

# Reducing poverty, inequality and vulnerability

Progress on population and development  
in BRICS countries



Supported by



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# Foreword

The South Africa National Population Unit,<sup>1</sup> in collaboration with IPPF (International Planned Parenthood Federation), takes great pleasure in introducing this publication on population matters in the BRICS countries. In this publication, we pay special attention to and focus on reducing poverty and inequality, and vulnerable groups. We believe that the publication will contribute to collaboration through dialogue, cooperation, sharing of experiences and capacity building on population-related matters of mutual concern.

BRICS countries realize that a focus on reducing poverty and inequality, and addressing vulnerable groups, is imperative. The Action Plan of the New Delhi Declaration of the 2012 BRICS Summit identified “cooperation on population related issues” as a new area of cooperation to explore, and the eThekweni Action Plan of the 2013 BRICS Summit mandated meetings on population matters.

The purpose of this publication is to form and maintain a strong relationship among BRICS countries to encourage them to integrate population factors into their national development plans by exchanging ideas and expertise, as well as the challenges and experiences facing their countries. We envisage that countries will discuss and share their knowledge on topics such as:

- gender and women’s rights
- sexual and reproductive health and reproductive rights
- demographic transition and post-transition challenges, including population structure change and population ageing
- mortality reduction and increasing life expectancy
- social integration of migrant farmers during rapid urbanization
- information on population and health, including data collection and utilization
- sharing information and experience on improving the equity and quality of the health of women and children
- discussing and comparing policy responses and interventions by the countries

This publication draws on the presentations and thematic papers covering the above topics by BRICS’s population and development experts and members responsible for their population and development departments which were presented during the BRICS inaugural seminar in Hazyview, South Africa, in March 2014.

India was not represented at the seminar, therefore this publication only covers Brazil, China, Russia and South Africa. In areas where delegations did not report, the publication only reflects the contributions that were made. In instances where other sources are used, these are listed in the bibliographical footnotes.

This publication concludes by providing suggestions and lessons that BRICS countries could learn from each other which is the real aim and objective of this publication. These suggestions and lessons form a vital part of our all-inclusive publication because they offer a clear rationale for the significance of BRICS population officials and experts to meet and share experiences, expertise, knowledge, information and challenges they are currently facing in their countries.

We wish to thank all the members of the BRICS countries, who made it possible for this publication to be what it is, and for all the experiences, expertise and challenges shared through dialogues and capacity building on population-related issues.

While this publication is based on presentations by government delegations, the interpretations presented in this report do not necessarily reflect the views of the governments of the BRICS members, nor of the National Population Unit or IPPF.

#### *Note*

Occasionally in this report, data are reported using the ethnic grouping categories under which the statistics were originally gathered in-country. These terms are now historical, and the terminology is not endorsed by IPPF.

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<sup>1</sup> The National Population Unit is located in the Department of Social Development, in the Republic of South Africa.

# Executive summary and background

At first glance, the five BRICS nations – Brazil, Russia, India, China and South Africa – appear to have little in common and these differences must be recognized before attempting to build on the convergences. However, the governments have embarked on an exciting and remarkable opportunity to share and learn from each other on matters relating to population and development.

The five countries have different political systems. They have also reached varying levels of economic development. China leads the group in economic size, growth and trade. Furthermore, the member states are differently situated in relation to resources, absolute consumption and energy intensity. They have differing demographic trends. Brazil has a predominantly urban population, while India is still largely rural. Russia has an ageing population, while South Africa is relatively young. Nevertheless, the five nations will contribute greatly to the world's growing middle class.

## WHAT IS BRICS?

The BRIC (Brazil, Russia, India and China) idea was first conceived in 2001 by Goldman Sachs as part of an economic modelling exercise to forecast global economic trends over the next half century. The acronym 'BRIC' was first used in 2001 by Goldman Sachs in its Global Economics Paper number 66, 'Building Better Global Economic BRICs'.

Since 2008, the leaders of Brazil, Russia, India and China – the BRIC countries – have met annually to discuss issues of global significance. The four foreign ministers met on the fringes of the United Nations General Assembly in autumn 2006. The first meeting of their leaders was held in Sapporo on the eve of the G8 Hokkaido Toyako Summit in 2008, and their first stand-alone summit took place the following year in Yekaterinburg, Russia. Since then, ministers responsible for foreign affairs, finance and the economy, trade, agriculture and health have met. At officials' level, meetings have been held to discuss science and technology, national security, competition and statistics.

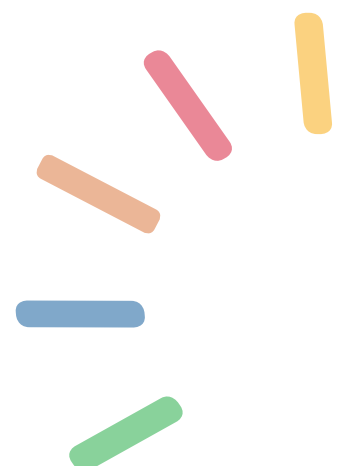
## EXPANSION – FROM BRIC TO BRICS

At their meeting in New York on 21 September 2010, BRIC foreign ministers agreed that South Africa should be invited to join BRIC. Accordingly, South Africa was invited to attend the 3rd BRIC Summit in Sanya, China, on 14 April 2011, thereby expanding BRIC to BRICS.

While the BRICS concept was first created to refer to the investment opportunities of the rising emerging economies, the leaders' meetings transcend the financial context to embrace a wide range of summit-level issues relating to global governance, such as development, peace and security, energy and climate change, and social issues including population matters.

## BRICS COLLABORATION

BRICS governments realize that a focus on reducing poverty and inequality, and addressing vulnerable groups, is imperative. The Action Plan of the New Delhi Declaration of the 2012 BRICS Summit identified "cooperation on population related issues" as a new area of cooperation to explore, and the eThekweni Action Plan of the 2013 BRICS Summit mandated meetings on population matters. This led to meetings of BRICS ministries responsible for population and development. A BRICS inaugural seminar of officials and experts in population matters was held in Hazyview, South Africa, in March 2014, where a cooperation framework was adopted.



The specific objectives of the framework include:

- to collaborate through dialogue, cooperation, sharing of experiences and capacity building on population-related issues of mutual concern to member states
- to encourage the integration of population factors into national development plans to advance economic growth and development in member states
- to encourage collaboration among member states in the build-up to the Commission on Population and Development and the review of the International Conference on Population and Development Beyond 2014; this includes contributing to the UN development agenda beyond 2015

In the framework, BRICS governments recognize the vital importance of the demographic dividend to advance sustainable development, as well as the need to integrate population factors into national development plans, and to promote long-term balanced population development. BRICS governments also recognize that the demographic transition and post-transition challenges, including population ageing and mortality reduction, are among the most important challenges facing the world today.

BRICS governments confirmed their strong commitment to address social issues generally and, in particular, gender inequality, women's rights and issues facing young people. The member states reaffirmed their determination to ensure sexual and reproductive health and reproductive rights for all.

The framework is based on the guiding principles of the International Conference on Population and Development Programme of Action and key actions for its further

implementation. In order to achieve mutually beneficial outcomes, the framework operates according to the principles of equality, transparency, efficiency, mutual understanding and consensus. The cooperation initiatives in the framework may be adjusted and enriched, and will evolve as issues of concern to the BRICS members develop and change in future.

The BRICS's cooperation on population-related issues is intended to add value to existing inter-governmental and multi-lateral initiatives. The initiatives should be pragmatic, with innovative approaches on issues of substance. In addition, the initiatives should be supportive of the work done in the United Nations context on population and related social matters.

Thematic areas of work will include social issues in general with a focus on the following:

- gender and women's rights
- sexual and reproductive health and reproductive rights
- demographic transition and post-transition challenges, including population structure change, population ageing and mortality reduction, and increasing life expectancy and social integration of migrant farmers during rapid urbanization
- information on population and health, including data collection and utilization
- sharing information and experience on improving the equity and quality of health of women and children

The suggested thematic areas of work will be pursued through capacity building and training; exchange of information, knowledge and expertise; and sharing best practices and lessons learned through national experiences, challenges and successes.

# Overview of thematic areas

This report discusses four thematic areas where BRICS member states can learn from each other. The four thematic areas are demography, gender and the empowerment of women, sexual and reproductive health and reproductive rights, and the demographic transition and post-transition challenges.

This report also discusses and compares policy responses and interventions by the countries. In common with other countries, the BRICS sometimes experience difficulties translating policies into effective action.

## DISCUSSION AND COMPARISON OF POLICY RESPONSES

In **Brazil**, social policies are translated into action by decentralizing and translating national policies into local policies. Brazil has over 5,000 municipalities which are responsible for implementing policies at the local level. Public participation is key and civil society plays an important role in localizing policies as well as in implementing policies.

The federal government is responsible for designing, partially financing and monitoring the policies and their implementation; policies are, however, implemented locally. Local municipalities can adjust policies according to their context, and local government works with a consortia, including encouraging civil society organizations at local level to design their own local programmes. Trying out different approaches while learning from the experience is a valuable way of working. Local councils exist for each sector; for example, a local council on children's rights, a local council on education, and so on. These local councils are responsible for implementing locally developed or adjusted programmes.

Follow-up of the implementation of local policy occurs in all three government spheres – federal, state and municipal – with the objective of strengthening monitoring in an integrated and shared manner. This action enables implementation of these policies to be adapted to regional, cultural factors as well as their local needs and realities. Local governments sometimes struggle with adapting policies, and designing programmes and projects that are suited to their particular local needs. Local governments also at times struggle to be accountable to the federal government; this is an impediment as their next budget depends on being able to demonstrate accountability.

**Russia** has implemented ambitious population policies since 2005. The population has been roughly stable since 2007. The policies were translated into action for each ministry, as all ministries are responsible for the implementation of population matters on state, regional and municipal levels.

In 2006, in a bid to compensate for the country's demographic decline, the Russian government started to simplify immigration laws and launched a state programme to provide assistance for the voluntary immigration of ethnic Russians from former Soviet republics. This programme includes, among other things, facilitating the voluntary resettlement of compatriots living abroad for permanent residence in the Russian Federation, as well as stimulating the return of emigrants to the Russian Federation; attracting skilled foreign professionals, and facilitating the integration of immigrants into Russian society along with developing tolerance in relations between the local population and immigrants.

Russia has special nationwide programmes to attract former compatriots. Incentives include tax and housing privileges, land ownership, medical services, education, jobs, and financial support that includes a 'stipend' (calculated at half the level of average wages in the region) paid to them for six months while they find a job. These initiatives have contributed to Russia being one of the top destination countries for immigrants, although migration also takes place by people who are not given incentives.

To increase the country's total fertility rate, Russia provides incentives, including pregnancy and childbirth benefits, such as a one-off payment at the time of the birth and an additional benefit which is determined by the regional administration; monthly maternity leave benefits; as well as monetary incentives to mothers who give birth to or adopt a second child. Those with three or more children are also given land for individual housing construction for free.

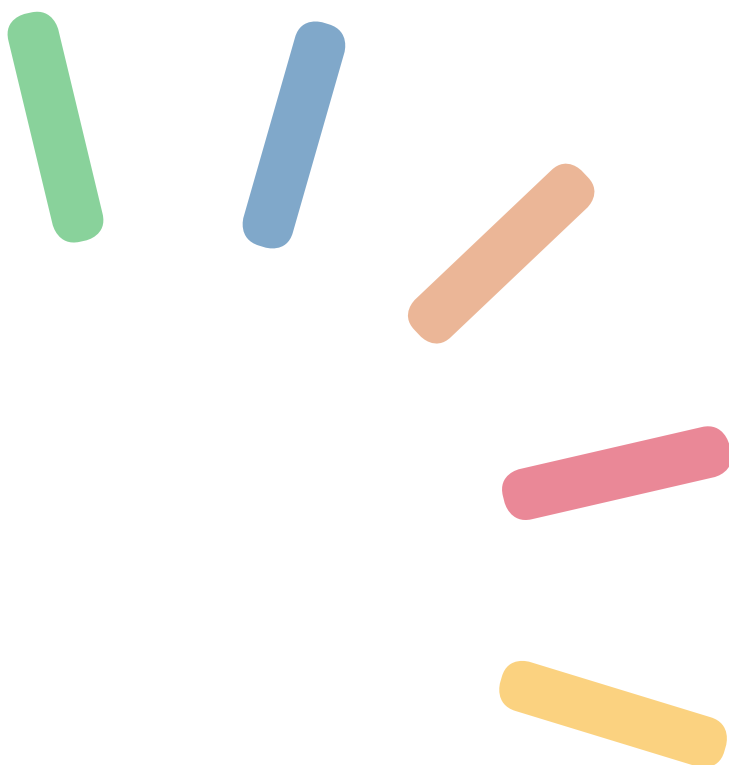


**China** has developed and implemented policies and programmes to encourage highly skilled and/or educated workers to return to China. China's policies are not recent – the country has had open policies encouraging in-migration since the 1980s, but has only recently seen an increase in the return of highly skilled Chinese back to the country. Conditions are now more conducive in China, as foreign companies are opening businesses there which, in turn, attract highly skilled researchers and scientists. The 'gap' between China and other countries has decreased and China offers many opportunities, resulting in many Chinese eager to start their careers in their home country, particularly in science and technology, rather than in the countries abroad where they studied.

China recognizes population development as a long-term process that requires a long-term plan. The population of China increased significantly in the 1960s, 1970s and 1980s. Using relevant data to ascertain the long-term impact, China developed relevant population policies, focusing on very strict population control. Although the Chinese population is still growing, the population control policy has now been adjusted as China wants to increase its total fertility rate from 1.6 to 1.8, particularly in relation to

its working population. Average family size is now 3.1. China is addressing challenges related to the sex ratio imbalance and gender equality, and has also begun to focus on positive policies that address ageing. Life expectancy is now 74.8 years. The country offers free contraceptives, and family planning workers are assigned to each village.

**South Africa** has made great strides to improve the implementation of legislation and policies with continued efforts to empower women by providing them with choices through expanded access to education, health services, skills development, employment and involvement in decision making at all levels. The country has a social assistance policy which aims to improve the living conditions and well-being of the poorest and most vulnerable people in the country. It provides benefits in cash or in-kind to enable beneficiaries to meet their basic needs. This is non-contributory and is financed through general tax revenues. By February 2014, there were approximately 16 million beneficiaries most of whom are children and the elderly. The country also provides free basic services to all its citizens.





# Chapter 1

## Demography of BRICS

We explore the demography of the five BRICS countries, looking at population size and implications for a demographic dividend; fertility and allied socio-economic issues; maternal, infant and under-five mortality; and life expectancy, a measure of a country's health care system.



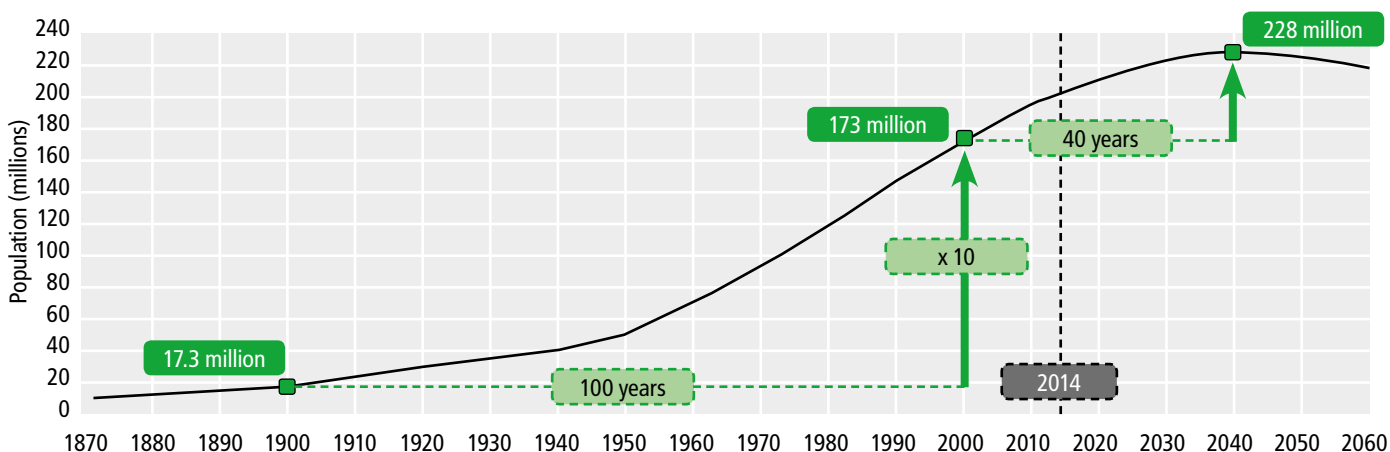
## POPULATION SIZE

The population size of BRICS countries varies enormously, with China having the highest and South Africa having the lowest. China and India are the world's two most populous countries with a population size of 1.36 and 1.25 billion respectively. Brazil and Russia have large populations of 199 and 140 million, while South Africa stands at 51.8 million. BRICS accounts for more than 40 per cent of the world's population.

