

# Introduction

Population factors are not neutral with respect to the development process. Within the United Nations System, it is the responsibility of the United Nations Population Fund (UNFPA) and its partners to create the conditions to ensure that they will be integrated in poverty reduction strategies and development planning processes, not only in those aspects directly related to health and reproduction, but across the full range of issues that constitute the Population and Development agenda. The Millennium Development Goals (MDGs), which originated from the Millennium Summit of 2000 and at present constitute the principal international guideline for the development process, share a broad thematic intersection with the International Conference on Population and Development (ICPD) Programme of Action (PoA) agreed upon in Cairo in 1994. The potential achievement of each of them depends to some extent on the attainment of the other. Former UN Secretary-General, Kofi Annan, has made this point on several occasions, like his message to the Fifth Asian and Pacific Population Conference and Regional Conference on ICPD+10 in Bangkok, in December 2002:<sup>1</sup>

*“The Millennium Development Goals, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women’s rights, and greater investment in education and health, including reproductive health and family planning.”*

It is important to take note of the various overlaps and reinforcements between the ICPD PoA and the MDGs. With respect to the spread of HIV/AIDS, both documents not only establish priorities, but they also set time-bound and measurable targets to combat, rather than simply prevent the epidemic. In other areas, the ICPD PoA goes further than the MDGs, especially regarding population issues and reproductive health (RH). The empowerment of women, the third MDG, will not be realised without ensuring universal access to sexual and reproductive health (SRH) services, an explicit goal of the ICPD PoA.

Although the Cairo goal of universal access to quality RH services by 2015 is fundamental to reducing poverty, child and maternal mortality, the spread of HIV/AIDS, gender inequalities, and environmental degradation – as outlined above –, it was not originally spelt out as one of the MDGs.<sup>2</sup> This situation was, nevertheless, recently modified by the

---

<sup>1</sup> UN Press Release SG/SM/8562: <http://www.un.org/News/Press/docs/2002/SGSM8562.doc.htm> (last seen: March 2007).

<sup>2</sup> Only the ICPD target of universal access to SRH services, including family planning, was not included in the original set of MDGs (Crosette, 2005; ESCAP, 2004), but specific Targets that are intrinsically related to it were, such as gender equity (MDG 3), maternal health (MDG 5), and HIV/AIDS prevention (MDG 6, Target 7). Finally, ICPD+5 added the need to prevent HIV/AIDS as a population concern, which also constitutes MDG Target 7, under Goal 6 (Prevention of HIV/AIDS, Malaria and Other Diseases).

announcement of the former Secretary-General to the General Assembly, in October 2006, that four new Targets are being proposed, namely:

- Full and productive employment and decent work for all (under MDG 1);
- Universal access to reproductive health (under MDG 5);
- Universal access to treatment for HIV/AIDS (under MDG 6); and
- Significant reduction of the rate of loss of biodiversity (under MDG 7).

To the extent that the ICPD and the MDGs are not only complementary, but also parallel in time (both have 2015 as a deadline for meeting their targets), they should maintain a constant dialogue in the process of public policy formulation. Specifically, the MDGs should take the ICPD into consideration, in more than one way:

**Politically:** The Cairo PoA has mobilised major sectors of civil society around the promotion of issues that are also relevant in the context of the Millennium Development agenda; this is a potential that the MDGs should build on and reinforce.

**Strategically:** Most of the issues raised in the MDG agenda are causally linked to the objectives of the ICPD PoA. These linkages need to be taken advantage of, in order to expedite the realisation of the former by investing in the latter.

**Analytically:** As has been repeatedly observed, the monitoring of the MDG agenda involves a need to produce more and better social indicators on a variety of social issues, including the need to obtain better basic data from surveys and censuses. The ICPD PoA is one of the contexts in which these needs were addressed and quantifiable targets were proposed. The MDG indicators should build on this experience.

**Contextually:** The ICPD PoA addresses a number of issues that provide a context for the development of actions to achieve the MDG agenda. For example, programmes that seek the improvement of living conditions in urban slums (Goal 7) can hardly be formulated realistically without taking into account the realities of rural-to-urban migration.

**With regard to issues of social equality:** The MDGs make no explicit reference to the reduction of regional, racial, generational, or several other kinds of inequalities which are important social contexts for their realisation, as well as important objectives in their own right. The Cairo PoA addresses these issues more explicitly.

