Population Division
Department of Economic and Social Affairs
United Nations Secretariat

FERTILITY, CONTRACEPTION AND POPULATION POLICIES

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ESA/P/WP.182
25 April 2003

English Only

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United Nations
New York, 2003

NOTE

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Printed in the United Nations, New York

PREFACE

The Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat is responsible for providing the international community with up-to-date and scientifically objective information on population and development.

A major characteristic of the United Nations conferences held in the 1990s is the emphasis placed on ensuring the proper monitoring of the implementation of their goals and recommendations. The Programme of Action adopted by the International Conference on Population and Development at Cairo, in 1994 recommended that actions should be taken to measure, assess, monitor and evaluate progress towards meeting the goals of the present Programme of Action.[1] As part of its work programme, the Population Division is responsible for the global monitoring of the implementation of the Programme of Action of the 1994 International Conference on Population and Development as it was for the Plan of Action of the 1974 World Population Conference.

The present publication is part of the effort of the Population Division to disseminate the information resulting from its monitoring activities in relation to fertility, contraception and population policies. Responsibility for this publication rests with the Population Division.

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[1] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, annex, para. 13.6.

CONTENTS

TABLES

FIGURES

ANNEX TABLE

INTRODUCTION

Governments' views and policies with regard to the use of contraceptives have changed considerably during the second half of the 20th century. At the same time, many developing countries have experienced a transition from high to low fertility with a speed and magnitude that far exceeds the earlier fertility transition in European countries. Government policies on access to contraceptives have played an important role in the shift in reproductive behaviour. Low fertility now prevails in some developing countries, as well as in most developed countries. The use of contraception is currently widespread throughout the world. The highest prevalence rates at present are found in more developed countries and in China.

This chapter begins with a global overview of the current situation with regard to Governments'views and policies on contraception. It then briefly summarizes the five phases in the evolution of population policies, from the founding of the United Nations to the beginning of the 21st century. It examines the various policy recommendations concerning contraception adopted at the three United Nations international population conferences, and it discusses the role of regional population conferences in shaping the policies of developed and developing countries.

As part of its work programme, the Population Division of the United Nations Secretariat is responsible for the global monitoring of the implementation of the Programme of Action of the 1994 International Conference on Population and Development (ICPD). To this end, the Population Division maintains a Population Policy Data Bank, which includes information from many sources. Among these sources are official Government responses to the United Nations Population Inquiries; Government and inter-governmental publications, documents and other sources; and non-governmental publications and related materials (United Nations, 2002a).

I. GLOBAL OVERVIEW OF CURRENT GOVERNMENT VIEWS AND POLICIES ON FERTILITY AND PROVIDING ACCESS TO CONTRACEPTIVE METHODS

At the beginning of the 21st century, the percentage of countries that reported that they were satisfied with their fertility level continued to decline, with the result that only 38 per cent of countries found the present level satisfactory (see table 1). Far more countries considered fertility to be too high rather than too low, but the percentage of countries that viewed fertility as too high, after rising from 1976 to 1996, leveled off after 1996 at about 45 per cent. Among countries in less developed regions, 58 per cent considered fertility too high, while more than three fourths (78 per cent) of the 49 least developed countries said fertility was too high in 2001. By contrast, the percentage of countries that considered fertility to be too low has been climbing over the last three decades. Of the more developed countries, fully half now consider fertility to be too low (up from 21 per cent in 1976), while 48 per cent are satisfied with the level of fertility. Seven per cent of countries in less developed regions considered fertility to be too low in 2001.

In the past, dissatisfaction with the level of fertility has not necessarily translated into a policy intervention. In 1976, more than one half of countries (52 per cent) did not intervene to modify the level of fertility. By 2001, the percentage of non-interventionist countries had fallen to one-third (table 2, figure I). However, countries that view fertility as too high are more likely to

TABLE 1. GOVERNMENT VIEWS ON THE LEVEL OF FERTILITY: 1976, 1986, 1996 AND 2001

Year	(Number of countries)				(Percentage)			
	Too low	*Satisfactory*	*Too high*	*Total*	*Too low*	*Satisfactory*	*Too high*	*Total*
				A. By level of development				
				World				
1976	16	79	55	150	11	53	37	100
1986	22	75	67	164	13	46	41	100
1996	28	78	87	193	15	40	45	100
2001	34	74	85	193	18	38	44	100
				More developed regions				
1976	7	27	0	34	21	79	0	100
1986	9	25	0	34	26	74	0	100
1996	19	28	1	48	40	58	2	100
2001	24	23	1	48	50	48	2	100
				Less developed regions				
1976	9	52	55	116	8	45	47	100
1986	13	50	67	130	10	38	52	100
1996	9	50	86	145	6	34	60	100
2001	10	51	84	145	7	35	58	100
				Least developed countries				
1976	3	26	13	42	7	62	31	100
1986	2	20	26	48	4	42	54	100
1996	0	11	38	49	0	22	78	100
2001	0	11	38	49	0	22	78	100

Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12).

TABLE 1. (CONTINUED)

Year	*B. Major area*							
	(Number of countries)				*(Percentage)*			
	Too low	*Satisfactory*	*Too high*	*Total*	*Too low*	*Satisfactory*	*Too high*	*Total*
				Africa				
1976	5	25	18	48	10	52	38	100
1986	3	17	31	51	6	33	61	100
1996	1	11	41	53	2	21	77	100
2001	1	11	41	53	2	21	77	100
				Asia				
1976	2	18	17	37	5	49	46	100
1986	7	17	14	38	18	45	37	100
1996	7	20	19	46	15	43	41	100
2001	8	19	19	46	17	41	41	100
				Europe				
1976	7	22	0	29	24	76	0	100
1986	9	20	0	29	31	69	0	100
1996	18	24	1	43	42	56	2	100
2001	23	19	1	43	53	44	2	100
				Latin America and the Caribbean				
1976	2	9	16	27	7	33	59	100
1986	3	15	15	33	9	45	45	100
1996	1	14	18	33	3	42	55	100
2001	1	15	17	33	3	45	52	100
				Northern America				
1976	0	2	0	2	0	100	0	100
1986	0	2	0	2	0	100	0	100
1996	0	2	0	2	0	100	0	100
2001	0	2	0	2	0	100	0	100
				Oceania				
1976	0	3	4	7	0	43	57	100
1986	0	4	7	11	0	36	64	100
1996	1	7	8	16	6	44	50	100
2001	1	8	7	16	6	50	44	100

Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12)..

Table 2. Government policies on the level of fertility: 1976, 1986, 1996 and 2001

Year	Raise	Maintain	Lower	No intervention	Total	Raise	Maintain	Lower	No intervention	Total
A. By level of development										
	(Number of countries)					*(Percentage)*				
					World					
1976	13	19	40	78	150	9	13	27	52	100
1986	19	16	54	75	164	12	10	33	46	100
1996	27	20	82	64	193	14	10	42	33	100
2001	26	19	86	62	193	13	10	45	32	100
					More developed regions					
1976	7	7	0	20	34	12	21	0	59	100
1986	8	6	0	20	34	24	18	0	59	100
1996	16	4	1	27	48	33	8	2	56	100
2001	15	4	1	28	48	31	10	2	56	100
					Less developed regions					
1976	6	12	40	58	116	5	10	34	50	100
1986	11	10	54	55	130	8	8	42	42	100
1996	11	16	81	37	145	8	11	56	24	100
2001	11	14	85	35	145	8	10	59	24	100
					Least developed countries					
1976	1	2	6	33	42	2	5	14	79	100
1986	2	4	15	27	48	4	8	31	56	100
1996	0	3	32	14	49	0	6	65	29	100
2001	0	4	34	11	49	0	8	69	22	100

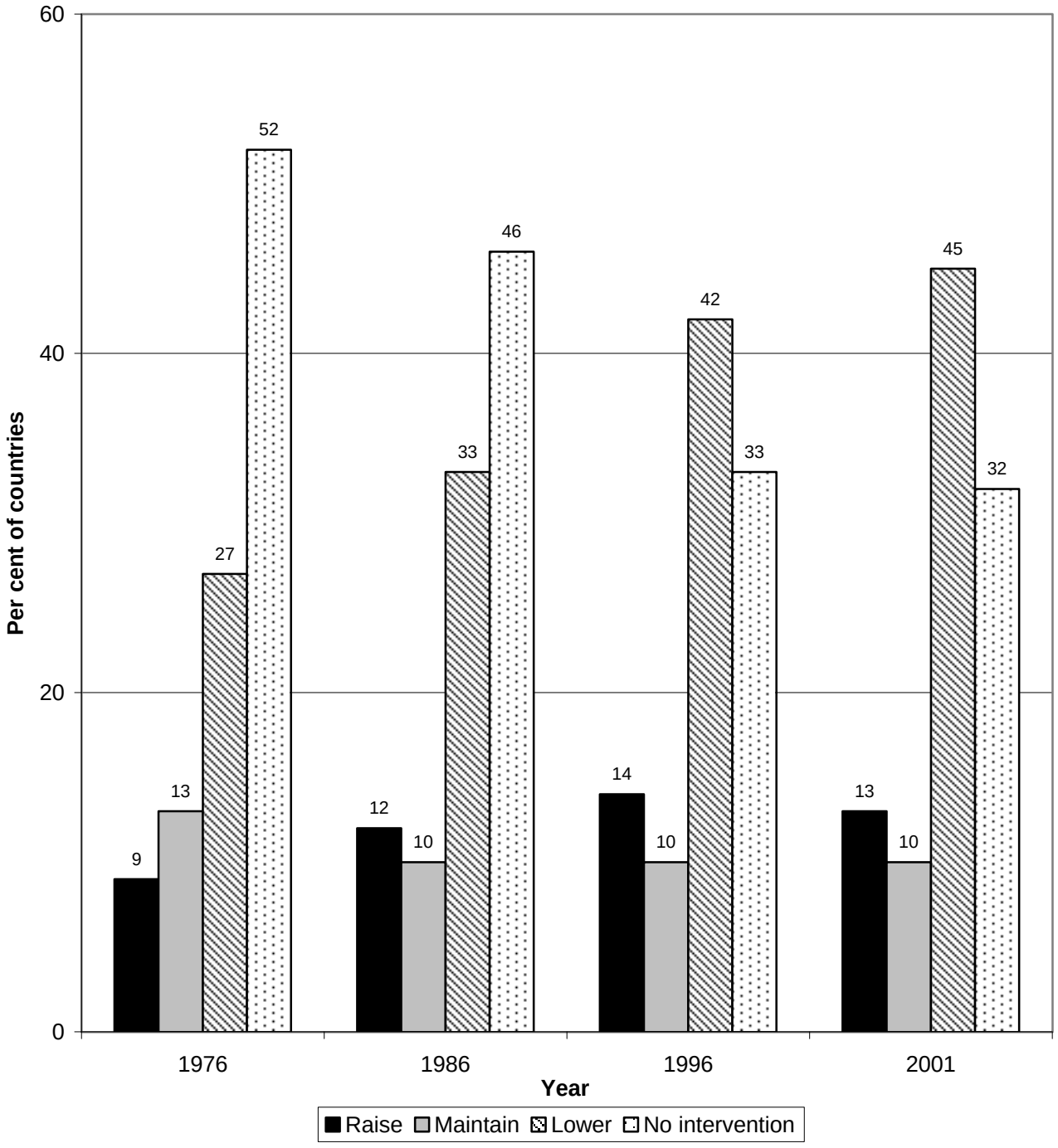
Source: National Population Policies 2001 (United Nations publication, Sales No. E.02.XIII.12).