### BRAZIL'S POPULATION GROWTH

**Figure 1: Brazil – population size and projected growth**

Actual and expected evolution of the Brazilian population 1872–2060

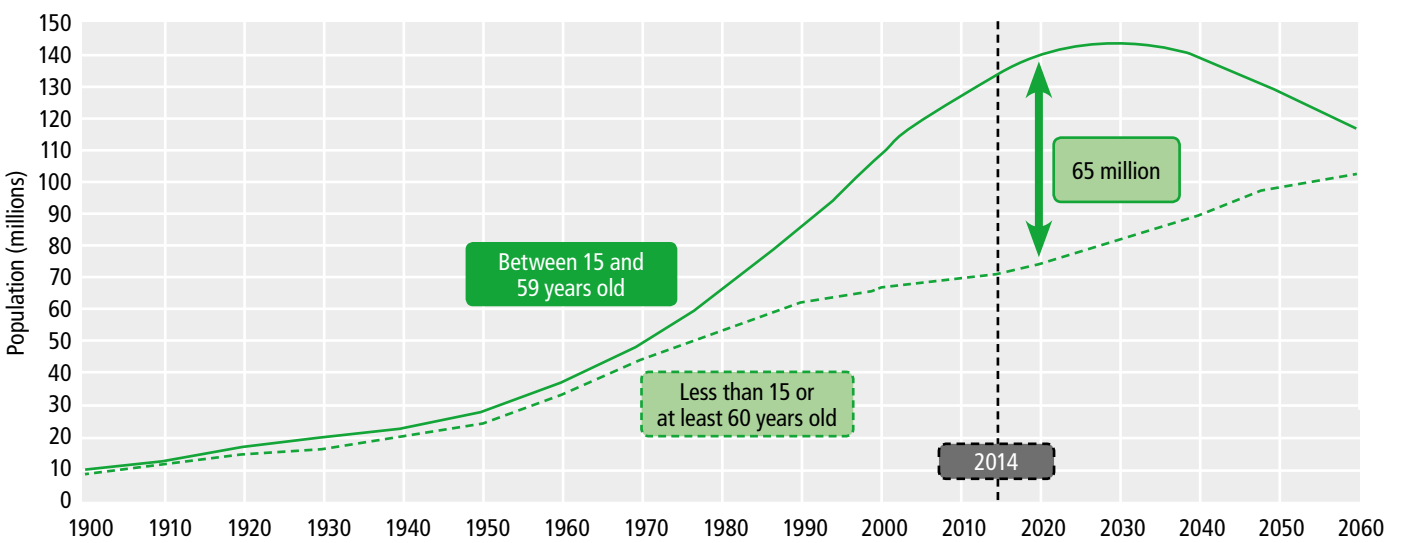


Source: Secretariat for Strategic Affairs of the Presidency of Brazil (SAE/PR) based on population records and projections from Brazilian Institute of Geography and Statistics (2012).

Figure 1 shows the population growth of Brazil from the year 1870 to 2060. As shown in the graph, Brazil's population multiplied by 10 in 100 years; it moved from 17.3 million to 173 million between the years 1900 and 2000. In 2014 it reached 199.49 million. It is projected to grow to 228 million by the year 2040, which is a growth of 28.51 million in 40 years.

**Figure 2: Brazil – demographic bonus**

Evolution of the Brazilian population by age groups 1900–2060



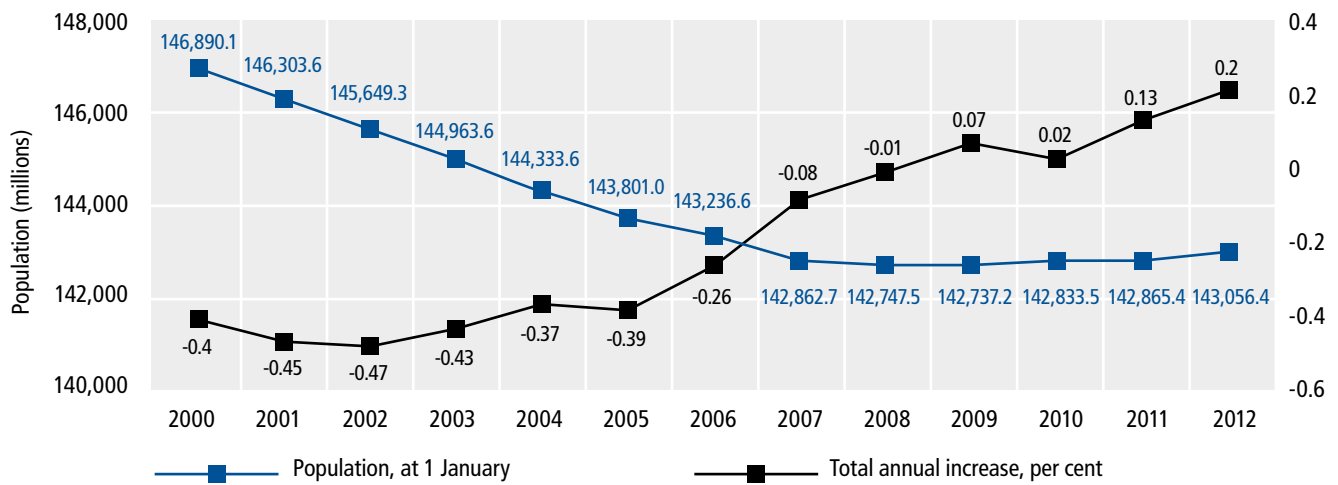
Source: Secretariat for Strategic Affairs of the Presidency of Brazil (SAE/PR) based on population records and projections from Brazilian Institute of Geography and Statistics (2012).

Brazil is currently experiencing a youth bulge. There are almost 65 million people between the ages of 15 and 59 years. This means that Brazil has a high proportion of its population in the economically active age range, and can therefore reap a demographic dividend if it can successfully provide sustainable, formal job opportunities for this population. This will benefit the economic growth of the country.



## RUSSIA'S POPULATION GROWTH

Figure 3: Russia – population growth



The population size of Russia stood at 143,056,400 in 2012. It was recorded at 143,657,134 in January 2014. The population size declined steadily from the year 2000 and started to stabilize in the year 2007. It started showing a positive annual increase from the year 2009 and, although it is growing by a very small margin, growth has remained positive since then.

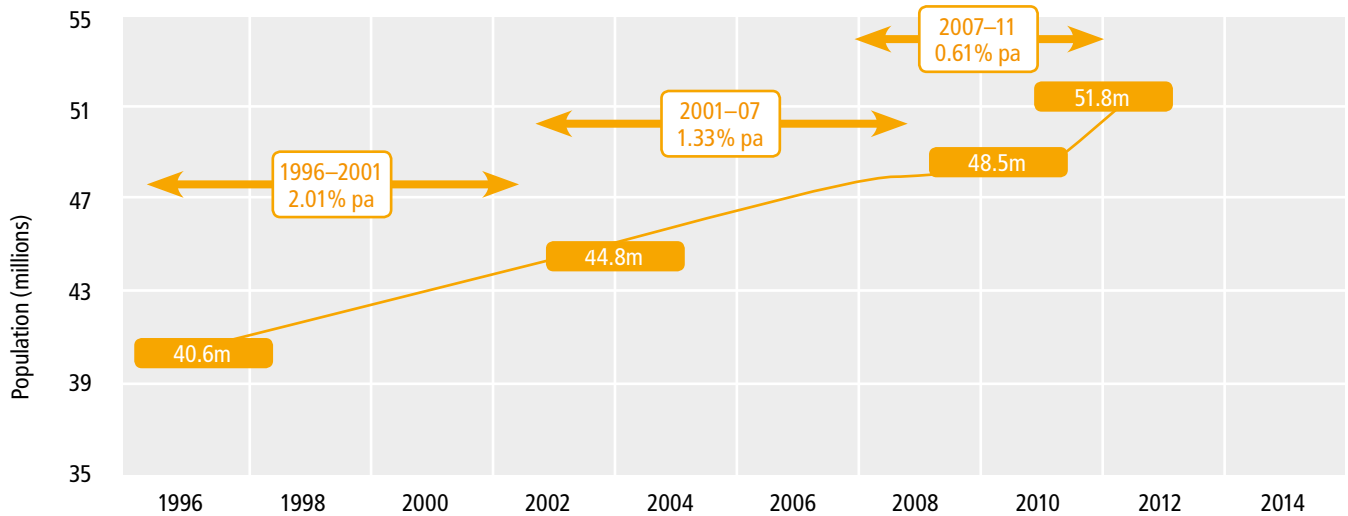
## CHINA'S POPULATION GROWTH

China has the highest population in the world. In 1949, the total population of China was 540 million, accounting for one-quarter of the world's population at that time. By 1970 it had reached 830 million. The Chinese government concentrated its efforts on curbing the population growth of the country by advocating for family planning in cities in the 1960s, and then in both cities and rural areas in the early 1970s. In 1982, family planning was announced as a fundamental national policy of the country and written into the constitution. China is still facing a vast and ever-growing population size which reached 1.36 billion at the end of 2013.



**SOUTH AFRICA'S POPULATION GROWTH**

**Figure 4: South Africa – population growth 1996–2011**



South Africa's population size grew from 40.6 million in 1996 to 44.8 million in 2001, and then to 51.8 million in 2011. The growth rate is now declining and will continue to decline due to HIV/AIDS and a decline in fertility. According to the 2011 census, the population is made up of 51 per cent females and 49 per cent males. 'Black Africans' are the vast majority at 79.8 per cent, while 'coloureds' are at 9 per cent, 'whites' at 8.7 per cent and 'Indians/Asians'<sup>2</sup> are at 2.5 per cent. The median age in South Africa is 25 years and the working age population continues to increase.

<sup>2</sup> These are the ethnic grouping categories under which the statistics were originally gathered in-country. These terms are now historical.

## FERTILITY

The total fertility rate of BRICS countries is low, with India and South Africa having the highest fertility rates of 2.6 and 2.4, and China and Russia having the lowest at 1.6 and 1.5 respectively. Brazil has the highest adolescent fertility (15–19 years) at 71 births per 1,000 girls, followed by South Africa at 54 births per 1,000 girls, while China has the lowest at six births per 1,000 girls. This means that Brazil has the highest incidence of teenage pregnancy among the five countries.

**Table 1: BRICS – fertility rates**

Country	Total fertility rate 2011	Adolescent (15–19) fertility 2005–10
Brazil	1.8	71
Russia	1.5	30
India	2.6	39
China	1.6	6
South Africa	2.4	54

Source: World Health Organization (2013) *World Health Statistics 2013*. Geneva: WHO.

### FERTILITY IN BRAZIL

In Brazil, fertility decline was a longer, more gradual process for highly educated women or high income families. It happened at a much faster pace, albeit at a later stage, for women from poorer socio-economic backgrounds. The fast pace of fertility decline among poor families can be attributed to improvements in their living conditions, which also occurred at a much faster pace.

The fertility decline can be attributed to Brazil's human capital investments, such as access to better education, health care (including access to free contraceptives) and more economic opportunities for women. More women were able to join the workforce which contributed to a decline in the fertility rate of the country. The decline in fertility also contributed significantly to a decline in inequality (both income and asset inequality): in other words, more women joining the workforce and delaying having children, and families with fewer children, resulted in more disposable income which could be invested in savings, or improving the quality and standard of life for those families. It is therefore possible to infer a relationship between fertility decline and a decline in inequality.

### FERTILITY IN RUSSIA

In 2007, Russia's key population concern was to stimulate the birth rate of the country which led to the introduction of new measures and incentives. These measures and incentives included paying financial allowances to encourage women to give birth as a way of increasing the country's fertility levels and population growth. The country also has a maternity capital programme: women who give birth to or adopt a second or consecutive child are entitled to special financial assistance. The policy stipulates that the maternity capital should be spent in the following ways: 1) acquiring housing or improving the housing conditions of the family; 2) paying for the children's education; and 3) investing in a retirement fund for the mother.

The policy stipulations ensure that the money goes towards improving the life of the children and the mother all the way through to old age. Other incentives for families with three or more children include reducing the amount that households pay for housing and communal services, free local transport, and free meals in kindergartens and schools.

### FERTILITY IN CHINA

China has adjusted its population control policy as it wants to increase its total fertility rate from 1.6 to 1.8, particularly as far as the working population is concerned. The country has made efforts to keep girls in school and to provide young women with employment, and this has contributed to maintaining the low fertility.

### FERTILITY IN SOUTH AFRICA

Fertility decline in South Africa can be attributed to the increase in education and economic participation. There is a continuous increase in the number of women who postpone marriage and childbearing in pursuit of education and employment. If fertility continues to decline, the population could number 58.5 million by 2030.

Teenage fertility has also declined, but teenage pregnancy remains high. The incidence of teenage pregnancy, particularly among those in school, is high. Initiatives are needed to reduce teenage pregnancy, including among learners, and to make adolescents aware of the benefits of delaying the birth of their first child until adulthood.

## MORTALITY

Although BRICS countries have managed to decrease their mortality rates, maternal mortality, infant mortality and under-five mortality remain worryingly high. South Africa in particular seems to be struggling with maternal mortality as it increased from 250 deaths per 100,000 live births in 1990 to 300 deaths per 100,000 live births in 2010. Infant mortality increased from 48 deaths per 1,000 live births in 1990 to 52 deaths per 1,000 live births in 2000 but later decreased to 35 deaths per 1,000 live births in 2011.

The leading causes of maternal deaths in **South Africa** are related to HIV/AIDS and complications in pregnancy. Non-pregnancy-related infections account for 40.5 per cent: these are deaths due to HIV infection complicated by tuberculosis (TB), pneumocystis pneumonia (PCP) and pneumonia. Obstetric haemorrhage accounts for 14.1 per cent, complications of hypertension in pregnancy account for 14.0 per cent, and pregnancy-related sepsis accounts for 9.1 per cent, including septic miscarriage and puerperal sepsis.

Over the past two decades, **Brazil** has reduced its maternal mortality rate by 54 per cent. Currently, the maternal mortality rate is 62 for every 100,000 live births. The Brazilian government prioritizes the maternal mortality agenda by intensifying the Rede Cegonha strategy (a Ministry of Health initiative to ensure quality care for all mothers and children from the confirmation of pregnancy through the first two years of a child's life). Initiatives to reduce maternal mortality have been implemented since 2003 and positive results are beginning to show. Investigating cases of women's death is an important part of these initiatives. In 2013, investigations of declared maternal death reached 87 per cent; and investigations of deaths of women of fertile age reached 85 per cent. These high investigative percentages are due to efforts by Brazil to intensify the surveillance of maternal deaths and data reliability.

Between 1990 and 2012 there was an 82 per cent reduction in the risk of death due to abortion, 72 per cent reduction in death from haemorrhage, hypertension dropped by 69 per cent and puerperal infection dropped by 63 per cent. Diseases of the circulatory system, with negative consequences for pregnancy, have fallen by 25 per cent.

**China** has achieved a significant decline in its maternal mortality ratio, from 120 per 100,000 live births in 1990 to 37 per 100,000 live births in 2010. The country conducts capacity-building initiatives focused on training midwives and high quality hospital personnel as an intervention to reduce its maternal mortality rate.

**Table 2: BRICS – maternal mortality ratios 1990–2010**

Country	Maternal mortality ratio		
	1990	2000	2010
Brazil	120	81	56
Russia	74	57	34
India	600	390	200
China	120	61	37
South Africa	250	330	300

Source: World Health Organization (2013) *World Health Statistics 2013*. Geneva: WHO.

**Table 3: BRICS – infant mortality rates 1990–2011**

Country	Infant mortality ratio		
	1990	2000	2011
Brazil	49	31	14
Russia	23	18	10
India	81	64	47
China	39	29	13
South Africa	48	52	35

Source: World Health Organization (2013) *World Health Statistics 2013*. Geneva: WHO.