Most of the present document will be concerned with the strategic and contextual issues, to provide the technical rationale for statements such as that of the former Secretary-General cited in the opening paragraph. Analysing population issues within the context of the MDGs may shed light on how aggregate demographic trends and individual reproductive behaviour can contribute or interfere with the achievement of these goals or how the implementation of the ICPD may offer shortcuts to their achievement.

*“The ICPD Programme of Action’s focus on population and development-related efforts, such as increasing access to reproductive health services, promoting gender equality, and nurturing a better understanding of the linkages between population dynamics, development and poverty, is a prerequisite to the achievement of the larger development goals of the MDGs, such as eradicating poverty and hunger.” (UNFPA, 2004 a: 1)*

It is particularly important to consider that it is a real danger that all eight MDGs may be met while leaving behind the most disadvantaged sections of the population. As the MDGs are established as national averages, they lack a diversity perspective, such as the needs of specific groups; indigenous peoples, children, adolescents, people with disabilities and older persons, which are addressed in the Cairo PoA.

*“(...) Are national averages sufficient to evaluate progress towards meeting well-defined development objectives? Evidently, in one of the most unequal regions in the world, an analysis of averages is not enough to properly account for the living conditions and lack of opportunities present in large social groups. (...) Averages give a false sense of progress for to reach a goal on the average does not imply, necessarily, to improve the living conditions across broad sectors of the population or regions within the country. In fact, social progress often eludes the poor and the disadvantaged. Only disaggregated analysis can gauge with greater accuracy the effort that the country must exert in order to provide minimal development opportunities to those who traditionally have been excluded in terms of education, health and living conditions. Disaggregate information aids in identifying where the resources need to be invested in order to close the existing social gaps.” (Alarcón, Mejía & Zepeda, 2006: 5)*

Four of the five quantitative targets of the ICPD PoA were echoed (some in attenuated form) in the MDGs. These are the following:

- Universal access to primary education: “All countries should further strive to ensure complete access to primary school or equivalent levels of education by girls and boys as quickly as possible and in any case before 2015” (Para. 11.6).
- Access to secondary and higher education: “Beyond the achievement of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training” (Para. 4.18).
- Reduction of infant and child mortality: “By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under 5 mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further” (Para. 8.16).
- Reduction of maternal mortality: “Countries should strive to effect significant reductions in maternal mortality and morbidity by the year 2015 (...) to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socioeconomic and ethnic groups should be narrowed” (Para. 8.21).

Looking at the relationship from the vantage point of the MDGs, five of them demonstrate a clear overlap with the ICPD and the ICPD+5 (Bernstein & White, 2004): Goals 2, 3, 4, 5, and 6. Goal 1 (Poverty reduction) is strongly related, but in a less straightforward manner.

Arguably, Goals 7 and 8 are too, although less so. A UN Population Division seminar in November 2004, on the links between population and MDGs, concluded that particularly halving poverty and hunger, promoting gender equality, reducing child and infant mortality, and controlling HIV/AIDS will be more likely if the ICPD agenda is achieved. In other words, all the eight MDGs depend, directly or indirectly, on the ICPD.

Despite the recent addition of an RH Target, it is a curious fact that population problems, as a development challenge in their own right, have not made it into the MDG agenda. This signals a break with past priorities. Had the Millennium Summit taken place in 1975, to set a development agenda for 2000, population would likely have been one of its central concerns. However, as fertility has declined, the nature of the “population problem” has changed, and because its public image as the need to curb the “population explosion” no longer applies as strongly, there is now much greater scepticism regarding the place population and RH deserve among the major development challenges of the 21st century.

Some alternative forums, like the NGO-driven Copenhagen Consensus (2004), did identify population, and particularly migration, as one of the world’s top 10 challenges, even though it assigned a relatively low priority to projects in this area.<sup>3</sup> Former UN Secretary-General Kofi Annan has stated that the growth of the world economy depends on migration (United Nations, 2005 b), and the present Secretary-General Ban Ki-Moon recently declared that:

*“For many years, Member States of the United Nations found it hard to discuss the sensitive issue of migration in the international arena. So the topic was never too high on the UN agenda – until the High-Level Dialogue at UN Headquarters in New York last September. (...) For decades, the toil of solitary migrants has helped lift entire families and communities out of poverty. Their earnings have built houses, provided health care, equipped schools, and planted the seeds of businesses. They have woven together the world by transmitting ideas and knowledge from country to country. They have provided the dynamic human link between cultures, societies, and economies. Yet only recently have we begun to understand not only how much international migration impacts development, but how smart public policies can magnify this effect.”<sup>4</sup>*

According to Skeldon (2005: 56), “every MDG has some linkage, direct or indirect, with migration.” Other population issues addressed by the ICPD – such as rapid urbanisation, population ageing, and low social status of women – could impair progress towards achieving the MDGs, whereas the demographic bonus could be an important facilitator.