TABLE 2. (CONTINUED)

Year	(Number of countries)					(Percentage)				
	Raise	Maintain	Lower	No intervention	Total	Raise	Maintain	Lower	No intervention	Total
					B. Major area					
					Africa					
1976	2	2	12	32	48	4	4	25	67	100
1986	3	3	21	24	51	6	6	41	47	100
1996	2	3	36	12	53	4	6	68	23	100
2001	1	3	38	11	53	2	6	72	21	100
					Asia					
1976	2	9	14	12	37	5	24	38	32	100
1986	8	6	13	11	38	21	16	34	29	100
1996	7	9	19	11	46	15	20	41	24	100
2001	8	7	20	11	46	17	15	43	24	100
					Europe					
1976	7	7	0	15	29	24	24	0	52	100
1986	8	6	0	15	29	28	21	0	52	100
1996	16	4	1	22	43	37	9	2	51	100
2001	15	5	1	22	43	35	12	2	51	100
					Latin America and the Caribbean					
1976	2	0	10	15	27	7	0	37	56	100
1986	0	0	15	18	33	0	0	45	55	100
1996	1	1	18	13	33	3	3	55	39	100
2001	1	1	19	12	33	3	3	58	36	100
					Northern America					
1976	0	0	0	2	2	0	0	0	100	100
1986	0	0	0	2	2	0	0	0	100	100
1996	0	0	0	2	2	0	0	0	100	100
2001	0	0	0	2	2	0	0	0	100	100
					Oceania					
1976	0	1	4	2	7	0	14	57	29	100
1986	0	1	5	5	11	0	9	45	45	100
1996	1	3	8	4	16	6	19	50	25	100
2001	1	3	8	4	16	6	19	50	25	100

Source: National Population Policies 2001 (United Nations publication, Sales No. E.02.XIII.12).

Figure I. Government policies on the level of fertility, 1976-2001



Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12).

intervene than countries that view fertility as too low. In 2001 practically the same percentage of countries that considered fertility too high (44 per cent) had adopted policies to lower fertility (45 per cent). In contrast, of the countries that considered fertility to be too low, eight of the 34 countries in this category did not have a policy in place to raise fertility.

An important determinant of reproductive behaviour, as well as of maternal and child health, has been Government policies on providing access to contraceptive methods. Direct support entails the provision of family planning services through Government-run facilities, such as hospitals, clinics, health posts and health centres and through Government fieldworkers. Government support for methods of contraception has been steadily increasing during the last quarter of the twentieth century. By 2001, 92 per cent of all countries supported family planning programmes and contraceptives, either directly (75 per cent), through government facilities, or indirectly (17 per cent), through support of non-governmental activities, such as those operated by family planning associations (see table 3). Despite the pervasiveness of Government support for contraceptive methods, the demand for family planning services is believed to outstrip the supply. It has been estimated that as of 2000, some 123 million women did not have ready access to safe and effective means of contraception (Ross and Winfrey, 2002).

In many countries, Government support for contraception preceded the formulation of population policies. The responses to the first United Nations Population Inquiry in 1963 indicated that of the 53 countries that replied, none had formulated policies aimed at altering the reproductive behaviour of their respective populations. Nevertheless, many countries supported the distribution of contraceptive supplies. In Africa, particularly Northern Africa, many countries began providing direct support for contraceptive distribution as early as the mid 1970s. These Governments supported contraceptive methods as part of basic reproductive health services even in the absence of policies to reduce population growth or fertility levels. Moreover, many countries in Asia (excepting Western Asia) and Latin America and the Caribbean were also early supporters of family planning.

During the last 30 years, nearly all countries have shifted their policies in favour of increased direct or indirect support for contraceptive methods. Even previously pronatalist Governments, which in the past had wanted to maintain or even increase the rate of population growth, have gradually changed their stance and now accept family planning and contraception as an integral part of maternal and child health programmes. At the same time, some countries, particularly in Europe (for example, Austria, Denmark, France, Italy and Switzerland) have reduced support for family planning programmes, possibly as a response to below-replacement fertility rates, or an acknowledgement that the private sector was meeting demands for contraception without Government subsidies (see Annex table).

In Eastern Europe, profound economic and political changes have been accompanied by a sharp decline in fertility, resulting in some of the lowest fertility rates in the world. Several reasons have been suggested to explain the situation: political instability has led to a “fear of the future” and a reluctance to have children; the economic crisis has lowered per capita income and living standards; and new forms of the family, which favour low fertility, have been adopted (Economic Commission for Europe, 2002). Although most countries in Eastern Europe considered fertility to be too low in 2001, they continue to support access to contraceptive methods.

Policy formulation and implementation differ according to level of development. In developing countries, there is a clear trend towards increased Government support for methods of contraception (figure II). This trend is especially visible in the group of least developed countries,

TABLE 3. GOVERNMENT POLICIES ON PROVIDING ACCESS TO CONTRACEPTIVE METHODS: 1976, 1986, 1996 AND 2001

A. By level of development

Year	*(Number of countries)*					*(Percentage)*				
	Limits	*No support*	*Indirect support*	*Direct support*	*Total*	*Limits*	*No support*	*Indirect support*	*Direct support*	*Total*
					World					
1976	10	28	17	95	150	7	19	11	63	100
1986	7	18	22	117	164	4	11	13	71	100
1996	2	26	18	143	189	1	14	10	76	100
2001	1	16	32	144	193	1	8	17	75	100
					More developed regions					
1976	3	4	6	21	34	9	12	18	62	100
1986	3	4	8	19	34	9	12	24	56	100
1996	1	12	7	28	48	2	25	15	58	100
2001	1	8	17	22	48	2	17	35	46	100
					Less developed regions					
1976	7	24	11	74	116	6	21	9	64	100
1986	4	14	14	98	130	3	11	11	75	100
1996	1	14	11	115	141	1	10	7	82	100
2001	0	8	15	122	145	0	6	10	84	100
					Least developed countries					
1976	4	14	6	18	42	10	33	14	43	100
1986	2	4	7	35	48	4	8	15	73	100
1996	0	3	3	42	48	0	6	6	88	100
2001	0	2	4	43	49	0	4	8	88	100

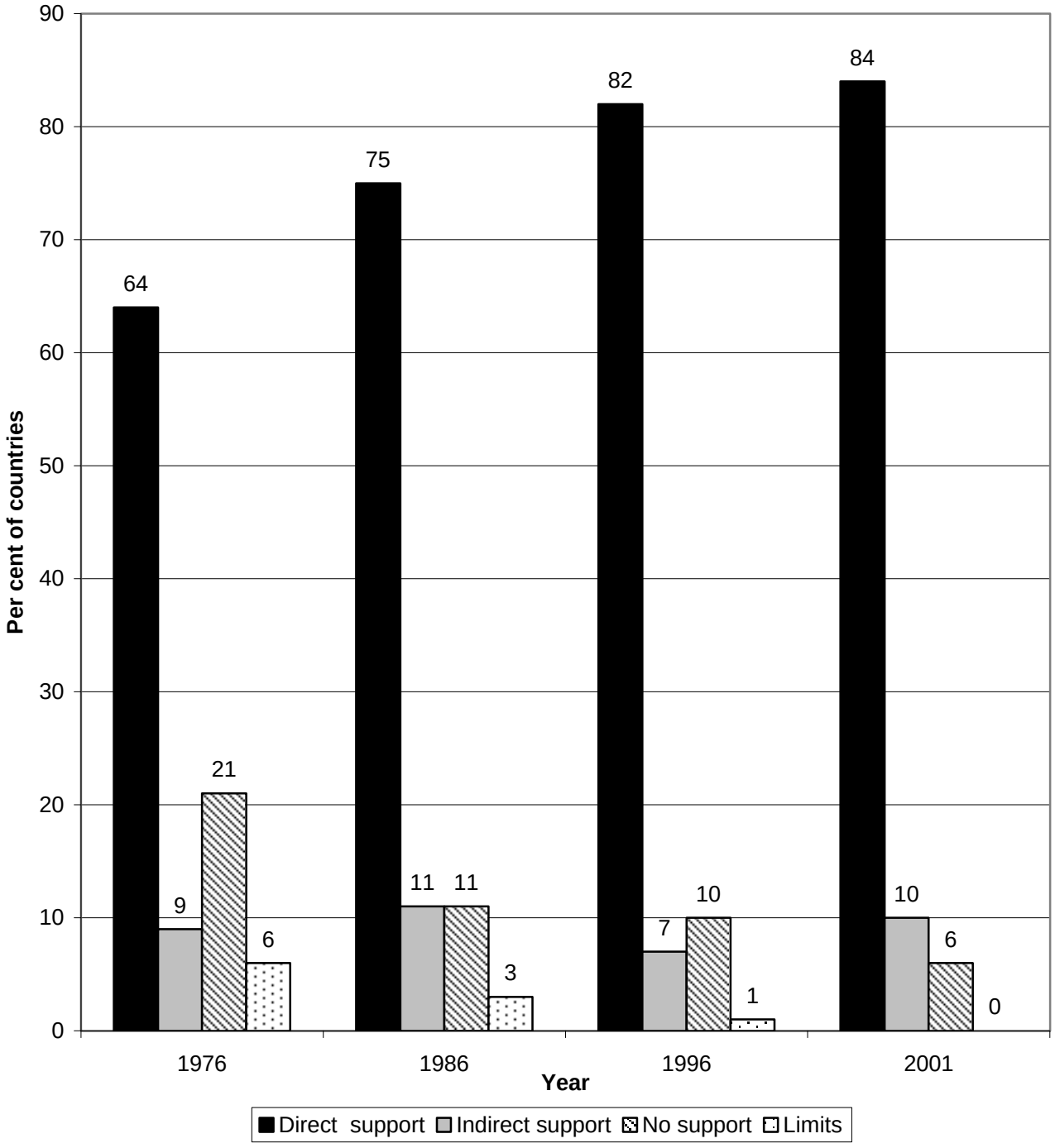
Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12).