The under-five mortality rate in BRICS countries is on the decline. Russia and South Africa are both experiencing a slow decline as their under-five mortality decreased by only 15 deaths per 1,000 live births in the last 21 years. Although India had the highest decrease of 53 deaths per 1,000 live births in the 21 years, its rate remains high at 61 deaths per 1,000 live births. China, which has the highest population size in BRICS, has the second lowest at 15 deaths per 1,000 live births. There are lessons to be learned from China on how to keep mortality rates low, regardless of population size.

**Table 4: BRICS – under-five mortality 1990–2011**

Country	Under-five mortality ratio		
	1990	2000	2011
Brazil	58	36	16
Russia	27	21	12
India	114	88	61
China	49	35	15
South Africa	62	74	47

Source: World Health Organization (2013) *World Health Statistics 2013*. Geneva: WHO.

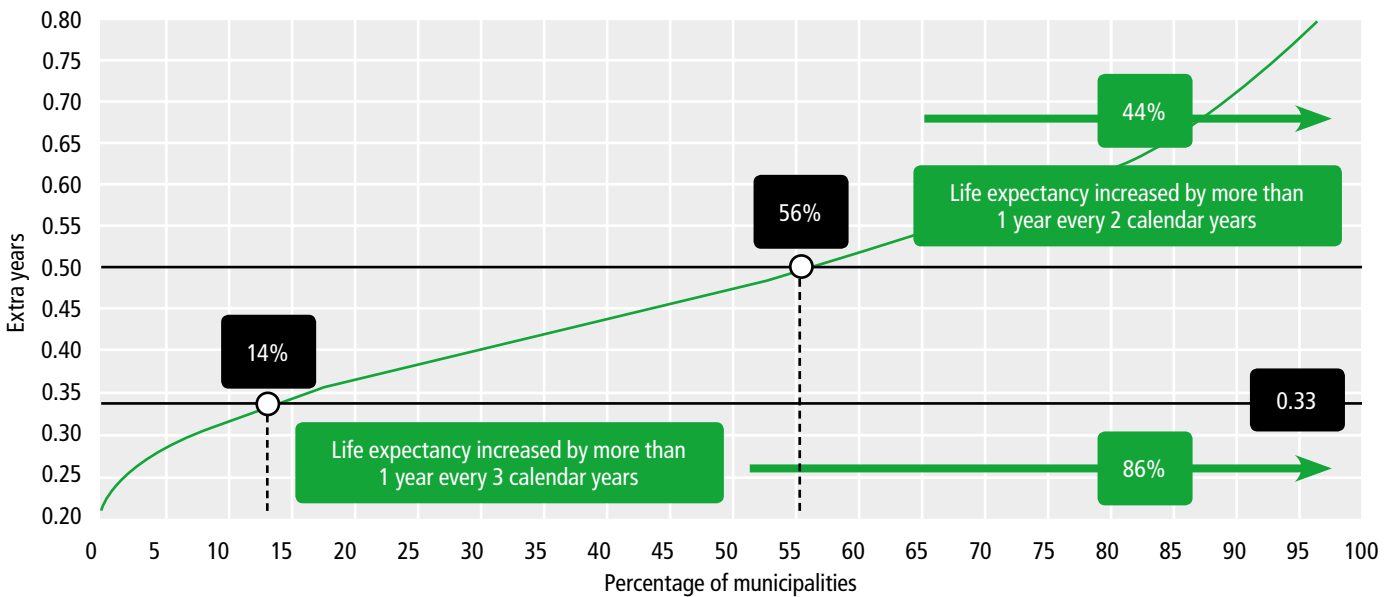
## LIFE EXPECTANCY

Life expectancy is considered as one of the health indicators of a country. A high life expectancy indicates that a country is able to take care of its citizens and support a healthy population, whereas a low life expectancy means the country is facing challenges with its health care system.

### LIFE EXPECTANCY IN BRAZIL

**Figure 5: Brazil – life expectancy**

Average annual increase in life expectancy in Brazilian municipalities 1991–2010

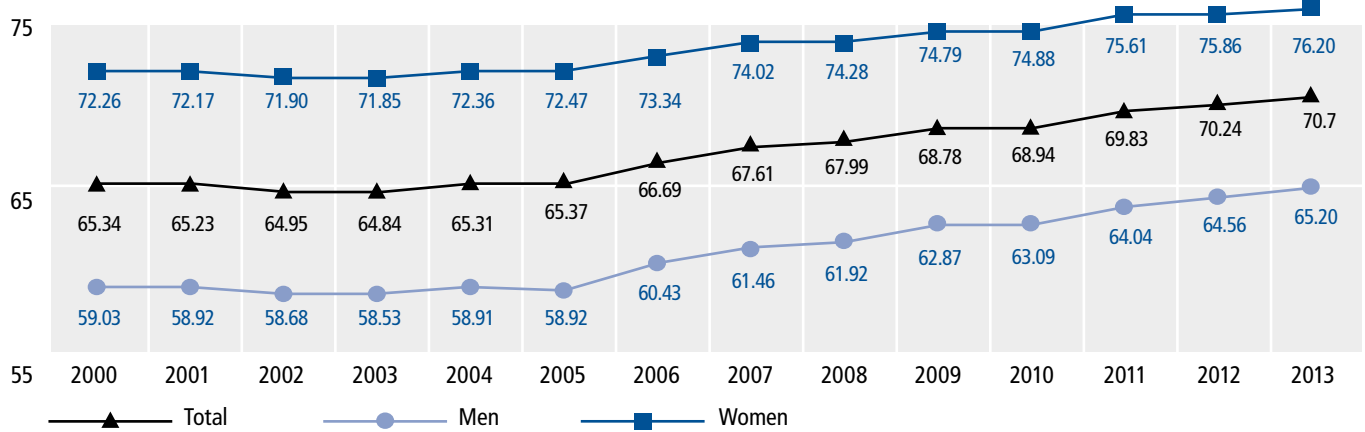


Life expectancy in Brazil has been increasing year by year. According to the World Bank, life expectancy was 73.6 years in 2012. Among other factors, this is due to the State providing health services as a right to all its citizens, and decentralization of health services to various levels of local government – municipal, state and federal.



## LIFE EXPECTANCY IN RUSSIA

Figure 6: Russia – life expectancy

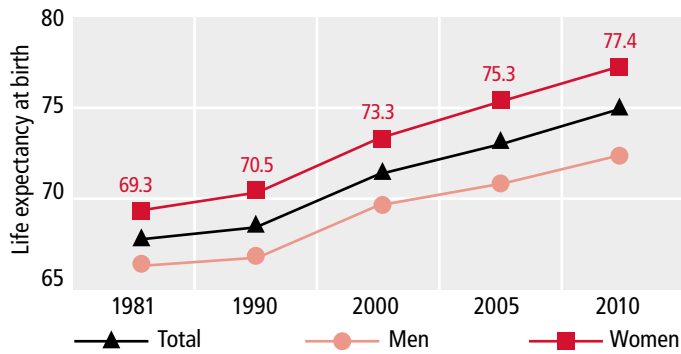


Life expectancy in Russia decreased dramatically in the 1990s. Between 1991 and 2003, life expectancy fell by 4.9 years for men and 2.4 years for women. A slow rise began in 2000, at an average of 65.3 years for the total population, with men at 59.0 years and women at 72.2 years. A noticeable rise was seen by 2007, at 67.6 years for the total population, with 61.4 and 74.0 for men and women respectively. In May 2012, a Presidential decree was adopted that aims to further increase life expectancy to 74 years by 2018. Total life expectancy increased to 70.7 years in 2013.



### LIFE EXPECTANCY IN CHINA

**Figure 7: China – life expectancy**



China has managed to greatly increase the life expectancy of its population. The average life expectancy in China was 37 years in the mid-1920s. However, it increased and reached 74.8 years by 2010. Women in China have always had higher life expectancy compared to men, as in most countries around the world.

### LIFE EXPECTANCY IN SOUTH AFRICA

Life expectancy has been increasing in the past decade. It increased to 61.2 years in 2014, with 59.1 years for men and 63.1 years for females. This compares to an average of 56.2 years in 2012 with 58.1 years for men and 54.1 years for women. One major contributor to increasing life expectancy is the free availability of antiretroviral treatment which prolongs life for people living with HIV. Another contributor is the increased access to free health services for all citizens.



## Chapter 2

# Gender and the empowerment of women

Here we look at gender-related factors that affect the empowerment of women, including policies to encourage their participation in the labour force to enable them to contribute financially to the well-being of their family; gender income inequality; women in leadership positions and taking political and community decision-making roles; universal access to education; and the impact of gender-based violence and strategies to combat violence against women.

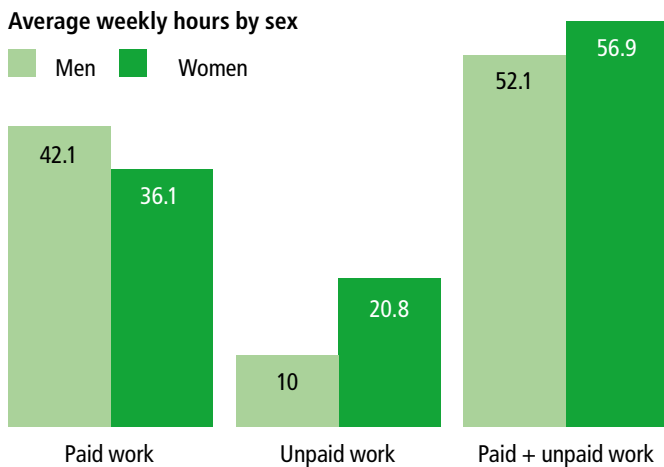


## LABOUR FORCE PARTICIPATION

### LABOUR FORCE PARTICIPATION IN BRAZIL

Brazil has specific policies to increase the employment of women and is seeing increased participation of women in the labour force. In the years 2001 to 2011, there was a 24 per cent increase in women in the economically active section of the population. Despite the increasing number of economically active women, a large number are still unavailable for work.<sup>3</sup> Brazil recognizes the persistent sexual division of labour with women providing more unpaid work in the home and as carers, compared to men.

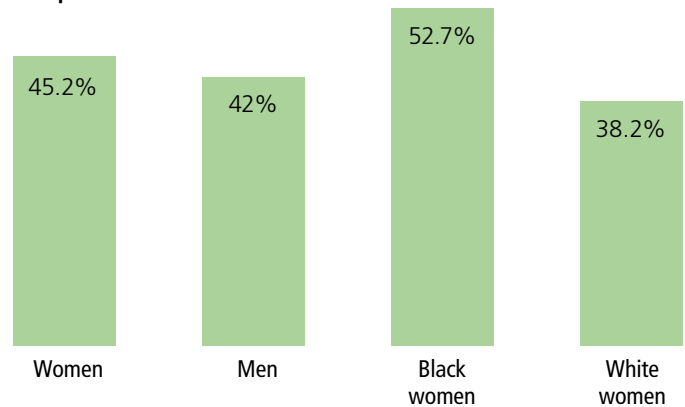
**Figure 8: Brazil – sex distribution in paid versus unpaid work**



Source: Brazilian Institute of Geography and Statistics (2011–12), Pesquisa nacional por amostra de domicílios (PNAD).

**Figure 9: Brazil – sex and race distribution in the informal sector<sup>4</sup>**

### Composition of informal sector



Source: Brazilian Institute of Geography and Statistics (2012), Pesquisa nacional por amostra de domicílios (PNAD).

In Brazil, women are more active in unpaid work than men. In 2012, 36.1 per cent of women were doing paid work while 20.8 per cent were engaged in unpaid work, compared to 42.1 per cent of men who were in paid work with only 10 per cent active in unpaid work. Statistically, at 56.9 per cent, women constitute the majority of the working age population but they are in the minority when it comes to paid work that can contribute to the financial well-being of their families. Although the rate of women working in the formal private sector is growing faster than the rate for men, the majority of women are still working in lower paid sectors. A quarter of all employed women are in domestic work, self-consumed production<sup>5</sup> and non-paid jobs, compared to only 5.6 per cent of men. The country has 5.8 million domestic workers of whom 92 per cent are women. There are 45.2 per cent of women in the informal sector compared to 42 per cent of men.

<sup>3</sup> Brazilian Institute of Geography and Statistics, Pesquisa nacional por amostra de domicílios (PNAD), (2012).

<sup>4</sup> These are the ethnic grouping categories under which the statistics were originally gathered in-country.

<sup>5</sup> An example of self-consumed production is subsistence agriculture, where the crops grown are eaten by the family.

### LABOUR FORCE PARTICIPATION IN RUSSIA

Russia has employment policies that encourage women's labour force participation by keeping a balance between child care and employment. These policies encourage employment of women after maternity leave and facilitate their reintegration into employment, giving women flexible employment options (for example, part-time, working from home) by providing them with professional training and retraining according to labour market demand and by creating new job opportunities with safe working conditions. All these are efforts by the State to ensure that women are able to increase the fertility rate of the country without worrying about sacrificing their careers in the process.

### LABOUR FORCE PARTICIPATION IN CHINA

In China, 71.1 per cent of women aged 18–64 are active in the labour force; they constitute 46 per cent of employed labour. There is a high concentration of female employees in the education, culture, health, sports, commercial and retail, and service sectors. There are increasing numbers of women joining new, emerging and high-tech industries. The government and women's organizations provide training to women to give them skills to be employable and also to enable them to start their own businesses. There have also been improvements in occupational protection for women, such as the increase in maternal insurance for urban employees from 26 per cent in 2000 to 95 per cent in 2010. There was a 20 per cent increase in the enterprises implementing the Regulation on Occupational Protection of Women Employees, between 2005 and 2010. The country is, however, aware that there is still some gender discrimination in the labour market: women's income is lower, and the official retirement age of female employees is five years younger than their male counterparts.

### LABOUR FORCE PARTICIPATION IN SOUTH AFRICA

The 2011 census recorded an unemployment rate of 29.8 per cent, showing that 34.6 per cent of females and 25.6 per cent of males were unemployed. The labour absorption rate is lower for 'black/African' women at 28.8 per cent, compared to 62.5 per cent for 'white' women. It is also higher for 'white' women than 'black African'<sup>6</sup> men at 40.8 per cent. Women are more dependent on survivalist activities<sup>7</sup> in the informal sector where wages are low, and where there is high insecurity and increased vulnerability. Unemployment has recently increased more for women (from 26.3 to 34.6 per cent) than for men (from 20 to 25.6 per cent).

Although women's share in wage employment in the non-agricultural sector has increased since 1995, large disparities in male and female wages persist. Women also continue to be dependent on work that can be characterized as survivalist activities with low wages and huge insecurities (Department of Social Development, 2010:51). The government's Poverty Alleviation and Skills Development Programmes open avenues for women to enter the labour force and to broaden their opportunities for career changes.<sup>8</sup>

6 These are the ethnic grouping categories under which the statistics were originally gathered in-country.

7 South African women entrepreneurs frequently engage in 'survivalist activities' such as sewing cooperatives, chicken farming, candle making, home gardening, and arts and crafts. These activities are also commonly referred to as micro-enterprise projects.

8 Department of Social Development (2010) *Progress Review of the Implementation of the White Paper on Population Policy for South Africa (1998) and the ICPD Programme of Action (1994)*.

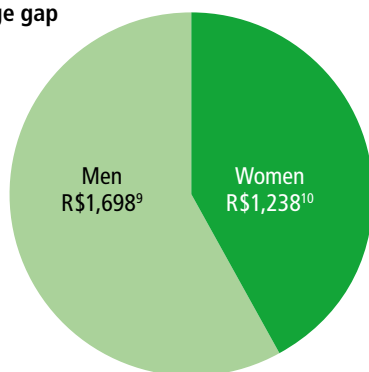
## GENDER INCOME INEQUALITY

### GENDER INCOME DISTRIBUTION IN BRAZIL

Brazil, in common with the other BRICS member states, has been experiencing gender income inequality challenges for decades. Income distribution is higher for males than for females although the gap between the two is slowly decreasing.

**Figure 10: Brazil – gender income distribution**

Gender wage gap



**The last decade has seen an increase of 31.4 per cent in female net income, of which 38.5 per cent is in the informal market.**

**In 2002, there was an average income gap of 30 per cent. In 2012 this had dropped to 27 per cent, a slow but important reduction.**

Source: Brazilian Institute of Geography and Statistics (2012), Pesquisa nacional por amostra de domicílios (PNAD).