Despite the former, the case for the importance of population issues in development so far has been made mostly for SRH. Thus, the Alan Guttmacher Institute and UNFPA argue that universal access to SRH may help to achieve 7 of the 8 MDGs (Singh et al., 2003: 6):

<sup>3</sup> Four of the other nine challenges of the Copenhagen Consensus overlap with MDGs (malnutrition and hunger, education, communicable diseases, sanitation and water) and five do not (conflicts, financial instability, governance and corruption) or only in part (climate change, subsidies and trade barriers). Policies to deal with the needs of an ageing population are not mentioned by either.

<sup>4</sup> Address to the Inaugural Global Forum on Migration and Development in Brussels, 10 July 2007.

*“Goal 1: Eradicate extreme poverty and hunger: Smaller families and wider birth intervals as a result of contraceptive use allow families to invest more in each child’s nutrition and health, and can reduce poverty and hunger for all members of a household. At the national level, fertility reduction may enable accelerated social and economic development.*

*Goal 2: Achieve universal primary education: Families with fewer children, and children spaced further apart, can afford to invest more in each child’s education. This has a special benefit for girls, whose education may have lower priority than that of boys in the family. In addition, girls who have access to contraceptives are less likely than those who do not to become pregnant and drop out of school.*

*Goal 3: Promote gender equality and empower women: Controlling whether and when to have children is a critical aspect of women’s empowerment. Women who can plan the timing and number of their births also have greater opportunities for work, education, and social participation outside the home.*

*Goal 4: Reduce child mortality: Prenatal care and the ability to avoid high-risk births (e.g. those to very young women and those spaced closely together) help prevent infant and child deaths. Children in large families are likely to have reduced health care, and unwanted children are more likely to die than wanted ones.*

*Goal 5: Improve maternal health: Preventing unplanned and high-risk pregnancies and providing care in pregnancy, childbirth and the postpartum period save women’s lives.*

*Goal 6: Combat HIV/AIDS, malaria and other diseases: Sexual and reproductive health care includes preventing sexually transmitted diseases, including HIV/AIDS. In addition, reproductive health care can bring patients into the health care system, encouraging diagnosis and treatment of other diseases and conditions.*

*Goal 7: Ensure environmental sustainability: Providing sexual and reproductive health services may help stabilize rural areas, slow urban migration and balance natural resource use with the needs of the population.”*

These interactions are echoed almost verbatim in a recent document from DANIDA (2006), with the addition under MDG 1 that “reducing the burden of pregnancy and childcare on women allows them to engage in income producing activities to a greater extent thereby contributing on both a household and macroeconomic level.” UNFPA (2005 g) also mentions that family planning programmes produce tangible savings to health systems, and that family planning and maternal health services promote health and productivity.

Less often has it been pointed out, however, that the following also constitute crucial linkages between population issues and the MDG agenda:

- The link between fertility/family size and social mobility;
- The effects of the demographic bonus and other demographic transformations on economic inequality and thereby on poverty;

- The link between poverty and morbidity;
- The link between unwanted pregnancies, household composition, and poverty;
- The poverty effects of population ageing;
- The link between poverty and rural-urban migration;
- The link between poverty and international migration, through the economic growth, macro-economic equilibrium, and distributional effects of remittances;
- The link between macro-demographic trends and potential investments in education;
- The potential contribution of sexual and life skills education;
- The effects of migration on education through brain drain and brain gain;
- The economic costs and poverty effects of violence against women;
- The effects of migration on gender equality;
- The effects of women's roles on child health;
- The effects of women's employment opportunities on poverty reduction;
- The effects of migration on child mortality;
- The causal link between abortion and maternal mortality;
- The causal link between migration and the spread of AIDS;
- The effects of the medical brain drain on the prevention of child mortality and AIDS;
- Population and the sustainable use of space;
- The role of population distribution and migration on environmental vulnerability.

