48	14	5	61	59	20	23
Ghana, 1993	4,156,000	23	46	63	35	48	50	15	58
Kenya, 1993	7,241,000	25	16	62	26	52	59	18	52
Madagascar, 1992	3,554,000	23	21	19	11	53	60	1	21
Malawi, 1992	2,607,000	23	12	19	8	63	56	18	39
Mali, 1987	2,539,000	23	30	8	1	67	62	20	18
Namibia, 1992	358,000	23	30	44	26	42	38	15	50
Niger, 1992	2,171,000	23	19	5	0	75	63	21	11
Nigeria, 1990	26,099,000	23	29	34	4	54	49	17	10
Rwanda, 1992	2,012,000	25	7	36	3	25	36	7	40
Senegal, 1992/1993	1,966,000	23	46	11	6	52	54	19	26
Tanzania, 1991/1992	7,166,000	23	27	62	10	57	65	16	20
Togo, 1988	970,000	23	41	15	4	56	59	15	44
Uganda, 1988/1989	5,108,000	23	14	22	5	68	69	22	35
Zambia, 1992	2,370,000	24	54	48	23	61	68	17	33
Zimbabwe, 1994	2,708,000	24	27	82	30	50	55	14	47

North Africa & Middle East

Egypt, 1992	14,315,000	22	44	65	23	29	40	13	16
Morocco, 1992	6,160,000	22	45	28	7	19	39	6	22
Sudan, 1989/1990	6,760,000	23	41	58	7	26	61	12	15

Tunisia, 1988	1,992,000	22	60	39	6	13	36	5	23
Yemen, 1991/1992	3,490,000	23	23	9	1	41	35	11	u
Asia									
Bangladesh, 1993/1994	28,919,000	24	13	33	9	66	85	18	23
China, 1988	202,060,000	16	20	51	23	8	22	3	u
India, 1992/1993	197,168,000	21	27	50	25	49	58	9	16
Indonesia, 1994	42,591,000	21	38	84	41	33	51	14	12
Pakistan, 1990/1991	32,452,000	22	36	29	9	31	38	7	9
Philippines, 1993	15,398,000	22	59	81	50	21	26	4	41
Sri Lanka, 1987	3,805,000	21	14	u	u	16	31	8	28
Thailand, 1987	11,565,000	20	26	34	11	24	28	14	31
Turkey, 1993	12,382,000	20	58	90	50	25	42	6	22
Latin America & Caribbean									
Bolivia, 1993/1994	1,695,000	22	64	62	26	39	39	13	42
Brazil, 1986	33,510,000	20	74	47	23	31	31	17	50
Colombia, 1995	7,527,000	21	75	63	35	37	36	16	43
Dominican Republic, 1991	1,680,000	21	68	65	35	33	52	18	36
Ecuador, 1987	2,610,000	22	60	56	26	35	39	15	27
Guatemala, 1987	2,599,000	24	37	21	9	50	48	17	20
Mexico, 1987	20,635,000	22	73	62	17	35	41	15	33
Paraguay, 1990	1,104,000	22	50	42	21	37	34	14	22
Peru, 1991/1992	5,355,000	22	79	69	46	27	36	12	52
Trinidad & Tobago, 1987	279,000	21	41	90	51	30	40	13	39
Developed Countries									
France, 1994	7,719,000	13	80§	84§	82	7	15	2	35§

Germany, 1992	9,053,000	11	87**	100	100	u	u	4	u
Japan, 1992	15,736,000	13	83**	100	100	2	4	1	u
United Kingdom, 1993	7,253,000	12	90**	100	u	u	u	7	u
United States, 1988	36,508,000	14	76**	100	98	19	23	14	73

*Except in Central African Republic, Tunisia, Yemen, Indonesia, Pakistan and Thailand, where it is the percentage of women with secondary or higher education. †In North Africa and the Middle East and Asia never-married women are assumed to have had no births. ‡Based on all births at ages 15-19 in the previous five years, except in Burundi, Mali, Togo, Uganda, Sudan and Mexico, where based on the last birth among women 15-19 in the previous five years. §% for ages 20-24. **% for total population; source, see ref. 1, A-2. Note: u=unavailable.

Other populous countries included in this report—Bangladesh, Brazil, Indonesia, Mexico, Nigeria, Pakistan and the United States—each have 20-43 million adolescents. Adolescents are one-quarter of the total population in most developing countries and about one-seventh in developed countries (Table 1, column 2).

During adolescence, young people very much need the support and guidance of their parents and families. This is a time of rapid growth—physically and emotionally. It is a time when adolescents begin to develop their own standards as well as question the values of their family and community. While providing guidance has never been a simple task, vast social change makes it even more difficult for parents to know how to help their children and prepare them for the future.

This report focuses on childbearing during adolescence. Its main purpose is to increase worldwide awareness of the extent to which adolescents are becoming parents and of the consequences of pregnancy and childbearing at an early age.

Parents, governments and communities in general are concerned about early childbearing for many reasons. It can limit educational attainment, restrict the skills young people bring to the work force (and their capacity to support themselves financially), and reduce their quality of life.

In addition, sexual relationships at an early age put young people at risk of contracting sexually transmitted diseases (STDs). Some STDs can affect a woman's ability to have children, and others, such as AIDS, can be life-threatening. Pregnancy may result in serious medical complications when adolescents give birth or have unsafe, clandestine abortions. And adolescents who give birth before marriage may be disowned by their families; many are then left with the responsibility of raising the child by themselves.

This report compiles data about adolescents in 44 developing and five developed countries, covering 75% of the world's total population. The countries included all have comparable data from national fertility surveys, and in all but six countries, the data are from the Demographic and Health Surveys (DHS), an international research effort. The developed countries are included to illustrate both similarities and differences in adolescent behavior worldwide.

Unfortunately, the reproductive behavior of young men has not been studied as much as that of young women. However, whenever such information is available, it is included.

Changing Living Conditions

One of the most significant factors altering the face of the developing world is the widespread migration of people from rural areas to cities and towns. In leaving farms and close-knit villages, young people often experience a weakening of extended family ties and face a diminished social support network. Nonetheless, the search for better work opportunities and better living conditions has increased the

proportion of the world's population living in urban areas from about 30% in 1950 to 45% in the mid-1990s.¹

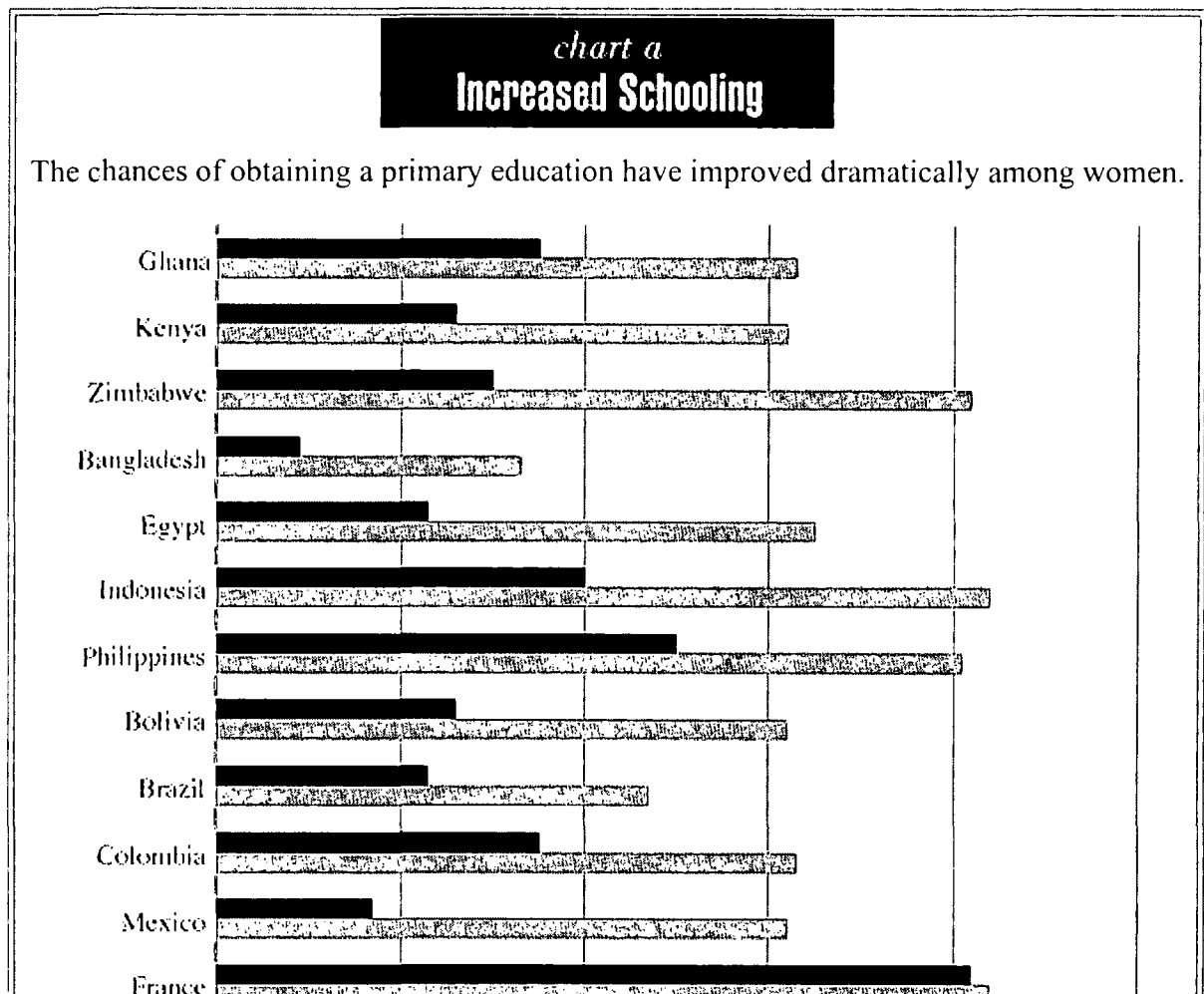
Sub-Saharan Africa is less urbanized than many regions of the world, yet the proportion of young women who live in urban areas ranges from 25-50% in 13 of 20 countries, according to data in Table 1, column 3. The proportions are believed to be at least as high for young men.

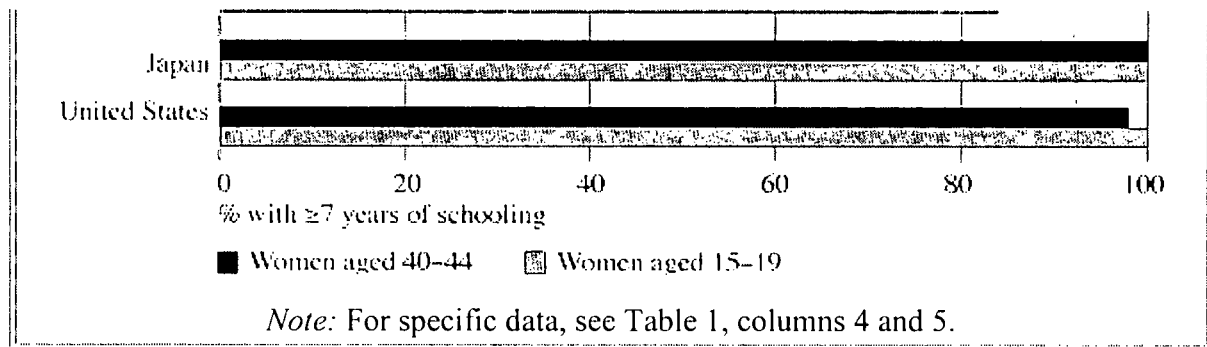
Most countries in Asia have a similar proportion of young women living in urban areas, and those in North Africa and the Middle East are at the upper end of the 25-50% range. In Latin America and the Caribbean, the proportions are much higher, a range of 50-75% in all but two of the 10 countries in this report. In developed countries, most of which have been highly urban for decades, more than 75% of young people live in urban areas.

Educational Needs

As societies are changing and becoming increasingly urban, young people have greater need for education; fortunately, more are obtaining at least primary schooling. Young women aged 15-19 are two to three times more likely than women aged 40-44 to have at least seven years of education (Table 1, columns 4 and 5). In other words, an increasing proportion of young people are completing primary school and may have some secondary schooling. In some of the North African and Asian countries, increases have been especially dramatic.

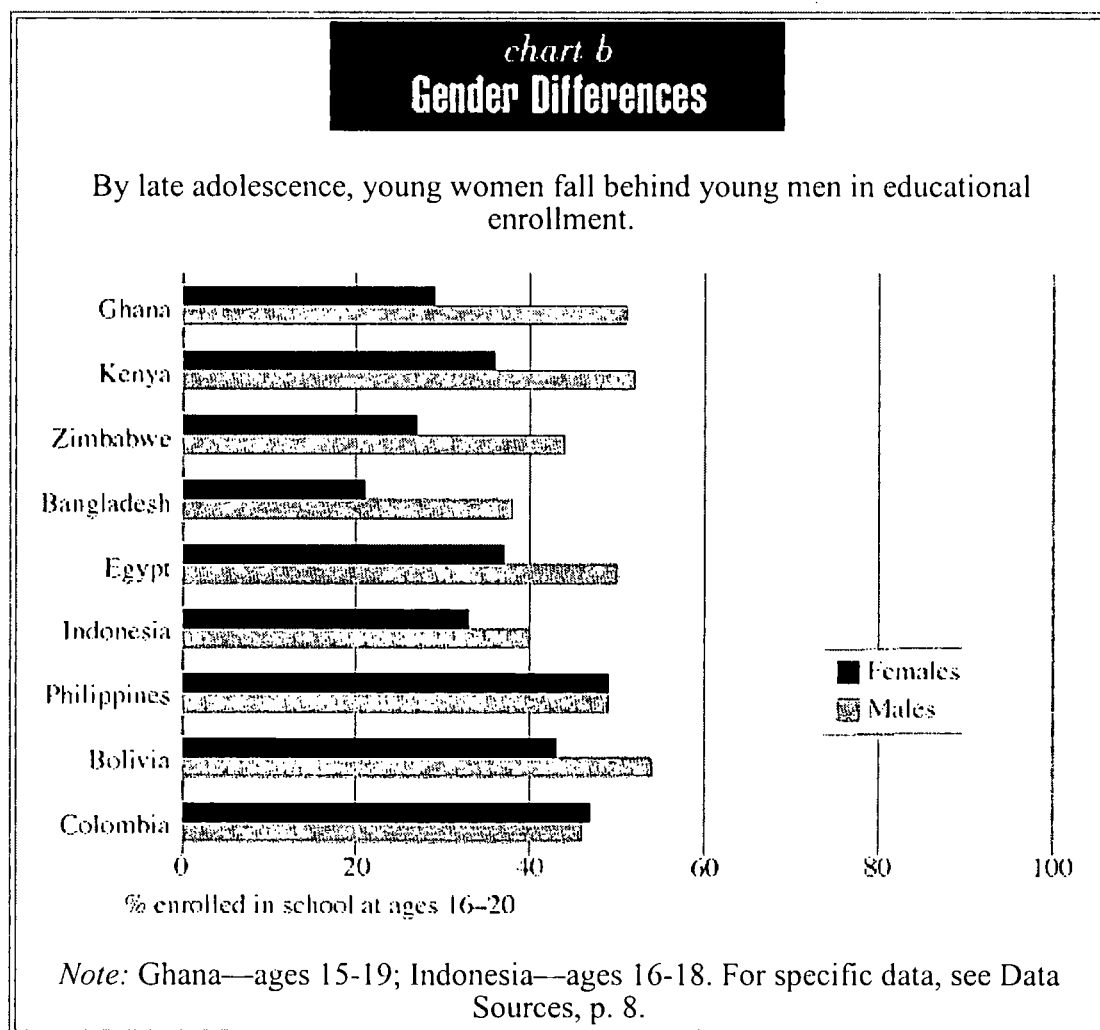
Chart A illustrates some of the changes. In Kenya, for example, 62% of women aged 15-19 have seven or more years of education, compared with only 26% of 40-44 year-old women. In Bangladesh, 33% of 15-19-year-olds have at least seven years of schooling, compared with only 9% of 40-44-year-old women.