TABLE 3. (CONTINUED)

Year	Limits	No support	Indirect support	Direct support	Total	Limits	No support	Indirect support	Direct support	Total
	(Number of countries)					*(Percentage)*				
B. By major area										
Africa										
1976	3	14	7	24	48	6	29	15	50	100
1986	0	7	6	38	51	0	14	12	75	100
1996	0	4	5	43	52	0	8	10	83	100
2001	0	3	5	45	53	0	6	9	85	100
Asia										
1976	3	7	2	25	37	8	19	5	68	100
1986	4	5	4	25	38	11	13	11	66	100
1996	1	9	3	32	45	2	20	7	71	100
2001	0	5	7	34	46	0	11	15	74	100
Europe										
1976	3	4	5	17	29	10	14	17	59	100
1986	3	4	6	16	29	10	14	21	55	100
1996	1	12	6	24	43	2	24	7	66	100
2001	1	8	13	21	43	2	9	37	51	100
Latin America and the Caribbean										
1976	1	3	2	21	27	4	11	7	78	100
1986	0	2	4	27	33	0	6	12	82	100
1996	0	1	3	29	33	0	3	9	88	100
2001	0	0	2	31	33	0	0	6	94	100
Northern America										
1976	0	0	0	2	2	0	0	0	100	100
1986	0	0	0	2	2	0	0	0	100	100
1996	0	0	0	2	2	0	0	0	100	100
2001	0	0	1	1	2	0	0	50	50	100
Oceania										
1976	0	0	1	6	7	0	0	14	86	100
1986	0	0	2	9	11	0	0	18	82	100
1996	0	0	1	13	14	0	0	7	93	100
2001	0	0	4	12	16	0	0	25	75	100

Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12).

Figure II. Government policies on providing access to contraceptive methods, 1976-2001: Less developed regions



Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12).

which have moved from having a low percentage of supportive Governments in the early 1970s to almost unanimous support at the present time. Data referring to 2001 show that the least developed countries have the highest percentage (96 per cent) of Governments with direct and indirect support policies in place. Only two least developed countries, Equatorial Guinea and Lao People's Democratic Republic, offer no official support for contraception. By contrast, in developed countries, there has been a shift away from direct support of contraception to indirect support. Among the more developed countries, 62 per cent had implemented direct support policies in 1976, whereas in 2001, fewer than half (46 per cent) had such policies in place (figure III).

II. FIVE PHASES IN THE EVOLUTION OF GOVERNMENT POLICIES

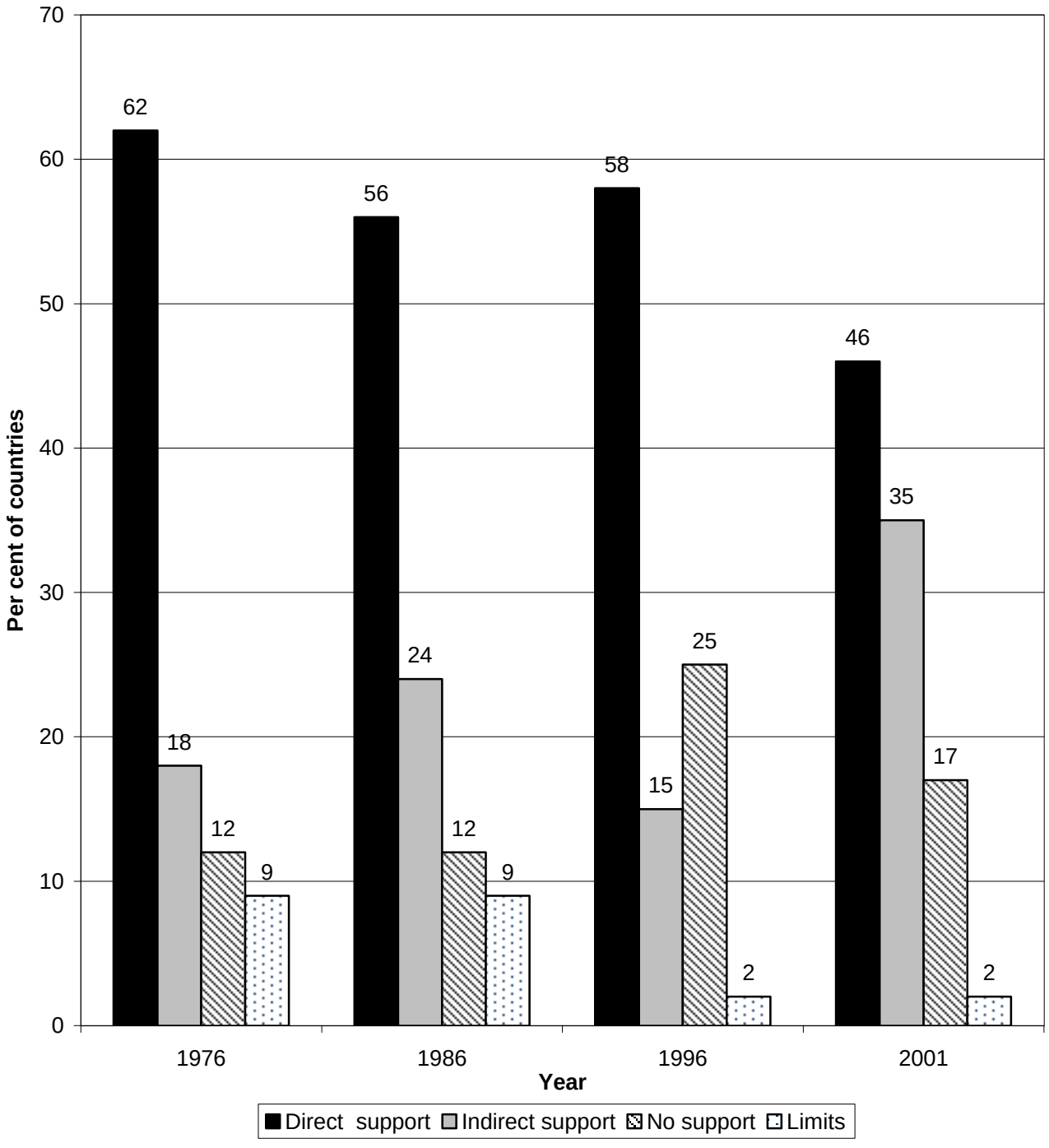
The evolution of population policies can be divided into five phases: (a) the 25-year period following the establishment of the United Nations (1945-1970); (b) the decade of the 1974 World Population Conference in Bucharest (1970-1980); (c) the decade of the 1984 International Conference on Population in Mexico City (1980-1990); (d) the decade of the 1994 International Conference on Population and Development (ICPD) in Cairo (1990-2000); and (e) the beginning of the 21st century.

A. Population policy development following the establishment of the United Nations, 1945-1970

During the first decades following the establishment of the United Nations, population and development were only beginning to emerge as concerns of the international community. Demographic data were generally lacking or deficient, as many countries had never conducted a census. Thus, knowledge of global population trends was limited, while the relationship between rapid population growth and economic development was only beginning to be explored. Moreover, fertility and family planning were not generally considered to be appropriate areas for government intervention. However, by the 1950s, the United Nations had established a programme of technical assistance in the field of population, focusing on demographic data collection and analytical studies rather than family planning activities (Gille, 1987). The earliest requests for technical assistance came from the Governments of Brazil, India, Indonesia and Thailand.

It was in this context that the United Nations organized the World Population Conference in Rome in September 1954. Unlike subsequent international population conferences, the Rome conference was a scientific exchange of information. Participants consisted of demographers and population specialists who did not represent governments. The Conference addressed the entire gamut of population issues and helped to establish the importance of demographic research for population policy. The inadequacy of statistics for much of the world's population was highlighted, as were ideological differences, particularly between Western countries and representatives of the USSR, who contended that rapid population growth was only a problem for capitalistic societies (Macura, 1987). An important outcome of the Conference was its focus on the need to study all populations in the context of their particular economic, social and cultural conditions. Although the main emphasis of the Rome Conference was on demographic research and gaps in knowledge, it also provided a platform for wider concerns, indicating that the importance of global population trends was beginning to be acknowledged.

Figure III. Government policies on providing access to contraceptive methods, 1976-2001: More developed regions



Source: National Population Policies, 2001 (United Nations publication, Sales No. E.02.XIII.12).

In 1959, a Presidential Committee on the United States foreign aid programme, chaired by General William Draper, Jr., recommended that the United States Government should assist countries that requested help in designing programmes to deal with rapid population growth and that it should support research on the topic. President Eisenhower rejected this recommendation, saying emphatically that it was not a proper function or responsibility of Government. Within a few years, however, attitudes began to change dramatically. The United Nations General Assembly had designated the 1960s as the UN Decade of Development, reflecting a growing international consensus that development should be an important objective of United Nations assistance. Evidence was accumulating that rapid population growth could wipe out the gains accruing to economic development by diverting resources from investment to consumption (Coale and Hoover, 1958; Notestein, 1964). Modernization, it was felt, required investment not only in capital equipment but also in human capital, such as health and education. High birth rates and a young population hampered the ability of developing countries to save and invest sufficiently in order to raise the country's per capita income and improve living standards. Coale and Hoover (1958) estimated that in India, reducing fertility by 50 per cent would in a generation induce a level of per capita income about 40 per cent higher than if fertility had not been reduced.

Several developing countries, without support from more developed countries, began to respond to rapid population growth by introducing family planning programmes. In 1959, the Government of India declared that it supported all methods of family limitation, including sterilization. In Pakistan, a group of citizens founded the Family Planning Association of Pakistan and opened family planning clinics in several cities, with no financial support from the Government. Similar activities to limit population growth occurred in Japan, Singapore, and some small island states of the Caribbean and the Pacific. The Government of Egypt, recognizing the problem of its rapidly growing population, established a national family planning programme in 1962 (Johnson, 1994). These developments were crucial in persuading potential donor countries like the United States, as well as the United Nations, that international action on population concerns was both timely and appropriate. In 1961, the United Nations Population Commission made an important statement on population policy: it said that each Government had the responsibility to make its own policies and devise its own programmes for dealing with its population issues, and that the United Nations should encourage and assist Governments in obtaining basic population data and carrying out studies on the demographic aspects of their economic and social development problems. The statement also said that the United Nations should provide technical assistance to Governments who requested it for national projects of research, experimentation and action for dealing with problems of population (United Nations, 1987).