ECLAC (2004 a) notes that there is a limited account of demographic factors in poverty reduction strategies and other public policies. Leete and Schoch (2002: 9) note the same about the final document of the World Summit on Sustainable Development:

*“Just when the World Bank’s World Development Report 2003 rediscovered the idea that demographic transition is central to poverty reduction and sustainable development, the main outcome documents of the World Summit on Sustainable Development ignore the analytical linkages between population, demographic dynamics and sustainable development (World Bank, 2002 b; United Nations, 2002 a).”*

This also applies to the national MDG Reports (MDGRs) of which almost all the countries of the Latin American and Caribbean (LAC) region have now prepared at least one. These are valuable documents because they provide a picture of how the countries themselves, as the main stakeholders in the effort to achieve these targets, see the situation and provide information on the strategies they have devised for this purpose (ECLAC, 2005 a). However, with a few notable exceptions such as the regional MDGR produced by ECLAC (2005 a), the MDGRs have so far paid very little attention to population and SRH issues. Even chapters devoted to maternal health often fail to mention the consequences of short birth intervals, unsafe abortion, and access to contraception. In several reports, infant health is presented in relation mainly to health services, vaccination, nutrition, and medicines – little is mentioned about reproductive patterns, breastfeeding, and the need for family planning. The 2003 *Human Development Report*, on the MDGs, is also exemplary for its scarcity of references to population and SRH issues. In its first chapter, it does recognise that:

*“The Millennium Development Goals have been widely acclaimed, inspiring new energy for action against poverty, but they have also been criticized for being too narrow, leaving out development priorities such as strong governance, increased employment, reproductive health care and institutional reform of global governance.”*  
(UNDP, 2003: 30)

However, having said that, the report makes few further references to population related issues. More recently, the Maquette for MDG Simulations (MAMS), a model developed by UNDP and the World Bank (Bourguignon et al., 2004; Lofgren & Díaz-Bonilla, 2006), has set out to quantify the economywide implications of country commitments with 5 of the 18 MDG Targets and 6 of the 48 indicators, using the Computable General Equilibrium (CGE) methodology. An important merit of this model is that it goes beyond mere cost accounting and, in principle, allows the assessment of synergies between the different Targets. However, apart from the fact that it considers a rather limited set of Targets (excluding, for example, hunger, gender equity, AIDS and other major diseases, and environmental issues other than water and basic sanitation), the model considers few if any of the population interactions that are the object of the present document. The macro-simulation is entirely concerned with resource flows and the sensitivity of the Targets to the investments applied to them. Population appears only in the form of aggregate population growth. The micro-simulation that may be appended to the model does consider some household level interactions, but most of the causal links mentioned in the present document are not acknowledged. In practice, this places important limits on the capacity of the model to consider synergies between the Targets because these synergies do not depend only on the quantity of resources employed, but also on the specific strategies chosen. For example, the reduction of under 5 child mortality through actions that try to limit the number of pregnancies in girls under age 18 will have different implications for the reduction of maternal mortality than an equally successful campaign to increase the coverage of childhood vaccination.

More surprisingly, the recent in-depth needs assessment of the Dominican Republic (COPDES/United Nations/ONAPLAN/Millennium Project, 2005), which constitutes one of the pilot studies supported by the UN Millennium Project for the evaluation of resources and public policy measures needed to comply with the MDGs, pays some attention to SRH and to sexual and reproductive rights (SRR) in the context of gender equity, but again ignores population issues in all other contexts. This is all the more remarkable because the Dominican Republic is one of the countries of the region with the largest proportions of migrants living abroad and a substantial proportion of its GDP is generated by remittances. Yet neither migration, nor urbanisation or ageing are ever mentioned in the study as obviously relevant conditioning factors in the achievement of poverty reduction, universal access to education, or environmental sustainability. Even the gender implications of international migration and trafficking of women are not considered.

One of the documents emerging from the MDG exercise that does pay attention to population factors is *Investing in development: a practical plan to achieve the Millennium Development Goals*, produced by the UN Millennium Project (2005 a). Apart from suggesting access to SRH as a separate Target under Goal 5, the latter document promoted various

extensions to the concept of gender equity – several of these intersect with the population area. In addition, it made several references to population factors in the outcome documents of the different Task Forces.<sup>5</sup> Giving further expression to the recommendations contained in this document, the World Summit of September 2005 confirmed the importance of RH in the attainment of the MDGs, as countries committed themselves in the outcome document to:

*“Achieving reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.” (United Nations, 2005 a: para. 57g)*

Given all of the above, the present document intends to take a detailed look at each MDG, to assess how they are causally dependent on demographic trends, individual reproductive behaviour, gender issues, and the promotion of SRH. It is being published as one of the activities of Project RLA5P201 “Regional Support to Population and Development in the Implementation of the MDGs”, which is being developed jointly with the Institute for Applied Economic Research (IPEA) of Brazil, located in the Brasília office of IPEA. Apart from contributions from consultants, the Guide incorporated research going on at IPEA, particularly in the chapters on poverty and education. The purpose is to demonstrate how progress in the goals laid down in the ICPD may actually contribute to achieving the MDGs. The Guide is primarily based on the experiences of LAC region, as reflected in national and regional MDGRs and various research documents, but much of it also applies to other regions, which is why it is being published in English.