However, in many countries, the actual proportion of young women who have some secondary schooling is still very low. In most Sub-Saharan African countries, only 40% have attended any secondary school, and in most North African, Middle Eastern or Asian countries, no more than half have done so. In Latin America as well, the proportion of young women who have attained secondary schooling is 40-70% in eight of the 10 countries in Table 1.

Unfortunately, despite the educational gains that have occurred in the developing countries over the last 30 years, young women still fall behind young men in educational opportunities. By the time they reach late adolescence (ages 16-20), young women are much less likely to be enrolled in school than young men, as is the case in seven of the nine countries shown in Chart B.



School enrollment may not mean that the individual is attending classes regularly, but in all nine countries, 38-54% of young men aged 16-20 are enrolled in school, while in six of these countries,

27-37% of young women are enrolled. However, gender disparities are less for 11-15-year-olds, an age-group in which 70-90% of both young men and young women in all but two of these countries are enrolled in school.

In addition to young women being less likely than young men to attend school, they may face unique barriers to completion: They are generally expelled from school if they become pregnant, and they rarely return once they have left.

Sexual Relationships Before Marriage

As young people postpone marriage to later ages, the likelihood of beginning a sexual relationship prior to marriage increases in both developed and developing countries. Consequently, so does the chance of unintended pregnancy, abortion or birth among unmarried adolescents. Worldwide, young men and women are increasingly attending school together, and this increased interaction may also contribute to the incidence of sexual relationships prior to marriage.

Traditionally, in some parts of Sub-Saharan Africa, premarital sexual relationships are encouraged because young women are expected to prove their fecundity prior to establishing a union. In most Sub-Saharan African countries, 40% or more of 20-24-year-old women have sexual intercourse prior to their first marriage—and before the age of 20.² In many Latin American countries, as many as 30% of women report having premarital sex before their 20th birthday. The actual level of premarital sexual activity may be higher than the reported level because single women may not feel it is acceptable to acknowledge that they are sexually active.

However, not all adolescent sexual activity is consensual. Sexual abuse, incest and rape are troubling realities in developing and developed countries alike. In Uganda, nearly half (49%) of sexually active primary school girls report being forced to have sexual intercourse, and 22% anticipate receiving gifts or money in exchange for sex.³ In the United States, seven in 10 women who have sex before age 14, and six in 10 who have sex before they reach age 15, report having had sex involuntarily.⁴

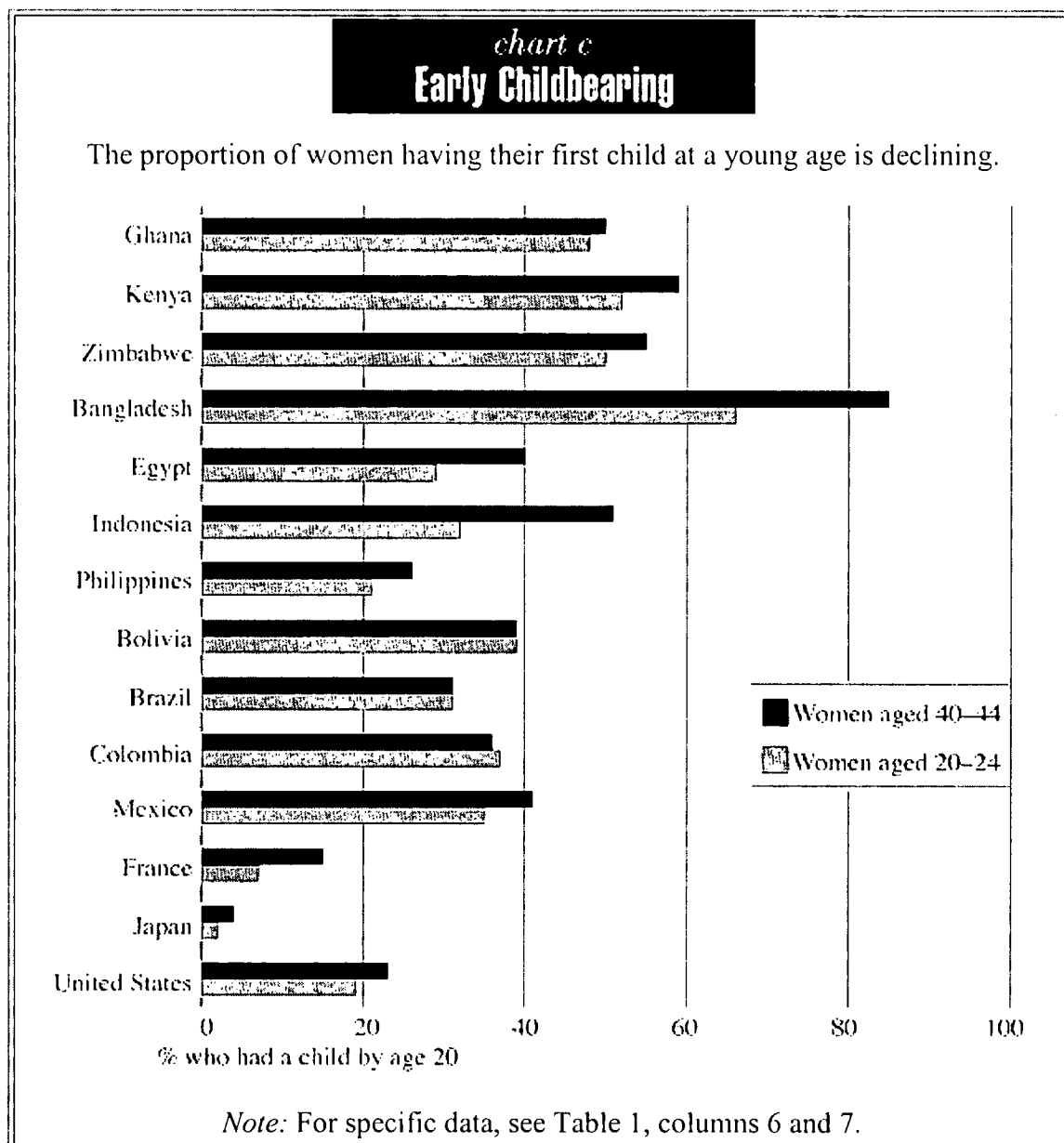
When Adolescents Have Babies

The number of adolescents giving birth each year is staggering. In fact, slightly more than 10% of all births worldwide—almost 15 million—are to young mothers.⁵

However, in the past 20-30 years, early childbearing has been declining in many countries of Asia, North Africa and the Middle East. In seven of these countries in Table 1 (columns 6 and 7), the proportion of women aged 20-24 who had their first child as an adolescent is 15-35 percentage points lower than that of women now aged 40-44. For example, in Indonesia, 51% of women aged 40-44 had their first child during their adolescent years, as compared with 33% of younger women.

By comparison, little change has occurred in Latin America and Sub-Saharan Africa. In most countries in these regions, declines are small, and in 12 countries, young women are now a little more likely to have a child during adolescence than were older women (Botswana, Burkina Faso, Cameroon, Central African Republic, Malawi, Mali, Namibia, Niger, Nigeria, Colombia, Guatemala and Paraguay). Improvements in general health conditions and nutrition, especially in Sub-Saharan Africa, are contributing to a lower age at menarche and to increased fecundity during adolescence.

Overall, about 35% of young women in Latin America and the Caribbean have their first child before their 20th birthday, and an even higher proportion (50-60%) do so in most countries in Sub-Saharan Africa. As Chart C illustrates, the United States has one of the highest levels of adolescent childbearing in the developed world, with 19% of young women giving birth before age 20. This is almost three times the level in France and nine times as high as in Japan.



In most of Sub-Saharan Africa and Latin America, 15-20% of all births are to women aged 15-19 (Table 1, column 8). In Asia, North Africa and the Middle East, however, the proportion of births to adolescents is much lower, ranging from 3-14% in all but one of these countries. In these regions, recent social changes have brought about increases in the age at which women begin their first union and have their first child.

In Latin America and the Caribbean, Sub-Saharan Africa and the developed countries, childbearing among unmarried young women is more common than in Asia, North Africa and the Middle East. For example, 5-16% of married women aged 20-24 had their first birth before marriage in most Latin American countries and in the United States; 13-30% did so in most Sub-Saharan African countries, but only 2% or fewer did so in North Africa, the Middle East or Asia.⁶

Early Childbearing

Having a baby is probably one of the most significant events in a person's (or a couple's) life. Having a baby during adolescence is much more complicated and potentially hazardous than having a baby as an adult, however.

Within any society, childbearing among adolescents is most common among the poor. As a result of poverty, these young mothers may be malnourished, a factor that contributes to poor pregnancy outcomes. In fact, in some countries, females—young and old alike—receive less food, or less nutritious food, and lower quality health care than boys and men.

In the United States, and probably most other countries too, pregnant adolescents are less likely than older pregnant women to obtain adequate prenatal care. A lack of prenatal care means that pregnancy-related complications, often present among young women, may not be identified and treated.

When a woman becomes pregnant before age 18, birth can be dangerous for both mother and baby. If the mother's pelvis is undersized because of incomplete skeletal growth, she may suffer prolonged or obstructed labor. The risk of death during childbirth is 2-4 times higher among mothers aged 17 or younger than among mothers aged 20 or older.⁷

Mortality and morbidity rates are also higher among infants born to young mothers. The risk of dying in the first year of life is typically greater by 30% or more among babies whose mothers are aged 15-19 than among those born to mothers aged 20- ;^{29.8}

Do Adolescents Want To Be Parents?

Young women aged 15-19 in most Sub-Saharan African and Latin American countries report that a high proportion of their births are unplanned—either not wanted at the time the birth occurred or not wanted at all (Table 1, column 9). Young married women, as well as unmarried women, experience unplanned and unwanted births—even in countries where early marriage and childbearing are the norm.

One-third or more of all births to adolescents are unplanned in 11 of the 20 Sub-Saharan African countries and seven of the 10 Latin American countries included in this report. About one-fifth were unplanned in all but two of the remaining countries in these regions. And in Asian countries with few adolescent births (the Philippines, Sri Lanka, Thailand and Turkey), 22-41% are unplanned.

Unplanned births among adolescents are also quite common in the developed world. They are especially high in the United States, where 73% of 15-19-year-old women giving birth report that the pregnancy is unplanned.

While a substantial proportion of adolescent mothers report that their births are unplanned, more than half say that the birth is a wanted one. In countries where social change has been slow in coming, where the desired family size is relatively large, where most childbearing occurs within marriage, or where Islam is the predominant religion, adolescents are more likely to report that their births are wanted than in countries where the reverse conditions prevail. These reports may reflect the adolescents' conscious choice or they may reflect conformity to a common belief in some countries that young women should have their first child soon after marriage.

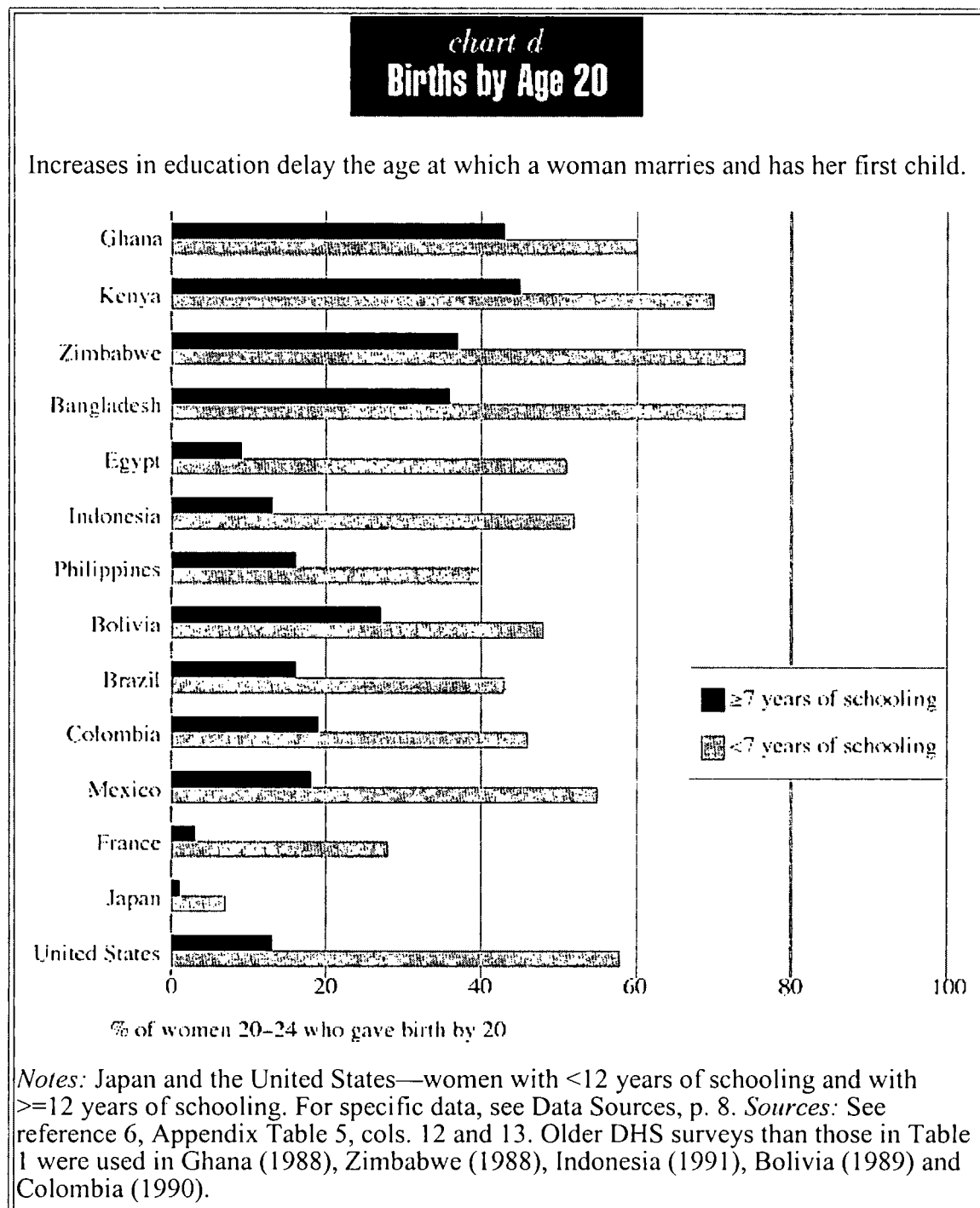
Faced with an unplanned pregnancy, some young women turn to abortion—whether legal or illegal in their country. When the abortion is performed by an untrained person, or under unsanitary conditions, the procedure can result in illness, infection, infertility and even death. Because young women may have difficulty locating a provider of safe abortion and paying for such a procedure, they often delay obtaining an abortion until a later, more difficult, gestational stage. For all these reasons, they are more likely than older women to be hospitalized with life-threatening complications from the procedure.⁹

Education Helps Delay Childbearing

The higher a woman's level of education, the more likely she is to postpone marriage and childbearing. Adolescents with little schooling are often twice as likely—and sometimes three times as likely—as those with more education to have a baby before their 20th birthday.

As Chart D shows, 46% of young Colombian women with less than seven years of schooling have their first child by age 20, compared with 19% of those with more education. The contrast is even greater in

Egypt, where 51% of less educated women have their first birth before the age of 20 compared with only 9% of better educated women.



The link between lack of education and early childbearing is also strong among adolescents in the United States. Some 58% of young American women who receive less than a high school education give birth by their 20th birthday, compared with 13% of young women who complete at least 12 years of schooling.

In some countries, girls and young women may not be given even the opportunity to attend school and are expected to marry at a young age. Therefore, the average young woman in these countries has little education and has her first baby during her adolescent years. However, the low level of education is not the cause of early childbearing; rather, the coincidence of the two is usually a characteristic of living in impoverished and rural environments.

Conclusions

The sheer numbers of young people—as well as the values, health, education and productive skills they attain—will profoundly affect the future of society. This basic fact strongly argues that increased attention should be given to the well-being of adolescents worldwide.