In 1962, the United Nations General Assembly passed Resolution 1839 on population growth and economic development, which established the guidelines for United Nations activity in the population field for the next decade and more. Among other things, it called for increased research on the relationship between population growth and economic and social development; it recommended that the Second World Population Conference, to be held in Belgrade in 1965, pay special attention to this relationship; and it directed the Secretariat to conduct an inquiry among Governments concerning problems in the realm of population and development (GA Resolution 1839 (XVII) of 18 December 1962).

The Belgrade conference in 1965, like the conference in Rome more than a decade earlier, was a scientific gathering, with experts participating in their individual capacities. It differed, however, in that it took a broader approach to the population problem and provided a forum where experts could examine population trends and assess their implications. Ideological differences continued: some countries objected to the involvement of the United Nations in population policy and family planning, as well as in research on methods of fertility control. A new tide of interest was spreading through the Organization. The United Nations Economic and Social Commission for Asia and the Pacific called upon the United Nations to expand the scope of technical assistance. In addition, the Economic Commission for Latin America and the Caribbean cited survey results demonstrating that people were more favourably disposed than political leaders to population limitation. Chile became the first country in Latin America to incorporate family planning services within the national health service, largely because of concerns with the increasing number of illegal abortions.

The papers presented at the Second World Population Conference in Belgrade discussed national family planning programmes in some 20 developing countries, and the question appeared to be not whether programmes were needed but whether they were effective. The right of parents to control the number of children had been established earlier as a basic human right; at the Belgrade conference, that principle was situated in its social and international context (Macura, 1987).

The right to family planning is not explicitly mentioned in the United Nations Universal Declaration of Human Rights, but some have argued that it may be inferred from the rights to privacy, conscience, health and well-being set forth in various United Nation's conventions and declarations (United Nations, n.d.). For example, the Secretary-General noted in 1967 that

> the Universal Declaration of Human Rights describes the family as the natural and fundamental unit of society. It follows that any choice and decision with regard to the size of the family must inevitably rest with the family itself, and cannot be made by anyone else. But this right of parents to free choice will remain illusory unless they are aware of the alternatives open to them. Hence, the right of every family to information and the availability of services in the field is increasingly considered as a basic human right and as an indispensable ingredient of human dignity (Statement on Population by UN Secretary-General U Thant, 10 December 1967).

Several months later, the International Conference on Human Rights, held in Teheran, moved towards a more explicit recognition of family planning as a human right. Its groundbreaking Proclamation of Teheran, adopted on 13 May 1968, provided a foundation for conferences and population activities that followed. The Conference proclaimed that "the protection of the family and of the child remains the concern of the international community. Parents have a basic human right to determine freely and responsibly the number and spacing of their children" (United Nations, n.d.). It recognized that moderating population growth would enhance the opportunities for the enjoyment of human rights and the improvement of living conditions. It also urged Member States, as well as United Nations bodies and agencies to pay close attention to the implications of population increase for the exercise of human rights. This proclamation gave enormous encouragement and impetus to the family planning movement and to its supporters, who had argued that all children should not only be wanted children, but also, by implication, that Governments had an obligation to accept responsibility for the provision of family planning information and services to enable couples to plan the size of their families.

By the 1960s, significant progress had been made in developing new types of contraceptives. The introduction of the oral contraceptive pill and the intrauterine device (IUD) separated sexual activity from pregnancy and allowed women to exert some control over their reproductive lives. Both the pill and the IUD were suitable for large-scale family planning programmes. Research continued on making contraceptives safe, more effective, easier to use and less expensive.

B. Population policies, 1970-1980

By the end of the 1960s, concern was growing in the United States and Europe about population increases in developing countries and the strains placed on resources. For example, a bill was introduced in the United States Congress in 1967 to appropriate funds to support voluntary family planning programmes in "friendly" foreign nations. Later that year, the Secretary-General of the United Nations established a trust fund—the United Nations Trust Fund for Population Activities—to assist developing countries in addressing their population problems.

As the decade of the 1970s began, rapid population growth had come to be widely viewed by specialized agencies of the United Nations as a major obstacle to development in the area of maternal health (WHO), children's health (UNICEF), food security (FAO), education (UNESCO), the welfare of workers (ILO) and investment for development (World Bank). There was still reluctance on the part of the United Nations and others to move beyond demographic research and analysis and support population activities that would directly influence demographic variables, in particular, fertility (United Nations, n.d.). The reluctance was due in part to the fear that family planning would be viewed as a way for developed countries to avoid helping developing countries.

However, in response to the request from developing countries for population assistance and the concerns about the consequences of rapid population growth, the United Nations Population Trust Fund was transformed into the United Nations Fund for Population Activities (UNFPA) in 1970. By 1972, more than 50 countries had made commitments to contribute to the Fund. The Fund's mandate from the United Nations Economic and Social Council required it

> to promote awareness, both in developed and developing countries, of the social, economic and environmental implications of national and international population problems, of the human rights aspects of family planning, and of possible strategies to deal with them in accordance with the plans and priorities of each country; [and] to extend systematic and sustained assistance to developing countries at their request in dealing with their population problems; such assistance to be afforded in forms and by means requested by the recipient countries and best suited to meet the individual country's needs (ECOSOC Resolution 1763 (LIV) of 18 May 1973).

A turning point in the consideration of population policy issues at the global level occurred at the sixteenth session of the United Nations Population Commission in 1971. At this session, population policy was no longer treated in a cautious and indirect manner but as an explicit major concern (United Nations, 1987). The Commission discussed the role of population in the International Development Strategy for the Second United Nations Development Decade, as well as activities to commemorate the World Population Year in 1974, so designated by the General Assembly (GA Resolution 2683 (XXV) of 11 December 1970). The Commission hoped

to encourage the development of national population policies that were suited to specific country needs and conditions, within the framework of a "global population strategy", which would slow down and stabilize world population growth (United Nations, 1987). A complete review of policies intended to affect fertility—including such controversial methods as abortion and sterilization—was published by the Secretariat in 1972 (United Nations, 1987).

By 1974, international public opinion generally favoured measures to deal with rapid population growth. Moreover, Governments were more favourable towards adopting population policies, while opposition was diminishing (Macura, 1987). The World Population Conference, held in Bucharest in 1974, focused on policy issues rather than scientific questions. The participants were Government representatives and political leaders rather than technical experts and demographers, as was the case in the two earlier United Nations Population Conferences. In a number of countries, particularly in Asia, as well as in Latin America and some countries of Northern Africa, national policy makers were becoming increasingly aware of the consequences of rapid population growth. Moreover, by the 1970s, modern contraceptives had been further improved and were more widely available, thus facilitating the promotion of their use (Finkle and McIntosh, 2002).

The negotiations in Bucharest were mainly focused on the rationale for family planning—that is, whether rapid population growth was the major reason for the slow pace of economic development. Representatives agreed that development and not population control was the overriding objective of the World Population Plan of Action (WPPA), the policy document produced by the Bucharest conference. The WPPA also stressed national sovereignty in domestic policy making. This was particularly important for the newly independent countries of Africa, which perceived the WPPA as a threat to their national sovereignty (Finkle and McIntosh, 2002). The WPPA recommended that all countries respect and ensure "the right of persons to determine, in a free, informed and responsible manner, the number and spacing of their children…" (paragraph 29a). The document encouraged further research to evaluate available family planning techniques (paragraph 78i), but it did not go so far as to provide any recommendation in favour of family planning and the provision of modern family planning methods.

The WPPA was a major international strategy; the final text did not emphasize population policies, but highlighted aspects of social and economic policy (Macura, 1987). This was due in part to the need to develop a consensus among mainly Western states, who believed that rapid population growth was a serious impediment to development, and a group of developing countries, led by Algeria and Argentina, who believed that the population problem was a consequence, not a cause, of underdevelopment, and that it could be solved by a new international economic order (Macura, 1987). Nevertheless, the WPPA had an enormous impact on world opinion, and modifying population growth was now considered a legitimate concern for Government policy. Moreover, international population assistance had become widespread in many developing countries.

C. Population policies, 1980-1990

By the early 1980s, world population growth had declined appreciably, despite the unfavourable economic conditions prevailing at that time. Ten years after the Bucharest conference, at the International Conference on Population in Mexico City in 1984, Government representatives again debated questions of population and family planning (United Nations,

1984a). Four expert group meetings and five regional meetings preceded and prepared for the conference in Mexico City. The two main objectives of the conference were to review and appraise the WPPA and to make recommendations for the further implementation of the Plan (Macura, 1987).

The development of population policies and programmes and the expansion of international cooperation and assistance were at the top of the agenda. The final document went beyond the basic concepts of reproduction and family planning already set forth in the WPPA. In the Mexico City document, family planning programmes and the provision of modern contraception were now strongly advocated as the right of all couples and individuals (recommendations 25 and 30). As in the Bucharest document, further research in human reproduction and fertility regulation was encouraged (recommendation 69). The references to urgency and universality and the specific reference to the rights of individuals were introduced at Mexico City; they were not found in the WPPA. In the years following the adoption of the WPPA, some countries in Africa (for example, Burundi, Burkina Faso, Central African Republic and Niger) reversed their stance and adopted policies more favourable towards contraception. In addition, several countries in Latin America (Guyana, Suriname and Uruguay), which had maintained a rather conservative approach, also moved towards supporting contraceptive use.

D. Population policies, 1990-2000

The final major global United Nations population conference of the twentieth century, the International Conference on Population and Development (ICPD) held in Cairo in 1994, produced the Programme of Action (United Nations, 1994a). This Programme built upon and further extended the goals and recommendations of the previous intergovernmental conferences on population and development (United Nations, 1999). Two prominent aspects of the Programme of Action, the integration of population and development issues and the attention given to women, have their roots in both the earlier 1974 and 1984 United Nations population conferences (United Nations, 1999). However, its recommendations break new ground in several areas. Integrating family planning and women's health services and promoting the rights of women were key issues on the agenda discussed at the conference. The Programme of Action strongly urged Governments to make reproductive health services available to "all individuals of appropriate ages" (paragraph 7.6). All Governments were encouraged to assess the unmet need for good-quality family-planning services (paragraph 7.16) and to take steps to meet this need. They were also encouraged to expand the provision of maternal and child health services in the context of primary health care (paragraph 8.22). Moreover, for the first time in such a document, the Programme of Action mentioned men's fertility, citing the need to assign high priority to the development of new methods for fertility regulation for men (paragraph 12.14).