The country has an income transfer policy which aims to provide income for needy families. The implementation of the policy has resulted in more than 14 million families receiving allowances ranging from US\$35 to US\$120. Women represent 54 per cent of the beneficiaries. This is one of the government's ways of ensuring that all people are able to afford basic needs and services. Women are the majority pensioners but only one-third of retirement benefit holders. The State is finding it more difficult to implement retirement benefit for rural women because of family provision traditions, where a man is supposed to be the provider for the household. A new law approved in 2013 states that housewives with a lower income are entitled to retirement and other social benefits.

### GENDER INCOME DISTRIBUTION IN CHINA

In China, women's average annual income compared to that of men is 67.3 per cent in urban areas and 56 per cent in rural areas. In 2010, the percentage of loans for production and business provided by the State was 9 per cent to women and 14 per cent to men; among them, 37.3 per cent of women and 36.9 per cent of men received small loans, including government subsidized interest payments. This strategy is giving the population capital so they can generate sustainable income for their families instead of depending on government social security for continuous income.

### GENDER INCOME DISTRIBUTION IN SOUTH AFRICA

According to the 2011 gender statistics report from Statistics South Africa, 72.9 per cent of women receive a monthly income of less than R1,250<sup>11</sup> compared to 52.1 per cent for men. Only 11.8 per cent of women receive a monthly income of R3,206<sup>12</sup> or more compared to 25.1 per cent of men. These data show a large gap in gender income in the country.

9 US\$146.21 at 12 November 2014.

10 US\$106.60 at 12 November 2014.

11 US\$107.64 at 12 November 2014.

12 US\$276.07 at 12 November 2014.

## WOMEN IN LEADERSHIP POSITIONS

In **Brazil**, women have very strong participation in social movements but a limited presence in formal leadership positions and political representation.

**Table 5: Brazil – women candidates: women in Parliament and executive office**

Women candidates Election (year)	President	Senator	Governor	Federal congresswoman	State congresswoman
2002	0%	11.5%	9.85%	8.19%	12.56%
2006	28.6%	15.91%	12.68%	12.66%	14.27%
2010	22.2%	13.28%	11.04%	19.42%	21.06%

**Table 6: Brazil – elected women: women in Parliament and executive office**

Women candidates Election (year)	President	Senator	State governor	Federal congresswoman	State congresswoman
2002	0%	12.3%	7.4%	8.2%	12.56%
2006	0%	14.8%	11.11%	8.97%	11.61%
2010	100%	14.81%	7.4%	8.77%	12.85%

Political participation of women in **China** is low, the same as in the other BRICS countries. In 2013, women's representation in the National People's Congress was 23.4 per cent. Women in community leadership roles were 49.6 per cent in urban and 21.4 per cent in rural areas in 2010. Findings from the Survey on the Social Status of Women conducted in 2010 shows that 54.1 per cent of women have been involved in democratic supervision<sup>13</sup> and 18.3 per cent of women had taken the initiative to raise suggestions at their workplace or in communities. Over the last five years, 83.6 per cent of rural women participated in village committee elections, and 70.4 per cent reported having taken the elections seriously and "tried their best to know the

candidates well before voting." The proportion of women in decision making and management is still low, and promotion of men is faster than that of women. The country aims to increase women's participation in decision making and promotion to high-rank positions by providing women with more training and by improving its labour policy.

In relation to women in leadership positions in **South Africa**, women's access to political power and decision making improved significantly after the 1994 elections and the country has already surpassed many of the requirements set in the international, regional and sub-regional instruments. According to the United Nations Development Programme, South Africa is one of the top 10 countries in the world with the highest number of women in national parliaments (United Nations Development Programme, 2013). In 1994, 111 women formed part of the 400 Members of Parliament in the National Assembly, constituting 28 per cent of all MPs. In 2009, the number of female Members of Parliament in the National Assembly grew to 173, or 43 per cent of all MPs, and women were appointed to cabinet portfolios previously associated with masculinity, such as the Ministries of Defence and Military Veterans and Labour.

<sup>13</sup> Democratic supervision means that the non-communist political parties exercise supervision on the Communist Party of China and the government organs under its leadership, within the framework of the multi-party cooperation and political consultation. The supervision may be conducted by putting forward opinions, suggestions and criticisms to the Communist Party of China Central Committee; making suggestions and criticisms on major issues on the basis of investigations and inspection reports; and members of non-communist political parties may exercise a supervisory role by serving as inspectors, auditors and education supervisors of the government.

## EDUCATION

**Brazil** has day care and education policies to ensure that all children get equal access to basic education. The day care policy is designed to increase the proportion of children attending day care centres. In 2000, only 9.4 per cent of children attended day care centres. In 2012, the number of children attending day care centres increased to 33.9 per cent. Over 3 million students attend elementary school full time.

In **South Africa** equitable access to education for boys and girls has been achieved in primary as well as secondary school. However, completion of secondary school education remains a challenge for many, as does entry into higher education and completion of post-school qualifications. While there has been improvement since 1996 gender differences between the numbers of men (7.2 per cent) and women (9.9 per cent) over the age of 20 with no formal education were noted in the 2011 census. While enrolment rates are high, attendance and drop-out rates remain a major challenge. In an attempt to curb school drop-out, girls who are pregnant are allowed to continue their schooling during the pregnancy and after giving birth.

## GENDER-BASED VIOLENCE

Despite BRICS countries apparently having the prerequisite policies, legislation and mechanisms to address gender-based violence and intimate partner violence, violence against women remains high. Challenges include the perpetuation of perceptions, attitudes, values, beliefs and subsequent behaviour that is rooted in patriarchy, resulting in high acceptance of violence against women in intimate relationships. High proportions of women and men seem to accept violence against women as the norm. These patriarchal perceptions, attitudes and values also prevail in the institutions that have to address violence against women.

### COMBATING GENDER-BASED VIOLENCE IN BRAZIL

**Figure 11: Brazil – policies to combat gender-based violence**

#### NATIONAL NETWORK Integral Care for Women and Adolescents in Situations of Domestic and Sexual Violence



#### Law number 12.845 August 2013

Legislates on the compulsory and integral care for people in a sexual violence situation

#### Decree number 7.958 March 2013

Guidelines for the care of victims of sexual violence by public safety professionals and the national public health system



#### Current situation

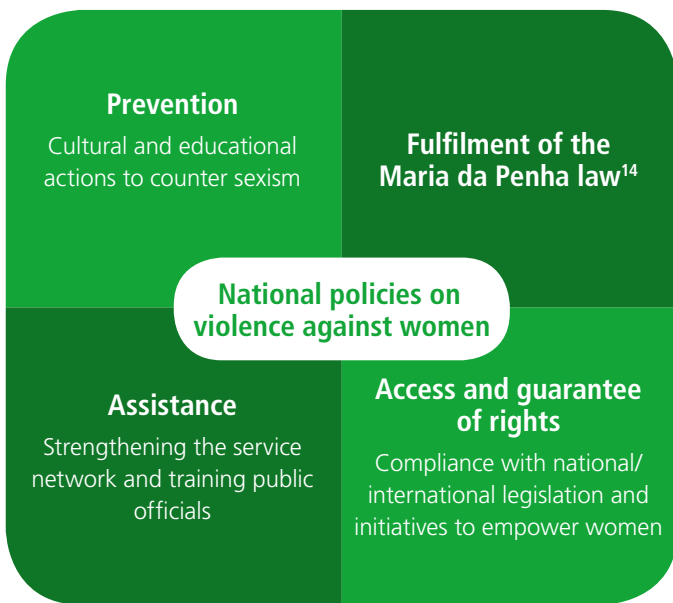
- 557 health services providing sexual violence care
- 402 health services providing domestic violence care
- 211 legal abortions, under the terms of the 2013 legislation
- 1,625 legal abortion procedures in 2012

#### Notification form





**Figure 12: Brazil – national policy on violence against women**



Brazil experiences high levels of violence against women and the elderly. Brazil has comprehensive legislation that took eight years to develop. The Health Department in Brazil plays a key role in addressing gender-based violence, developing numerous policies and ways to reduce violence against women and integrate other ministries in the fight against violence. It has established a 'National Network – Integral Care for Women and Adolescents in Situations of Domestic and Sexual Violence' – making provision for women and their children to leave abusive households. Brazil's current mechanisms to address gender-based violence include 557 health services for the care of victims of sexual violence and 402 health services for the care of victims of domestic violence.

<sup>14</sup> The Maria da Penha law (2006) is the first Brazilian law providing comprehensive measures to inhibit domestic violence against women. This law has introduced conceptual innovations, such as recognizing different forms of violence – physical, psychological, sexual, property-related and moral – as well as defining domestic violence against women regardless of the actor's or victim's sexual orientation. It has also introduced emergency protective measures for victims and the preventive arrest of offenders if they are found to pose a risk to the victim's physical or mental integrity. The bill gives special attention to the way victims should be treated in police stations that specialize in domestic violence cases; has provided for victims to be assisted by multi-disciplinary teams; and has improved their access to justice by creating rules such as the need for legal assistance at all procedural stages. It has also introduced new mechanisms of assistance to women experiencing domestic violence, as well as conferring on them the right to keep their employment. In addition, it has created small claims courts for family and domestic violence against women with civil and criminal competence.

The country has two specific campaigns about violence against women: one is called The One Who Loves Embraces campaign, which was introduced by the Ministry of Women; and another called Truck Drivers, Go Well, which is run in collaboration with a major oil distributor in Brazil, aimed at preventing violence against women on the road. Brazil has a national policy on violence against women. The country has also harmonized its policies and integrated services to reinforce support for women. However, there are institutional and legal gaps in dealing with gender-based violence. The success of the policies is hindered by the challenge of enforcing the policy measures through programmes.

### COMBATING GENDER-BASED VIOLENCE IN CHINA

China has a national working committee for women and children which, among other things, regulates laws on dealing with gender-based violence. The national working committee also collaborates with more than 20 ministries and organizations mandated to deal with violence against women in the country. Initiatives to address gender-based violence started at grassroots level, drawing in civil society and research institutions, thereby emphasizing the importance of community participation. There is an All China Women's Federation which trains community social workers on how to address gender-based violence.

China has developed guidelines, referred to as The Program for the Development of Chinese Women (2011–20) which identifies major indicators and strategies to safeguard women's rights and improve their participation in Chinese society. Indicators were identified and strategies developed for health, education, the economy, decision making and management, social welfare, the environment and legal protection. Implementation of these strategies is monitored and evaluated on a continuous basis.

Key projects are underway to combat gender inequality in general and gender-based violence in particular. These include changing common views from ignorance to awareness, and gender-sensitive and anti-gender-based domestic violence training for both the legal and health systems and in preparation for the development of new laws that will address gender-based violence. The Care for Girls campaign promotes non-discriminatory concepts to address traditional patriarchal views that value boys more than girls, and also calls for awareness of harmful practices that discriminate against girls while, at the same time, making efforts to raise their status in the family.

## COMBATING GENDER-BASED VIOLENCE IN SOUTH AFRICA

South Africa has a progressive constitution and legislation, and an enabling legal system that protects human rights and dignity, including freedom from discrimination on the basis of sexual orientation and gender identity, yet discrimination and violence against women, lesbians, gay and bisexual people are still common.

The country has an Inter Ministerial Committee on Gender Based Violence, chaired by the Minister of Social Development, whose brief includes addressing gender-based violence. Through this committee, specific responsibilities are assigned to each department, including the Department of Justice and Constitutional Development, the Department of Health and the Department of Women. The South African government tries to provide comprehensive services to victims of violence against women, including shelters and the establishment of a gender-based violence council. The Department of Justice and Constitutional Development is now in the process of appointing forensic social workers who will treat cases of sexual and physical violence against women with the appropriate sensitivity and professional conduct, and treat survivors with dignity and respect. The first conviction for the practice of Ukuthwala<sup>15</sup> was recently handed down by a South African court. This was seen as a victory by gender advocates.

The country runs campaigns against gender-based violence called 'The 16 Days of Activism for No Violence Against Women and Children' which is an international awareness-raising campaign. It takes place every year from 25 November (International Day for the Elimination of Violence Against Women) to 10 December (International Human Rights Day). The period includes Universal Children's Day and World AIDS Day. During this period, the South African government runs an activism campaign to make people aware of the negative impact of violence against women and children and to act against abuse. Every year, government, civil society organizations and the business sector work together to broaden the impact of the campaign. By supporting this campaign, thousands of South Africans have also helped to increase awareness of abuse and build support for victims and survivors of abuse.

Other efforts include 'The One Man Can Campaign' which supports men and boys to take action to end domestic and sexual violence and to promote healthy, equitable relationships that men and women can enjoy – passionately, respectfully and fully. In addition, 'Brothers for Life' is a national campaign mainly targeting men aged 30 and over: this seeks to address the risks associated with having multiple and concurrent partnerships, sex and alcohol, and gender-based violence; it also seeks to promote HIV testing, male involvement in the prevention of mother-to-child transmission and health-seeking behaviours in general.

<sup>15</sup> Ukuthwala – abducting young women or girls and forcing them into marriage, often with older men and often with the consent of their parents.

## Chapter 3

# Sexual and reproductive health and reproductive rights

Sexual and reproductive health and reproductive rights are explored in this chapter, including the availability and use of contraceptive methods and access to services; the role of sexuality education in changing perceptions and behaviour; public health services, in particular infant and maternal health, and abortion-related issues; and measures to tackle HIV and AIDS in the general population, and for mothers and children specifically.

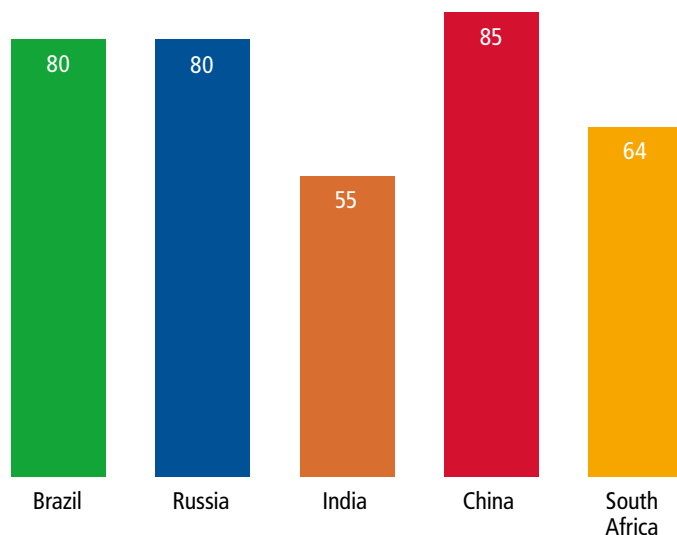


The International Conference on Population and Development Programme of Action sets out the objective to attain “universal access to reproductive health by 2015”, which is also recognized in the Millennium Development Goals. The areas of priority concern in sexual and reproductive health are quality family planning services; maternal, prenatal and child health care; adolescent sexual and reproductive health education and services; and prevention and control of HIV/AIDS, sexually transmitted infections and reproductive tract infections.

BRICS countries made some progress towards achieving the objectives of the International Conference on Population and Development Programme of Action measured through a number of indicators, described in this chapter.

## CONTRACEPTIVE METHODS

**Figure 13: BRICS – percentage of contraceptive use 2010**



Source: Alkema et al (2013) National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *The Lancet*; 381(9878): 1642–52.

### CONTRACEPTIVE USE IN BRAZIL

Brazil has comparatively high contraceptive use, similar to levels in Russia. The country’s 1988 Federal Constitution established the responsibility of the State in relation to family planning (Article 226): “Based in the principles of dignity of the human person and of responsible paternity, family planning is a free decision of the couple, being due to the State to offer resources for such right, void any form of coercion from official or private institutions.”

The Federal Constitution ensures access to a wide range of contraceptive methods; mandates the development of policies and programmes to eradicate discrimination based on sexual orientation and gender identity; aims to eliminate preventable causes of maternal morbidity and mortality; and ensures universal access to sexual care services and quality reproductive health care. These services take into account the different needs of men, women, adolescents and youths, people who are lesbian, gay, bisexual or transgender, people living with disabilities, and those who are vulnerable, among others.

The availability and use of a wider choice of contraceptive methods among women of childbearing age shows a significant change compared to 1996, when contraception was restricted to two methods: at that time 40 per cent of women were sterilized and 20.7 per cent were using the pill. By 2006, female sterilization had decreased from 40 to 29 per cent and condom use increased from 4 to 12 per cent. Use of injectable contraception trebled to 4 per cent from 1.2 per cent. The use of pills and the intrauterine device increased from 20.7 to 24.7 per cent, and from 1.1 to 1.9 per cent respectively.