Some improvements are already occurring. The level of education among young people is much higher than that of their parents, and the expectation that young people should obtain at least some secondary schooling is growing. The proportion of women who have a child during their adolescent years is declining in some parts of the world, and recognizing the impact of childbearing on educational attainment, parents and communities increasingly discourage sexual activity, marriage and motherhood at a young age. The growing acceptance by many governments of the need to improve the status and health of women has focused policymakers' attention on the situation of youth, especially that of girls and young women.

However, there is need for continued efforts at all levels. Too many young people either do not attend school or drop out before completing primary school. In many countries, girls are receiving less education than boys. In some areas, early marriage and early childbearing continue to be accepted—even encouraged—resulting in a high proportion of women who begin their first union or marriage and have their first child while still adolescents. Moreover, a substantial proportion of pregnancies and births to young women in all countries are mistimed or unwanted, and where legal abortion is unavailable, adolescents may resort to unsafe, clandestine abortion as an alternative.

Some governments do not yet accept the importance of improving the quality and reach of education, and many do not accept doing so for boys and girls equally. Furthermore, in some communities, parents may not accept the value or the need for girls to be educated. Even when governments, communities and families are convinced of the importance of better educational and employment opportunities for young people, and of working toward greater equality between the sexes, political will is still needed to ensure that resources are appropriately directed.

The need for policy initiatives that increase educational opportunity is especially great among young women who are poor, and therefore, are more likely than better-off adolescents to leave school, marry and begin childbearing at an early age. The difficulty of implementing policies that promote behavior change and broaden opportunities cannot be underestimated. Yet, it is imperative that governments, communities and families take responsibility for and actively work toward creating an environment that will enable and inspire young people to better themselves—and their world.

References

1. United Nations (UN), *World Urbanization Prospects: The 1994 Revision*, New York, 1995.
2. The Alan Guttmacher Institute (AGI), "Sexual Relationships and Marriage Worldwide," *Women, Families and the Future*, New York, 1995.
3. J. Noble, J. Cover and M. Yanagishita, *The World's Youth 1996*, wall chart, Population Reference Bureau, Washington, D.C., 1996.
4. AGI, *Sex and America's Teenagers*, New York, 1994.
5. UN, unpublished tabulations of age-specific fertility rates, 1990-2045; and ----, *The Sex and Age Distribution of the World's Populations: The 1994 Revision*, New York, 1995.
6. AGI, *Hopes and Realities: Closing the Gap Between Women's Aspirations and Their Reproductive Experiences*, New York, 1995, Table 5, col. 14.
7. A.P. McCauley and C. Salter, "Meeting the Needs of Young Adults," *Population Reports*, Series J,

Technology

The New York Times
ON THE WEB

[Home](#)
[Site Index](#)
[Site Search](#)
[Forums](#)
[Archives](#)
[Marketplace](#)

January 13, 1999

Free Speech Debated in Suit Over Anti-Abortion Web Site

By SAM HOWE VERHOVEK

PORTLAND, Ore. -- "The Nuremberg Files: Visualize Abortionists on Trial," proclaims the site on the World Wide Web. With simulated blood dripping from fetus parts, the site leads a cyber-visitor to the "main archive," listing the names of dozens of doctors and clinic workers around the country who provide abortions.

For some of the people the site calls "baby butchers," the information includes photographs, home addresses, license plate numbers, the names of their spouses and children. A few doctors, including Barnett A. Slepian of Amherst, N.Y., near Buffalo, who was fatally shot by a sniper last fall, have a line through their names, denoting that they have been killed; those who have been wounded have their names listed in gray.

For a Federal court jury here, hearing a civil case brought by Planned Parenthood and several doctors against some of the most militant abortion opponents in the country, the trial will boil down to this question: is the Web site constitutionally protected free speech?

The plaintiffs, who are seeking up to \$200 million in damages, have brought their case under the 1994 Federal Freedom of Access to Clinic Entrances Act, which makes it illegal to use "force or threat of force" against anyone seeking or providing an abortion, and allows clinics to seek unlimited damages if workers are harmed or intimidated. But as simple as the question before the jury sounds, the legal issues are not.

For one thing, this is the first major case brought under the law that does not involve direct personal threats or an actual physical confrontation. While the plaintiffs say the Web site amounts to a solicitation of murder, the defendants contend that it is a legal informational tool.

The Web site, which is named for the German city in which Nazis were put on trial after World War II, explains: "A coalition of concerned citizens throughout the U.S.A. is cooperating in collecting dossiers on abortionists in anticipation that one day we may be able to hold them on trial for crimes against humanity.

ALLEGED ABORTIONISTS AND THEIR ACCOMPLICES

We are seeking to establish a list of the names of all the abortionists who are active in the United States and to make this information available to the public.

This is a list of the names of the abortionists who are active in the United States and to make this information available to the public.

This is a list of the names of the abortionists who are active in the United States and to make this information available to the public.



This is a list of the names of the abortionists who are active in the United States and to make this information available to the public.

ABORTIONISTS: the baby butchers

This is a list of the names of the abortionists who are active in the United States and to make this information available to the public.

A page from an anti-abortion Web site, which, with its list of names and addresses of abortion providers, is at the heart of a lawsuit.

We anticipate the day when these people will be charged in perfectly legal courts once the tide of this nation's opinion turns against the wanton slaughter of God's children."

But abortion is legal. And in the climate surrounding the issue -- the National Abortion Federation says there have been 7 killings, 15 attempted murders, 99 acid attacks, 154 arson incidents and 39 bombings involving abortion clinics or workers in the last two decades -- the plaintiffs here say that radical anti-abortion groups are clearly using devices like the Web site to incite more violence and deny women access to abortion services.

"Just like bounty hunters of the Old West, the defendants want to stop the doctors by any means -- dead in their tracks," Maria Vullo, a lawyer for the plaintiffs, told jurors. "It's terrorism."

In testimony here on Monday, Dr. Warren Hern, of Boulder, Colo., said his life had been turned into a nightmare by the protesters, who have also put his face on their "Deadly Dozen" flier, which looks like a wanted poster and says he and other doctors are "Guilty of Crimes Against Humanity."

"It has made me feel a great sense of personal isolation," Dr. Hern told the jurors, explaining that he now wears a bulletproof vest, covers his windows, always sits with his back toward the wall and is leery of any contact with strangers.

But the roster of 14 defendants, which includes the American Coalition of Life Advocates, an umbrella group that has been described as too extreme by more mainstream anti-abortion groups, say most of the information they provide could be found in telephone directories.

Furthermore, they say, nothing in the "Nuremberg Files" advocates violence against the doctors or clinic workers, although the site does include links to other Web pages that defend killing abortion workers as legally justifiable homicide, and to a letter from prison from Paul J. Hill, who murdered a doctor in Pensacola, Fla., in 1994. In it, he describes "the joy I felt after shooting the abortionist, and still feel today."

In opening arguments last week, Chris Ferrara, a lawyer for the defendants, said the case was baseless.

"This is a case about the threat to kill or injure, which is simply not there," he said. "Opinions? Yes, sometimes harsh. But no violence."

Judge Robert E. Jones of Federal District Court, has turned down requests from the defendants to dismiss the case outright, in effect ruling that the Web site was not automatically protected free speech.

In some ways, Judge Jones seems to have signaled that the plaintiffs may have a valid case.

Quoting an appeals court ruling in another case, Judge Jones wrote that "alleged threats should be considered in light of their entire factual context, including the surrounding events and the reaction of the listeners."

Jonathan Entin, a law professor at Case Western Reserve University in Cleveland, said the case posed a difficult question of where to draw the line between protected free speech and illegal threats. The basic standard set by the Supreme Court is that speech is protected unless it is directed toward and likely

to produce "imminent lawless action," he said.

"The problem for the plaintiffs is, the Web site does not explicitly say, it is your moral duty to go out and kill these people or maim them or harm their family," Professor Entin said. "On the other hand, in the context in which this case is being litigated, we know there are people who are out there who are willing to go out and kill people who perform abortions. So the question is, to what extent will people take seriously the implicit message on this Web site, which is clearly that all right-thinking people should use whatever means necessary to stop people from performing abortions?"

Other experts said that if the Web site specifically advocated murder, it would almost certainly be found to be illegal, and, conversely, if it did not list doctors' names and addresses, it would almost certainly be considered protected speech. But the question before the jury, where in the middle does it belong?

"The issues in this case are very tricky," said David J. Fidanque, executive director of the American Civil Liberties Union of Oregon, which has filed a friend-of-the-court brief, arguing that the jury must focus not only on the fear the list may have spurred in the doctors, but also on the intent of the abortion opponents who contributed to it.

Though the case happens to represent one of the first major jury trials regarding free speech and threats on the Internet, several legal experts agreed that the core issue would be the same if the abortion opponents had published the list of doctors in a newspaper or flier.

In addition to seeking damages, the plaintiffs want an injunction from Judge Jones that could essentially force the abortion opponents to cease circulating the files. Among the named defendants are Michael Bray, a minister and author of a book called "A Time to Kill," which argues that killings of abortion doctors can be justifiable, and C. Roy McMillan, director of an anti-abortion group in Mississippi who has said that "it wouldn't bother me if every abortionist in the country today fell dead from a bullet."

In testimony this afternoon, another defendant, Andrew Burnett, publisher of Life Advocate Magazine of Portland, defended publishing the names and addresses of doctors on the Web site with the address www.christiangallery.com/atrocity. He said his own address had been published numerous times in The Oregonian, the daily newspaper in Portland, after he was arrested in abortion protests.

It was a jarring experience, Burnett said, but one that made him realize how committed he was to his cause. Of the lists, he said: "It's a legitimate way to have people reconsider what they do for a living."

Related Sites

These sites are not part of The New York Times on the Web, and The Times has no control over their content or availability.

- [The Nuremberg Files](#)
- [Freedom of Access to Clinic Entrances Act](#), from the Web site of the National Abortion Federation

[Text version]

Fact Sheet V

Promoting Reproductive Health Services for Women

"Certain choices are too personal for politics." **President Clinton and Vice President Gore**

The President is committed to ensuring that all women have access to reproductive health and family planning services, that all women are able to determine the number and spacing of their children, and that abortion is safe, legal and rare.

Reversed the Gag Rule

During his first week in office, President Clinton reversed the previous administration's attempts to prevent federally funded family planning clinics from providing full information on options for resolving unintended pregnancies. A notice of proposed rule making for permanent reversal has been issued.

Supports Reproductive Health and Family Planning

Under President Clinton, the annual budget for the Title X Family Planning Program has increased from \$173.4 million to \$193.3 million. This program is the primary federal mechanism for direct provision of reproductive health and family planning services to low-income women. It is estimated that subsidized family planning services, such as those provided through Title X, prevent more than 1 million unintended pregnancies and 500,000 abortions each year. In addition, the President reversed the ban, instituted in 1987 by the Reagan Administration, on privately funded abortion services in U.S. military hospitals; and repealed the Mexico City policy, established in 1984 banning U.S. funding support to international organizations that include abortion services in their reproductive health and family planning programs. In 1994, at the International Conference on Population and Development in Cairo, the United States agreed with more than 150 nations to promote reproductive health for all women and to address the threat to women's health from unsafe abortion.

Establishing Clinic Safety

President Clinton signed the Freedom of Access to Clinic Entrances Act to fight the escalating violence against women and doctors at women's health clinics.

Moved Forward with Reproductive Research

President Clinton ordered that the ban on mifepristone, a drug that terminates pregnancy without surgery, be revisited. Currently, the drug is undergoing clinical trials in the U.S.

Establishing Services for Victims of Rape and Incest

Under President Clinton, the Department of Health and Human Services implemented a congressionally ordered change to Medicaid to include abortion services for women whose pregnancies result from rape or incest, in addition to saving the life of the woman.

Office of Women's Initiatives and Outreach. Phone: 202 456-7300; Fax: 202 456-7311

[[Accomplishments Page](#)] [[Office Home Page](#)]

To comment on this service send mail to feedback@www.whitehouse.gov

[Read our Privacy Policy](#)

ISSUES IN BRIEF

The U.S. Family Planning Program Faces Challenges and Change

Although a woman's reproductive years span half of her lifetime, the typical American woman today wants only two children—a goal that is unrealistic without the use of contraception. In 1990, approximately 30.5 million women were considered to be at risk of unintended pregnancy (that is, they were sexually active and fertile, but were neither pregnant nor desiring pregnancy); over 15 million were low-income women and teenagers in need of subsidized contraceptive services. The nation's organized family planning program was established to address their needs.

One in three women who made a family planning visit in 1988 — the last year for which comprehensive data are available — reported going to a publicly funded family planning clinic. These clinics complement the private health care system in several ways: They serve Medicaid-eligible women when other providers refuse to accept them; provide subsidized services to low-income women who are not eligible for Medicaid; offer more extensive counseling on contraceptive methods; provide confidential services for teenagers and other women who may not be able to discuss reproductive health issues with their regular physicians; and offer contraceptive supplies at a lower cost than is usually available elsewhere.

This *Issues in Brief* describes the current structure and funding of the national family planning program, and the reproductive health and other preventive services it provides. It examines the impact of the program on the prevention of unintended pregnancies, births and abortions as well as on the reduction of low birth weight and infant mortality. It also discusses the central role that Title X of the Public Health Service Act, the historic core of the federal effort, plays in determining the shape and substance of the national family planning service delivery system.

Overview

History. Studies conducted during the 1960s showed that rates of unwanted childbearing among low-income women were at least twice as high as those among the more affluent—a phenomenon that could be traced in large part to inequalities in access to family planning services. By the end of the decade, a sizable, bipartisan consensus had emerged favoring government support of voluntary family planning programs as a means of expanding economic development, alleviating poverty, avoiding welfare dependency and improving the health of women and their families.

In the meantime, Congress had amended a number of federal laws to allow family planning services to be provided under certain existing programs. In 1965, as part of the so-called War on Poverty, federal funds were made available for family planning through the Office of Economic Opportunity. In 1967, Title IV-A of the Social Security Act was amended to require state welfare agencies to offer and provide family planning services to women receiving public assistance.

Then, in 1970, with broad bipartisan support, legislation establishing Title X of the Public Health Service Act was enacted and signed into law by President Richard Nixon, creating for the first time a comprehensive federal program devoted entirely to the provision of family planning services on a national basis. In his Message on Population Growth and the American Future, delivered the preceding year, President Nixon declared that "no American woman should be denied access to family planning assistance because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of family planning services...to all who want but cannot afford them."

Following the enactment of Title X, public expenditures for family planning grew rapidly in the early 1970s, as the clinics Title X helped to create became established across the country. By fiscal year 1983, \$340 million in public — federal and state — funds were being spent to provide family planning services to 5 million women at nearly 5200 separate services sites.

A combination of politics and fiscal pressures during the 1980s, however, forced family planning clinics to confront both budget cuts and new administrative restrictions. Congress has not formally reauthorized Title X since 1985. (The authorization process restates congressional support for a program and sets new funding ceilings.) Congressional appropriations have continued, but in the absence of an authorization, funding levels have inevitably been lower. Despite these struggles, publicly funded agencies have continued to provide services to increasing numbers of low- and moderate-income women and teenagers.

Sources of Funding for Family Planning Services. Public funds to provide family planning services come from diverse programs with different focuses (see Figure 1). The single largest source of funding is the federal-state Medicaid program (Title XIX of the Social Security Act). While the large majority of family planning agencies — 83% — derive at least some income from Medicaid reimbursements, few rely heavily on it. Medicaid does not fund family planning clinics or provide services directly. Instead, it is an insurance mechanism whereby federal and state governments reimburse physicians and other health care professionals for the medical services, including family planning, they have provided to eligible individuals.

Many poor women are not eligible for Medicaid coverage. To be eligible for Medicaid in most states, a woman must be single, have already had a child (or be pregnant) and meet income eligibility requirements that are often extremely low; nationwide, the average income eligibility ceiling is only about 50% of poverty, or approximately \$6000 a year for a family of three.

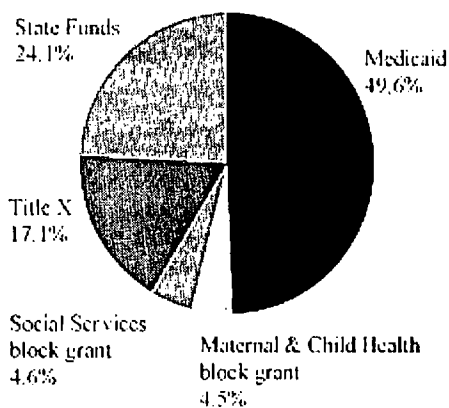
Poor and low-income women who do not qualify for Medicaid are dependent on clinics for family planning services. In contrast to Medicaid, Title X is a "categorical" grant program that supports the establishment and operation of clinics. It is the only federal program dedicated solely to funding family planning and related reproductive health care services.

