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WOMEN, DEVELOPMENT AND
DEMOGRAPHIC TRENDS IN CENTRAL AMERICA:
A GENERAL OVERVIEW

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Introduction

At the World Conference to Review and Apprise the Achievements of the United Nations Decade for Women: Equality, Development and Peace, was stated that forward-looking strategies for the advancement of women at the regional level should be based on a clear appraisal of demographic trends so as to provide a realistic context for their application.

Taking these considerations into account, the following document sets forth an analysis of those demographic changes during the period 1950-1980 in Central America which have had the greatest bearing on the status of women, and should be considered in the design of development policies.

The first chapter deals with the fertility patterns in Central America.

The second chapter concerns mortality among the female population and underscores the great strides made during the period 1950-1980 in increasing women's life expectancy at birth. Emphasis is also placed, however, on the fact that a great deal could still be done by the governments to further reduce mortality in the region. Reference is made in this section to the main causes of death among women, and a number of examples are given in order to illustrate the extent to which the various causes of death have been an influential factor in changes in the life expectancy at birth of the female population.

The third chapter focuses on changes in the age structure of the female population which are chiefly attributable to the decreases in fertility and mortality, as well as on the implications of these changes for the design of policies concerning women. In this regard, the need for more information concerning the status of older women is stressed.

The fourth chapter contains information concerning migration by women, both within countries and internationally.

This paper includes among other sources information contained in a more comprehensive document prepared by this author for the Fourth Regional Conference on the Integration of Women in The Economic and Social Development of Latin America and The Caribbean, organized by ECLAC in Guatemala City, from 27 to 30 of September, 1988.

I. WOMEN'S REPRODUCTIVE BEHAVIOUR

The adequate information concerning women's fertility would facilitate the work of the organizations responsible for formulating policies on employment, health, education, housing and, in general, all policy measures whose objective is the creation of conditions of well-being for women.

In addition, fertility statistics and indicators are necessary in order to ascertain the extent to which the women of the region have an equal ability to exercise their right to freely decide the number and spacing of the children they will have.

Furthermore, the awareness of fertility trends is an especially important factor in the design of social policies aimed at making it easier for women to reconcile motherhood with their participation in all spheres of society as active agents of development.

1. Fertility patterns in Central America

The change in fertility patterns has been associated with the course taken by the development process in the countries of Central America. The average number of children per woman thus varies from one country to another in the region, as well as within each country, depending on the level of modernization that has been attained.

One indication of this change is the drop in the average number of children per woman (as measured by the total fertility

rate) 1/ which is to be observed in the period 1980-1985 as compared to the period 1950-1955.

In Costa Rica and Panama, countries classified as being at an advanced stage of modernization. 2/ 3/ showed a drop in fertility from high levels for the period 1950-1955 (an average of about 6 children per woman) to medium levels in the period 1980-1985, when the average had fallen to around 4.

In Mexico, a country where modernization has been rapid and uneven, fertility also dropped from high to medium levels.

In those countries where modernization is still an incipient process (El Salvador, Guatemala, Honduras, and Nicaragua), fertility rates are still high despite the fact that a slight decrease has been recorded. For these countries as a group, the rate stood at over 6.5 children per woman at the beginning of the period in question; by its end, the average remained above 5 in all of these countries and was still over 6 in most of them.

In addition to these differences in fertility levels from one country to another, reproductive behaviour varies markedly among different groups of women within the same country depending on the socioeconomic stratum to which they belong, whether they reside in urban or rural areas, and their differing personal traits.

In Honduras, a country where modernization is still an incipient process, the fertility rate as of 1980 was still high. In this country, the total fertility rate in areas defined as being major urban centres dropped from 5.6 to 3.7 children per woman between 1960 and 1980. In the rural areas of Honduras, however, the rate held steady at about 8 children per woman during this period. This means that whereas the total fertility rate for women in rural areas was 1.6 times greater than the

rate for women in major urban centres at the beginning of the period, by the end of the period this gap had widened to 2.2.