In many ways, the document mirrors the recent document *Public choices, private decisions: Sexual and Reproductive Health and the Millennium Development Goals* by Stan Bernstein and Charlotte Juul Hansen (UN Millennium Project, 2006), which constitutes one of the products of UNFPA’s participation in the UN Millennium Project. The differences between both documents are basically two. To the extent that the present study is focused on the LAC region, it is in a position to be more specific with respect to some issues than the study by Bernstein and Juul Hansen, which has a worldwide scope. This also allows the present publication to present more detailed evidence, especially at the country level. On the other hand, this document dedicates more attention to wider Population and Development issues, especially migration and spatial distribution, than the study by Bernstein and Juul Hansen, which is more focused on SRH. It is hoped that users of the two publications, particularly in the LAC region, will find them to be complementary.

Now that RH has found its place in the MDG agenda as a separate Target, it becomes more necessary than ever to argue the case of these other population dimensions in the realisation of the MDGs, without necessarily abandoning the more traditional arguments

<sup>5</sup> The Millennium Project was established in 2002, under the leadership of Prof. Jeffrey Sachs, Special Advisor to the Secretary-General on the MDGs. Task forces were established on hunger; education and gender equality (2 groups); child health and maternal health; HIV/AIDS, malaria, TB, and access to essential medication (4 groups); environmental sustainability; water and sanitation; improving the lives of slum dwellers; trade; and science, technology and innovation.

supporting the contribution of SRH to the process. All of these issues, therefore, will be taken up in the present Guide, in addition to the more traditional ones.

The overview below summarises the target and indicator frameworks of both agendas, to facilitate the comparison of their scopes. The MDG indicators are the 48 standard indicators defined by United Nations Secretariat, IMF, OECD, and the World Bank (United Nations, 2001). The ICPD indicators are derived from the regional monitoring system for the LAC region designed by CELADE (2001), complemented with additional indicators proposed in the minimum list of 17 prepared and agreed on by WHO (2001 a).

Table I.1: Comparative framework for the ICPD, ICPD+5 and MDG targets

ICPD PoA	MDGs
Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training, bearing in mind the need to improve the quality and relevance of that education (Para. 4.18).	Ensure that all boys and girls complete a full course of primary schooling.
Countries should strive to reduce their infant and under-5 mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 live births and an under-5 mortality rate below 60 deaths per 1,000 live births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further (Para. 8.16).	Reduce by two thirds the mortality rate among children under 5.
Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half by 2015. The realisation of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of maternal mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socioeconomic and ethnic groups should be narrowed (Para. 8.21).	Reduce by three quarters the maternal mortality ratio.
All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate age as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family planning counselling, information, education, communication, and services for pre-natal care, safe delivery and post-natal care; prevention and appropriate treatment of fertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other RH conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health care programmes (Para. 7.6).	Access to reproductive and sexual health services, including family planning (Note: in the actual Target proposed in 2006 by former Secretary-General Kofi Annan, the formulation is limited to reproductive health: see section 5.5.)
ICPD + 5	MDGs
Governments and civil society, with the assistance of the international community, should, as quickly as possible, and in any case before 2015, meet the Conference's goal of achieving universal access to primary education; eliminate the gender gap in primary and secondary education by 2005; and strive to ensure that by 2010 the net primary school enrolment ratio for children of both sexes will be at least 90%, compared with an estimated 85% in 2000 (Para. 34). Governments, in particular of developing countries, with the assistance of the international community, should: (...) reduce the rate of illiteracy of women and men, at least halving it for women and girls by 2005, compared with the rate in 1990 (Para. 35(c)).	Ensure that all boys and girls complete a full course of primary schooling.