The language of the Programme of Action is striking because of the openness and clarity with which it addresses numerous sensitive issues (United Nations, 1995). In particular, it denounces social ills such as infanticide, rape, incest, trafficking in women, adolescents and children, use of children in prostitution and pornography and sexual harassment of women. It also condemns harmful practices meant to control women's sexuality, such as female genital mutilation. The document emphasizes the value of open and active discussion of sensitive issues as a positive step in increasing knowledge and understanding of human reproductive behaviour. In this respect, it differs markedly from the World Population Plan of Action and the Mexico City recommendations, neither of which used the words "sexual" or "sexuality."

Several important new concepts were introduced in the Programme of Action. The empowerment of women as "a cornerstone of population and development-related programmes", along with gender equality and equity, provides the basis for addressing numerous themes related to women, including education for girls, the pressures on women's time, gender-based disparities in income and the safety of women in abusive relationships. In the area of reproduction and health, the new concepts of safe motherhood and unsafe abortion were introduced and elicited much discussion and negotiation. Women's issues are interwoven throughout the text, so that approximately one third of the 243 recommendations for action explicitly mention women or girls (United Nations, 1995).

The extensive and varied preparatory process for the ICPD at the national, regional and international levels gave a great impetus to Governments to review and to reformulate their population policies, especially their approach to fertility regulation. This was particularly true for several francophone countries in Africa and some countries in Western Asia, which removed legal barriers to the use of modern contraception.

E. Population policies at the beginning of the 21st century

Since the International Conference on Population and Development, considerable progress has been achieved in many countries in implementing the objectives of the Programme of Action. A review and appraisal of this progress undertaken by the United Nations five years after the ICPD found that reproductive health programmes had been established in many countries, with rising contraceptive use among couples indicating greater accessibility to family planning and more freedom to choose the number and spacing of the children they desired (United Nations 1999). However, many births were still unwanted or mistimed, and modern family planning methods remained unavailable to large numbers of couples worldwide (United Nations, 1999). The threat of sexually transmitted infections (STIs), including HIV/AIDS, has increased in many countries, but access to information and services was still restricted for adolescents, in spite of their enhanced biological susceptibility to STIs.

More recently, regional conferences have addressed the progress made in Africa and in Asia and the Pacific. A meeting in January 2002 in Yaounde, Cameroon, reported increased awareness among policy makers of the concepts of reproductive health and reproductive rights and more political commitment at the highest level among African countries. Most countries in Africa have revised their population policies and have incorporated reproductive health programmes and strategies (UN ECA, 2002b). For example, information and education campaigns have been undertaken in a number of countries, including Gabon, Nigeria, South Africa and the United Republic of Tanzania, to sensitize the population about reproductive health and HIV/AIDS. Côte d'Ivoire and Lesotho have established counseling centres for the most vulnerable segments of the population, especially young people. Mali has launched a new initiative to promote the status of women. Lesotho has also introduced training in contraceptive logistics management for family planning service providers; improved access to family planning services at the community level; and developed a Parent Education Programme manual (UN ECA, 2002b). However, despite efforts at all levels to improve reproductive health and eradicate HIV/AIDS, Africa still faces a number of challenges not found in many other regions, including the spreading HIV/AIDS pandemic, conflict, food insecurity, poverty and a substantial burden of debt.

In Asia and the Pacific, the Fifth Asian and Pacific Population Conference, held in Bangkok in December 2002, noted that since ICPD, some countries had successfully integrated family planning with other components of reproductive health services. For example, the Islamic Republic of Iran, the Republic of Korea, Sri Lanka and Thailand are providing integrated services, whereas in other countries—for example, Indonesia and Viet Nam—several Government organizations were responsible for different service components (UN ESCAP, 2002). Other countries, including Cambodia, Lao People's Democratic Republic and Mongolia, had incorporated quality-of-care issues in the training curricula of service providers. Bangladesh, Philippines, Thailand and Viet Nam had encouraged the involvement of communities and the private sector and introduced social-marketing mechanisms to provide non-clinical methods of contraception (UN ESCAP, 2002). A survey of countries in the region found that, although there was a clear desire to provide integrated reproductive health services, major obstacles—especially management arrangements, financial constraints, training of service providers and logistic systems—hindered progress. Many countries with high fertility and low contraceptive prevalence reported that their programmes were not ready for integration and considered that the move towards a reproductive health approach would dilute family planning efforts.

III. GOVERNMENT POLICIES IN DEVELOPING COUNTRIES

A. Africa

With the exception of Equatorial Guinea, Gabon and Libyan Arab Jamahiriya, all countries in Africa either directly or indirectly support the distribution of contraceptives. The large majority of these countries—48 out of 53—provide direct government support for the distribution of family planning methods, whereas several countries—Somalia in Eastern Africa, Cameroon, Central African Republic and Chad in Middle Africa and Sierra Leone in Western Africa—make contraception available by supporting the activities of non-governmental agencies.

In the early 1970s, the situation was quite different (UN ECA, 2002a). Only 26 countries out of 48 provided direct or indirect support for contraception, while almost half the countries prohibited contraception. The earliest support for contraceptive methods was in the countries of Southern and Northern Africa. The countries of Middle and Western Africa have traditionally given little support. One reason for the lack of support was the perception in the 1970s that Africa was underpopulated, and that overpopulation was mainly a matter of uneven spatial distribution. Only a few countries in Africa had explicit population policies targeted towards curbing population growth. Several countries supported family planning programmes as part of basic reproductive health services, but most of this support was indirect and was channeled through NGOs. This approach was preferred even by countries that had no explicit policies in place to alter population growth or fertility.

By the mid 1970s, nine countries (Democratic Republic of the Congo, Ghana, Kenya, Madagascar, Mauritius, Seychelles, Uganda, United Republic of Tanzania and Zambia) had adopted legislation that was supportive of family planning. In Southern Africa, all countries excepting Namibia, which only gained independence in 1990, were early supporters of contraception. Countries in Northern Africa, with the exception of the Libyan Arab Jamahiriya, were also early supporters of family planning. Most Governments, however, believed that problems related to population were due to a lack of economic growth and development. This was

the essential message of the First African Population Conference held in Ghana in 1971. The conference also acknowledged the need for trained professionals in demography and demonstrated that African Governments were becoming increasingly more aware of population problems.

Some Governments, particularly in the francophone countries of Middle and Western Africa, had pronatalist policies inherited from their colonial past. Family planning activities and contraceptives were not permitted in the former French colonies because of the existing 1920 French law forbidding both abortion and the promotion of contraception. This situation has changed over time. Countries have either repealed the law or no longer enforce it. A pioneer was Tunisia, which in 1961 repealed the former colonial law that prohibited the advertisement of contraception. Among the francophone countries to follow suit were Mali in 1972, Cameroon and Senegal in 1980, Côte d'Ivoire in 1982 and Burkina Faso in 1986. All these countries abrogated laws that had made contraceptives illegal.

In many African countries, family planning services and contraceptives first became available after the Alma Ata Conference in 1978 (WHO, 1978), when many Governments, particularly in Africa, adopted a primary health-care strategy with integrated family planning services. This approach provided the framework for countries to re-orient official policies: contraception was made available as a way to assist couples to have the number and spacing of children they desired, and as a means to improve the quality of life for women and children in particular. Thus, Governments such as Benin, Cameroon and Mali, which while pronatalist, began to provide indirect support for family planning services.

A major milestone in the history of contraceptive policies was the Second African Population Conference held in Arusha in early 1984 (United Nations, 1984). This conference was also an essential part of the preparatory process leading up to the international conference in Mexico City later that year. The Arusha Conference adopted the Kilimanjaro Programme of Action, which provided the framework for the formulation and implementation of population policies and programmes in Africa. The Programme of Action was still strongly linked to the socio-economic development of the region, but it increasingly recognized the importance of family planning services. Recommendations concerning family planning included the following:

- Governments should acknowledge that family planning and child spacing strengthen the stability of the family;

- Countries should incorporate family planning services into maternal and child health-care services;

- Governments should ensure the availability and accessibility of family planning services to all couples or individuals seeking them and should offer services free or at subsidized prices;

- Governmental national family planning programmes should make available a variety of methods to allow choice to all users.

The integration of family planning programmes into maternal and child health services during the late 1970s and early 1980s put new emphasis on allowing Governments to assist couples to plan the size of their families and the timing of childbirth. This provided an incentive for some Governments with restrictive policies to revise their policies. The clear endorsement of

family planning programmes, both in the Kilimanjaro Programme of Action and the Mexico City recommendations, gave Governments a strong rationale to modify their stance. Some Governments moved from prohibiting the distribution of contraception towards official support. For example, in Eastern Africa, Burundi, Comoros, Malawi, Somalia and Zimbabwe began providing support, as did Cameroon, Central African Republic and Sâo Tome and Principe in Middle Africa. In Western Africa, Guinea and Niger also modified their policies in this direction. Some countries that had permitted the distribution of contraceptives through NGOs, established Government facilities to provide family planning services. These countries included Angola, Democratic Republic of the Congo, Ethiopia, Nigeria, Senegal, Sierra Leone and Togo.

Other francophone countries—Benin, Burkina Faso, Côte d'Ivoire and Chad—derived considerable impetus from the preparatory process and follow-up events surrounding the international population conference in 1984. The Governments of these countries began to support the work of Non-governmental organizations in providing contraceptive services and eventually moved towards directly providing family planning services. Only Djibouti tightened policies in the 1980s and abandoned all governmental support until the late 1990s, when it adopted a more supportive position.

The increased availability of timely and accurate population data and demographic analysis afforded policy makers the possibility of understanding the relationships between population and development and the consequences of high fertility, young age structure, urbanization and the spread of the HIV/AIDS virus. These pressing demographic concerns were discussed at the Third African Population Conference held in Dakar in 1992 (United Nations, 1992). The outcome of the conference, the Dakar/Ngor Declaration, clearly reflected the growing commitment of African heads of state to finding solutions for the most urgent demographic concerns in order to enhance the quality of life. The Declaration recommended the establishment of a follow-up mechanism to accelerate the implementation of the Kilimanjaro programme, and, for the first time in the African context, it recommended quantitative population targets:

- Recommendation 1: Population policies and programmes should be integrated into development strategies. They should focus on strengthening social sectors with a view to influencing human development and they should work towards the solution of the population problem by setting quantified national objectives for the reduction of population growth. The aim is to bring down the regional natural growth rate from 3.0 to 2.5 per cent by the year 2000 and to 2.0 per cent by the year 2010.