A similar situation was observed in regard to the decrease in fertility among women according to the socioeconomic strata to which they belong. While the total fertility rate for women in the upper-middle stratum declined between 1960 and 1980 from 6.0 to 3.8 children per woman, the rate for women belonging to the low-income agricultural wage-earning stratum remained above 8 children per woman. In other words, the difference between the rates for women in the low-income agricultural wage-earning stratum and those belonging to the upper-middle stratum rose from 1.3 in 1960 to 2 in 1980.

The persistence as of 1980 of such high fertility rates both in rural areas and in the low-income agricultural wage-earning stratum may either be a reflection of the actual state of affairs or may be due to problems associated with the quality of the data or to the use of invalid assumptions as a basis for the own-children method that was employed in estimating the total fertility rate.

It is interesting to note that even in Costa Rica, a country at an advanced stage of modernization in which, as stated earlier, a sharp decrease in fertility has taken place, differences among the reproductive behaviour of the various sectors of women, although they have tended to lessen, continue to exist (Rosero, 1981).

Between the years 1960 and 1979, the fertility rate for women in urban areas fell from 5.9 to 3 children per woman while, during the same period, the total fertility rate for women in rural areas dropped from 9.0 to 4.0 children per woman. This means that whereas in 1960 the fertility rate for women in rural areas was 1.6 times higher than the rate for women residing in

urban areas, in 1979 the average number of children per woman in rural areas was 1.3 times higher than that recorded in urban areas.

Information concerning the differences in the average number of children born to women belonging to the various socioeconomic strata is not available for the period 1960-1979 in the case of Costa Rica. Nonetheless, in view of the close relationship between women's educational levels and their membership in given socioeconomic groups, it is useful to compare female fertility rates on the basis of educational levels. The fertility rate for women having less than three years of formal education decreased from 9 to 4.8 children between 1960 and 1979, while the rate for women having over seven years of schooling dropped from 4.4 to 2.8 children per woman during the same period. In other words, whereas women at the lowest educational level had 2.1 times more children than more educated women in 1960, in 1979 women with fewer years of schooling had 1.7 times more children than women having a higher educational level.

2. The control of fertility

At the Nairobi Conference in 1985, as well as at the International Conference on Population, the need was underscored for governments --regardless of the nature of their population policies-- to promote access to family planning services.

In Central America, most of the information concerning awareness and use of methods of contraception has been supplied by the World Fertility Survey, specific surveys dealing with contraceptive use and the surveys conducted by Westinghouse Health Systems (Rosero, 1981). Nevertheless, this information is not complete. Data are not available for all the countries, and

total agreement has not been reached as to which methods should be included in the definition of contraceptives, with the major point of disagreement being whether traditional methods should be included or not. The information used in this report refers to all contraceptive methods except the prolongation of breastfeeding and postpartum abstinence.

There are grounds for stating that there is a widespread awareness of the existence of contraceptive methods in Central America. In most of the countries of the region for which information was gathered by the World Fertility Survey, nearly 100% of women who had ever been married or who had participated in consensual unions had heard of the existence of methods for controlling fertility. This awareness was lower only in Mexico (88%).

Nonetheless, actual access to methods for controlling fertility is not equally widespread and appears to differ markedly depending on the degree of development achieved by the country in question (United Nations, 1984).

In the countries at an advanced stage of modernization for which information was available, the proportion of the women who were married or were participating in consensual unions who were using some type of contraceptive method at the time the surveys were taken (around 1980) ranged between 50% and 64%. However, in countries where the modernization process is incipient, the level was only about 20%.

In addition, in all the countries of the region for which data could be obtained, marked differences were observed between urban and rural areas as regards the use of contraceptive methods, and these differences were even greater in countries where modernization has been a more recent process.