<p>Governments should strive to ensure that by 2015 all primary health care and family planning facilities are able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases; and barrier methods (such as male and female condoms and microbicides if available) to prevent infection. By 2005, 60% of such facilities should be able to offer this range of services, and by 2010, 80% of them should be able to offer such services (Para. 53).</p> <p>Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50% by 2005, 75% by 2010 and 100% by 2050. In attempting to reach this benchmark, demographic goals, while legitimately the subject of government development strategies, should not be imposed on family planning providers in the form of targets or quotas for the recruitment of clients (Para. 58).</p>	<p>Reproductive health care and unmet need for contraception.</p>
<p>By 2005, where the maternal mortality rate is very high, at least 40% of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50% and by 2015, at least 60%. All countries should continue their efforts so that globally, by 2005, 80% all births should be assisted by skilled attendants, by 2010, 85%, and by 2015, 90% (Para. 64).</p>	<p>Reduce by three quarters the maternal mortality ratio.</p>
<p>Governments, with assistance from UNAIDS and donors, should, by 2005, ensure that at least 90%, and by 2010 at least 95%, of young men and women aged 15-24 have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection. Services should include access to preventive methods such as female and male condoms, voluntary testing, counselling and follow-up. Governments should use, as a benchmark indicator, HIV infection rates in persons 15-24 years of age, with the goal of ensuring that by 2005 prevalence in this age group is reduced globally, and by 25% in the most affected countries, and that by 2010 prevalence in this age group is reduced globally by 25% (Para. 70).</p>	<p>Halt and begin to reverse the spread of HIV/AIDS.</p>

Source: UNFPA, 2003 c

Table I.2: Comparative framework for the ICPD and MDG indicators

ICPD	MDGs
<p>Contextual indicators for population and public policies</p> <p>Population structure</p> <ul style="list-style-type: none"> <li>• Total population</li> <li>• Population (male)</li> <li>• Population (female)</li> <li>• Population 0-14 (percentage)</li> <li>• Population 15-64 (percentage)</li> <li>• Population + 65 (percentage)</li> <li>• Population + 80 (percentage)</li> <li>• Total dependency ratio</li> <li>• Youth dependency ratio</li> <li>• Elderly dependency ratio</li> </ul> <p>Population growth</p> <ul style="list-style-type: none"> <li>• Total growth rate</li> <li>• Growth rate 0-14</li> <li>• Growth rate 15-64</li> <li>• Growth rate over 65</li> <li>• Growth rate over 80</li> <li>• Gross birth rate</li> <li>• Gross mortality rate</li> </ul> <p>Population distribution</p> <ul style="list-style-type: none"> <li>• Urbanisation (percentage)</li> <li>• Primacy of main city (ratio)</li> <li>• Urban population – Cities 2,000-20,000</li> <li>• Urban population – Cities 20,000-50,000</li> <li>• Urban population – Cities 50,000-500,000</li> <li>• Urban population – Cities 500,000-1,000,000</li> <li>• Urban population – Cities + 1,000,000</li> <li>• Urban female/male ratio</li> <li>• Rural female/male ratio</li> </ul> <p>Demographic ageing</p> <ul style="list-style-type: none"> <li>• Elderly population (percentage)</li> <li>• Ageing index</li> <li>• Households with elder people (percentage)</li> <li>• Households with elder people 1 person (percentage)</li> <li>• Single generation households with elderly people + 1 person (percentage)</li> <li>• Multigenerational households with elderly people (percentage)</li> <li>• Elderly female/male ratio</li> </ul>	