The recommendations also established quantitative targets for contraceptive prevalence for the first time:

- Recommendation 9: Steps should be taken to make available and promote the use of all tested available contraceptive and fertility regulation methods, including traditional and natural family planning methods. A choice of methods should be available, and a goal should be set for doubling regional contraceptive prevalence, from about 10 to about 20 per cent by the year 2000 and 40 per cent by the year 2010.

B. Asia and Oceania

Asia and Oceania encompass a large variety of countries, including developed countries, less developed countries and least developed countries. They represent a wide variety of socio-economic situations and cultural diversity and are home to some of the most populous countries in the world—China, India, Japan and Indonesia—as well as countries with small populations, such as Brunei Darussalam, Maldives and the small island nations in Oceania. Western Asian countries, which held separate regional conference to address their population concerns, are discussed in the next section of this chapter.

Most countries in the regions supported access to contraceptive methods in 2001, and most Governments provided direct support. Of the 45 countries in the regions (not including Western Asia), 80 per cent directly supported access and 13 per cent provided indirect support. Only Brunei Darussalam, Lao People's Democratic Republic and Turkmenistan provided no support. All countries in Eastern Asia and Oceania provided either direct or indirect support for access to contraceptive methods, and all three of the most populous countries (China, India and Indonesia) provided direct support.

Countries in these regions were among the first to recognize the negative consequences of rapid population growth and to search for solutions. In general, there has been more emphasis in these regions than others on modifying fertility to reduce population growth. By the early 1960s, knowledge and understanding of the demographic situation was common in some of the most populous Asian countries. The impact of high population growth on socio-economic development was at the top of the agenda at the First Asian Population Conference in 1963. By the early 1970s, the majority of countries had initiated Government programmes to provide family planning services and contraceptives.

The declarations of the various regional population conferences reflect a strong commitment to support family planning. The recommendations of the Second Asian Population Conference held in Tokyo in 1972 emphasized the need for strong family planning programmes to curb high population growth (United Nations, 1972). At the Third Asian and Pacific Population Conference, held in Colombo in September 1982 (United Nations, 1982), the emphasis shifted from limiting fertility to acknowledging the pivotal interrelationships between demographic factors and development policies. The Conference's recommendations again stressed the need to provide family planning information and to make available a variety of methods. Moreover, a broader approach that linked family planning efforts to health programmes and other aspects of social development was considered crucial for improving the quality of life. This new focus was reflected in the change of policies in Maldives and Myanmar, which were among the last countries in the region to adopt supportive policies.

The Bali Declaration on Population and Sustainable Development, which was the final document adopted at the Fourth Asian and Pacific Population Conference in 1992, further stressed the fact that family planning and maternal and child health programmes have played an integral role in influencing population growth and improving the quality of life (United Nations, 1992). For the first time, special attention was given to the need to design information programmes and services for youth and adolescents (recommendation 23).

C. Western Asia

Western Asian countries supported access to contraception by a large majority (88 per cent) in 2001, even though there are as many countries in the region that want to raise fertility as want to lower it. (Two countries, Azerbaijan and Qatar, want to maintain fertility at the current level; both provide direct support for contraceptives.) Of the countries that provide support, two thirds provide direct support. Only Oman and United Arab Emirates provide no support for contraceptive access. Saudi Arabia, which had limited access to contraceptive methods from 1976 to 1996, was providing indirect support by 2001.

In the early 1970s, many countries of Western Asia considered their population growth to be too low and provided no support for contraception and family planning. But in the following years, awareness increased of the negative consequences of high population growth. Bahrain, Iraq, Jordan and the Syrian Arab Republic were early supporters of policies in favour of contraception. For many countries in the region, however, the most urgent population issues were spatial distribution, internal migration and refugees rather than fertility and family planning. This was the background for the First Regional Population Conference in Beirut in early 1974 (UN ECWA, 1974) and the Regional Consultation Meeting held in Damascus (United Nations, 1974b) that same year.

At these conferences there was much debate on the terminology of family planning. Up until that time, family planning had been based on a broad social welfare and health outlook. Only later in the 1970s were national policies formulated to reduce population growth. Under the topic "Population and Health," the conferences agreed to "give attention to family health and its relationship to the size of the family and spacing between pregnancies". Family planning as a separate issue and the use of modern contraception were not further discussed at these two meetings.

As a consequence of the preparatory process leading to the International Population Conference held in Mexico City in 1984, some countries increased support for family planning activities and the use of contraception. In the late 1980s, for example, Bahrain modified its policies and moved from providing indirect support to direct governmental support for the use of contraception.

The introduction to the Amman Declaration of Population in the Arab World, which was the outcome of the Second Regional Population Conference held in Amman in 1984, emphasized that "as a result of this rapid and continuous increase in the population, it was imperative to formulate appropriate plans and policies to meet their basic human needs…" (United Nations, 1984c). The Preamble of the declaration states that "the Regional Population Conference in the Arab World is convinced that the new circumstances…make it necessary to consider the formulation of an Arab Plan of Action for population policies in the coming decade." The consensus reached by participating member states on the issue of birth control and family planning demonstrated a general shift towards support for birth control in the context of primary health care, particularly to improve the health conditions for women and children.

- Principle 8: "The practice of birth control by couples is a human right guaranteed by international covenants…The Arab countries should endeavor to safeguard this right by providing facilities for the dissemination of knowledge and effective means for the practice of family planning on the basis of free choice…"

The next round of regional and sub-regional meetings was held in the early 1990s in preparation for the International Conference on Population and Development held in Cairo in 1994. Rapid population growth and high infant and child mortality in the region necessitated urgent action. The regional Arab Population Conference convened in Amman in 1994 adopted the Second Amman Declaration on Population and Development (United Nations, 1994b). In point 8 of the General Principles, the Declaration articulated the "right of couples to choose freely the number and spacing of their children. To enable them to exercise this right, they must have access to the necessary education, information and services. Present and future demand for family planning must be met. The Arab States should be called upon…to provide for family planning services as a basic human right of couples."

One objective of the Declaration was for countries to achieve appropriate population growth rates. In the case of countries wishing to reduce population growth, family planning services would need to be developed and enhanced. Several recommendations strongly supported the provision of information on and access to family planning within the maternal and child health-care framework, as well as the integration of family planning services into the primary health-care system (recommendations 36d, 40, 41). Cooperation with non-governmental organizations on these matters was recommended (recommendation 43).

These principles—particularly placing family planning and contraception services within the framework of primary health care—provided the impetus for some countries to begin supporting contraceptive services, at least indirectly. In the late 1990s, Kuwait and Qatar made family planning services and counseling available through public and private health facilities. The Government of Saudi Arabia moved from a rather restrictive approach to indirect support for activities conducted by non-governmental organizations. Iraq, after a decade of rather restrictive policies, moved to direct support of contraception.

D. Latin America and the Caribbean

Support for access to contraceptive methods was very strong in Latin America and the Caribbean in 2001. Of 33 countries in the region, 31 (94 per cent) provided direct support and 2 (6 per cent) provided indirect support. Support was nearly as strong in 1996, when 29 of 33 offered direct support and 3 provided indirect support. Only Argentina provided no support in 1996. This near unanimity with regard to access to contraceptives shows a dramatic change in the region in the last few decades.

Until the 1960s, many Latin American Governments were generally not supportive of family planning efforts and the use of contraception. However, rapid population growth and its socio-economic implications, particularly in urban areas, persuaded some Governments to consider the relationships between population and development. Consequently, contraception has been widely available in Government facilities in most of the countries in Latin America and the Caribbean since the early 1970s. Only the Bahamas had initially channeled support through non-governmental institutions. The region is noteworthy for Government recognition of the unmet demand for contraceptives and family planning services.

Several countries in the region, however, did not provide access to contraceptive methods until the early or mid 1980s. Among them were Argentina, Belize, Bolivia, Guyana, Suriname and Uruguay. Nevertheless, by 2001, almost all countries in Central and South America, with the exception of Argentina and Belize, had policies in place to provide direct support for contraception.

The Economic Commission for Latin America and the Caribbean (ECLAC) has played an important role in providing research and analysis on the interrelations between population and development. High population growth, high abortion rates and significant rural-urban migration flows were the background against which population issues and their social and economic implications were discussed at the Latin American Preparatory Meeting for the World Population Conference, held in Costa Rica in 1974 (United Nations, 1974d). Most Governments acknowledged the need to support family planning programmes in general, but their strategies for implementation differed widely. However, the need for families to "decide freely on the number and spacing of the children" (paragraph 22) was recognized by all countries. In the decade following the conference, many countries gradually adopted policies in support of family planning and contraception.

In the early 1980s, during the preparatory process for the Third International Population Conference in Mexico City, some countries that were not supportive of family planning moved towards providing access to contraception through Government facilities. These countries included Bolivia, Guyana and Uruguay. The recommendation referring to contraception adopted at the regional preparatory meeting strongly supported access to contraception as part of the basic human right to decide freely on the number and spacing of children (United Nations, 1984d). By this time almost all countries had official maternal and child health/family planning programmes, whose common objectives were to provide family planning information and services and to improve coverage in rural areas and marginal urban areas. However, the severe economic crisis of the 1980s forced some Governments to cut back expenditures in this area, which seriously curtailed the availability of services.

In spite of budget constraints, Governments strongly recommended support for reproductive health care and family planning (recommendations 3, 6, 20 and 21) during the Latin American and Caribbean Regional Conference on Population and Development, held in Mexico City in 1993. The document further considered that "the opportunity to regulate fertility [is] a universally recognized human right" (recommendation 35). A major objective was to improve living conditions, particularly for marginalized segments of the population in rural and less developed urban areas.

IV. GOVERNMENT POLICIES IN DEVELOPED COUNTRIES

A. Europe and Northern America

Nearly three fourths (73 per cent) of European countries provided either direct or indirect support for contraceptive methods by 1996. By 2001 the proportion rose to 88 per cent (see table 3). Ireland, the last country in Europe to permit the use of modern contraception, began providing direct support in the early 1990s. Several countries, however, provide no support for contraceptive methods, including Andorra, Germany, Greece, Italy, Slovakia and Switzerland. Others—for example, Bosnia and Herzegovina, Czech Republic, France, Luxembourg and the Netherlands—provide only indirect support. The majority of countries, however, provide direct Government support for contraceptives.