It might well be argued that the differences existing both between and within countries as regards the proportion of the women who are either married or participating in consensual unions who use methods of contraception should not come as a surprise, it being assumed that this divergence is simply associated with differences in prevailing reproductive patterns. Nevertheless, in attempting to assess the extent to which women in the region are able to avail themselves of their rights, it is important to try to find out whether women, as participants in the human partnership, have access to the necessary means for freely taking a decision as to the number of children they will have.

One way of learning more about this phenomenon is to compare the proportion of women stating that they have had at least as many children as they desire with the proportion of married women or women in consensual unions who use some type of contraceptive method. Since the women using contraceptive methods include not only those who do not want their family to grow any more, but also those who wish to space out the births of their children, it is to be expected that the proportion of women using some type of method of contraception will be greater than the proportion stating that they have had at least as many children as they desire.

However, among the countries for which information was available, this proved to be the case only in Costa Rica and Panama belonging to the group described as being at an advanced stage of modernization.

The difference between the proportion of married women or women in consensual unions who use some type of contraceptive method and the proportion stating that they have had at least as many children as they desire was seen to be greater within countries according to the women's place of residence.

In most of the countries, this difference was positive in the large cities, which would indicate a greater degree of access to methods of contraception.

The situation was just the opposite, however, in rural areas. Only in Costa Rica was the proportion of women using some type of contraceptive method larger than the proportion stating that they have already had the number of children they desire.

3. Abortion in Central America

A discussion of women's reproductive behaviour in the region would not be complete without mentioning the incidence of abortion.

One of the consequences of limited degree of access to the use of methods of contraception (i.e., women's socio-cultural, economic and geographic possibilities of using contraceptive methods) is the existence in the region of what is almost always a hidden problem: the practice of an undetermined number of abortions, many of which are carried out under conditions that place the life of the woman in question at risk.

Induced abortions are legal only in Cuba. In all the other countries of the region, such abortions constitute an offence which is punishable under the corresponding country's legislation.

For this reason, it is extremely difficult to ascertain the actual frequency of abortion. There is, however, general agreement as to the fact that the number of induced abortions which take place is high. The various studies conducted on this subject all indicate that a large number of induced abortions are carried out in the region using primitive, dangerous and

septic procedures and that the death rate in this connection is four times greater than that associated with pregnancies carried to full term (Weisner, 1986).

Abortions practised under such conditions frequently endanger the life of the mother and usually have a severe emotional impact and serious physical repercussions on the women concerned, along with the resulting family-related and social consequences.

In Costa Rica, a number of research projects on abortion in San José have indicated that the proportion of aborted pregnancies ranges between 8.7% and 11.9%. A survey taken in Managua in 1968 indicated that 10% of all pregnancies ended in abortion (Rosero, 1976; Pérez, 1970).

According to the information gathered in these same surveys, the proportion of pregnancies ending in abortion increases substantially in the case of women aged 30 years and over. For instance, in Panama City 50% of the pregnancies of women between 40 and 44 years of age were aborted.

The proportion of aborted pregnancies is a useful measurement because it provides information on the frequency of abortions among women exposed to the risk of abortion (i.e., pregnant women). However, since this is a measurement of the risk of abortion in terms of the number of pregnancies and therefore depends upon the frequency of the latter, it does not provide a measurement of the real incidence of abortion.

In order to ascertain the actual incidence of this phenomenon, the ratio of abortions to women of childbearing age should be examined. Based on the above, by analyzing the proportion of abortions among women of childbearing age, it may be seen that, in absolute terms, the incidence of abortion is

greater during the prime years of the reproductive period (i.e., among women between 20 and 34 years of age), which is the age group in which the frequency of pregnancy is the highest.

II. FEMALE MORTALITY

The Nairobi Forward-Looking Strategies for the advancement of Women called for "the creation and strengthening of basic services for the delivery of health care with due regard to levels of fertility and infant and maternal mortality and the needs of the most vulnerable groups and the need to control locally prevalent endemic and epidemic diseases". Furthermore, governments which had not already done so were urged to "undertake, in co-operation with the World Health Organization, the United Nations Children's Fund and the United Nations Fund for Population Activities, plans of action relating to women in health and development in order to identify and reduce risks to women's health and to promote the positive health of women at all stages of life".