<p>Poverty</p> <ul style="list-style-type: none"> <li>Population under national poverty line</li> <li>Population under national poverty line (male)</li> <li>Population under national poverty line (female)</li> <li>Population under extreme poverty line</li> <li>Population under extreme poverty line (male)</li> <li>Population under extreme poverty line (female)</li> </ul> <p>Malnutrition in children</p> <ul style="list-style-type: none"> <li>Malnutrition under 5 (total)</li> <li>Malnutrition under 5 (male)</li> <li>Malnutrition under 5 (female)</li> </ul>	<p>Goal 1. Eradicate extreme poverty and hunger</p> <p>Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day</p> <ul style="list-style-type: none"> <li>Proportion of population below US\$ 1 (1993 PPP) per day (World Bank)</li> <li>Poverty gap ratio [incidence x depth of poverty] (World Bank)</li> <li>Share of poorest quintile in national consumption (World Bank)</li> </ul> <p>Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger</p> <ul style="list-style-type: none"> <li>Prevalence of underweight children under 5 years of age (UNICEF-WHO)</li> <li>Proportion of population below minimum level of dietary energy consumption (FAO)</li> </ul>
<p>Education</p> <ul style="list-style-type: none"> <li>Illiteracy rate (male)</li> <li>Illiteracy rate (female)</li> <li>Primary education net ratio (male)</li> <li>Primary education net ratio (female)</li> <li>Secondary education net ratio (male)</li> <li>Secondary education net ratio (female)</li> <li>Higher education net ratio (male)</li> <li>Higher education net ratio (female)</li> </ul>	<p>Goal 2. Achieve universal primary education</p> <p>Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</p> <ul style="list-style-type: none"> <li>Net enrolment ratio in primary education (UNESCO)</li> <li>Proportion of pupils starting grade 1 who reach grade 5 (UNESCO)</li> <li>Literacy rate of 15-24 year-olds (UNESCO)</li> </ul>
<p>Gender</p> <ul style="list-style-type: none"> <li>Gender parity index primary education</li> <li>Gender parity index secondary education</li> <li>Gender parity index higher education</li> <li>Households headed by women</li> <li>Economic participation rate (male)</li> <li>Economic participation rate (female)</li> <li>Employed according to qualification, female manual workers</li> <li>Employed according to qualification, female administrative personnel</li> <li>Employed according to qualification, female professionals and technicians</li> <li>Employed according to qualification, female in directing positions</li> <li>Gap according to qualification, female manual workers</li> <li>Gap according to qualification, female administrative personnel</li> <li>Gap according to qualification, female professionals and technicians</li> <li>Gap according to qualification, female in directing positions</li> <li>Female parliamentarians (percentage)</li> </ul>	<p>Goal 3. Promote gender equality and empower women</p> <p>Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015</p> <ul style="list-style-type: none"> <li>Ratio of girls to boys in primary, secondary, and tertiary education (UNESCO)</li> <li>Ratio of literate women to men, 15-24 year-olds (UNESCO)</li> <li>Share of women in wage employment in the non-agricultural sector (ILO)</li> <li>Proportion of seats held by women in national parliament (IPU)</li> </ul>
<p>Maternal and child attention</p> <ul style="list-style-type: none"> <li>Child mortality rate</li> <li>Child mortality rate (male)</li> <li>Child mortality rate (female)</li> <li>Infant mortality rate</li> <li>Infant mortality rate (male)</li> <li>Infant mortality rate (female)</li> <li>Perinatal mortality rate</li> <li>Low birth weight prevalence</li> <li>Vaccination coverage against measles</li> <li>Vaccination coverage (complete)</li> <li>Maternal mortality ratio</li> <li>Antenatal care coverage</li> <li>Births attended by skilled health personnel</li> <li>Availability of basic essential obstetric care</li> <li>Availability of comprehensive essential obstetric care</li> <li>Positive syphilis serology prevalence in women</li> <li>Prevalence of anaemia in women</li> <li>Percentage of obstetric and gynaecological admissions owing to abortion</li> <li>Reported prevalence of women with FGM</li> </ul>	<p>Goal 4. Reduce child mortality</p> <p>Target 5: Reduce by two thirds, between 1990 and 2015, the under 5 mortality rate</p> <ul style="list-style-type: none"> <li>Under 5 mortality rate (UNICEF-WHO)</li> <li>Infant mortality rate (UNICEF-WHO)</li> <li>Proportion of 1-year-old children immunised against measles (UNICEF-WHO)</li> </ul> <p>Goal 5. Improve maternal health</p> <p>Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio</p> <ul style="list-style-type: none"> <li>Maternal mortality ratio (UNICEF-WHO)</li> <li>Proportion of births attended by skilled health personnel (UNICEF-WHO)</li> </ul>
<p>General mortality</p> <ul style="list-style-type: none"> <li>Life expectancy</li> <li>Life expectancy (male)</li> <li>Life expectancy (female)</li> </ul>	