## CONTRACEPTIVE USE IN RUSSIA

Russia was equal to Brazil in its use of contraceptives by 2010. In November 2011, a Federal Law on the fundamentals of health care for the citizens in the Russian Federation stated: “Every citizen has the right to free-of-charge family planning consultations as required by his/her medical indications.” There is currently no specialized family planning programme within the Russian health care system. Family planning services are provided by the general women’s health care system, such as maternity institutions. Russian contraceptive behaviour has long been characterized by heavy reliance on less effective traditional methods of preventing pregnancy (the calendar or periodic abstinence methods, and withdrawal). These methods have a fairly high failure rate, resulting in unintended pregnancies many of which end in abortion.

There is now, however, a decline in the abortion rate triggered primarily by changes in contraceptive behaviour, as manifested by an increase in the number of women using contraception, and in the proportion using more effective modern methods. A survey revealed that women of reproductive age are well aware of contraceptive methods: virtually all women (99.5 per cent) had heard of at least one modern method while fewer were aware of at least one traditional method (87 per cent). On average, respondents recognized at least three modern methods – the condom (99 per cent), oral contraceptives (97 per cent) and the intrauterine device (93 per cent). The intrauterine device is widely advertised, and is the most prescribed method. The country is continuing to run awareness campaigns and advertisements to ensure that all sexually active citizens know about the options they have and how to access them.

## CONTRACEPTIVE USE IN CHINA

In 2010, China had the highest percentage of contraceptive use in BRICS countries due to strict policies that were previously implemented to reduce population growth. In 1982, family planning was announced as a fundamental national policy written into the constitution, and population planning was written into the National Planning for Social and Economic Development. In December 2001, the Population and Family Planning Law of the People’s Republic of China was enacted and family planning-related mechanisms were set up at all levels of government, with dedicated family planning workers assigned to each village or community. In addition, a large number of non-governmental organizations sprang up, such as the China Family Planning Association which is the largest non-governmental organization in China with 90 million current members.

The Family Planning Law mandates for free provision of contraceptives and related family planning commodities. The government works hand in hand with the China Family Planning Association and its millions of members to ensure that family planning services reach those who are poor, under-served or marginalized. The contraceptive method most frequently chosen is the intrauterine device. The government runs an ongoing and extensive communication and education campaign. It also offers free contraceptives such as condoms and other contraceptive methods to all citizens: this forms part of efforts to uphold the fundamental national policy of family planning in order to stabilize the fertility level at around 1.8. The low fertility levels help the country to concentrate efforts on enhancing the quality of life of the newborn population; to pay attention to accumulation of human capital; to respond positively to population ageing; to curb the problem of skewed sex ratio at birth and promote gender equality; and to manage the orderly movement and reasonable distribution of population.



## CONTRACEPTIVE USE IN SOUTH AFRICA

South Africa also provides free contraceptives to all its citizens. The country promotes the use of contraceptives for a number of reasons, including to reduce unwanted pregnancy which, in turn, leads to decreased pregnancy-related mortality; to decrease abortion-related mortality; to delay first pregnancy in adolescents; to reduce high parity;<sup>16</sup> to reduce closely-spaced pregnancies; and to improve infant and child outcomes including reducing infant mortality.

The country recently adopted a new contraceptive and fertility planning policy which was written against the backdrop of high HIV prevalence. It promotes dual protection, including male and female condoms; it introduces implants for women; intrauterine devices are being reintroduced to the country; it offers fertility counselling for HIV-positive and HIV-negative women; and it addresses the needs of special groups such as people living with disabilities. Although the country has made great improvements and has increased access to sexual and reproductive health services since 1998, these have been undermined by a decreased life expectancy and increased maternal mortality rate, both linked to HIV and AIDS.

## SEXUALITY EDUCATION

Introducing comprehensive sexuality education in schools could potentially contribute to changing the perceptions, attitudes and values of boys and girls and subsequently lead to behaviour change. Comprehensive sexuality education should also be geared towards changing the attitudes of teachers and parents. It can be difficult for parents and teachers to speak to young people about sex in a way that enables them to make informed and mature choices. Sexuality education is also about more than just sharing factual information; it should also focus on issues such as self-esteem, peer pressure, gender relations and other related topics.

**Russia** has comprehensive sexuality education in schools which aims to promote healthy sexual behaviour among Russian youth. Topics include reproductive health, preventing sexually transmitted infections and HIV, gender relations, family relationships and family law in the Russian Federation. These topics are delivered through a regular multi-component educational programme aimed at providing young adults with family and health knowledge and skills. It is, however, not clear to what extent some of these topics – for example, gender relations, family relationships and family law – address gender equality and issues relating to gender-based violence.

**China** currently provides sexuality education. This programme started 12 years ago, but China does not have a national sexuality education curriculum.

**South Africa** does not yet have a comprehensive sexuality education programme, but life orientation has been introduced as a compulsory school subject in all 12 grades. It includes modules on sexuality, sex and related matters, for example gender relations, and HIV and AIDS. The National Population Unit is working with the Department of Basic Education to develop a suitable curriculum that also addresses a range of population matters.

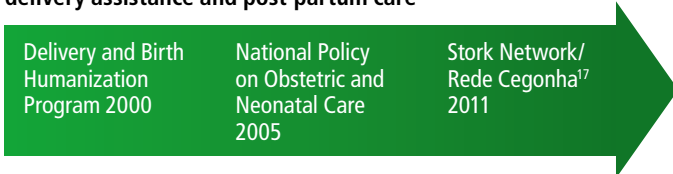
<sup>16</sup> Parity is the number of pregnancies carried to viable gestational age. Parity indicates the number of >20-week births (including viable and non-viable, ie stillbirths). Pregnancies consisting of multiples, such as twins or triplets, count as one birth for the purpose of this notation.

## MATERNAL HEALTH

### MATERNAL HEALTH IN BRAZIL

**Figure 14: Brazil – maternal health**

**Broadening access to and improving the quality of prenatal care, delivery assistance and post-partum care**



Brazil has a programme that is changing maternal and neonatal care (upgrading the model of delivery care and post-partum care). It focuses on increasing the availability of rapid tests for HIV and syphilis; better provision of early pregnancy testing in primary care units: increasing access to contraceptive methods to prevent unplanned pregnancy; linking pregnant women to the facility where their baby will be delivered; better training and qualifications in prenatal care; choice of a birthing companion; improvement in the ambience of maternal care and following good practice guidelines; including an obstetric nurse in the care team; and out-of-hospital care.

**Figure 15: Brazil – legal framework for abortion**

- Decree law number 2.848, 7 December 1940, Penal Code
- Technical Standard of Humanized Care for Abortion/Ministry of Health
- Non-compliance with fundamental precept number 54 (STF/2012), assured in Brazil, the therapeutic interruption of pregnancy of anencephalic fetus

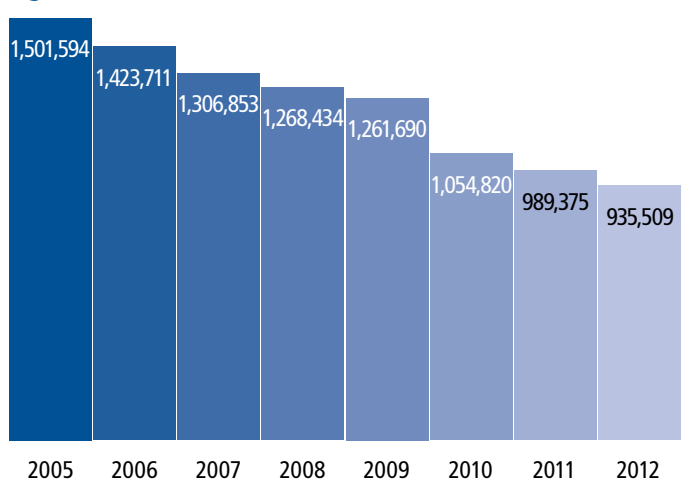
Brazil has a legal framework on abortion that ensures provision of safe abortions in the country.

### MATERNAL HEALTH IN RUSSIA

Russia conducted a reproductive health survey and the findings on maternal health revealed that 99 per cent of births were delivered in a hospital between 2006 and 2011. The majority of providers were city hospitals (68 per cent), followed by district level maternity or hospital maternity wards (27 per cent), and 3 per cent referral hospitals. The use of antenatal care was almost universal among women who delivered between 2006 and 2011. Fewer than 1 per cent of pregnant women did not receive antenatal care (mostly women living in rural areas). Nearly 90 per cent of pregnant women initiated antenatal care in the first trimester, and 71 per cent completed 10 or more appointments. Eighty per cent of women received post-partum care, ranging from 84 per cent in Moscow to 76 per cent in rural areas. Ninety-six per cent of newborn babies received a well-baby check-up, the majority of these (61 per cent) during the first week following delivery.

The National Priority Health Care Project was set up in October 2007, following a Presidential decree to establish top priorities for social and demographic development. The priorities include improving maternal and infant health, reversing fertility decline, and reducing maternal and infant mortality. Measures have been designed to accelerate the implementation process under the National Priority Health Care Project. This project aims for Russia to have 32 new and ultra-modern perinatal centres by 2016.

**Figure 16: Russia – abortion statistics 2005–12**



<sup>17</sup> This is a Ministry of Health initiative to ensure quality care for all mothers and children from the confirmation of pregnancy through the first two years of a child's life.

Russia has one of the highest numbers of abortions per woman of childbearing age in the world. In 1991, about 3,608,000 abortions were performed. The number declined steadily over the years and, by 2002, the number had fallen to 1,802,000. By 2005, the number had decreased to 1.5 million abortions annually. The country's 2011 official statistics record a figure of 989,000.

Even though the incidence of abortion has declined rapidly, these figures are still high; the average proportion for the last few years is one abortion per two births. In the recent past, Russian women overall had far more abortions than live births. This has now changed so that only women aged 35 and older report more lifetime abortions than live births.

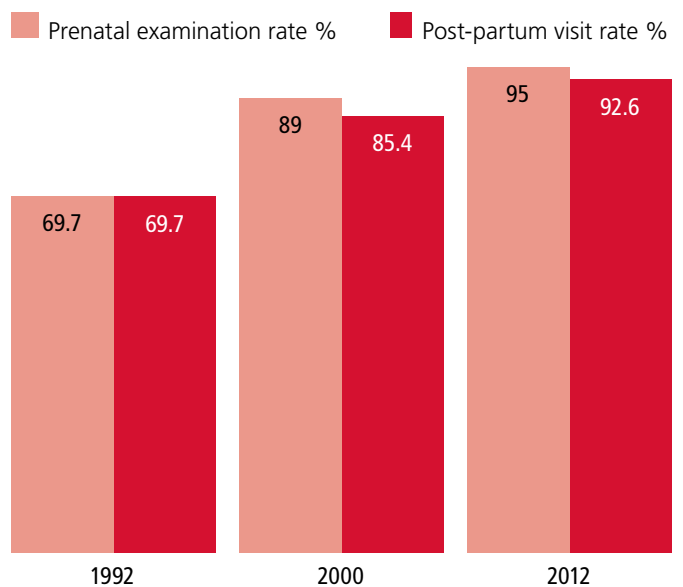
The country has put in place new measures regarding abortions, and made amendments to the Basic Law on Citizens' Healthcare adopted in 2011, as an attempt to reduce abortion rates. Some of the new amendments include a compulsory waiting period of up to one week between the woman's first visit to a public clinic for a free abortion and the actual procedure (seven days for the gestational age of 8–10 weeks, and two days for the gestational age of 4–7 or 11–12 weeks); granting doctors the right to refuse to perform an abortion, based on his or her conscientious objections (except for abortions on medical grounds and cases when a replacement for the doctor cannot be found); reduction of legal preconditions for getting a second trimester abortion (the only social indication for pregnancy termination in the second trimester is for a pregnancy that occurred as a result of rape); and restrictions on advertisements for abortion services by profit-making organizations.

Psychological counselling in the country has been enhanced. Staff positions for pre-abortion psychologists are being created in women's health clinics, and there already exist higher education programmes to prepare workers for this role. Centres of medical and social support for pregnant women in difficult situations are being created – this is an important component of a package of measures aimed at reducing abortions. The main goal is to provide medical and socio-psychological assistance to women in cases of unplanned pregnancy by presenting positive alternatives to abortion, and providing accessible and high quality medical care to restore reproductive health.

## MATERNAL HEALTH IN CHINA

China provides free basic public health services to all. This includes provision of five antenatal care appointments and examinations plus two post-partum visits, as well as health management of children aged 0–6. The country has a programme that subsidizes rural women to have a hospital delivery. Between 2009 and 2013, the central government invested 14 billion yuan;<sup>18</sup> altogether 47 million rural pregnant women were subsidized.

Figure 17: China – maternal health



The incidence of antenatal examinations and post-partum visits in China increased from around 70 per cent to above 90 per cent between 1992 and 2012. This indicates that more and more women have become aware of the importance of this programme and that the country has made great strides in making the services accessible to all women, including women in rural areas.



## YOUTH FRIENDLY SERVICES IN CHINA

The country provides capacity building and training for clinic counsellors, allowing them to provide quality and appropriate sexual and reproductive health services to adolescents. Free clinics also provide Chinese adolescents with youth friendly sexual and reproductive health services that include high quality counselling services, as well as training on how to use contraceptives correctly, including condoms.

## YOUTH FRIENDLY SERVICES IN SOUTH AFRICA

South Africa has a National Adolescent Friendly Clinic Initiative (NAFCI) coordinated by the Reproductive Health Research Unit, in the University of Witwatersrand and Chris Hani Baragwaneth Hospital, in partnership with LoveLife. The initiative was set up because of the recognition that a successful sexual health campaign must be supported by health services that accommodate the needs of young people. Public health clinics were identified as the most effective way to deliver the services in order to be able to reach many adolescents in the country. The initiative was conceptualized and implemented between 1999 and 2005, reaching all nine provinces by January 2001 (Youth Friendly Health Services, 2011). The aim of NAFCI was to improve the quality of youth friendly health services at the primary care level and to strengthen the public sector's ability to respond appropriately to adolescent health needs. The three key objectives of the initiative were:

- to make health services accessible and acceptable to adolescents
- to establish national standards and criteria for adolescent health care in clinics throughout the country
- to build the capacity of health care workers to provide high quality adolescent health services

NAFCI devised a participatory approach, using national and international consultation as well as focus groups with adolescents, to design the programme and develop the standards for adolescent friendly health services. It adopted a quality improvement approach that benefits all clients who use the services, with special attention to the needs of adolescents (Youth Friendly Health Services, 2011). An assessment of clinic use by 10–19-year-olds in 32 NAFCI clinics between 2002 and 2004 showed that there was a statistically significant increase in average monthly clinic utilization (340 in 2002, rising to 420 in 2004). The longer NAFCI is implemented in clinics, the more client visits are recorded at the clinics. Clinics where NAFCI was implemented for more than 30 months have 598 youth clients per month on average.<sup>19</sup>

<sup>19</sup> MIET Africa (2011) *Literature Review: Youth Friendly Health Services. South Africa*.

## HIV/AIDS

### HIV/AIDS IN BRAZIL

Brazil is one of the countries facing an HIV/AIDS epidemic. In 33 years, the country saw 686,478 HIV/AIDS cases registered of which 67 per cent are men and 35 per cent are women. In terms of race, 44.7 per cent are 'white' people, 51.7 per cent are 'black (coloured and black)'<sup>20</sup> and 0.5 per cent are from other ethnic groups. Since 2008, the rate of HIV/AIDS cases in young males has grown faster than for females. HIV/AIDS has been found in 0.38 per cent of pregnant women. The country has designed a Find Out Program, to stimulate the mobilization of society in favour of HIV testing and diagnosis.

A school census conducted in 99,316 primary schools shows that 94 per cent of schools teach some theme related to health promotion and preventive education, and 52 per cent developed actions related to the prevention of HIV/AIDS through the Health and Prevention in School programme. This programme was set up in 2007 by Presidential Decree number 6.286, jointly with the Ministry of Health and the Ministry of Education, and reaches 18 million pupils in school. The country is still experiencing a major challenge with the diagnosis and treatment of sexually transmitted infections and HIV/AIDS.