1. The decrease in female mortality in the region

During the period between 1950 and 1980, a significant decrease in female mortality was recorded in the region, along with a consequent increase in longevity. This decline in mortality can be detected by means of an analysis of life expectancy at birth.

Two of the countries at an advanced stage of modernization (Costa Rica, and Panama) had moderately low female mortality rates at the beginning of the period, with life expectancies at birth of over 56 years. A relatively large decrease in mortality was recorded in these countries during the period concerned and, as a result, by the end of the period the life expectancies in these cases had risen to over 72 years.

Mexico had moderately high mortality rate at the beginning of the period, with a life expectancy at birth in 1950-1955 of around 52 years. By the end of the period, the life expectancy of the female population had risen to over 66 years, for a gain of more than 14 years in the life expectancy at birth.

Those countries in which the modernization process is incipient (Guatemala, Honduras, El Salvador and Nicaragua) had a high female mortality rate at the beginning of the period with life expectancies at birth of about 45 years. Mortality showed a major decrease in these countries, with gains of over 15 years in the life expectancy at birth. In most of these countries, women's life expectancies at birth are now over 61 years.

The data referred to above indicate that women's life expectancy at birth has increased more in the countries where mortality rates were very high at the beginning of the period. This increase was made possible by the application of low-cost measures which succeeded in raising the life expectancy of the female population substantially. However, an analysis of female mortality by cause of death provides a number of examples which indicate that many women still die as a result of diseases that could have been prevented. Governments could still accomplish a great deal, therefore by implementing health policies designed to further reduce female mortality and thereby increase the life expectancy of women in the region.

In designing policies aimed at creating healthful conditions for women, it is important to consider the fact that the increase in the life expectancy of the female population has been accompanied by a broadening of the gap between the life expectancies of men and women. This gap, which during the period 1950-1955 was approximately three years in most of the countries, is currently about six years.

As will be discussed below, there is some debate as to the reasons why women have a greater life expectancy at birth than men.

On the basis of these differences, it might be mistakenly concluded that women are in a better situation than the male population as regards matters pertaining to their health. However, although women probably do have a genetic advantage in this respect, there are indications that this advantage is not fully manifested, as will be seen later on, due to sex discrimination against women in the field of health care.

2. Causes of death among the female population

As noted above, in designing health policies for the female population it is particularly important to have access to adequate statistics on causes of death.

Information concerning the distribution of causes of death can help guide the efforts of health organizations in the most appropriate direction; furthermore, if these data are available at an appropriate level of disaggregation by age according to area of residence as well as other characteristics which help identify the women belonging to certain socioeconomic groups, then the efforts of such organizations could also be directed towards the most vulnerable groups within the female population.

However, the information available in the region concerning causes of death suffers from severe limitations which hamper its widespread use.

Among the countries at an advanced stage of modernization, the top-ranking causes of death for both women and men are those diseases whose decline is associated with scientific progress,

such as malignant tumours. Given the fact the populations in these countries are older, other main causes of death include degenerative diseases, cerebro-vascular ailments and heart disease.

In contrast, in countries in which the modernization process is not as advanced, the major causes of death include diseases whose decrease is associated with the adoption of environmental health measures or the expansion of basic health care services. Some of these causes are enteritis and other diarrhoeic diseases, measles and other ailments.

3. Causes of death and their relation to changes in women's life expectancy

If adequate information were available on the causes of death among the female population, it would be possible to gain a more in-depth understanding of the impact of each such cause in terms of changes in life expectancies between any two given periods or between different populations. 5/

Purely for purposes of illustration, some of the most significant results obtained by applying the Pollard method in Guatemala City, and Mexico City will be discussed below. These findings provide a more detailed picture of how female mortality has changed and point up some aspects of these changes which should be studied more extensively (Pollard, 1986).