Until 1985, Title X constituted the single largest source of public funds for family planning. In 1992, Title X still helped to support 76% of all family planning agencies, providing more than 20% of the budgets for over half of them. Thus, Title X continues to provide the underpinnings for the entire national family planning effort, enabling clinics established with its funds to take fuller advantage of Medicaid reimbursements and other funding sources.

Clinic services are also partially supported in most states with federal funds from the Maternal and Child Health and Social Services block grants (Titles V and XX of the Social Security Act), but with a few exceptions, family planning services are only a small component of these broad programs. In addition, state contributions to family planning services have grown considerably in recent years. In 1992, only five states did not use any of their own funds for family planning services; 69% of family planning agencies received some support from state appropriations.

Figure 1

Several public programs fund contraceptive services.



Percent Distribution, Fiscal Year 1992

Who Provides Publicly Funded Family Planning Services. In 1992, a total of 2610 agencies provided organized family planning services — 1430 health departments, 170 Planned Parenthood affiliates, 260 hospitals and 750 other types of agencies. Together, these agencies operated more than 5400 individual clinic sites. Of these, 52% were operated by state health departments, 15% by Planned Parenthood affiliates, 6% by hospitals and 27% by other agencies. Over the last 10 years, there has been a decrease in the proportion of clinics run by health departments and an increase in those operated by other agencies, such as independent family planning councils and community and migrant health centers.

The average number of clients served at each clinic site in 1992 was 1010. Planned Parenthood affiliates had both more clinic sites and larger caseloads, serving 4-8 times as many clients per agency as the other types of agencies. While Planned Parenthood affiliates reported an average of 2040 clients per clinic site, health department clinics, many of which are located in rural or sparsely populated areas, served an average of 760 clients annually.

Who Receives Services at Publicly Funded Family Planning Clinics. Data from the 1988 National Survey of Family Growth (NSFG), conducted periodically by the National Center for Health Statistics (NCHS) of the federal Centers for Disease Control and Prevention, show that the number of women who received their most recent family planning services at a publicly subsidized clinic rose from 6.1 million in 1982 to 7.1 million in 1988.

The trend toward greater use of family planning clinics is promising. Nonetheless, gaps in the provision of services remain. According to the 1988 NSFG, only 84% of women in households with incomes below 200% of poverty who were at risk of unintended pregnancy were using contraception. In contrast, 92% of women with higher incomes were using some form of contraception.

Another indicator of the continuing need is a 1995 NCHS report indicating that, overall, U.S. women have an average of 3.3 pregnancies over their lifetime, of which only 1.8 are wanted births. White women average 2.8 pregnancies, 1.6 of which are wanted births; black women average 5.1 pregnancies, of which 1.8 are wanted births; and Hispanic women average 4.7 pregnancies, of which 2.6 are wanted births.

Services Provided in Publicly Funded Family Planning Clinics. Besides providing contraceptive methods and related counseling, family planning clinics conduct many related tests and examinations (see Table 1). In fact, one study found that women who had obtained family planning services from a clinic during the previous 12 months were much more likely than women who had not to have received a pelvic exam and other essential health screening, regardless of the number of visits or source of payment for the visit.

The large majority of agencies also provide contraceptive and STD/HIV services to men and have special programs targeted at teenagers. Over half of the agencies conduct educational programs emphasizing the postponement of sexual activity, and three-quarters report that their counselors spend extra time with teenage clients, particularly to provide information and counseling on sexually transmitted diseases.

The Impact of Publicly Funded Family Planning Services

Publicly funded family planning services have been responsible for preventing large numbers of unintended pregnancies, abortions and births to low-income women, and especially to unmarried women and teens.

- Publicly subsidized family planning services prevent 1.2 million unintended pregnancies in the United States each year. By assisting women and families to prevent these unwanted pregnancies, the national family planning effort prevents 509,000 unintended births and 516,000 abortions each year. (The remainder would end in miscarriages.)
- Each year, publicly subsidized family planning services prevent 798,000 unintended pregnancies to unmarried women, thereby avoiding 344,000 out-of-wedlock births and 350,000 abortions.
- Each year in the United States, publicly funded family planning programs prevent 256,000 unintended pregnancies to teenagers; this avoids 110,000 teenage births and 112,000 abortions.
- Because many of the women receiving publicly funded family planning services would be eligible for other publicly subsidized care if they became pregnant, each public dollar spent to provide family planning services saves more than \$4 that would otherwise be spent to provide medical care, welfare benefits and other social services. Over \$3 is saved in medical costs alone.
- Publicly subsidized family planning programs help 281,000 women already enrolled in welfare avoid becoming pregnant each year; these efforts prevent 123,000 current welfare recipients from having an additional birth, and 122,000 abortions.
- In addition, publicly funded family planning programs prevent 80,000 pregnancies to women who are not currently enrolled in welfare but who would become welfare recipients if they gave birth; these efforts prevent 35,000 women from giving birth and becoming dependent on welfare each year, and prevent 35,000 abortions.

The data also show that public funding of family planning services prevents poor birth outcomes and improves women's overall health.

- Publicly funded family planning services increase the likelihood that pregnant women will obtain adequate prenatal care. Women who do not obtain sufficient prenatal care are about twice as likely as those who do to have a low-birth-weight baby, the leading cause of infant mortality in the United States. A study of 45,000 women who gave birth in North Carolina in 1989 and 1990 found that women who used family planning services in the two years before conception were more likely to begin prenatal care early and to receive adequate levels of care throughout their pregnancies. As a result of publicly funded family planning services provided between 1982 and 1988, 107,000 fewer women gave birth after having obtained inadequate prenatal care, according to a recent national study.
- That study also found that publicly funded family planning services provided between 1982 and 1988 prevented 20,000 low-birth-weight deliveries, 6500 infant deaths and 5500 neonatal deaths.
- A recently published analysis of Wisconsin's chlamydia prevention program, which includes family planning clinics as primary screening and treatment sites, found steep declines in the incidence and complications of the infection. Between 1987 and 1991, the incidence of new infections in women decreased by 27-50% in clinic populations. Between 1986 and 1991, hospitalization rates declined by 33% for pelvic inflammatory disease and by 20% for ectopic

pregnancy, both serious complications of chlamydia.

The benefits of publicly funded family planning services in the United States have long been recognized. Leading authorities in public health have agreed on its demonstrated effectiveness, not just in preventing pregnancy, but in improving the health of women and their children (see Table 2).

The Key Role of Title X

While no longer its largest funder, the Title X program continues to be the glue that holds the national family planning service delivery system together, largely determining both its structure — through its nationwide network of clinics — and the substance of the services that are provided to low- and moderate-income women and teenagers. In 1990, 5.3 million family planning clients were served by clinics administered by Title X-supported agencies.

Women who received services at Title X-supported clinics in 1990 were predominantly young, poor and had never had a child. Black women, who are more likely than others to be poor, were disproportionately represented among the clinic population. At the same time, when all clinic clients are taken into account, about 42% of the women using Title X-funded clinics were married; 69% were 20 years or older; and 63% were non-Hispanic whites.

Title X is administered by the Department of Health and Human Services (DHHS), which is responsible for allocating the funds appropriated annually by Congress among the 10 federal health regions. In each region, the health administrator receives applications from, and awards grants on a competitive basis to, public and nonprofit private agencies that provide contraceptive services as well as training, technical assistance and other support.

In 1991, there were a total of 85 primary Title X grantees, ranging from 1-4 per state. Fifty Title X grantees were state and local health departments; 12 were independent family planning councils; eight were Planned Parenthood affiliates; 15 grantees were other types of agencies.

Some Title X grantees operate family planning clinics directly, distributing grant funds among their various facilities. Others allocate the money to "delegate agencies," which administer the operation of individual clinics. Agencies providing family planning services, whether primary Title X grantees or their delegates, are diverse, community-based organizations. Recipients of Title X funds (in addition to those listed above) include: university medical centers, community action organizations, community health centers, nursing service organizations and a wide variety of nonprofit agencies, many of which are located in places where little or no other reproductive health care is available.

In 1991, 814 separate delegate agencies received Title X funds; Title X grantees and delegate agencies together administered approximately 4100 clinics that year. Clinics administered by Title X agencies were located in each state and in at least two-thirds of all counties. Over half of these clinics (58%) were administered by state and local health departments; 17% by Planned Parenthood affiliates; and the remaining 25% by hospitals, regional or local family planning councils, Indian nations and community organizations.

Title X also determines the substance of the services offered to individuals. Each grantee is ultimately responsible for ensuring that its delegate agencies and the clinics they run meet the program's requirements. The Title X statute requires that a grantee provide "a broad range of acceptable and effective methods and services." Both the Title X regulations and official program guidelines outline in greater detail protocols for the provision of family planning services that comport with nationally recognized medical standards, including a mandate to offer the full range of contraceptive methods and related counseling as well as to provide confidential services.

Any woman, regardless of age or whether she has had a child, may go to a Title X-funded clinic for family planning services. However, the amount each individual pays for the services she receives depends upon her income. If her income level is at or below 100% of the federal poverty level, by law she should receive completely subsidized services, including the contraceptive method she chooses. She will be charged on a sliding fee scale if her income is between 100-250% of poverty; and she will pay

full fees if her income is above 250%.

The Title X regulations and guidelines serve to ensure that eligible women receive subsidized services based appropriately on their incomes; low-income women tend to be charged higher fees in family planning clinics that do not receive Title X funds.

Title X and Politics. As the one federal program devoted to the provision of family planning services, Title X has also been the focal point for much of the political wrangling over reproductive health issues.

Title X and Teens. From the beginning, Title X has required that services be made available without regard to age or marital status. Consequently, Title X-supported clinics have always served adolescents confidentially and without regard for their ability to pay.

In 1981, Congress amended Title X to require that "to the extent practicable, [Title X-funded] entities... shall encourage family participation." Shortly thereafter, the Reagan administration proposed new regulations — better known as the "squeal rule" — requiring that all parents whose adolescents visited a family planning clinic be notified by registered mail.

Although over 40,000 letters of protest against the proposals were filed with DHHS from medical, health and civic groups, the regulations were finalized. Most comments made the argument that the regulations were trying to mandate open family communication which, although everyone agreed is desirable, is not always possible.

Two federal appeals court judges eventually barred the regulations' enforcement on constitutional grounds, and they were withdrawn without ever going into effect. Since that time, Congress has repeatedly rejected mandatory notification or consent for contraception, and Title X-supported clinics have maintained the policy of encouraging, but not requiring, parental involvement in minors' reproductive health decisions.

Title X and Abortion. Since its inception in 1970, the Title X statute has prohibited use of the program's funds for "abortion as a method of family planning." Repeated, congressionally requested investigations during the 1980s found that all Title X-funded clinics were operating in full compliance with the law. Of the more than 4000 Title X-funded clinics nationwide, approximately 80 provide abortions, all with other than Title X funds. More than half of these clinics are in hospitals.

However, problem pregnancy counseling, and requested referrals for medical and social services that are not offered under Title X, have been standard practice and are required by Title X guidelines. Even so, DHHS in 1988 promulgated new regulations (ordered the previous year by President Ronald Reagan) that, among other changes, would have prohibited doctors and other health professionals in Title X-funded clinics from providing any abortion-related information or referrals on the grounds that Title X funds were to be spent only on "pre-pregnancy related services."

The regulations generated more than 75,000 comments. Thirty-six state governments, a host of national health, medical and civic groups, and all 25 deans of the nation's schools of public health wrote in opposition, expressing concern that withholding this information would violate their medical ethics and standards; moreover, they pointed out, many of the women who depend on Title X services often have no other place to go for the information.

The legality of the so-called gag rule was upheld by the U.S. Supreme Court in 1991. Subsequently, however, it was roundly rejected in Congress. In 1992, both houses of Congress passed legislation both to reauthorize Title X and overturn the gag rule. The legislation was vetoed by President George Bush. The Senate overrode the veto by a vote of 73-26. The House vote was 266-148, only 10 votes short of the necessary two-thirds. A series of last-minute court orders blocked actual enforcement of the regulations, and they were ultimately withdrawn in 1993 at the direction of President Bill Clinton.

Looking Ahead

The proportion of public funding for family planning services from different sources has shifted greatly

over the last period. In 1992, Medicaid expended \$319 million — 50% of all public funding-for contraceptive services, up 81% from its 1981 level. In contrast, Title X, at \$110 million, accounted for only 17%. After adjustment for inflation, Title X expenditures for contraceptive services decreased by 72% between 1980 and 1992. Total public expenditures for contraceptive services dropped by 27% during that period.

At the same time, the cost of providing family planning services appears to have risen in several areas, such as contraceptive supplies and related laboratory expenses (between 1991 and 1992, the average price for oral contraceptives to publicly funded family planning clinics rose 42%) and STD and HIV counseling, testing and treatment. In 1993, among the agencies that do offer and provide them, these services constitute, on average, 26% of the agency's contraceptive services budget.

Furthermore, family planning clinics are being called upon to provide care to people with other health problems. In recent years, for example, the proportion of patients coming to family planning clinics in need of screening or treatment for STDs has increased dramatically. Forty percent of all medical visits to one Title X grantee in 1990 involved testing or treatment for STDs, compared with only 10% of visits in 1980. Some providers cannot absorb these additional costs; they are forced to forgo testing and to treat patients based on their examinations alone.

Moreover, since these clients frequently have no other source of care, Title X-assisted clinics must address their health needs more comprehensively, by offering such corollary health services as screening for diabetes or cholesterol levels, prenatal care, programs on smoking cessation and counseling on substance abuse. All of these efforts consume additional resources, in both staff time and money, usually without extra funding.

Despite evidence that, in sheer numbers, family planning clinics served more people in 1991 than in 1981, many family planning providers have been forced to cut or change the nature of their services, a development likely to have an increasingly serious impact on the accessibility of services to their clients. Some providers report that new clients have to wait longer for an appointment, or that they have been compelled to require higher fees for their services or to take a higher proportion of clients who can afford to pay. For poor women seeking to prevent an unintended pregnancy, these changes could present insurmountable obstacles.

According to a report recently issued by the Institute of Medicine, during the 1980s — when real (inflation adjusted) spending on publicly subsidized family planning services dropped and Title X went unauthorized — unintended pregnancy in the United States began to increase, reversing the downward trend of previous years. Ironically, this situation has led some critics to argue that Title X should be defunded entirely on the grounds that it has failed to solve our national problems of unintended teenage pregnancy and out-of-wedlock births. Some critics go so far as to argue that contraception itself is a failure, and that the provision of family planning services has made these problems worse.

Incontrovertibly, contraception works: While no contraceptive, or contraceptive user, is perfect, the fact remains that the 10% of American women at risk of unintended pregnancy who do not use contraception at all account for 53% of all unintended pregnancies. Public support for family planning works, too. Even its strongest supporters readily admit that the national family planning program will never, by itself, reduce the nation's unintended pregnancy rate to zero. At the same time, they point out that the availability of affordable, voluntary family planning services remains the only major programmatic intervention that — in a cost-effective manner — has been demonstrated to reduce unintended pregnancy, avert the need for abortion and improve birth outcomes and the overall reproductive health of the women in the United States.

Table 1

Family planning agencies provide a broad range of services ...