### HIV/AIDS IN RUSSIA

Russia's national legislation guarantees access for all citizens to free large-scale prevention programmes and HIV/AIDS testing, as well as free access to high quality medical care and protection of rights for people living with HIV or AIDS. The proportion of people living with HIV at present is 41.7 per 100,000 population. After several years of the epidemic spreading rapidly, a level of stabilization has recently been registered with the number of new cases staying at a level of fewer than 60,000 per year.

The country's National Priority Health Project consists of a comprehensive system of measures to combat HIV infection. The main priority is to enhance the multi-sectoral programme for primary prevention and promotion of healthy lifestyles aimed at motivating people to consciously give up risky behaviour patterns. It focuses on measures to prevent HIV infection among groups at high risk, including those engaging in risky behaviours, through motivation to accept voluntary HIV testing, systematic treatment, and counselling and social support.

The annual coverage of the population, in particular of high risk groups, by voluntary HIV testing is 22–25 million people – in other words, 15 to 17 per cent of the total population of Russia. Credibility of data on HIV prevalence and early detection are ensured. Seventy per cent of those detected for the first time as HIV-positive are diagnosed at the very early stages of the disease.

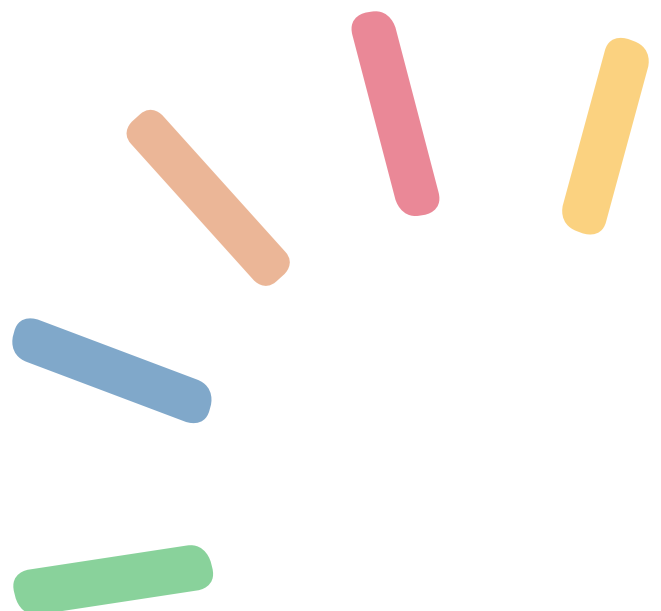
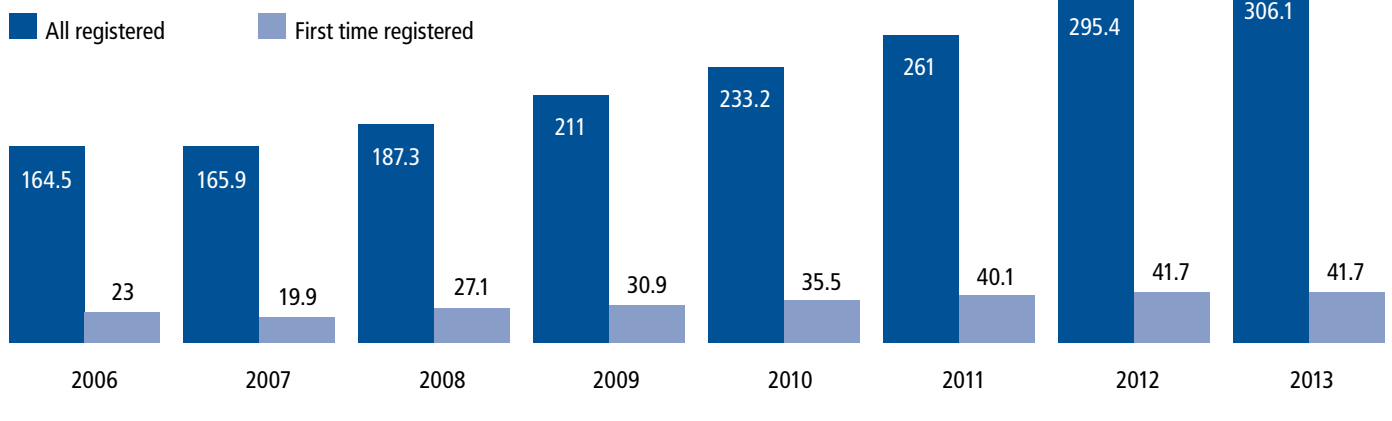
Innovative prevention technologies have been designed, taking into account specific cognitive and psychological aspects of different age and social groups, especially for children and youth. These measures have brought the share of HIV-infected youth down by 11.2 times to 2.2 per cent, and the share of HIV-infected children by 48 times to 0.1 per cent. There is a special emphasis on measures to prevent mother-to-child transmission of HIV. More than 90 per cent of pregnant HIV-positive women were reached by these measures, which amounts to a 35 per cent increase in five years. The number of infected newborn children decreased more than two times, and more than 50,000 healthy children were born to HIV-positive mothers.

Along with prevention services, the Russian government provides free antiretroviral drugs to all who need them. Effectiveness of medical and social assistance made it possible for 73 per cent of children who were infected with HIV in the 1990s to lead a normal life, to enter universities and colleges, to create families and to have healthy children.

20 These are the ethnic grouping categories under which the statistics were originally gathered in-country.

Injecting drug users are still among the most at-risk and vulnerable groups to contract HIV in Russia. Heterosexual couples, followed by men who have sex with men and sex workers are also vulnerable to contracting HIV. There is an anti-drug federal service that works with drug users, monitoring their behaviour to ensure that the virus is not spread through the use of shared needles, as well as other preventative strategies.

**Figure 18: Russia – HIV-positive population per 100,000**

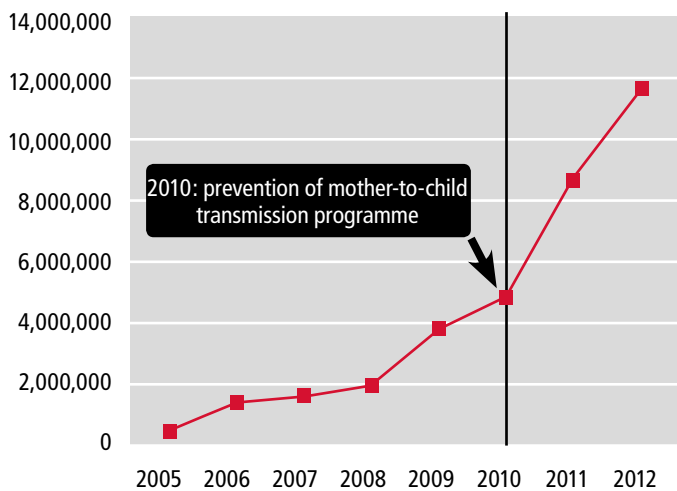


### HIV/AIDS IN CHINA

China, in general, has a low HIV/AIDS prevalence rate nationwide, even though HIV/AIDS is higher in some provinces than in others. The most at-risk groups in China, as in Russia, include drug users and sex workers. China has high level political champions to help control the spread of HIV. There are also major HIV prevention and control programmes and strategies to provide free services to vulnerable groups, including drug users and sex workers. Integrated programmes to prevent mother-to-child transmission of HIV/AIDS, syphilis and hepatitis B are also available to all citizens.

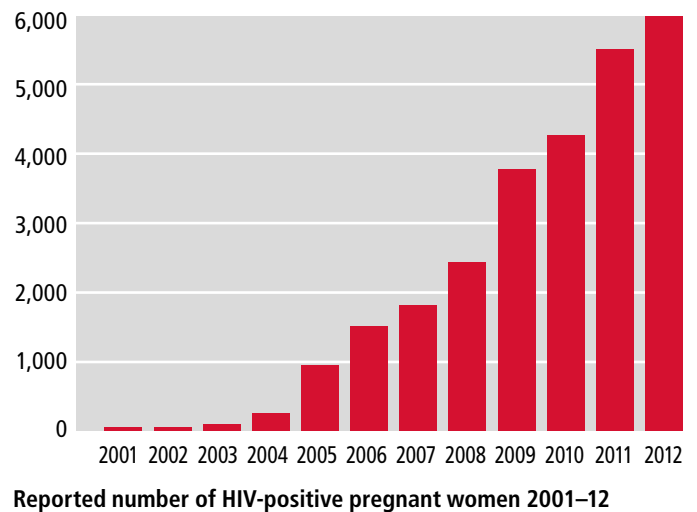
In 2009–13, the central government invested 3.6 billion yuan<sup>21</sup> to support the prevention of mother-to-child transmission work in particular areas. Comprehensive intervention services were freely given to pregnant women infected with HIV, syphilis or hepatitis B and their children.

**Figure 19: China – HIV counselling and testing in pregnant women**



Increasing numbers of pregnant women have received HIV testing, particularly since 2010. By the end of 2013, more than 47 million pregnant women had received HIV counselling and testing in the project areas.

**Figure 20: China – prevention of mother-to-child transmission**

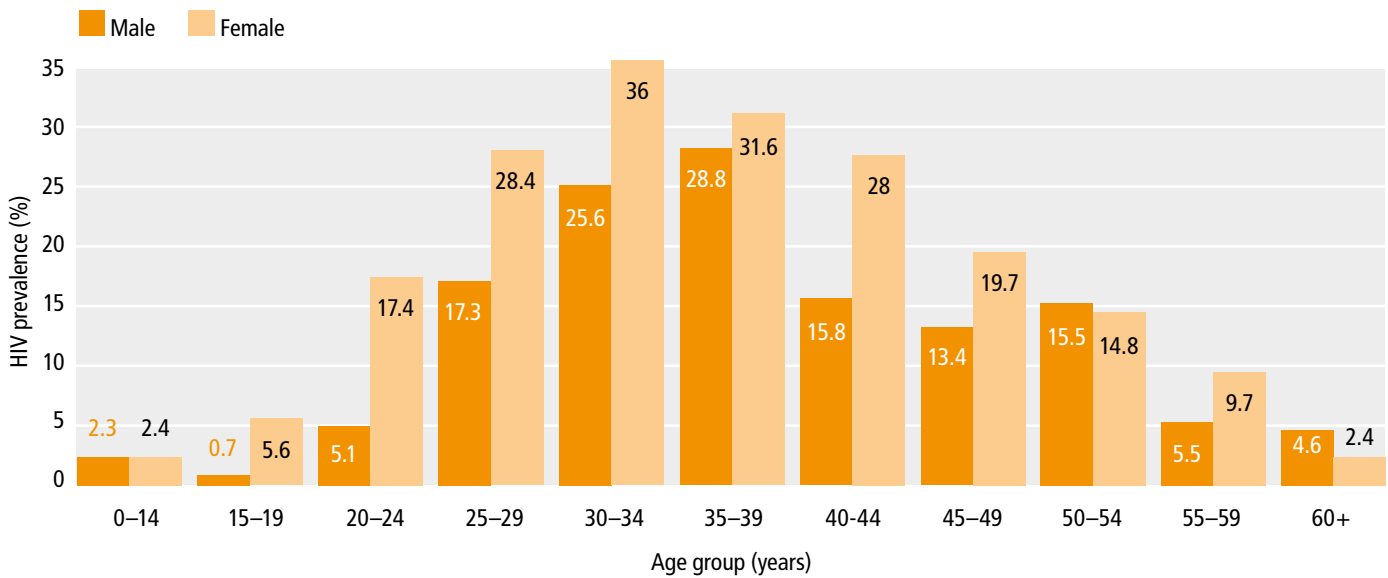


More than 25,000 HIV-positive women were diagnosed and received services free of charge.

21 US\$586.08 million at 12 November 2014.

HIV/AIDS IN SOUTH AFRICA

Figure 21: South Africa – HIV prevalence by age and sex 2012



Source: Shisana O, Rehle T, Simbayi LC, Zuma K, Jooste S, Zungu N, Labadarios D and Onoya D et al (2014) *South African National HIV Prevalence, Incidence and Behaviour Survey, 2012*. Cape Town: Human Sciences Research Council.

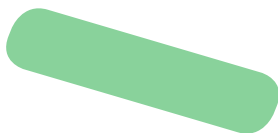
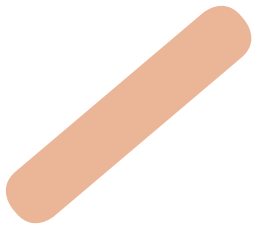
South Africa has a high female HIV/AIDS prevalence. A total of 18.8 per cent of the population is infected with HIV/AIDS. That is 14.5 per cent of the total male and 23.2 per cent of the total female population. According to SWEAT<sup>22</sup> in 2013, South African sex workers had a 59.6 per cent HIV/AIDS prevalence rate. Of all new HIV infections, 19.8 per cent were related to sex work (5.5 per cent among sex workers, and the remaining 14.3 per cent among clients and clients’ partners). Only 5 per cent of sex workers have access to HIV prevention services.

The country provides free antiretroviral treatment to all its citizens. The use of antiretroviral treatment has increased the lifespan of

HIV-positive women who can now be there for their children. Medical male circumcision has also been introduced to reduce the risk of sexually transmitted infections and HIV infection.

Despite the efforts of the government, the country continues to have high rates of new HIV infections, especially among young women. Sexually transmitted infections among young women continue to be very common, in turn increasing the risk of contracting HIV. The country has developed an HIV/AIDS and Tuberculosis National Strategic Plan for 2012 to 2016 to intensify the fight against these diseases.

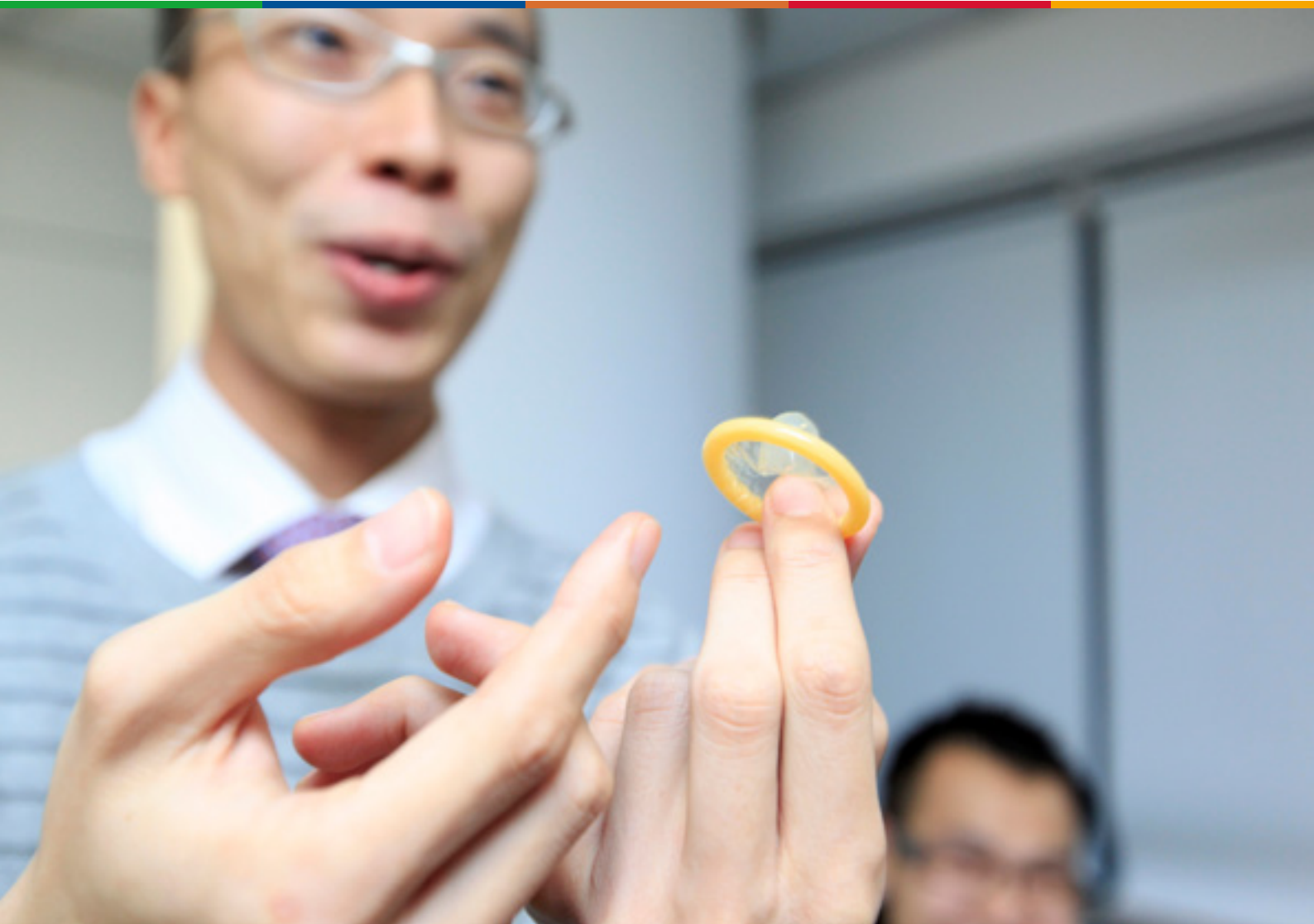
22 SWEAT is the Sex Workers Education and Advocacy Taskforce. For more information, see <http://www.sweat.org.za/>



## Chapter 4

# Demographic transition and post-transition challenges

Three aspects concerning the challenges of demographic transition are discussed: policies and laws in connection with population ageing, and their effects on the health and status of older people; urbanization – internal migration from rural to urban areas – and how this affects countries with both sparse and densely populated areas; and how effective migration policies can enhance a country.