<p>Sexually-transmitted diseases and HIV</p> <ul style="list-style-type: none"> <li>• HIV prevalence rate among pregnant women</li> <li>• HIV prevalence rate among population of fertile age</li> <li>• Knowledge of prevention practices of STDs and HIV/AIDS</li> </ul>	<p>Goal 6. Combat HIV/AIDS, malaria and other diseases  Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS</p> <ul style="list-style-type: none"> <li>• HIV prevalence in pregnant women aged 15-24 years (UNAIDS-WHO-UNICEF)</li> <li>• Condom use rate of the contraceptive prevalence rate (UN Population Division)</li> <li>• Condom use at last high-risk sex (UNICEF-WHO)</li> <li>• Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (UNICEF-WHO)</li> <li>• Contraceptive prevalence rate (UN Population Division) (now under the new RH Target of MDG 5)</li> <li>• Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years (UNICEF-UNAIDS-WHO)</li> </ul> <p>Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases</p> <ul style="list-style-type: none"> <li>• Prevalence and death rates associated with malaria (WHO)</li> <li>• Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures (UNICEF-WHO)</li> <li>• Prevalence and death rates associated with tuberculosis (WHO)</li> <li>• Proportion of tuberculosis cases detected and cured under DOTS (internationally recommended TB control strategy) (WHO)</li> </ul>
<p>Fertility and family planning</p> <ul style="list-style-type: none"> <li>• Number of births</li> <li>• Total fertility rate</li> <li>• Unwanted fertility (percentage)</li> <li>• Contraceptive prevalence rate</li> <li>• Unsatisfied demand for family planning</li> <li>• Prevalence of infertility in women</li> </ul> <p>Adolescent sexual health</p> <ul style="list-style-type: none"> <li>• Fertility rate, women 15-19</li> <li>• Adolescent mothers (percentage)</li> <li>• Knowledge of contraceptive methods, men 15-19</li> <li>• Knowledge of contraceptive methods, women 15-19</li> <li>• Knowledge of fertile period, women 15-19</li> </ul>	
<p>Basic sanitation</p> <ul style="list-style-type: none"> <li>• Access to safe drinking water</li> <li>• Access to sanitary service</li> </ul>	<p>Goal 7. Ensure environmental sustainability  Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources</p> <p>Proportion of land area covered by forests (FAO)</p> <ul style="list-style-type: none"> <li>• Ratio of area protected to maintain biological diversity to surface area (UNEP-WCMC)</li> <li>• Energy use (kg oil equivalent) per US\$ 1,000 GDP (PPP) (IEA, World Bank)</li> <li>• Carbon dioxide emissions per capita (UNFCCC, UNSD) and consumption of ozone-depleting CFCs (ODP tons) (UNEP – Ozone Secretariat)</li> <li>• Proportion of population using solid fuels (WHO)</li> </ul> <p>Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation</p> <ul style="list-style-type: none"> <li>• Proportion of population with sustainable access to an improved water source, urban and rural (UNICEF-WHO)</li> <li>• Proportion of population with access to improved sanitation, urban and rural (UNICEF-WHO)</li> </ul> <p>Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers</p> <ul style="list-style-type: none"> <li>• Proportion of households with access to secure tenure (UN-HABITAT)</li> </ul>
	<p>Goal 8. Develop a global partnership for development  Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development and poverty reduction – both nationally and internationally  Target 13: Address the special needs of the least developed countries. Includes: tariff and quota-free access for least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p>

	<p>Target 14: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</p> <p>Target 15: Official development assistance (ODA), market access, and debt sustainability</p> <ul style="list-style-type: none"> <li>• Net ODA, total and to LDCs, as percentage of donors' gross national income (OECD)</li> <li>• Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) (OECD)</li> <li>• Proportion of bilateral ODA of OECD/DAC donors that is untied (OECD)</li> <li>• ODA received in landlocked developing countries as a proportion of their gross national incomes (OECD)</li> <li>• ODA received in small island developing countries as a proportion of their gross national incomes (OECD)</li> <li>• Proportion of total developed country imports (by value and excluding arms) from developing countries admitted free of duty (UNCTAD, WTO, World Bank)</li> <li>• Average tariffs imposed by developed countries on agricultural products on textiles and clothing from developing countries (UNCTAD, WTO, World Bank)</li> <li>• Agricultural support estimate for OECD countries as percentage of their GDP (OECD)</li> <li>• Proportion of ODA provided to help build trade capacity (OECD, WTO)</li> </ul> <p>Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) (IMF, World Bank)</p> <ul style="list-style-type: none"> <li>• Debt relief committed under HIPC initiative (IMF, World Bank)</li> <li>• Debt service as percentage of exports of goods and services (IMF, World Bank)</li> </ul> <p>Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth</p> <ul style="list-style-type: none"> <li>• Unemployment rate of young people aged 15-24 years, each sex and total (ILO)</li> </ul> <p>Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries</p> <ul style="list-style-type: none"> <li>• Proportion of population with access to affordable essential drugs on a sustainable basis (WHO)</li> </ul> <p>Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications</p> <ul style="list-style-type: none"> <li>• Telephone lines and cellular subscribers per 100 population (ITU)</li> <li>• Personal computers in use per 100 population and internet users per 100 population (ITU)</li> </ul>
<p>Gender</p> <ul style="list-style-type: none"> <li>• Unemployment rate (male)</li> <li>• Unemployment rate (female)</li> </ul>	