In the course of a contraceptive visit . . . And beyond

Percentage of family planning agencies routinely providing various services in the course of a woman's contraceptive visit:

Pelvic exam 98
 Breast exam
 (including self-breast exam) 98
 Blood pressure measurement 98
 Pap smear 98
 Anemia screening 90
 Gonorrhea screening 70
 Cardiovascular problems 59
 Syphilis screening 49
 Chlamydia screening 46
 Diabetes 45
 Urinary tract infection screening 34
 Pregnancy tests 30
 Herpes screening 10

Percentage of family planning agencies offering various reproductive health and other services beyond contraception:

Female Clients

HIV testing 82
 Well-baby care 71
 Postpartum care 70
 WIC program 69
 Prenatal care 66
 Infertility counseling 57
 Social services 49
 Sports/work physicals 42
 Primary health care 40
 Colposcopy 32
 Genetic counseling 31
 Cryotherapy 30
 Midlife health program 29
 Mental health services 21
 Mammography 15
 Infertility treatment 11
 Abortion 8
 Day care 7

Male Clients

Condom distribution 93
 STD treatment 86
 STD screening 84
 HIV testing 79
 Sports/work physicals 36
 Social services 35
 Primary health care 33
 Infertility counseling 32
 Testicular cancer screening 30
 Mental health services 21
 Infertility treatment 5

Table 2

The Importance of Family Planning Is Widely Recognized

Institute of Medicine Committee to Study the Prevention of Low Birthweight: "[I]t is important to stress that both young teenage status and poverty are major risk factors for low birthweight and that Title X is specifically targeted at low-income women, including adolescents. As such, the program should be regarded as an important part of public efforts to prevent low birthweight." *Preventing Low Birthweight*; 1985

National Commission to Prevent Infant Mortality: "Infant mortality could be reduced by an estimated 10 percent if all women not desiring pregnancy used contraception." *Troubling Trends: The Health of America's Next Generation*; 1990

March of Dimes Birth Defects Foundation: "Family planning counseling and services are essential elements of preconception and interconception care. [We] affirm that family planning should be an integral part of perinatal care to improve pregnancy outcome." *Toward Improving the Outcome of Pregnancy: The 90s and Beyond*; 1993

Institute of Medicine Panel on Adolescent Pregnancy and Childbearing: "The availability of contraceptive services to adolescents depends heavily on public support, in particular funding through Title X, Medicaid and other federal and state maternal and child health programs. In light of the demonstrated effectiveness of contraceptive use in reducing early unintended pregnancy, continued support of these programs is essential." *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*; 1987

Institute of Medicine Committee on Unintended Pregnancy: "Financial barriers [to contraception] should be reduced by increasing the proportion of all health insurance policies that cover contraceptive services and supplies,...extending Medicaid coverage for all postpartum women...and continuing to provide public funding...for comprehensive contraceptive services, especially for those low-income women and adolescents who face major financial barriers in securing such care. This last point speaks to the major role that public financing programs, such as Title X and Medicaid, have played in helping millions of people secure contraception....It is essential that such public investment be maintained." *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*; 1995

© 1996 by The Alan Guttmacher Institute

Major Sources

D. Daley and R.B. Gold, "Public Funding for Contraceptive, Sterilization and Abortion Services, Fiscal Year 1992," *Family Planning Perspectives*, 25:244, 1993.

J.D. Forrest, "Title X Family Planning Clinic Network: Final Analysis," The Alan Guttmacher Institute, New York, 1992.

J.D. Forrest and S. Singh, "Public Sector Savings Resulting from Expenditures for Contraceptive Services," *Family Planning Perspectives*, 22:6, 1990, and special tabulations using data from the 1982 National Survey of Family Growth.

J.D. Forrest and S. Singh, "The Sexual and Reproductive Behavior of American Women, 1982-1988," *Family Planning Perspectives*, 22:206, 1990.

S.K. Henshaw and A. Torres, "Family Planning Agencies: Services, Policies and Funding," *Family Planning Perspectives*, 26:52, 1994.

S.D. Hillis, et al., "The Impact of a Comprehensive Chlamydia Prevention Program in Wisconsin," *Family Planning Perspectives*, 27:108, 1995.

D.J. Jamieson and P.A. Buescher, "The Effect of Family Planning Participation on Prenatal Care Use and Low Birth Weight," *Family Planning Perspectives*, 24:214, 1992.

Issues in Brief

Support for Family Planning Improves Women's Lives

Like the use of the telephone, the practice of family planning is so widespread and so routine in the United States that we almost take for granted its far-reaching benefits. Because American women using effective modern contraceptives can decide when to have their children and are able to bear only the number they want, they can plan their educational careers and their work, family and personal lives with an assurance that would have been impossible for their grandmothers.

In the developing world, family planning can bring these same benefits to women and do even more: By helping women prevent ill-timed or unwanted pregnancies, it can also save their lives and protect their health.

And for couples everywhere, the use of the condom and some other contraceptives helps protect against the spread of sexually transmitted diseases (STDs), which threaten the well-being and sometimes the survival of men and women worldwide.

Despite the many ways in which family planning benefits women and their families throughout the world, the support of developed countries—an essential component of financing and improving access to these necessary services in developing countries—is often under threat of being reduced or even eliminated. This *Issues in Brief* examines the advantages for women and society that family planning services bring, and that would be compromised if these services were curtailed.

High-Risk Childbearing

Every year, 585,000 women—99% of them in developing regions—die from causes related to pregnancy. These causes include the direct health consequences of high-risk pregnancies, unsafe abortions and difficult deliveries, as well as problems that arise soon after delivery. Maternal mortality ratios (representing the number of women who die every year from pregnancy-related causes per 100,000 live births) in Africa, Asia and Latin America are 10–100 times the ratios in the industrialized world (Table 1, column 1). UNICEF points out that "no public health problem shows greater disparity between rich and poor countries than maternal mortality."

table 1
Maternal Health Risks

Country and survey year	100,000 live births	Maternal deaths per births	% of women 20–24 with at least 1 birth by age 18	% of women 30–34 with at least 4 live births
Sub-Saharan Africa				
Botswana, 1988		250	26	53

Burkina Faso, 1992–1993	930	32	80
Burundi, 1987	1,300	8	69
Cameroon, 1991	550	46	68
Central Afr. Rep., 1994–1995	700	38	58
Côte d'Ivoire, 1994	810	44	69
Ghana, 1993	740	25	59
Kenya, 1993	650	28	68
Liberia, 1986	560	44	59
Madagascar, 1992	490	31	67
Malawi, 1992	560	38	74
Mali, 1995–1996	1,200	46	75
Namibia, 1992	370	18	45
Niger, 1992	1,200	53	81
Nigeria, 1990	1,000	35	68
Rwanda, 1992	1,300	8	67
Senegal, 1992–1993	1,200	34	70
Tanzania, 1996	770	25	64
Togo, 1988	640	30	74
Uganda, 1996	1,200	39	77
Zambia, 1992	940	34	72
Zimbabwe, 1994	570	23	58
North Africa & Middle East			
Egypt, 1995	170	15	46
Morocco, 1992	610	7	46
Sudan, 1989–1990	660	17	59
Tunisia, 1988	170	3	56
Asia			
Bangladesh, 1993–1994	850	47	60
India, 1992–1993	570	28	50
Indonesia, 1994	650	16	31
Pakistan, 1990–1991	340	17	62
Philippines, 1993	280	8	40
Sri Lanka, 1987	140	5	28
Thailand, 1987	200	9	18
Turkey, 1993	180	11	30
Latin America & Caribbean			
Bolivia, 1993–1994	650	19	48
Brazil, 1996	220	16	18
Colombia, 1995	100	18	21
Dominican Republic, 1996	110	22	30
Ecuador, 1987	150	16	44
El Salvador, 1985	300	u	47

Guatemala, 1995	200	26	56
Mexico, 1987	110	19	45
Paraguay, 1990	160	16	37
Peru, 1991–1992	280	12	36
Trinidad & Tobago, 1987	90	13	30
Developed Countries			
France, 1994	13*	2	6
Japan, 1992	16*	1	2
United States, 1995	13*	9	7

*Adjusted for underreporting; ratio based on national vital statistics would be lower. *Note:* u=unavailable. *Sources:* **Mortality**—United Nations Development Programme, *Human Development Report, 1996*, New York: Oxford University Press, 1996, pp. 154–155; **births by age 18**—The Alan Guttmacher Institute (AGI), *Into a New World: Young Women's Sexual and Reproductive Lives*, New York: AGI, 1998, Appendix Table 4, col. 3, p. 52; **at least four births**—for developing countries, special analysis of data from Demographic and Health Surveys; for France, Lavertu J, *Fécondité et calendrier de constitution des familles: Enquête Famille de 1990*, INSEE Résultats 579, Paris: Institut National de la Statistique et des Etudes Economiques, 1997; for Japan, special tabulations of the 1992 National Fertility Survey; for the United States, special tabulations of the 1995 National Survey of Family Growth.

The major causes of maternal deaths are similar throughout the developing world, although the relative importance of each varies from one region to another. Overall, the leading causes are hemorrhage, or excessive bleeding (accounting for 24% of all maternal deaths); preexisting conditions that are complicated by pregnancy (20%); sepsis, or acute infection with fever (15%); complications of unsafe induced abortions (13%); eclampsia (12%); obstructed or prolonged labor (8%); and ectopic pregnancy and other conditions (8%).

According to the World Health Organization (WHO), for every maternal death that occurs worldwide, an estimated 30 additional women suffer pregnancy-related health problems that can be permanently debilitating. Each year, approximately 17 million women are affected with such conditions as uterine rupture, uterine prolapse (a displacement from the normal position), hemorrhage, vaginal damage, urinary incontinence, obstetric fistula (a muscle tear that allows urine to seep into the vagina) and pelvic inflammatory disease (which can lead to permanent sterility).

The vast majority of pregnancy-related complications that lead to health problems or death can be prevented in the first place, or successfully treated, if the right medical care is available. High-quality and accessible prenatal and maternity care services are the major reasons for the low levels of death and disability associated with pregnancy and childbearing in developed countries. In the developing world, unfortunately, services are often of poor quality, and coverage is inadequate or, in some areas, completely lacking.

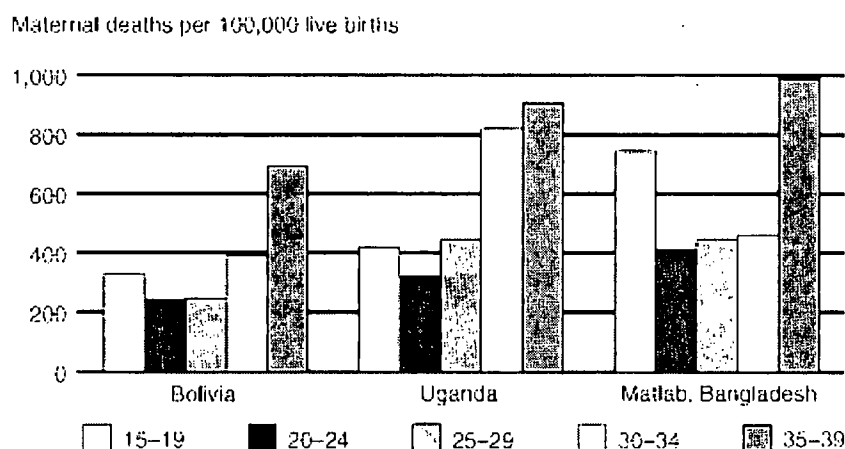
Most women in developing countries still give birth at home, helped by a close family member or traditional birth attendant. Fewer than one in five women obtain assistance from a trained doctor or nurse when they give birth in Burundi, Niger, Yemen, Bangladesh and Pakistan; fewer than one-half receive professional medical assistance in Ghana, Kenya, Mali, Nigeria, Senegal, Uganda, Egypt, Morocco, India, Indonesia, Bolivia and Guatemala. Even when women deliver in a hospital, the equipment, supplies, drugs, or operating rooms and trained staff needed to do cesarean sections or manage emergencies may be lacking.

Who Is Most at Risk?

Young Women and Mothers over 35. The risks of dying during pregnancy or childbirth are higher for women younger than 20 and for women 35 and older than for other women (Chart A). Teenagers' physical growth is usually incomplete, and their bodies have not developed sufficiently for pregnancy and delivery to proceed easily. Chronic malnutrition—which is widespread in poor countries—exacerbates the problem of insufficient or stunted physical growth. In addition, very young women are even less likely than older women to obtain prenatal or delivery care—especially if they are unmarried.

chart a
Maternal Mortality

Both younger and older women face an elevated risk of dying during pregnancy or childbirth.



Sources: **Bolivia and Uganda**—Demographic and Health Surveys, 1993–1994 and 1996, respectively. **Bangladesh**—Koenig MA et al., Maternal mortality in Matlab, Bangladesh, 1976–1985, *Studies in Family Planning*, 1988, 19(2):69–80.

The younger the adolescent, the greater her maternal risk. In Jamaica and Nigeria, for example, women younger than 15 are 4–8 times as likely to die during pregnancy or delivery as are women aged 15–19. Although pregnancies at such early ages are common only in certain parts of the world, many women in all developing regions have their first child by age 18. In most of Sub-Saharan Africa, in Bangladesh and India, and in one of the poorest countries of Latin America—Guatemala—25–53% of women aged 20–24 had their first child before their 18th birthday (Table 1, [column 2](#)).

Maternal risk is elevated for older women in part because they frequently have had many births and have spaced births closely, risk factors discussed next.

Women with Many Children. Women who have had five or more children are about 2–3 times as likely to die during pregnancy or childbirth as are those with two or three children. Millions of women worldwide face this increased risk, given the large family sizes that are typical in many regions. For example, the proportion of women aged 30–34 who have already had four or more children is especially high—ranging from about 40% to 80%—throughout Africa and the Middle East and in some Asian countries (Table 1, [column 3](#)).

For women who become pregnant many times, the problem is not just that they are more often exposed to obstetric risk, but also that frequent pregnancy, childbirth and

breastfeeding deplete women's physical resources and stamina. This makes it more difficult for them to fight the effects of heavy blood loss, infection or trauma during childbirth and after a delivery or abortion.

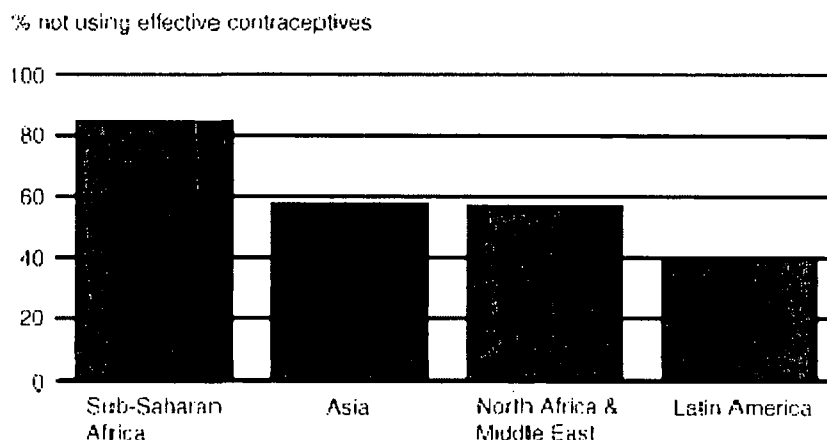
Women with Closely Spaced Pregnancies. Maternal depletion also threatens safe childbearing among women who become pregnant again before they have had time to recover fully from an earlier birth. This problem, too, is common: Births spaced less than two years apart account for one in 10 of all births in developing countries as varied as Liberia, Malawi, Senegal, Morocco, Sudan, India, Turkey, Bolivia, Brazil and Peru. They represent more than one in seven births in Madagascar, Niger, Tunisia, Pakistan, the Dominican Republic, and Trinidad and Tobago.

Even in developed countries, a short interval between pregnancies is a risk factor, moderately raising levels of preterm delivery and intrauterine growth retardation.

Women with Unwanted Pregnancies. Every year, an estimated 190 million women throughout the world become pregnant, and many of them did not want to conceive. In Latin America, an average of 40% of women of reproductive age who do not want to become pregnant for at least a couple of years, or ever again, are not using an effective contraceptive method; in Sub-Saharan Africa, the proportion is 85% (Chart B). Such women often cannot avoid having an unplanned pregnancy. It should come as no surprise, therefore, that many women seek abortions, and each year approximately 20 million of them obtain abortions under conditions in which the procedure is illegal and therefore unsafe, greatly increasing their risk of maternal morbidity and mortality.

chart b
Nonuse of Effective Methods

Many women who do not want to become pregnant are not using effective contraceptive methods.



Note: Percentages are regional averages, based on women aged 15–44, weighted by population size. *Source:* Special analysis of data from Demographic and Health Surveys.