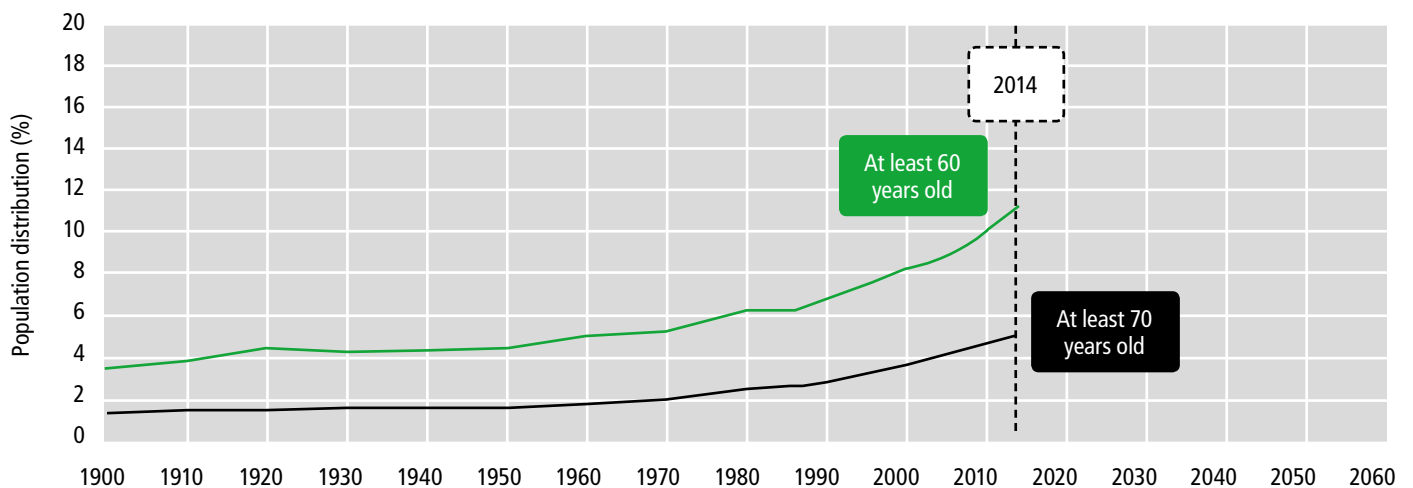
## POPULATION AGEING

### POPULATION AGEING IN BRAZIL

Brazil has good policies that address poverty eradication among older people involving significant financial transfers (for example, benefits, pensions). The country also has good laws that protect the rights of the elderly. These policies and laws, however, only address the most basic needs of older people. Brazil needs to decide quickly how to spend its budget – whether to increase

spending on youth and children (in the health and education sectors) so they can benefit in the labour market, or increase spending on the more complex and expensive health care needs and long-term care of the country's increasing number of older people. The population aged 70+ reached 4 per cent in 2014 and is continuing to increase.

**Figure 22: Brazil – population ageing: evolution of the percentage of the ageing population 1900–2060**



Source: Secretariat for Strategic Affairs of the Presidency of Brazil (SAE/PR) based on population records and projections from Brazilian Institute of Geography and Statistics.

### POPULATION AGEING IN RUSSIA

The ageing situation in Russia is at a very critical stage. Every eighth Russian, about 13 per cent of the population, is aged 65+. Russia is a country with a quickly ageing population. In 1970, the median age of the country was 30.5 years. By 2005, the median age had reached 37.3 years. In the year 1990, the population aged 65+ made up 9.9 per cent, and 10.2 per cent by the beginning of 1991, while youth aged 0–19 accounted for 29.9 per cent in 1991. Projections indicate that the proportion of the 65+ population will amount to 18 per cent by 2025.

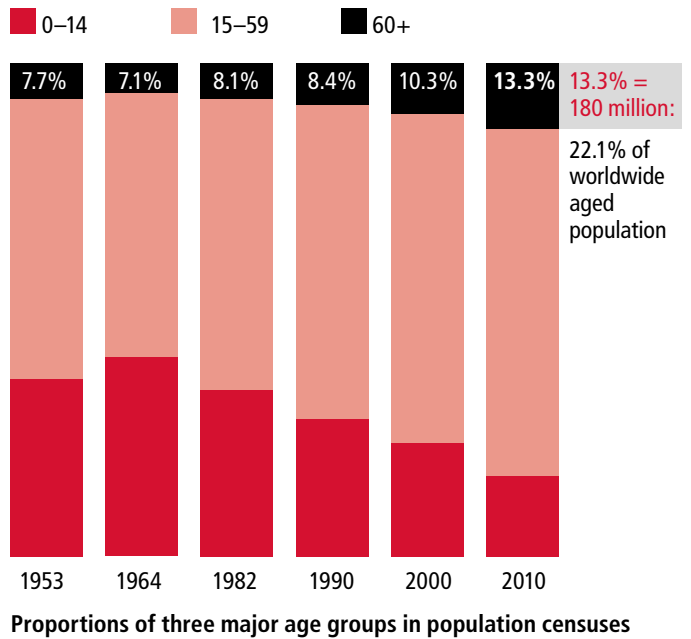


**POPULATION AGEING IN CHINA**

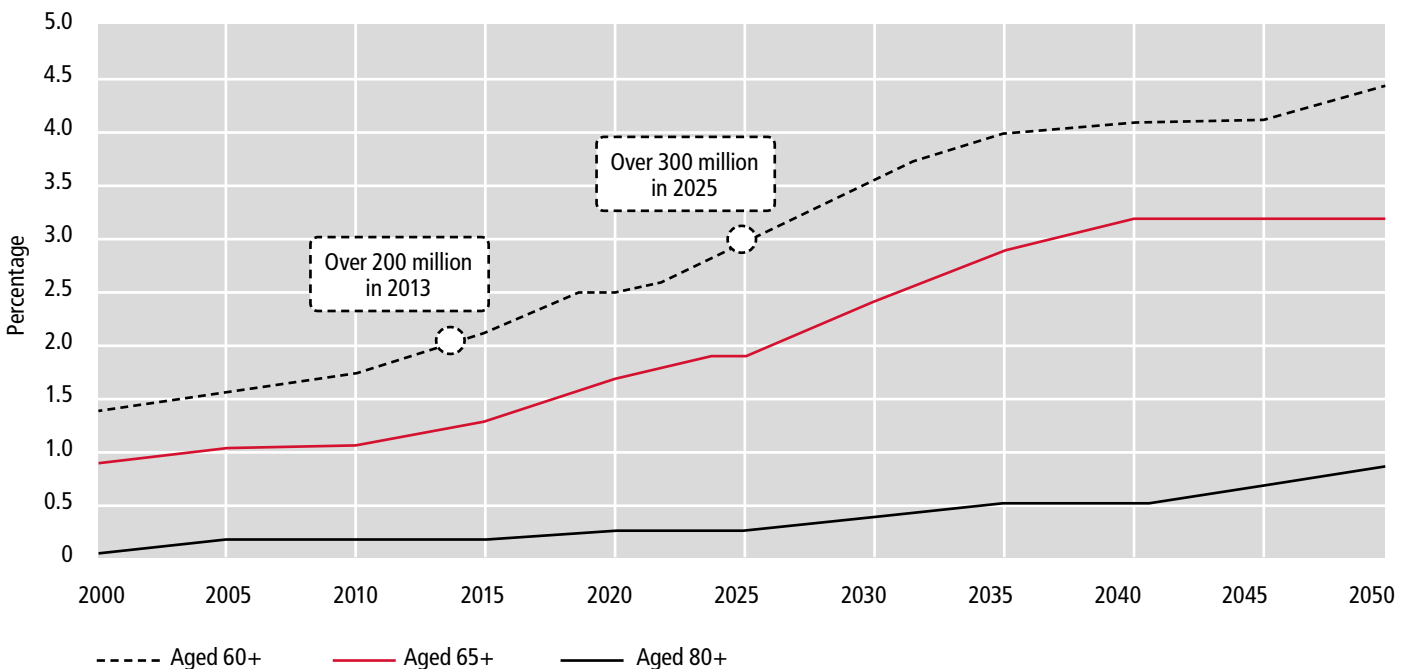
China has many elderly people and a rapid pace of population ageing. Over 300 million people are expected to be 60+ by 2015. There are notable differences among regions and between urban and rural areas. In 2010, the proportion of the population aged 60 and above was only 11.7 per cent in urban areas, but very high in rural areas at 15 per cent. There is a decline in the working age population, with working population ageing taking place at the same time. The working population started to decline from 2012, and is expected to drop down to 650 million (52 per cent of the total population) by 2050. More elderly people are living alone which creates challenges for care services.

In 2012, the Chinese government amended the Law on Protection of the Rights and Interests of the Elderly. In 2013, the State promulgated "Several Opinions of State Council for Accelerating the Development of Elderly Care Service Industry."

**Figure 23: China – proportion of ageing population**



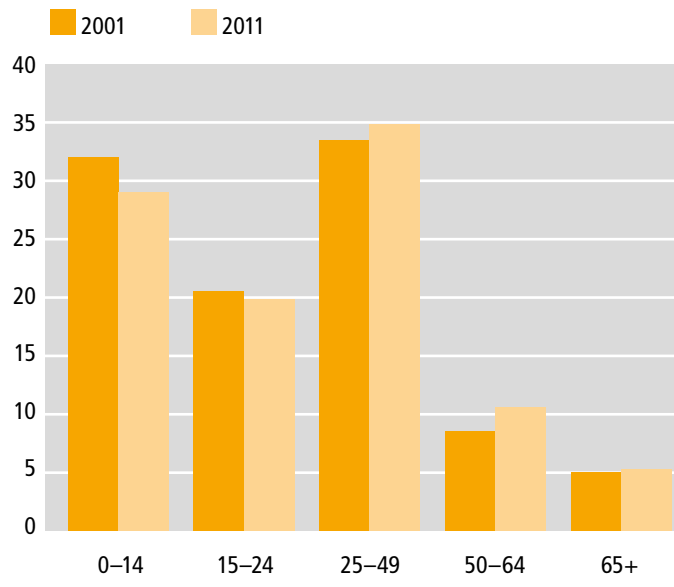
**Figure 24: China – rapid pace of population ageing**



## POPULATION AGEING IN SOUTH AFRICA

People aged 65 years and older constitute only around 5 per cent of the total South Africa population. The Social Assistance Act of 2004 mandates paying a social assistance allowance to certain groups of the population including older people. In February 2014, the country had 2,953,710 old age grant beneficiaries. There is a steady increase in the uptake of old age allowance. The Older Persons Act (number 13 of 2006) ensures the safety and protects the rights of the elderly.

Figure 25: South Africa – population ageing



## URBANIZATION

### URBANIZATION IN BRAZIL

Urbanization as such is not a big issue for Brazil; the important issue is the geographical distribution of the people. Brazil, like some of the other BRICS countries, has areas that are very sparsely populated, such as the Amazon. The Brazilian government would prefer to keep people in those areas. Urban areas, however, offer economic and infrastructure development, and therefore attract people. Brazil is learning from Russia's experience in Siberia and is also trying to provide all the necessary services in the Amazon to ensure that people in isolated areas remain there and do not migrate to urban centres.

### URBANIZATION IN RUSSIA

Russia has a population density of 8.4 people per square kilometre (22 per square mile), making it one of the most sparsely populated countries in the world. The population is most dense in the western part of the country, centring around Moscow and St Petersburg, and 73.8 per cent of the population is urban. Since 2012, Russia has had 13 cities with a population of over 1 million people. Twenty three per cent of the population (32 per cent of the urban population) live in the 18 largest cities which have over 700,000 people.

Urbanization is not a new phenomenon for Russia. Urbanization – internal migration from rural to urban areas – in Russia started in the 1950s, stabilized in the 1980s and remains stable. Urbanization has led to population concentrations in the western part of the country, leaving other parts sparsely populated. Traffic congestion in these highly populated areas is a major problem for Russia and is also among the worst in the world. The Russian government offers incentives to remain or settle in the northern and eastern parts of the country, the sparsely populated areas.

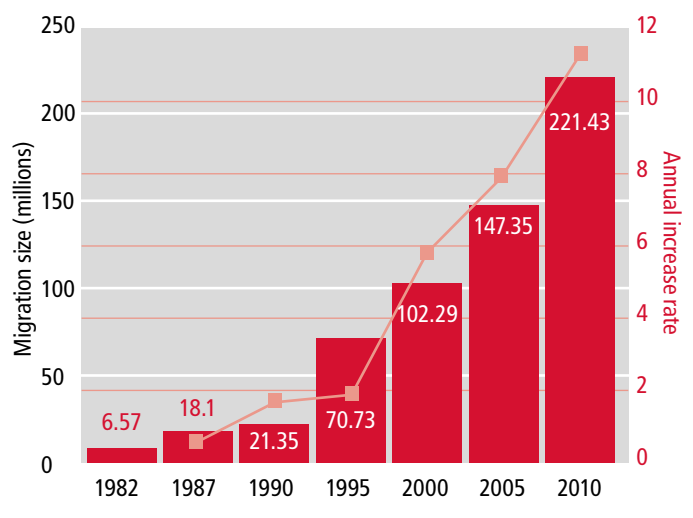
### URBANIZATION IN CHINA

Urbanization and industrialization developed relatively late in China. In 1978, the proportion of urban population was only 17.9 per cent. Since then, China has been reforming, energetically developing its economy and speeding up the process of industrialization. Over the years, China paid attention to changes in the population structure and how to make use of a larger working population (the demographic dividend).

As China invested in industrial development, the ratio between industry and agriculture changed, so labour had to change. China adjusted policies, making urbanization easier, thus making good use of the transfer from rural (agricultural) labourers to urban (industrial) labourers. As a result, large numbers of surplus workers in rural areas are shifting to non-agricultural industries. The country developed a Plan on Urbanization to ensure a more equal spread of the population throughout the country. Beijing, for example, has a very large population, whereas many rural provinces are sparsely populated. Beijing is currently working on agreements with neighbouring provinces about how to move some industries from Beijing to these provinces, in turn ensuring that people migrate from Beijing to these provinces.

Migration in China is not only related to time and space, but also related to household registration status. Migration is high for the 20–24 age group for both males and females. There has been a sharp increase in migration since 1995. Migration had reached an annual increase rate of around 10.5 in 2010.