In Eastern European countries, liberal abortion laws were enacted during the 1950s, and by the mid-1970s, abortion ratios in Eastern Europe and the Union of Soviet Socialist Republics were among the highest in the world (United Nations, 1992). Abortion became a major means of birth

regulation, partly because modern contraceptives (other than condoms) were essentially unavailable. Only, in the 1980s, did the situation begin to improve (United Nations, 1996). Prevalence rates for modern contraceptives, however, continue to be low in Eastern Europe compared with rates in other developed countries.

Following the dissolution of the former Union of Soviet Socialist Republics and Yugoslavia, and the division of Czechoslovakia, the number of countries that provided direct support for family planning through Government facilities increased significantly. A more recent development, in the second half of the 1990s, is the shift from direct to indirect support, as the State partially withdrew from health and welfare activities in former communist countries. Furthermore, in many countries of Europe, the widespread use of modern contraceptives and the increased involvement of non-governmental organizations and the private sector have contributed to a decline in Government support. Countries that shifted from direct to indirect support between 1996 and 2001 include Austria, Canada, Denmark, Kazakhstan, Latvia and Lithuania (see Annex table).

The United Nations Economic Commission for Europe (ECE) has convened a series of intergovernmental meetings on population-related issues and policies over the last three decades. The regional preparatory meeting for the Bucharest conference was held in Geneva in 1974 (United Nations, 1974c); the regional event for the Mexico City conference was conducted in Sofia in 1983; and consultations leading to the ICPD in Cairo were held in Geneva in 1993 (United Nations, 1994c).

The regional meeting in 1974 was one of the first among the member States of the ECE to address broad population questions from a policy point of view. Many delegations were concerned about declining population growth in some countries in the region, as well as high population growth in less developed countries. However, there was full agreement that population policies should be integrated with development policies as a whole and that "nations have the sovereign right to determine their population policies" (Principle h). Reference to family planning and contraception was made in the framework of maternal and child health care: "good maternal and child health contribute to the well-being of the family and the nation and are facilitated by small numbers of births" (Principle f). It was also mentioned in the context of improving the status of women: status would be improved by giving women "the opportunity to plan births" (Principle g). An emphasis on curbing population growth rates in the countries where they were still high was included in the Recommendations for Action in the final document.

In the early 1980s many Governments realized that their countries were experiencing major demographic changes. Declining fertility resulted in low population growth and the ageing of their populations. These topics, as well as several others, such as the high number of unwanted pregnancies in some member States and questions of population distribution and internal and international migration, were priority areas dealt with at the Second Regional Meeting on Population in 1983 (United Nations, 1983). Family planning was also discussed at this meeting, and all participating Governments considered that it was "a fundamental right of all couples and individuals to decide freely and responsibly the number and spacing of their children" (recommendation 32). They further considered that access to relevant information as well as to effective means of birth control should be assured by the Governments (recommendation 37). With regard to the need for international cooperation, all heads of state supported the view that "the rate of population growth in many developing countries is still very high and continues to be an important obstacle to the improvement of life" (recommendation 66). Delegates strongly endorsed the call to increase international assistance for population activities.

The European Population Conference, held in Geneva in 1993 (United Nations, 1994c), continued to endorse reproductive health and family planning (recommendations 8 to 10), but it was now in the context of reproductive rights and reproductive health. The conference recommended that Governments adopt measures to make available efficient family planning methods to all in need and to provide access to appropriate information and services related to reproductive health through governmental and non-governmental channels. It was stressed that all services should be available only upon request and that no "coercive, discriminatory or prejudicial approaches" should be applied (recommendations 56 and 57). As was the case in 1983, all Governments strongly supported the continuation of international cooperation in the field of population services (recommendation 47) in developing countries.

There is no direct relationship between the level of governmental support and the use of contraceptive methods in Europe. Some countries with supportive policies do not necessarily have the highest prevalence rates. This is the case in Belarus, Poland, Portugal, Romania and Ukraine. Countries that have continuously supported family planning services, such as Canada, the United States and the Scandinavian countries, are more likely to have high prevalence rates.

B. Australia, New Zealand and Japan

The Governments of Australia and New Zealand have had similar views on their level of fertility. Both countries have considered the level of fertility to be satisfactory sine 1976. In Japan, however, the Government changed its view in 1996 from satisfactory to too low. The three countries do not intervene to modify fertility, but all provide some support for access to contraceptive methods. Support in Australia has been indirect since 1976; Japan and New Zealand, which both provided direct support in 1996, changed to indirect support in 2001.

The low birth rate in Japan led the Government to propose legislation in 2002 that would review working conditions of both men and women with the aim of making careers more compatible with child rearing. All major companies would be asked to develop plans to improve child-care leave, provide shorter working hours for parents and offer work-share arrangements. The plan, known as the Plus One Proposal to End the Low Birth Rate, would encourage couples to have an additional child.

In Australia, a range of family-friendly measures aims to allow parents to choose between labour market activities or child-rearing, although options for part-time work and flexible working hours are not widely available. Social support is targeted on low-income families and especially single parents (OECD, 2002). Recent data indicating that Australia's total fertility rate had dropped to 1.73 children per woman have increased pressure on the Government to implement a scheme for paid maternity.

V. SUMMARY AND CONCLUSIONS

The second half of the twentieth century has been a period of unprecedented population change. During the past 50 years, the world experienced the highest rates of population growth and the largest annual population increases ever recorded in history. In response to these and other unparalleled demographic changes, Governments formulated a variety of policies and established a broad range of programmes. These policies and programmes were aimed at national development

objectives as well as improving the well-being of the population. Reproductive behaviour, for example, while once viewed as a private matter outside the purview of Government action, became widely accepted as a major concern of Governments.

Virtually all countries have shifted their policies toward supporting family planning. By 2001, 91 per cent of Governments were providing support either directly or indirectly for contraceptive methods. The practice of limiting access to family planning methods has almost vanished.

At the beginning of the 21st century, the most significant demographic concern in the world is HIV/AIDS (United Nations, 2000b). The HIV/AIDS crisis has spawned renewed interest in barrier methods of contraception, such as the condom. Despite the considerable efforts that have devoted to promoting the use of condoms, as part of HIV/AIDS education and prevention campaigns, condom use among couples remains low in affected countries (United Nations, 2002a).[1] A recent United Nations study found that while AIDS awareness is rising, behaviour, for the most part remains unchanged and risky.

The United Nations has been instrumental in promoting the international acceptance of family planning and the intervention of Governments to deal with a wide spectrum of their population issues. Through the convening of international and inter-governmental conferences, and the wide dissemination of research on demographic trends, population projections and the evolution of national population policies, the United Nations helped foster a mind-set on the issue of lowering high rates of population growth and fertility, as a means of facilitating socio-economic development, and also as a means of helping couples to achieve their desired family sizes. As a result, the international community, NGOs and civil society were mobilized to provide resources and marshall grass roots support for family planning efforts in developing countries based on the principle of human rights. This in turn led to the wide distribution and acceptance of effective, safe, low-cost and easy to use contraceptives. The United Nations also played a crucial role in situating family planning programmes within the wider framework of reproductive health and reproductive rights.

Adopting a supportive Government policy, however, is only the first step in ensuring the success of family planning programmes. Other necessary elements include implementing the programme and the commitment of sufficient resources over time. A variety of other factors also need to be considered, including the quality of care, traditional cultural attitudes towards family planning, ensuring client confidentiality, financial constraints, costs to users, the condition of the health care infrastructure, partnerships with non-governmental organizations and international donors, and civil conflicts that may disrupt the provision of supplies and services. Finally, measures for the monitoring and evaluation of programmes beyond their impact on fertility need to be elaborated.

First established at the World Population Conference, held at Bucharest in 1974, Principle 8 of the ICPD Programme of Action stressed that States should take all appropriate measures to

[1] For a discussion on the linkages between reproductive health care and HIV/AIDS programmes, as well as on levels and trends of contraceptive use, see *World Population Monitoring 2002, Reproductive rights and reproductive health: selected aspects* (United Nations publication, ESA/P/WP.171).

ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so.

More recently, the Secretary-General of the United Nations noted in his message to the Fifth Asian and Pacific Population Conference (Ministerial segment, Bangkok, Thailand, 11-17 December 2002), "the Millennium Development Goals,…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".

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Annex table 1. Government policies on providing access to contraceptive methods, by major region and country: 1976, 1986, 1996 and 2001

Country	*1976*	*1986*	*1996*	*2001*
Africa				
Eastern Africa				
Burundi	No support	Direct support	Direct support	Direct support
Comoros	No support	Direct support	Direct support	Direct support
Djibouti	..	No support	No support	Direct support
Eritrea	..	..	..	Direct support
Ethiopia	Indirect support	Direct support	Direct support	Direct support
Kenya	Direct support	Direct support	Direct support	Direct support
Madagascar	Indirect support	Direct support	Direct support	Direct support
Malawi	Limits	Direct support	Direct support	Direct support
Mauritius	Direct support	Direct support	Direct support	Direct support
Mozambique	Direct support	Direct support	Direct support	Direct support
Rwanda	No support	Direct support	Direct support	Direct support
Seychelles	Direct support	Direct support	Direct support	Direct support
Somalia	No support	Indirect support	Indirect support	Indirect support
Uganda	Direct support	Direct support	Direct support	Direct support
United Republic of Tanzania	Direct support	Direct support	Direct support	Direct support
Zambia	Direct support	Direct support	Direct support	Direct support
Zimbabwe	..	Direct support	Direct support	Direct support
Middle Africa				
Angola	..	Direct support	Direct support	Direct support
Cameroon	Indirect support	Direct support	Indirect support	Indirect support
Central African Republic	No support	Direct support	Direct support	Indirect support
Chad	Limits	No support	Indirect support	Indirect support
Congo	Direct support	Direct support	Direct support	Direct support
Dem. Rep. of the Congo	Direct support	Indirect support	Direct support	Direct support
Equatorial Guinea	No support	No support	No support	No support
Gabon	Limits	No support	No support	No support
Sao Tome and Principe	No support	Direct support	Direct support	Direct support
Northern Africa				
Algeria	Direct support	Direct support	Direct support	Direct support
Egypt	Direct support	Direct support	Direct support	Direct support
Libyan Arab Jamahiriya	No support	No support	No support	No support
Morocco	Direct support	Direct support	Direct support	Direct support
Sudan	Direct support	Direct support	Direct support	Direct support
Tunisia	Direct support	Direct support	Direct support	Direct support
Southern Africa				
Botswana	Direct support	Direct support	Direct support	Direct support
Lesotho	Direct support	Direct support	Direct support	Direct support
Namibia	..	..	Direct support	Direct support
South Africa	Direct support	Direct support	Direct support	Direct support
Swaziland	Direct support	Direct support	Direct support	Direct support