Lowering Maternal Risk

Family planning reduces the total number of pregnancies among women of childbearing age. For this reason alone, it can substantially lower levels of maternal mortality and morbidity. Furthermore, by helping women—especially those at highest risk—to space and limit their pregnancies, it can do more.

Even in parts of the world where women customarily marry as adolescents, contraceptive use to postpone pregnancy until after the teenage years would reduce maternal mortality associated with very early childbearing. What is more, women who wait to begin childbearing are less likely to have a large number of children than those who first give birth at a young age. And those who start practicing family planning early in their married lives are less likely than those who delay to have closely spaced births.

Finally, the prevention of unwanted pregnancies would mean a reduction in the more than 76,000 maternal deaths that result from unsafe abortions each year in developing countries—almost 15% of the total number of maternal deaths in these countries. The associated reduction in maternal morbidity might be even more impressive, given that 30 women suffer pregnancy-related disabilities for every woman who dies.

Offering STD Protection

Millions of men and women throughout the world suffer from STDs. In addition to the discomfort and embarrassment these diseases cause, some STDs greatly increase the likelihood of HIV transmission during sexual intercourse, and can have other serious health consequences.

Worldwide, the most common bacterial STDs (which are curable) are gonorrhea, trichomoniasis, candidiasis, syphilis, genital ulcers resulting from chancroid, and chlamydia. The most common viral STDs (which are incurable, though not necessarily untreatable) are hepatitis, herpes, genital warts and HIV.

An estimated 333 million new infections with curable STDs—or 11 for every 100 adults—occur worldwide every year (Table 2). In absolute numbers, South and Southeast Asia is the worst affected region. But an individual's risk of contracting one of these STDs is highest (one in four) in Sub-Saharan Africa.

table 2
Curable STDs

Region	New yearly infections (millions)	Yearly rate per 100 adults
World	333	11
South & Southeast Asia	150	18
Sub-Saharan Africa	65	25
Latin America & Caribbean	36	15
East Asia & Pacific	23	3
Eastern Europe & Central Asia	18	11
Western Europe	16	8
North America	14	9
North Africa & Middle East	10	6
Australasia	1	9

Source: World Health Organization (WHO), *An Overview of Selected Curable Sexually Transmitted Diseases*, Geneva: WHO, 1995.

According to the WHO's most recent global estimate, every year, 5.9 million individuals become infected with HIV—an increase over previous estimates. The vast majority of new infections are in Sub-Saharan Africa (four million) and South and Southeast Asia (1.3 million)—the regions with the highest STD rates.

Next to complete sexual abstinence—an impractical goal for most people—the most effective protection against the spread of both bacterial and viral STDs is the latex condom. If used correctly, this method—while offering contraceptive protection—can dramatically reduce the likelihood that an infected man or woman will pass the disease to a sexual partner.

The female condom, the sponge, and the diaphragm or cervical cap used with a spermicide also have the potential to reduce STD transmission. What is more, by reducing genital wart infections, all barrier and spermicidal methods offer some protection against the development of cervical cancer. However, while the effects of spermicidal methods on reducing the risk of certain STDs is clear, the evidence on their effects on HIV transmission remains inconclusive.

Other modern contraceptive methods also confer some health protection. The pill helps reduce a woman's chance of developing endometrial or ovarian cancer, and the longer it is used, the lower the risk. What is more, among women with chlamydia and gonorrhea, hormonal contraceptives reduce the chance of pelvic infection, ectopic pregnancy and infertility.

Family planning and reproductive health service providers help improve and even save the lives of both women and men by educating couples about healthy sexual behavior, the benefits of condom use, and STD prevention and treatment, and by linking clients and their families to other preventive and curative health services.

Empowering Women

Access to family planning services is affirmed as a universal human right in many United Nations documents. More concretely, it contributes to the advancement of women and to the fuller development of society.

Women who are able to defer childbearing until their 20s improve their chances of having time to obtain adequate schooling, develop work skills and acquire broad life experience. And women who bear only the number of children they want have increased opportunity and time to be in the labor market and to build competence and achieve personal fulfillment. Such participation in society enhances women's sense of self-worth and improves the well-being of their families.

The relationship between women's empowerment and family planning is often mutually reinforcing: As women obtain more education and gain the skills and confidence they need to go out into the world and earn money of their own, their desire and ability to plan their childbearing also grows. Moreover, women who practice family planning are more likely than those who do not to seek other types of health care services for their children and themselves.

Taking Effective Action

Helping women avoid high-risk and unwanted pregnancies remains an urgent health priority—especially where access to prenatal and emergency obstetric care is inadequate, and nutrition and overall health are poor. And the use of the latex condom is the only effective way known to prevent the transmission of STDs—including HIV—among sexually active couples. What is more, in many parts of the developing world, a woman's first referral to other important health services is often made through her initial contacts with a family planning provider, be it a clinic, community-based distributor or outreach worker.

In many developing countries, it will be difficult—and will take decades—to improve overall health and living conditions, and to change deeply entrenched, discriminatory cultural practices and attitudes that harm women and jeopardize their health. While these broad goals should continue to be pursued, the more widespread provision of family planning services is an achievable (and highly cost-effective) way of improving both women's lives and the well-being of couples and families everywhere.

Sources of Data

The Alan Guttmacher Institute (AGI), *Hopes and Realities: Closing the Gap Between Women's Aspirations and Their Reproductive Experiences*, New York: AGI, 1995.

AGI, Preventing Pregnancy, *Protecting Health: A New Look at Birth Control Choices in the United States*, New York: AGI, 1991.

National Academy of Sciences, *Contraception and Reproduction: Health Consequences for Women and Children in the Developing World*, Washington, DC: National Academy Press, 1989.

Safe Motherhood Initiative, Causes of maternal deaths, , accessed Apr. 9, 1998.

United Nations Children's Fund (UNICEF), *The Progress of Nations*, 1996, New York: UNICEF, 1996.

World Health Organization (WHO), *Abortion: A Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion*, Geneva: WHO, 1994.

Credits

Akinrinola Bankole and Susheela Singh oversaw data compilation and analyses used for this publication, which was written by Deirdre Wulf. This *Issues in Brief* was made possible by support from the Andrew W. Mellon Foundation and the Rockefeller Foundation.

© copyright 1998, The Alan Guttmacher Institute.

[About AGI](#) | [Home](#) | [Search](#) | [What's New](#)
[Feedback](#) | [Keep Me Informed](#) | [Purchase](#) | [Support](#)

CONTACT:

Susan Tew/Beth Frederick
212/248-1111 (phone)
212/248-1952 (fax)
info@agi-usa.org

NEGLECTING YOUNG WOMEN'S REPRODUCTIVE HEALTH NEEDS THREATENS WORLDWIDE PROGRESS

Education, Contraception and Health Services Are Lacking

Adolescent women throughout the world need improved access to education, information about sexuality and reproduction, and a full range of reproductive health services, regardless of their marital or childbearing status. Needed services include those for contraception, sexually transmitted diseases (STD) and pregnant and/or parenting women. The 260 million 15-to-19-year-old women throughout the world are the next generation of mothers, workers and leaders. For young women to fulfill these roles to the best of their abilities, their sexual experience must be acknowledged and their educational and reproductive health needs must be met, according to **a new report by The Alan Guttmacher Institute, *Into A New World: Young Women's Sexual and Reproductive Lives***. Consider:

- Up to 60% of adolescent births throughout the world are unplanned, and about one in nine adolescents lack the contraceptive protection they need to prevent an unwanted pregnancy;
- one-third to two-thirds of young women obtain less than seven years of schooling in most developing countries; and,
- over 300 million cases of curable STDs occur worldwide each year, with young women especially susceptible to these diseases and bearing the most serious consequences.

"The lives of the young women depicted in this report are to some extent already determined," comments the president of The Alan Guttmacher Institute, Jeannie I. Rosoff. "Most are no longer in school, many are married or mothers, and some have been exploited sexually. But the same fate does not need to befall their younger sisters, or the next generation of adolescents. Parents, communities and governments must recognize how quickly the world is changing, and how imperative it is to direct attention to improving the situation of girls and young women. Indifference, wishful thinking and denial will not prepare their children, particularly their girls, to take their rightful place in a modernizing world."

Today, there are more than one billion young men and women between the ages of 10 and 19 around the world—the largest generation of youth in history. The 541 million young women—281 million of whom are aged 10-14—are a formidable demographic force, and their pattern of childbearing has major implications for the size of the world's population.

The new report brings together comparable information from 53 developing and developed countries, covering five major regions—Asia, Latin America and the Caribbean, North Africa and the Middle East, Sub-Saharan Africa and Western Europe, the United States and Japan—representing about 75% of the world's total population. It demonstrates the diversity and commonality of young women's experiences in the education they receive; their patterns of marriage, sexual activity and childbearing; their contraceptive and reproductive health care needs; and the risks they confront as they deal with changing values around sexuality. Further, it identifies the vast individual and societal benefits to be realized in meeting these needs.

EDUCATION: *Girls continue to be disproportionately disadvantaged in their access to education, an increasingly important prerequisite for the modern world.* While more young women today get a basic education (seven or more years of schooling) than did their mothers, girls in many developing countries get less schooling than boys and those in rural areas get less than girls in urban communities. In some cultures, the benefits of equal, higher education for girls clash with traditional patterns of early marriage and motherhood, or compete with economic realities, such as needing them to work in the home.

- Throughout Latin America and in many African and Asian nations, the proportion of young women in rural areas who have seven or more years of education is one-half to one-third the proportion in urban areas and in some countries, educational disparities are even larger.
- Gender disparity in secondary education is common throughout North Africa, the Middle East and Sub-Saharan Africa, where half of the countries studied showed six or fewer young women attend secondary school for every 10 young men enrolled.

SEXUAL ACTIVITY AND MARRIAGE. *In a large part of the world, the majority of women have their first sexual experience as adolescents.*

- Eight in 10 young women in Sub-Saharan Africa have had first intercourse before age 20; four in 10 before marriage.
- Eight in 10 young women in five developed countries have had intercourse as adolescents; seven in 10 before marriage.
- Six in 10 young women in Latin America and the Caribbean have done so in adolescence; three in 10 before marriage.

A woman who marries as an adolescent may lack the education, the experience and the skills that a slightly older woman is likely to bring to her marriage and family. Levels of early union and marriage have typically declined from those a generation ago. Still, adolescent marriage remains common among women in some regions.

- In many countries of Sub-Saharan Africa, 40-60% of adolescent women marry by age 18, and in others, such as in Mali and Niger, more than three-quarters do so.
- In India and Bangladesh, 50-70% marry by age 18.
- Some 25-40% of young women form their first union by age 18 in most of Latin America and the Caribbean.
- In contrast, 10-30% of young women marry by age 18 in some North African and some Southeast Asian countries, and only 5% do so in China.

CONTRACEPTIVE USE. *Contraceptive use by married and unmarried adolescents is more common than in the past, but in most of the world, use is still low.* The majority of young women have heard about modern contraceptive methods, but they may lack access to these methods, lack information on their proper use or do not use one because they are expected to have a child soon after marriage. Many adolescents who want to practice modern contraception have little skill in negotiating contraceptive use with their sexual partners; have limited transportation and meager financial resources; and encounter services that are geared to older, adult women and that do not offer privacy and confidentiality to adolescents, especially if unmarried.

- About three to five in 10 married adolescents practice contraception in many countries in Latin America and the Caribbean.
- About seven in 10 adolescents practice contraception in developed countries such as the United States.
- Sexually active unmarried adolescents are more likely than married ones to practice contraception throughout Sub-Saharan Africa, and in the few countries of Latin America and the Caribbean for which information is available, they are as likely as their married counterparts to do so.
- Worldwide, 11% of adolescent women—or 29 million, both married and unmarried—are sexually active and do not want to have a child soon but lack the necessary protection to prevent an unwanted pregnancy, either because they are not using a contraceptive method or because they are using less effective methods.
- In Sub-Saharan Africa, North Africa and the Middle East, rates of contraceptive use are low among married young women—20-30% in Morocco, Namibia and Zimbabwe, and under 10% in many others.
- Nonetheless, in some countries in Sub-Saharan Africa, such as Ghana and Kenya, current levels are 3-5 times what they were 20 years ago.
- In Asia, contraceptive use among married adolescents is very low in India and Pakistan (less than 5%) but more common in Indonesia and Thailand (36% and 43%, respectively), where it has increased strikingly since the 1970s.

Possible

ADOLESCENT PREGNANCY AND CHILDBEARING. *Adolescent childbearing is declining in countries where it had been common, as access to education increases and as the social, health and economic advantages of delaying births become more widely recognized.* Still, in many parts of the world, women often have their first child before age 18, rural adolescents and those with little education are unlikely to delay childbearing, adolescent births are often unplanned, and very young adolescents experience health risks and problematic pregnancy outcomes more often than older adolescents or adult women.

- Each year, adolescents have more than 14 million births worldwide.
- The proportion of women who have their first child by age 18 ranges from 1% in Japan to 53% in Niger.
- One-fourth to one-half of all adolescent births in Latin America and the Caribbean are unplanned, as are 15-30% of those in North Africa and the Middle East and 40-60% in such Asian and Sub-Saharan countries as the Philippines, Ghana, Kenya, and Zimbabwe.
- In the United States, seven in 10 births to adolescents are unplanned.
- Across Sub-Saharan Africa, Asia, Latin America and the Caribbean, a woman who has her first child before age 18 will have an average of seven children by the time she has completed her family; however, if she waits until her early 20s, her family will average five or six children, and if she postpones childbearing until her late 20s, she will typically have three or four children.
- If today's young women were to have their first child two-and-one-half years later than is currently the average age at first birth, population growth by the year 2100 will be 10% lower than if no change occurs; if they postpone that first birth by five years, it will be 20% lower—a decrease of 1.2 billion people.

REPRODUCTIVE HEALTH SERVICES FOR YOUNG WOMEN. *Sexually active adolescents face a variety of risks, including exposure to unwanted pregnancy, unsafe abortion and sexually transmitted diseases, that threaten their sexual and reproductive health and may impair their future fertility.*

- In India, Egypt, Indonesia and the Philippines, 25% or less of adolescent mothers give birth in a hospital or health facility; in Bangladesh, the proportion is 3%.
- Young adolescents are more likely to experience premature labor, spontaneous abortion and stillbirths than are older women, and they are up to four times as likely as women older than 20 to die from pregnancy-related causes.
- The infants of very young mothers face a risk of death during the first year that is 30% higher than the risk faced by infants of adult mothers.
- Adolescent mothers need health care for themselves and their infants and social support to enable their continued schooling, for example.

Faced with an unwanted pregnancy, some young women seek clandestine abortions, which endangers their health—or their very life. Abortion-related infections are especially common in countries where abortion is legally restricted, and adolescents frequently comprise a large proportion of patients who are hospitalized for complications from such procedures.

- The rate of adolescent abortion varies from country to country, ranging from very low levels in Germany (3 abortions per 1,000 women aged 15-19) and Japan (6 per 1,000), to moderately high levels in Brazil (32 per 1,000) and the United States (36 per 1,000).
- In Malawi, Uganda and Zambia, adolescent women represent one-fourth to one-third of patients suffering from complications of unsafe abortions, and in Kenya and Nigeria, more than half of women with the most severe abortion complications are adolescents.
- In Latin America and the Caribbean, about one-tenth of all women hospitalized after an abortion are younger than 20, and adolescents comprise one-third of the women with the most serious infections.

Sexually transmitted diseases, including HIV/AIDS, are a major cause of reproductive tract infections that threaten the future fertility and lives of young women and affect the health of their newborns, potentially resulting in low birth weight, prematurity and increased susceptibility to infections and diseases.

- Each year, 8-9% of people aged 15-49 are estimated to be infected with a curable STD in North America and western Europe, and rates as much as three times as high in some regions of the developing world.
- Half of HIV infections occur among people younger than 25, and recent estimates show that some 7,000 15-24-year-olds are infected with HIV each day.
- In Botswana, Nigeria and Rwanda, 20% or more of pregnant adolescent women test positive for HIV.
- In some regions of the world, the AIDS epidemic has reached shockingly high proportions among adolescents; nearly 13% of all urban youth aged 14-20 in Rwanda are infected with HIV.