Figure 26: China – migration size and average increase rate



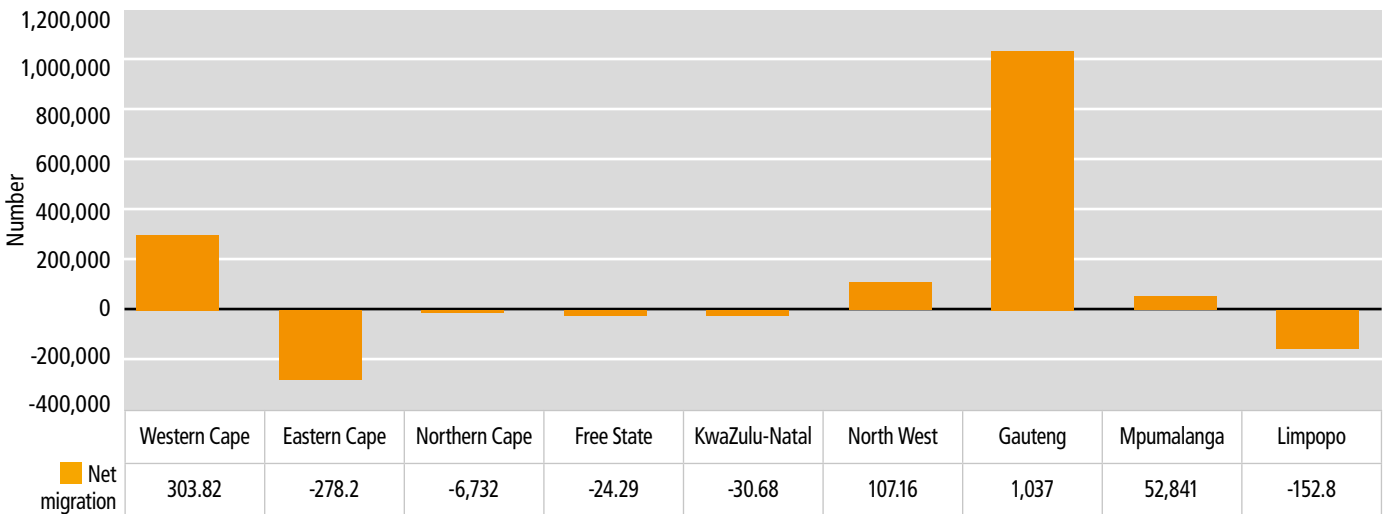
### URBANIZATION IN SOUTH AFRICA

South Africa is currently developing an urbanization framework in response to the rapid urbanization that is taking place; more than 60 per cent of the country is urbanized. Defining what urbanization means is a challenge as the country struggles to come up with an acceptable definition. Urbanization is currently broadly defined as living in big cities.

South African cities and towns offer a wider range of opportunities, including better employment opportunities.

The proportion of people living in urban areas in the country increased from 52 per cent in 1990 to 62 per cent in 2011, and the proportion of those living in rural areas declined from 48 per cent to 38 per cent in the same period. Gauteng, which has the largest share of the population (24 per cent), is also the largest (34 per cent) recipient of migrants. Only 56 per cent of people in Gauteng were born there.

Figure 27: South Africa – net migration 2001–11

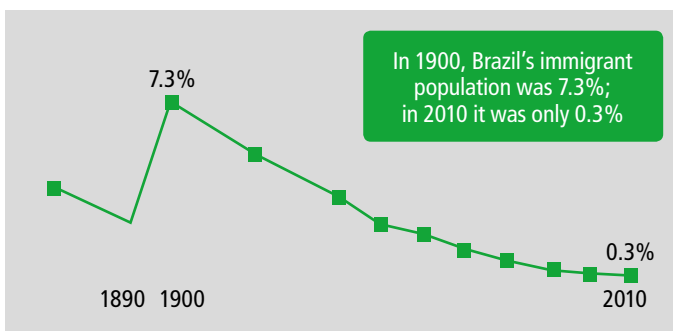


## INTERNATIONAL MIGRATION

### MIGRATION IN BRAZIL

Brazil seems to struggle to attract immigrants. In 1900, 7.3 per cent of the Brazilian population was made up of immigrants, but currently only 0.3 per cent of the population are immigrants. The country no longer seems to be a preferred destination and needs to change its immigration laws, making them more immigrant-friendly in order to attract immigrants to the country. Changes would have to include giving civil and political rights to immigrants.

**Figure 28: Brazil – international migration to Brazil**



Source: Instituto Brasileiro de Geografia e Estatística, Censos Demográficos. For more information, see <http://censo2010.ibge.gov.br/en/>

### MIGRATION IN RUSSIA

Russia has implemented numerous policies and offers a variety of incentives to attract highly skilled and educated migrants to Russia, particularly ethnic Russians from former Soviet countries. In 1994, there was a migration peak of 1,200,000, mostly ethnic Russians from ex-Soviet states fleeing for social, economic or political reasons. In recent years, 300,000 immigrants have arrived in Russia every year, of which almost half are ethnic Russians. During the same period, 970,000 people left the Russian Federation. Over the past 13 years, Russia received more than 3 million immigrants. Currently, there are estimated to be 4 million illegal immigrants from the ex-Soviet states. Immigration is the main reason that Russia did not suffer a substantial population decline.

In 2006, the Russian government started to simplify its immigration laws and launched a State programme providing assistance for the voluntary immigration of ethnic Russians from former Soviet republics. This programme includes, among other things, facilitation of the voluntary resettlement of compatriots living abroad for permanent residence in the Russian Federation, as well as stimulating the return of emigrants to the Russian Federation; attracting skilled foreign professionals and facilitating the integration of immigrants into Russian society; and promoting tolerance in relations between the local population and immigrants. Russia has special nationwide programmes to attract former compatriots. Incentives include tax and housing privileges, land ownership, medical services, education, jobs and financial support that includes a 'stipend' paid to them for six months (calculated at half the amount of average wages in the region) while they find a job. These initiatives have contributed to Russia being one of the top destination countries for immigrants. Migration also takes place among people who are not given incentives.

### MIGRATION IN CHINA

China has developed and implemented policies and programmes that encourage and attract the return of highly skilled citizens. China's policies are not recent – the country has had open and reformed policies encouraging migration since the 1980s, but has only recently seen an increase in the return of highly skilled Chinese back to the country. Conditions are now more conducive in China, as foreign companies are opening businesses in China thereby attracting highly skilled researchers and scientists. The 'gap' between China and other countries has decreased and China offers many opportunities, resulting in many Chinese eager to start their careers, particularly in science and technology, in their home country, instead of in the countries abroad where they studied.

### MIGRATION IN SOUTH AFRICA

The South African 2011 census data show that about 3.3 per cent of the South African population are non-citizens, and these non-citizens are made up of permanent, cross-border, circular and undocumented migrants, refugees and asylum seekers, as well as skilled professionals from across the continent. While most migrants move for economic reasons, the figures provided by 2011 census data on immigration in South Africa show that people migrate and stay in the country for a variety of reasons. In terms of documented migration, a total of 106,173 temporary residence permits and 10,011 permanent residence permits were granted by the Department of Home Affairs. According to the 2011 report on documented immigrants in South Africa published by StatsSA, out of the 196 countries in the world, people from 184 countries received temporary residence permits, from 128 countries received permanent resident permits; and the majority were from Zimbabwe, Nigeria, China, India, Pakistan and the UK.

A large number of undocumented migrants come to South Africa for economic reasons and they live in the country illegally, because 1) they stay longer after their permit expires, 2) they are asylum seekers who entered the country illegally and are still in the process of applying for asylum seeker's status, and 3) their asylum-seeking status has not yet been renewed.



## Chapter 5

# Lessons that countries can learn from each other

This chapter highlights lessons that BRICS countries can learn from one another on a wide range of issues, including decentralization, migration, making the most of the demographic dividend, supportive maternal policies, urbanization, overcoming sexual and reproductive health challenges, decreasing the total fertility rate, comprehensive sexuality education, and a range of measures to support girls, young women and people with disabilities.



BRICS countries could study how Brazil translates social policies into actions, by **decentralizing** these policies into local policies, following the motto 'There is no social policy that is not a local policy'; and by including public participation, because civil society plays an important role in localizing policies as well as in policy implementation.

Countries could study the 'reversing the brain drain' **migration** policies that both China and Russia have developed, and implement policies and programmes that encourage the return of highly skilled citizens back to their countries of origin.

Countries currently experiencing a **demographic dividend** could study how countries such as China and Brazil attained and successfully optimized their demographic dividend to the most rewarding level possible. By creating, designing and implementing relevant policies and programmes that are favourable to maximizing the benefits of demographic dividends, BRICS countries can successfully make the best use of the opportunity of having a large working age population.

Countries wishing to increase their **population size** could study Russia's maternity capital policy which is implemented at all levels and can include a lump sum paid out to a mother, private education for a child, or land and housing made available to a family with three or more children.

China demonstrates that **urbanization** problems can be addressed by planning ahead to ensure delivery of basic services to rural-urban migrants and to encourage job creation in medium sized cities. This in turn also helps to reduce poverty.

To increase access to **contraception**, countries could consider placing family planning outreach workers in each village. In China, this has led to easy availability of modern contraception and supported gender empowerment which can contribute to a reduction in abortion rates.

Countries wishing to decrease **fertility rates** could consider studying Brazil's human capital investments – including access to better education, health (including access to contraceptives), and more economic opportunities for women, enabling more women

to join the workforce – all measures that have contributed to a decline in the fertility rate of low socio-economic groups in Brazil.

South Africa has designed and implemented policies and programmes created to **protect women, children and people with disabilities**. Countries should not only focus on protecting women and children, they should also pay special attention to people with disabilities.

Russia has **comprehensive sexuality education** in schools that can promote healthy sexual behaviour among youth. Topics include reproductive health, preventing sexually transmitted infections and HIV, gender relations, family relationships and family law. This comprehensive approach could be useful when designing sexuality education programmes.

China has the largest population in the world yet has the lowest **HIV/AIDS** prevalence nationwide, mainly because it pays special attention to the most at-risk groups including drug users and sex workers. The country has major HIV prevention and control programmes and strategies to provide free services to vulnerable groups. Countries could study how China implemented its HIV-related policies and programmes.

BRICS countries can learn from each other about **rights-based policies** to enable people to stay in sparsely populated areas, and also about the need to invest in education and job creation in advance in order to derive maximum benefit from the demographic dividend.

Initiatives to address **gender-based violence** start at grassroots level, drawing in civil society and research institutions, and thereby accentuating the importance of community participation. This could potentially be an example of 'best practice'. BRICS countries may want to exchange ideas on how citizens and communities can be participants in their own development and in addressing gender issues. These issues include combating gender-based violence, reversing the high drop-out rate of girl children in secondary school, and how to address the impact of religious extremism on the status of women, and their access to sexual and reproductive health services, especially in relation to women exercising their sexual and reproductive rights.



# Conclusion and recommendations

There is a valuable opportunity for BRICS countries to share experiences and learn from one another.

Following the seminar, the meeting concluded with the adoption of the 'Framework for Collaboration by BRICS Countries on Population and Development Matters'. The framework sets out suggested thematic areas of work to initiate and promote opportunities for cooperation, dialogue and collaboration, including inter-alia:

- social issues in general, and gender and women's rights in particular
- sexual and reproductive health and reproductive rights
- demographic transition and post-transition challenges, including population structure change, population ageing, mortality reduction and increasing life expectancy, and social integration of migrant farmers during rapid urbanization
- information on population and health, including data collection and utilization, and sharing information and experiences on improving the equity and quality of health of women and children

Collaboration on these thematic areas of work will be pursued through:

## 1. CAPACITY BUILDING AND TRAINING

- Invite each other to training and capacity building programmes.
- In collaboration with the BRICS Academic Forum, develop a training programme on the demography and population policy responses in BRICS member states.

## 2. EXCHANGE OF INFORMATION, KNOWLEDGE AND EXPERTISE

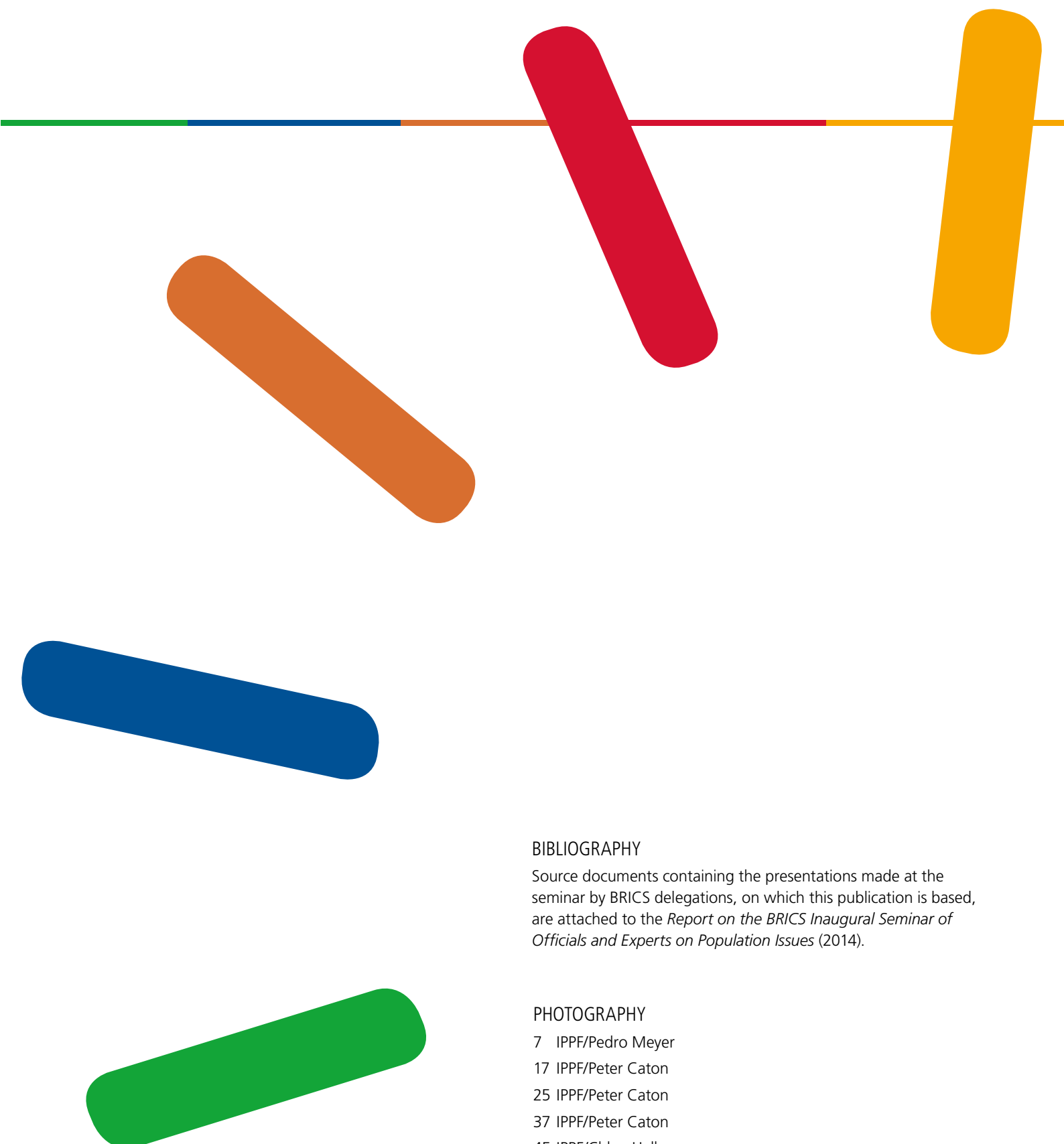
- Collaborate with the Academic Forum to exchange information on population and development matters.
- Member states may seek multi-lateral exchanges of knowledge through country visits and field trips.
- Engage in dialogues with civil society and the private sector.

## 3. SHARING OF BEST PRACTICES AND LESSONS LEARNED: NATIONAL EXPERIENCES, CHALLENGES AND SUCCESSES

- Convene one population seminar annually to share best practices and lessons learned (rotating among BRICS member states).
- BRICS member states to exchange evidence multi-laterally on best practices and lessons learned on population matters.
- BRICS member states to initiate multi-lateral population research seminars and the dissemination of relevant research evidence.
- BRICS member states to produce joint publications on population matters.
- BRICS member states to establish technical working groups in different priority areas (according to the thematic areas of work).
- BRICS member states to conduct annual international seminars on population matters of common interest.







#### BIBLIOGRAPHY

Source documents containing the presentations made at the seminar by BRICS delegations, on which this publication is based, are attached to the *Report on the BRICS Inaugural Seminar of Officials and Experts on Population Issues (2014)*.

#### PHOTOGRAPHY

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The South Africa National Population Unit, in collaboration with IPPF (International Planned Parenthood Federation), takes great pleasure in introducing this publication on population matters in the BRICS countries. In this publication, we pay special attention to and focus on reducing poverty and inequality, and vulnerable groups. We believe that the publication will contribute to collaboration through dialogue, cooperation, sharing of experiences and capacity building on population-related matters of mutual concern.

The purpose of this publication is to form and maintain a strong relationship among BRICS countries to encourage them to integrate population factors into their national development plans.

This publication offers out suggestions and lessons that BRICS countries could learn from each other – these provide a clear rationale for the significance of BRICS population officials and experts to meet and share experiences, expertise, knowledge, information and challenges they are currently facing in their countries.

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