Annex table (continued)

Country	*1976*	*1986*	*1996*	*2001*
Western Africa				
Benin	Indirect support	Indirect support	Direct support	Direct support
Burkina Faso	No support	Indirect support	Direct support	Direct support
Cape Verde	Direct support	Direct support	Direct support	Direct support
Côte d'Ivoire	No support	No support	Indirect support	Direct support
Gambia	Indirect support	Direct support	Direct support	Direct support
Ghana	Direct support	Direct support	Direct support	Direct support
Guinea	No support	Direct support	Direct support	Direct support
Guinea-Bissau	Indirect support	Direct support	Direct support	Direct support
Liberia	Direct support	Indirect support	Direct support	Direct support
Mali	Direct support	Direct support	Direct support	Direct support
Mauritania	No support	No support	Direct support	Direct support
Niger	No support	Direct support	Direct support	Direct support
Nigeria	Direct support	Direct support	Direct support	Direct support
Senegal	No support	Direct support	Direct support	Direct support
Sierra Leone	Direct support	Indirect support	Indirect support	Indirect support
Togo	Indirect support	Direct support	Direct support	Direct support
Asia				
Eastern Asia				
China	Direct support	Direct support	Direct support	Direct support
Dem. People's Rep. of Korea	Direct support	Direct support	Direct support	Direct support
Japan	Direct support	Direct support	Direct support	Indirect support
Mongolia	Direct support	Direct support	Direct support	Direct support
Republic of Korea	Direct support	Direct support	Direct support	Direct support
South-central Asia				
Afghanistan	Direct support	Direct support	Direct support	Direct support
Bangladesh	Direct support	Direct support	Direct support	Direct support
Bhutan	Direct support	Direct support	Direct support	Direct support
India	Direct support	Direct support	Direct support	Direct support
Iran (Islamic Republic of)	Direct support	Indirect support	Direct support	Direct support
Kazakhstan	..	..	Direct support	Indirect support
Kyrgyzstan	..	..	..	Direct support
Maldives	No support	Direct support	Direct support	Direct support
Nepal	Direct support	Direct support	Direct support	Direct support
Pakistan	Direct support	Direct support	Direct support	Direct support
Sri Lanka	Direct support	Direct support	Direct support	Direct support
Tajikistan	..	..	Direct support	Direct support
Turkmenistan	..	..	No support	No support
Uzbekistan	..	..	Direct support	Direct support
South-eastern Asia				
Brunei Darussalam	..	No support	No support	No support
Cambodia	Limits	Limits	Direct support	Direct support
Dem. Rep. of Timor-Leste	..	..	..	..
Indonesia	Direct support	Direct support	Direct support	Direct support
Lao People's Dem. Republic	Limits	Limits	No support	No support
Malaysia	Direct support	Direct support	Direct support	Direct support
Philippines	Direct support	Direct support	Direct support	Direct support

Annex table (continued)

Country	*1976*	*1986*	*1996*	*2001*
Singapore	Direct support	Direct support	Direct support	Direct support
Thailand	Direct support	Direct support	Direct support	Direct support
Viet Nam	Direct support	Direct support	Direct support	Direct support
Western Asia				
Armenia	..	..	Direct support	Direct support
Azerbaijan	..	..	Indirect support	Direct support
Bahrain	Indirect support	Direct support	Direct support	Direct support
Cyprus	No support	Direct support	Indirect support	Indirect support
Georgia	..	..	No support	Direct support
Iraq	Direct support	Limits	No support	Direct support
Israel	Direct support	Direct support	Direct support	Indirect support
Jordan	Direct support	Indirect support	Direct support	Direct support
Kuwait	No support	No support	No support	Indirect support
Lebanon	Indirect support	Indirect support	Indirect support	Indirect support
Oman	No support	No support	No support	No support
Qatar	No support	No support	No support	Direct support
Saudi Arabia	Limits	Limits	Limits	Indirect support
Syrian Arab Republic	Direct support	Direct support	Direct support	Direct support
Turkey	Direct support	Direct support	Direct support	Direct support
United Arab Emirates	No support	No support	No support	No support
Yemen	Direct support	Direct support	Direct support	Direct support
Europe				
Eastern Europe				
Belarus	Direct support	Direct support	Direct support	Direct support
Bulgaria	Direct support	Direct support	No support	Indirect support
Czech Republic	..	..	Indirect support	Indirect support
Hungary	Direct support	Direct support	Direct support	Direct support
Poland	Direct support	Direct support	Direct support	Direct support
Republic of Moldova	..	..	Direct support	Direct support
Romania	Direct support	Limits	Direct support	Direct support
Russian Federation	..	..	Direct support	Direct support
Slovakia	..	..	No support	No support
Ukraine	Direct support	Direct support	Direct support	Direct support
Northern Europe				
Denmark	Direct support	Direct support	Direct support	Indirect support
Estonia	..	..	No support	Indirect support
Finland	Direct support	Direct support	Direct support	Direct support
Iceland	Direct support	Direct support	Direct support	Direct support
Ireland	No support	Limits	Direct support	Direct support
Latvia	..	..	Direct support	Indirect support
Lithuania	..	..	Direct support	Indirect support
Norway	Direct support	Direct support	Direct support	Direct support
Sweden	Direct support	Direct support	Direct support	Direct support
United Kingdom	Direct support	Indirect support	Direct support	Direct support
Southern Europe				
Albania	Direct support	Direct support	Direct support	Direct support

Annex table (continued)

Country	*1976*	*1986*	*1996*	*2001*
Andorra	..	..	No support	No support
Bosnia and Herzegovina	..	..	Indirect support	Indirect support
Croatia	..	..	Direct support	Direct support
Greece	Limits	No support	No support	No support
Holy See	Limits	Limits	Limits	Limits
Italy	Indirect support	Direct support	Direct support	No support
Malta	No support	No support	No support	Indirect support
Portugal	Direct support	Direct support	Direct support	Direct support
San Marino	No support	No support	No support	No support
Serbia and Montenegro	..	..	Indirect support	Indirect support
Slovenia	..	..	Direct support	Direct support
Spain	Limits	Direct support	Direct support	Direct support
TFYR Macedonia [1/]	..	..	Direct support	Direct support
Western Europe				
Austria	Direct support	Direct support	Direct support	Indirect support
Belgium	Indirect support	Indirect support	Indirect support	Direct support
France	Direct support	Indirect support	No support	Indirect support
Germany	..	..	No support	No support
Liechtenstein	No support	No support	No support	Direct support
Luxembourg	Indirect support	Indirect support	Indirect support	Indirect support
Monaco	Direct support	Direct support	No support	No support
Netherlands	Indirect support	Indirect support	Indirect support	Indirect support
Switzerland	Indirect support	Indirect support	No support	No support
Latin America and the Caribbean				
Caribbean				
Antigua and Barbuda	..	Direct support	Direct support	Direct support
Bahamas	Indirect support	Indirect support	Indirect support	Direct support
Barbados	Direct support	Direct support	Direct support	Direct support
Cuba	Direct support	Direct support	Direct support	Direct support
Dominica	..	Direct support	Direct support	Direct support
Dominican Republic	Direct support	Direct support	Direct support	Direct support
Grenada	Direct support	Direct support	Direct support	Direct support
Haiti	Direct support	Direct support	Direct support	Direct support
Jamaica	Direct support	Direct support	Direct support	Direct support
Saint Kitts and Nevis	..	Direct support	Direct support	Direct support
Saint Lucia	..	Direct support	Direct support	Direct support
Saint Vincent and Grenadines	..	Direct support	Direct support	Direct support
Trinidad and Tobago	Direct support	Direct support	Direct support	Direct support
Central America				
Belize	..	No support	Indirect support	Indirect support
Costa Rica	Direct support	Direct support	Direct support	Direct support
El Salvador	Direct support	Direct support	Direct support	Direct support
Guatemala	Direct support	Direct support	Direct support	Direct support
Honduras	Direct support	Direct support	Direct support	Direct support
Mexico	Direct support	Direct support	Direct support	Direct support
Nicaragua	Direct support	Indirect support	Direct support	Direct support
Panama	Direct support	Direct support	Direct support	Direct support

Annex table (continued)

Country	*1976*	*1986*	*1996*	*2001*
South America				
Argentina	Limits	No support	No support	Indirect support
Bolivia	Direct support	Indirect support	Direct support	Direct support
Brazil	Indirect support	Direct support	Direct support	Direct support
Chile	Direct support	Direct support	Direct support	Direct support
Colombia	Direct support	Direct support	Indirect support	Direct support
Ecuador	Direct support	Direct support	Direct support	Direct support
Guyana	No support	Direct support	Direct support	Direct support
Paraguay	Direct support	Indirect support	Direct support	Direct support
Peru	Direct support	Direct support	Direct support	Direct support
Suriname	No support	Direct support	Direct support	Direct support
Uruguay	No support	Direct support	Direct support	Direct support
Venezuela	Direct support	Direct support	Direct support	Direct support
Northern America				
Canada	Direct support	Direct support	Direct support	Indirect support
United States of America	Direct support	Direct support	Direct support	Direct support
Oceania				
Australia/New Zealand				
Australia	Indirect support	Indirect support	Indirect support	Indirect support
New Zealand	Direct support	Indirect support	Direct support	Indirect support
Melanesia				
Fiji	Direct support	Direct support	Direct support	Direct support
Papua New Guinea	Direct support	Direct support	Direct support	Direct support
Solomon Islands	..	Direct support	Direct support	Direct support
Vanuatu	..	Direct support	Direct support	Direct support
Micronesia				
Kiribati	..	Direct support	Direct support	Direct support
Marshall Islands	..	..	Direct support	Direct support
Micronesia (Federated States of)	..	..	Direct support	Direct support
Nauru	Direct support	Direct support	Direct support	Direct support
Palau	..	..	..	Indirect support
Polynesia				
Cook Islands	..	..	Direct support	Direct support
Niue	..	..	..	Indirect support
Samoa	Direct support	Direct support	Direct support	Direct support
Tonga	Direct support	Direct support	Direct support	Direct support
Tuvalu	..	Direct support	Direct support	Direct support

Source: *National Population Policies 2001* (United Nations publication, Sales No. E.02.XIII.12)

Notes: Two dots (..) indicate that data are not available.

[1/] The Former Yugoslav Republic of Macedonia