Sexual relationships that result from force, coercion and abuse, and some cultural practices such as female genital mutilation, endanger the reproductive health of young people. Young women who are sexually abused are at risk of infection and unwanted pregnancy, and they may also suffer other trauma and psychological distress.

- In the United States, four in 10 women who have sex before age 15 report their first sexual experience as involuntary; in Santiago, Chile, nearly 3% of young women who have sex before age 18 say that rape is their first experience of sexual intercourse.
- Female genital mutilation, one cultural practice that endangers reproductive health, often results in lifelong pain during intercourse, recurrent pelvic infections and prolonged, obstructed labor and delivery.
- Sexual exploitation of children and adolescents for commercial gain is a multi-billion dollar illegal industry, according to UNICEF.

"Society must prepare young people to face a world far different from that of their parents," notes *Into A New World* in summarizing the challenges revealed in the new report. "They need the guidance and support of their family and their community, and the attention of a government committed to their development...the importance of investing in the lives of young men and women—of rethinking policies and priorities, committing financial resources and implementing programs—reaches far beyond sheer numbers. How well communities and nations meet the needs of young people not only will determine the kinds of lives these young people have, but also has ramifications for the lives of the children they bring into the world and for the societies they will build and maintain."

Purchase a Copy Now

The Alan Guttmacher Institute is a non-profit organization for reproductive health research, policy analysis and public education, with offices in New York and Washington, D.C.

Archived News Releases

[About AGI](#) | [Home](#) | [Search](#) | [What's New](#)
[Feedback](#) | [Keep Me Informed](#) | [Purchase](#) | [Support](#)

ISSUES IN BRIEF

Endangered: U.S. Aid for Family Planning Overseas

In the wake of groundbreaking international accords calling for greater political and financial attention to population and development issues, the United States is failing to fulfill its commitments. During the last two years, ultraconservatives in Congress have doggedly attacked U.S. participation in the International Conference on Population and Development in Cairo and the Fourth World Conference on Women in Beijing and have made U.S.-aided family planning programs a favorite target of their hostility. Cleverly using the divisive issue of abortion, they have attacked family planning efforts as promoting abortion by encouraging promiscuity, sabotaging parental authority and threatening family life.

Frustrated in their attempts to restore heavy-handed policies imposed on international family planning programs during the Reagan years, key members of the U.S. House of Representatives set out, instead, to undermine these programs through draconian funding restrictions. They succeeded: In 1995, while funding for most humanitarian aid was reduced by 20%, family planning was singled out for extra-ordinarily harsh treatment—a far deeper cut and a complicated allocation scheme that reduced even further the amount of funds actually available. Lawmakers gave no reprieve in 1996, as the disproportionate funding cut was extended for a second year. Another congressional test of this issue, however, is already slated for February 1997.

This Issues in Brief explores the political climate confronting family planning assistance. It describes the human toll that deep funding cuts will take in the form of more unplanned pregnancies and abortions, more women dying in pregnancy and childbirth, and more infant deaths. Finally, it discusses why U.S. leadership is critical to the global family planning effort and why it is fully consonant with American traditions and values.

The congressional elections of 1994 ushered into the House of Representatives a formidable bloc of antiabortion conservatives. Facing an electorate that is basically prochoice, however, they had few potential targets within their reach. Foreign assistance became an easy mark and the restoration of the so-called Mexico City policy became a rallying cry.

The Mexico City policy was first enunciated by the Reagan administration at the 1984 United Nations' population conference in that city; it was revoked by President Clinton nearly 10 years later. The policy deemed population growth a "neutral" phenomenon; to the extent it could be considered a problem, it would be solved by "market forces." The policy also declared that, henceforth, the United States would no longer "promote" abortion worldwide—something that, in fact, had been prohibited by law since 1973. The latter goal would be achieved by imposing strict new conditions on indigenous, private organizations abroad—conditions that could not be imposed on similar U.S.-based institutions. Under the Mexico City policy, these overseas organizations would be disqualified from receiving U.S. family planning aid if—with their own funds and in accordance with the laws of their own countries—they provided any abortion-related information or services.

The House endorsed the reimposition of the Mexico City restrictions on several occasions in 1995 but was rebuffed by the Senate each time. The Senate's refusal to reinstate these discriminatory and imperialistic restrictions, even after the House countered with varying versions, resulted in a lengthy showdown between the two chambers. As a consequence, a second—but equally devastating—assault by family planning opponents began to unfold: to decimate the program's funding.

In January 1996, almost four months into the new fiscal year and under immense pressure to head off a third governmentwide shutdown, both the Senate and the White House were forced to accept a self-described "compromise" proffered by the House leadership. As the price for dropping the Mexico City language, family planning would be stripped of much of its funding. First, an overall funding cut of 35%—a much deeper cut than that sustained by development assistance generally—was imposed. Second, to punish family planning even further, an unprecedented and complex set of funding rules

would be imposed. No funds would be made available until July 1—a full nine months into the fiscal year—and, perhaps most severe of all, the funds, once released, could only be doled out in monthly installments over the next 15 months.

The fiscal 1997 budget process brought more of the same. Still stymied by Senate and White House opposition to the Mexico City restrictions, the far-right demanded an extension of the same funding conditions. However, another test of the issue was built into the equation. The new law requires Congress to vote—by February 28, 1997—on a presidential "finding" (itself to be delivered by February 1) as to whether the funding limitations are having "a negative impact on the proper functioning" of the international family planning program. Assuming the president reports that they are, and both the House and Senate agree, the fiscal 1997 money will be released on March 1 instead of July 1.

A Major Setback

Meanwhile, the impact on the lives of millions of women who are served by these programs, and on their families, will be profound. As nations head into the 21st century, the largest generation in history is just reaching adulthood. The choices these young women and men make about family size will depend greatly on the contraceptive and reproductive health services available to them, and will help shape their futures and the world's thereafter.

Moreover, given that women are the primary caretakers and household managers throughout much of the developing world, their health and well-being undeniably determines how their children—especially their daughters—will fare in life. In the immediate future, the relatively dismal state of women's reproductive health throughout much of the developing world can be expected to worsen as a direct result of the severe cutback in U.S. family planning aid.

According to a 1996 report from the United Nations Children's Fund (UNICEF), almost 600,000 women die during pregnancy and childbirth each year; 75,000 of these women die attempting to abort an unwanted pregnancy themselves or with the help of an untrained and unsafe provider. All told, these deaths render at least one million children motherless every year.

UNICEF further estimates that for every woman who dies, "approximately 30 more incur injuries, infections and disabilities which are usually untreated and unspoken of, and which are often humiliating and painful, debilitating and lifelong." Improving access to quality family planning services, notes UNICEF, is paramount to improving maternal and child health in developing countries. It is well documented that mortality rates for women and children are highest when births are spaced too close together, when a woman has many children (more than four) and when births occur too early or too late in a woman's life. Yet the campaign by abortion opponents to decimate government-supported family planning services only assures that women and their families in the developing world will know more suffering and death.

Measuring the Impact

In early 1996, a consortium of expert organizations undertook an effort to quantify the impact of the steep reduction in family planning aid. Their calculations, which take into account only the 35% cut to the program's overall funding level, are conservative by design (see Methodology). Excluded from the analysis is the combined effect of the nine-month moratorium and the monthly "metering" of funds, which only adds to the financial hardship.

Based solely on the one-year, 35% cut, the consortium estimates that:

- 7 million couples in developing countries who would have used modern contraceptive methods will not have access to these methods.
- As a result, 4 million more women will experience unintended pregnancies, leading in turn to:
 - 1.9 million more unplanned births and 1.6 million more abortions (the remainder of the unintended pregnancies will end in miscarriages);
 - 8,000 more women dying during pregnancy and childbirth, including from unsafe abortion; and
 - 134,000 more infant deaths.

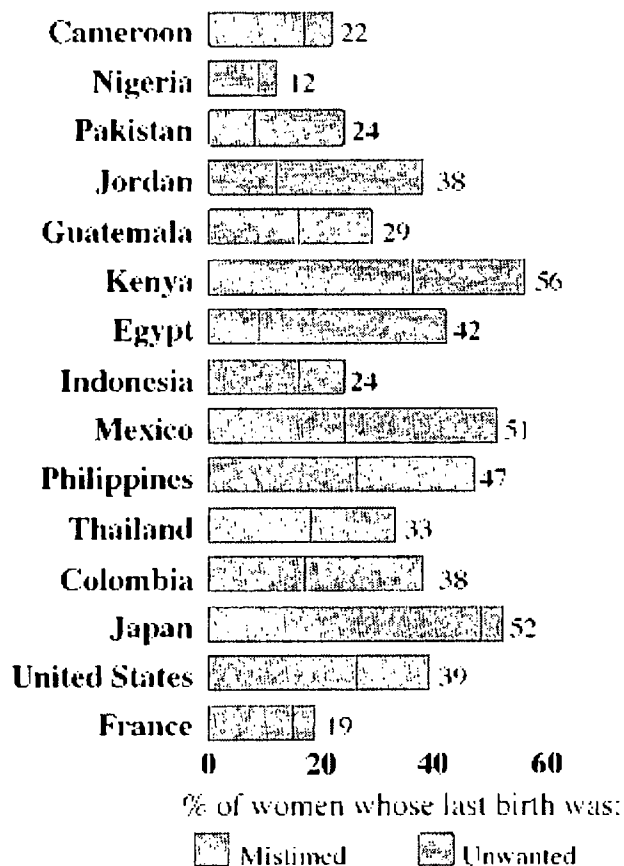
Unmet Needs The devastating cuts to U.S. family planning assistance abroad come at a time when increased access to family planning and related reproductive health care is crucial. Although progress has been made, the unmet need for quality contraceptive services remains considerable.

Over the last three decades, the size of the average family has fallen from roughly six children to about three. By having fewer children, parents are in a better position to provide for them and improve the family's quality of life overall. However, while women are striving—and succeeding, albeit with great difficulty—to have smaller families, a gap still exists between the number of children women say they want and the number they actually have. Many women give birth before they and their partners feel they are ready to care for a child, and substantial proportions of women—more than 50% in some countries—say their last birth was mistimed or unwanted. (see Chart 1).

Chart 1

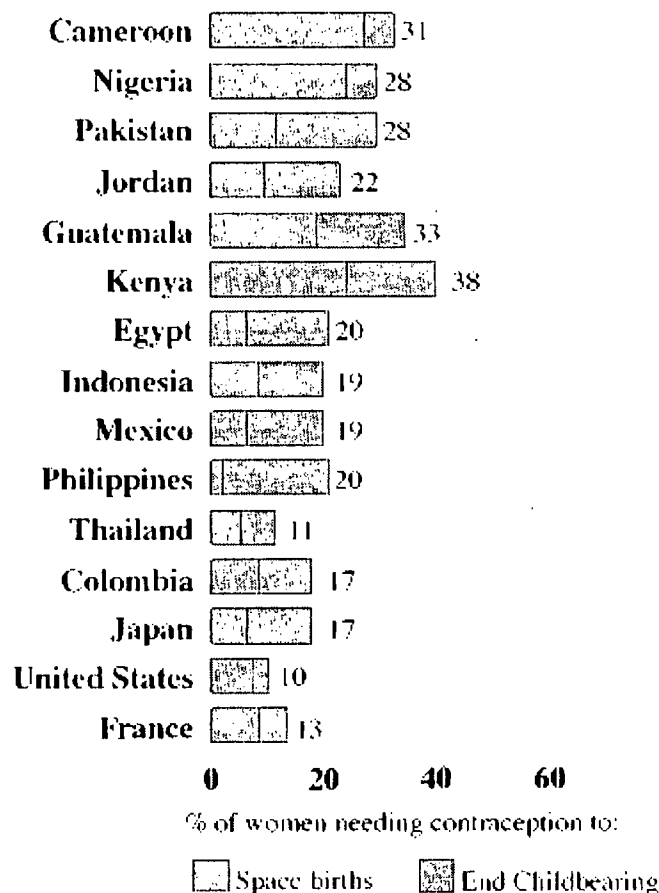
Unplanned Births

Many women say their last birth was mistimed or unwanted



Source: AGI, Hopes and Realities

The use of effective contraceptive methods has increased rapidly over the past 30 years throughout the developing world. Yet nearly 230 million women worldwide—roughly one in six women of reproductive age—are still in need of modern contraceptive methods to postpone or avoid future childbearing (see chart 2).

Chart 2**Unmet Need***Many women need family planning to postpone or end childbearing**Source: AGI, Hopes and Realities*

The high level of unmet need for family planning is a key reason why women have great difficulty in spacing their pregnancies and bearing the number of children they want. Determined to avoid an unplanned, unwanted birth, many women—in the absence of family planning or following a contraceptive failure—resort to unsafe abortion. Worldwide, more than one-quarter of pregnancies—about 52 million annually—end in abortion, often performed clandestinely and under unsanitary conditions.

Meeting the Challenges

Helping women narrow the gap between their child-bearing desires and what they actually experience is at the heart of U.S. family planning assistance. Enabling women to have the number of children they want, and when they want them, is central to the quality of their lives and the well-being of their families. And women's success in achieving their reproductive goals has important implications for the social and economic welfare of the communities and nations in which they live and, ultimately, for the future of the world.

Rapid population growth severely reduces the likelihood that developing societies can move out of poverty or that women can contribute to development on an equal footing with men. Providing women

with the means to control their fertility, primarily through improved access to quality family planning services, is, therefore, fundamental to human progress.

In this light, it is important to recognize that the impact of deep cuts to U.S. family planning aid will extend well beyond the delivery of contraceptive and reproductive health services to women and couples. On-going U.S. efforts to improve literacy rates and primary school education of girls, promote good nutrition, improve maternal and child health, and enhance women's participation in the economic and political spheres of society will feel the sting as well.

On the ground, these programs rarely operate in a vacuum, independent of each other. Rather, over the years, they have become increasingly integrated, partly to maximize resources but largely because such efforts naturally complement and reinforce one another. The extensive cuts to family planning assistance inevitably will affect other development endeavors.

U.S. Leadership

Currently, about three-quarters of the roughly \$4 billion spent to provide family planning services in developing countries is borne by the countries' own governments and by the women and men who use these services. The remainder is contributed by developed countries. Financial support from developed country governments—both to other governments directly and to indigenous nongovernmental organizations (NGOs) working in those countries—clearly plays a pivotal role in meeting the rapidly increasing contraceptive needs of couples in the developing world. And, it is no exaggeration to say that the U.S. program is the anchor of the global family planning effort on which other countries' contributions depend for stability and direction.

Should U.S. support for international family planning continue to erode, it is unrealistic to expect that other donor countries will—or could—make up for the loss of U.S. government funds. No other country, nor international organization for that matter, has the extensive field presence nor the vast array of technical resources and experience that the U.S. family planning effort has developed over the decades.

Moreover, American leadership has been crucial to forging alliances among governments and the private sector so that family planning and related social services are provided in a more integrated manner.

Reflecting American Values

Making family planning services widely available to all who want them is one of the surest ways to foster self-sufficiency, promote preventive health care and basic education, nurture strong and healthy families, and enhance the quality of life for all of us. In many ways, family planning reflects the core values that most social conservatives—indeed, most Americans—hold so dearly. It is ironic that the strongly held antiabortion views of some conservatives have been extended into the realm of family planning, which has long enjoyed strong bipartisan support in Congress and around the country as a means to reduce the incidence of abortion.

The American public supports humanitarian assistance—family planning and reproductive health services, child survival, education, environmental protection—not only as a necessary price for world leadership but also as the right thing for a wealthy country to do. In a recent nationwide poll conducted by the University of Maryland, those surveyed felt that 5% of the national budget was an appropriate level for the U.S. to spend on development assistance. Currently, less than 1% of the federal budget is earmarked for international aid, and less than half of that amount goes to humanitarian assistance.

Contributing "our fair share" to alleviate poverty and promote better health and nutrition among developing societies is a strongly held American value, one that has driven U.S. international assistance for many decades. And making quality family planning services available to all who want them has been a central tenet of American humanitarian aid. Clearly, it must remain so if our efforts are to succeed in improving the lives of women, supporting families worldwide and benefiting our own lives here at home.

Methodology

The potential effect of a 35% cut in U.S. funding for family planning is estimated by gathering and sometimes reconciling information from a wide variety of sources, ranging from national censuses and population estimates to country-specific surveys of women of reproductive age and special studies of contraceptive use and of pregnancy outcomes.

The estimates that follow reflect the knowledge and expertise of the following organizations: The Alan Guttmacher Institute, The Futures Group, Population Action International and the Population Reference Bureau, in consultation with the Population Council. The basic steps in reaching the estimation are as follows.

The first step in estimating the impact of the funding cut begins with determining how many of the couples who depend on U.S. funded family planning programs will lose their access to contraceptives.

- Population censuses and estimates indicate an estimated 829 million women of reproductive age are living today in developing countries other than China (which receives no U.S. family planning program support).
- Surveys of women in developing countries show that roughly 247.5 million of these women and their partners use modern methods of contraception to lengthen the time between the births of their children or to avoid having more children than they already have.
- Because of their poverty, 190.5 million, or 77%, of the couples in developing countries outside of China who are using modern contraceptive methods rely on public-sector family planning programs.
- The United States contributes about 17% of all public funds spent on family planning in developing countries other than China, accounting for 32.4 million couples using modern contraceptive methods. [Of these couples, 12.6 million are estimated to be protected by contraceptive sterilization or long-lasting methods including hormonal implants (such as Norplant) or intrauterine devices (IUDs).
- On an annual basis, 19.8 million couples depend on U.S. supported programs to obtain contraceptive supplies, such as pills, condoms or injectables, or to start use of a long-term method, such as voluntary sterilization, hormonal implant or IUDs.
- A cut in program resources of 35% means that 12.9 rather than 19.8 million couples will be able to be served in a year's time, leaving 7 million couples without access to contraceptive supplies or services.

The second step is estimating what effect losing U.S.-supported family planning services will have on the couples who are depending on them for contraceptive care.

- There are few other contraceptive choices in developing countries for women who lack access to modern contraceptives. A conservative estimate is that of the 7 million women losing services because of U.S. funding cuts 2.8 million will turn to traditional methods and 4.2 million will use no contraceptive.
- Because pregnancy rates are so much higher among couples relying on no method or on a traditional method than if they use a modern contraceptive, 4 million more unwanted pregnancies are expected in developing countries due to the drop in family planning program resources.
- About 40% of these unintended pregnancies are likely to end in induced abortion, even though it is often not legal and performed in unsafe conditions—accounting for 1.6 million abortions among the expected additional unwanted pregnancies.
- Some 47% of the unintended pregnancies are likely to end in unwanted births with the remaining 13% resulting in spontaneous abortions or miscarriages—accounting for 1.9 million unwanted births among the expected additional unwanted pregnancies.
- Maternal mortality rates in developing countries are high, about 4.1 deaths per 1,000 women giving birth, leading to an estimated 8,000 additional deaths due to pregnancy among the women facing additional unintentional pregnancies.
- Infant mortality rates in developing countries are high, with about 7.2% of all babies born dying before their first birthday, leading to an estimated 134,000 additional infant deaths among the women facing additional unintentional pregnancies.

Abortion in America

- 49% of pregnancies among American women are unintended; 1/2 of these are terminated by abortion.
- In 1996, 1.37 million abortions took place, down from an estimated 1.61 million in 1990. From 1973 through 1996, more than 34 million legal abortions occurred.
- Each year, 2 out of every 100 women aged 15–44 have an abortion; 47% of them have had at least one previous abortion and 55% have had a previous birth.
- An estimated 43% of women will have at least 1 abortion by the time they are 45 years old.
- Each year, an estimated 50 million abortions occur worldwide. Of these, 30 million procedures are obtained legally, 20 million illegally.
- 52% of U.S. women obtaining abortions are younger than 25: Women aged 20–24 obtain 32% of all abortions, and teenagers obtain 20%.
- 2/3 of women having abortions intend to have children in the future.
- While white women obtain 60% of all abortions, their abortion rate is well below that of minority women. Black women are more than 3 times as likely as white women to have
- On average, women give at least 3 reasons for choosing abortion: 3/4 say that having a baby would interfere with work, school or other responsibilities; about 2/3 say they cannot afford a child; and 1/2 say they do not want to be a single parent or are having problems with their husband or partner. an abortion, and Hispanic women are roughly 2 times as likely.

Contraception in America

- 11% of women having abortions have never used a method of birth control; nonuse is greatest among those who are young, unmarried, poor, black, Hispanic or poorly educated.

Safety of Abortion in America

- 1 death occurs in every 150,000 legal abortions, compared with 1 in every 34,000 in 1974.

Teen Pregnancy in America

- 13% of all U.S. births are to teens.
- 76% of births to teens occur outside of marriage.
- 1/4 of teenage mothers have a second child within 2 years of their first.
- Teens who give birth are much more likely to come from poor or low-income families (83%) than are teens who have abortions (61%) or teens in general (38%).
- In 1993, 3.8 million mothers aged 15–44 received welfare or Aid to Families with Dependent Children (AFDC); 55% of these women became mothers when they were teenagers. Only 5% were currently teenage mothers, and 83% of these—159,000—were aged 18–19; young teens, those aged 15–17 accounted for 32,000 of all mothers receiving AFDC.
- 7 in 10 teen mothers complete high school, but they are less likely than women who delay childbearing to go on to college. In part because most teen mothers come from disadvantaged backgrounds, **28% of them are poor in their 20s and early 30s; only 7% of women who first give birth after adolescence are poor at those ages.**
- 1/3 of pregnant teens receive inadequate prenatal care; babies born to young mothers are more likely to be low birth weight, to have childhood health problems and to be hospitalized than are those born to older mothers.
- Nearly 4 in 10 teen pregnancies (excluding miscarriages) end in abortion. There were about 289,000 abortions among teens in 1994.
- Since 1980, abortion rates among sexually experienced teens have declined steadily, because fewer teens are becoming pregnant, and in recent years, fewer pregnant teens have chosen to have an abortion.

Impact of Publicly Funded Family Planning Services in America

- Publicly subsidized family planning services prevent 1.2 million unintended pregnancies in the United States each year. By assisting women and families to prevent these unwanted pregnancies, the national family planning effort prevents 509,000 unintended births and 516,000 abortions each year. (The remainder would end in miscarriages.)
- Each year, publicly subsidized family planning services prevent 798,000 unintended pregnancies to unmarried women, thereby avoiding 344,000 out-of-wedlock births and 350,000 abortions.

- Each year in the United States, publicly funded family planning programs prevent 256,000 unintended pregnancies to teenagers; this avoids 110,000 teenage births and 112,000 abortions.
- Because many of the women receiving publicly funded family planning services would be eligible for other publicly subsidized care if they became pregnant, each public dollar spent to provide family planning services saves more than \$4 that would otherwise be spent to provide medical care, welfare benefits and other social services. Over \$3 is saved in medical costs alone.
- Publicly subsidized family planning programs help 281,000 women already enrolled in welfare avoid becoming pregnant each year; these efforts prevent 123,000 current welfare recipients from having an additional birth, and 122,000 abortions.
- In addition, publicly funded family planning programs prevent 80,000 pregnancies to women who are not currently enrolled in welfare but who would become welfare recipients if they gave birth; these efforts prevent 35,000 women from giving birth and becoming dependent on welfare each year, and prevent 35,000 abortions.
- The data also show that public funding of family planning services prevents poor birth outcomes and improves women's overall health.
- Publicly funded family planning services increase the likelihood that pregnant women will obtain adequate prenatal care. Women who do not obtain sufficient prenatal care are about twice as likely as those who do to have a low-birth-weight baby, the leading cause of infant mortality in the United States. A study of 45,000 women who gave birth in North Carolina in 1989 and 1990 found that women who used family planning services in the two years before conception were more likely to begin prenatal care early and to receive adequate levels of care throughout their pregnancies. As a result of publicly funded family planning services provided between 1982 and 1988, 107,000 fewer women gave birth after having obtained inadequate prenatal care, according to a recent national study.
- That study also found that publicly funded family planning services provided between 1982 and 1988 prevented 20,000 low-birth-weight deliveries, 6500 infant deaths and 5500 neonatal deaths.
- A recently published analysis of Wisconsin's chlamydia prevention program, which includes family planning clinics as primary screening and treatment sites, found steep declines in the incidence and complications of the infection. Between 1987 and 1991, the incidence of new infections in women decreased by 27-50% in clinic populations. Between 1986 and 1991, hospitalization rates declined by 33% for pelvic inflammatory disease and by 20% for ectopic pregnancy, both serious complications of chlamydia.

The Impact of Education on Reducing Adolescent Pregnancy

- Young women aged 15-19 are two to three times more likely than women aged 40-44 to have at least seven years of education. In other words, an increasing proportion of young people are completing primary school and may have some secondary schooling. In some of the North African and Asian countries, increases have been especially dramatic.
- In Kenya, for example, 62% of women aged 15-19 have seven or more years of education, compared with only 26% of 40-44 year-old women. In Bangladesh, 33% of 15-19-year-olds have at least seven years of schooling, compared with only 9% of 40-44-year-old women.
- The number of adolescents giving birth each year is staggering. In fact, slightly more than 10% of all births worldwide—almost 15 million—are to young mothers.
- Overall, about 35% of young women in Latin America and the Caribbean have their first child before their 20th birthday, and an even higher proportion (50-60%) do so in most countries in Sub-Saharan Africa. The United States has one of the highest levels of adolescent childbearing in the developed world, with 19% of young women giving birth before age 20. This is almost three times the level in France and nine times as high as in Japan.
- 46% of young Colombian women with less than seven years of schooling have their first child by age 20, compared with 19% of those with more education. The contrast is even greater in Egypt, where 51% of less educated women have their first birth before the age of 20 compared with only 9% of better educated women.
- The link between lack of education and early childbearing is also strong among adolescents in the United States. Some 58% of young American women who receive less than a high school education give birth by their 20th birthday, compared with 13% of young women who complete at least 12 years of schooling.

International Adolescent Pregnancies

- Up to 60% of adolescent births throughout the world are unplanned, and about one in nine adolescents lack the contraceptive protection they need to prevent an unwanted pregnancy.
- One-third to two-thirds of young women obtain less than seven years of schooling in most developing countries.
- Over 300 million cases of curable STDs occur worldwide each year, with young women

especially susceptible to these diseases and bearing the most serious consequences.

- One-fourth to one-half of all adolescent births in Latin America and the Caribbean are unplanned, as are 15-30% of those in North Africa and the Middle East and 40-60% in such Asian and Sub-Saharan countries as the Philippines, Ghana, Kenya, and Zimbabwe.
- In the United States, seven in 10 births to adolescents are unplanned.
- Across Sub-Saharan Africa, Asia, Latin America and the Caribbean, a woman who has her first child before age 18 will have an average of seven children by the time she has completed her family; however, if she waits until her early 20s, her family will average five or six children, and if she postpones childbearing until her late 20s, she will typically have three or four children.
- If today's young women were to have their first child two-and-one-half years later than is currently the average age at first birth, population growth by the year 2100 will be 10% lower than if no change occurs; if they postpone that first birth by five years, it will be 20% lower—a decrease of 1.2 billion people.

International Reproductive Health Services for Young Women

- In India, Egypt, Indonesia and the Philippines, 25% or less of adolescent mothers give birth in a hospital or health facility; in Bangladesh, the proportion is 3%.
- Young adolescents are more likely to experience premature labor, spontaneous abortion and stillbirths than are older women, and they are up to four times as likely as women older than 20 to die from pregnancy-related causes.
- The infants of very young mothers face a risk of death during the first year that is 30% higher than the risk faced by infants of adult mothers.
- Adolescent mothers need health care for themselves and their infants and social support to enable their continued schooling, for example.

International Adolescent Abortion Rates

- The rate of adolescent abortion varies from country to country, ranging from very low levels in Germany (3 abortions per 1,000 women aged 15-19) and Japan (6 per 1,000), to moderately high levels in Brazil (32 per 1,000) and the United States (36 per 1,000).
- In Malawi, Uganda and Zambia, adolescent women represent one-fourth to one-third of patients suffering from complications of unsafe abortions, and in Kenya and Nigeria, more than half of women with the most severe abortion complications are adolescents.

- In Latin America and the Caribbean, about one-tenth of all women hospitalized after an abortion are younger than 20, and adolescents comprise one-third of the women with the most serious infections.

Childbirth Related Deaths

Every year, 585,000 women—99% of them in developing regions—die from causes related to pregnancy. These causes include the direct health consequences of high-risk pregnancies, unsafe abortions and difficult deliveries, as well as problems that arise soon after delivery. Maternal mortality ratios (representing the number of women who die every year from pregnancy-related causes per 100,000 live births) in Africa, Asia and Latin America are 10–100 times the ratios in the industrialized world UNICEF points out that "no public health problem shows greater disparity between rich and poor countries than maternal mortality."

Most women in developing countries still give birth at home, helped by a close family member or traditional birth attendant. **Fewer than one in five women obtain assistance from a trained doctor or nurse when they give birth in Burundi, Niger, Yemen, Bangladesh and Pakistan; fewer than one-half receive professional medical assistance in Ghana, Kenya, Mali, Nigeria, Senegal, Uganda, Egypt, Morocco, India, Indonesia, Bolivia and Guatemala.** Even when women deliver in a hospital, the equipment, supplies, drugs, or operating rooms and trained staff needed to do cesarean sections or manage emergencies may be lacking.

Infant Mortality

Yet some older Americans can remember when infant deaths were as common in the United States as they are currently in many parts of the developing world (Chart A). In 1920, the U.S. infant mortality rate was as high as Nigeria's is today (87 infant deaths for every 1,000 live births); In 1965, it still equaled the current rate of 25 deaths per 1,000 in Sri Lanka, and in inner-city communities particularly, the rate remains close to that level.

Throughout the developing world, **babies born to women younger than 20 are, on average, one-third more likely to die than infants born to women in their 20s and 30s.** This is mostly because babies born to very young mothers are more likely to be premature, to be below-birth-weight and to suffer from complications at the time of delivery. And many adolescents do not know how to obtain or cannot afford good prenatal and delivery care. In addition, teenage births are likely to be first births, and first births always carry a higher risk than subsequent births.

The link between early childbearing and lower rates of infant survival in developing countries has serious implications. **One in five women aged 20–24 report having had their first child before their 18th birthday, and two out of five report doing so before they were 20.** This high incidence of teenage childbearing is partly because even when adolescents want to prevent pregnancy, they often face special problems in obtaining the contraceptive products or services

that would enable them to do so.

Repercussions of cuts to U.S. AID

Based solely on the one-year, 35% cut, the consortium estimates that:

- 7 million couples in developing countries who would have used modern contraceptive methods will not have access to these methods.

As a result, 4 million more women will experience unintended pregnancies, leading in turn to:

- 1.9 million more unplanned births and 1.6 million more abortions (the remainder of the unintended pregnancies will end in miscarriages);
- 8,000 more women dying during pregnancy and childbirth, including from unsafe abortion; and 134,000 more infant deaths.
- There are few other contraceptive choices in developing countries for women who lack access to modern contraceptives. A conservative estimate is that of the 7 million women losing services because of U.S. funding cuts 2.8 million will turn to traditional methods and 4.2 million will use no contraceptive.
- Because pregnancy rates are so much higher among couples relying on no method or on a traditional method than if they use a modern contraceptive, 4 million more unwanted pregnancies are expected in developing countries due to the drop in family planning program resources.
- About 40% of these unintended pregnancies are likely to end in induced abortion, even though it is often not legal and performed in unsafe conditions—accounting for 1.6 million abortions among the expected additional unwanted pregnancies.
- Some 47% of the unintended pregnancies are likely to end in unwanted births with the remaining 13% resulting in spontaneous abortions or miscarriages—accounting for 1.9 million unwanted births among the expected additional unwanted pregnancies. Maternal mortality rates in developing countries are high, about 4.1 deaths per 1,000 women giving birth, leading to an estimated 8,000 additional deaths due to pregnancy among the women facing additional unintentional pregnancies.
- Infant mortality rates in developing countries are high, with about 7.2% of all babies born dying before their first birthday, leading to an estimated 134,000 additional infant deaths among the women facing additional unintentional pregnancies.