In Guatemala City, the life expectancy of women rose by 7.6 years during the period 1969-1979. By applying the Pollard procedure, it can be seen that the most important factor in this increase was the decline recorded in some of the causes of death which are classified as being preventable. For both sexes, the greatest contribution to this increase in the life expectancy at birth was made by the decrease in the incidence of causes

considered to be "preventable by environmental sanitation measures" (with the decrease in such causes of death resulting in an increase of 3.4 years in the life expectancy of women at birth); the second most important factor was the reduction in causes of death regarded as being "preventable by vaccination", which accounted for 0.3 years of the increase in women's life expectancy at birth (Díaz, 1987).

On the other hand, however, within the category of preventable causes of death, those considered to be "preventable by early diagnosis" (e.g., breast and uterine cancer, whose frequency increased during the period in question) had an adverse impact on life expectancy, as did those diseases described as "preventable by means of a combination of measures".

In the case of Mexico, the life expectancy of women increased by 7.3 years ^{6/} during the period 1969-1982, with four years of this increase being due to the reduction in deaths attributable to preventable causes. Among these, the factor having the greatest positive impact was the decrease in deaths that could be prevented by the adoption of environmental sanitation measures and by means of a combination of measures designed to reduce the incidence of diseases associated with respiratory infections and pneumonia (Rodríguez, 1988).

In contrast, death that could have been prevented by means of a combination of measures during early infancy and deaths by violence had a negative effect as regards the change in the life expectancy of women.

As the above examples indicate, in all two cases the adoption of environmental sanitation measures and the implementation of mass vaccination programmes have helped to reduce mortality among the female population.

Despite the progress made in increasing the life expectancy of women, it is clear that much could still be done to improve the health conditions of the female population and thereby further increase women's life expectancy. This was clearly shown by a hypothetical exercise carried out in Guatemala City in which estimates were prepared of how much the life expectancy of women would increase if certain types of preventable causes of death were to be entirely eliminated. It was calculated that women's life expectancy at birth would rise by 1.53 years if all deaths attributable to diseases that could be prevented by vaccination and preventive treatment were to be eliminated, by 0.44 years if all those that could be prevented by early diagnosis and treatment were to be eradicated, by 4.2 years if all deaths that could be prevented by environmental sanitation measures were avoided, and by 4.8 years if all the causes of death that could be prevented by a combination of measures were eliminated.

4. Differences between the causes of death among men and women

As remarked earlier, women are known to have a greater life expectancy than men.

Even though the experts are not in complete agreement as to the reason for this phenomenon, one major school of thought relates this fact to genetic differences associated with women's reproductive functions.

It is important to be aware of the fact, however, that the lower level of mortality observed among women is not systematic in all age groups and that differences between male and female mortality are not similar with respect to all causes of death.

When the Pollard method was applied in the case of Mexico City to compare the differences between men and women as regards

the impact of the various causes of death, it was found that in some age groups female mortality attributable to preventable causes was higher than that of men. This fact points up the negative impact of cultural factors associated with the ways in which women are discriminated against in society.

While it is true that during the period 1980-1981 women in Mexico City had a life expectancy at birth that was 7.2 years greater than that of men, mortality among girls aged 1 to 4 years higher than among boys of the same ages as a result of the deaths occasioned by all the preventable causes. If it is assumed that preventive vaccination drives, the available means of early diagnosis, environmental sanitation measures and the possibility of avoiding death by accident or violence are the same for both sexes, then the possibility must be considered that the prevailing cultural patterns within the society are such that families may tend to devote greater attention to male than to female children.

In addition, higher female mortality was also observed from the age of 25 years onward in the case of Mexico City as a result of deaths that could have been prevented by early diagnosis. Unlike the difference observed in the 1-4 year age group, this was due to the impact of diseases that affect only women, such as breast and uterine cancer.

Finally, the causes of death having a negative influence on women's life expectancy as compared to that of men -- apart from those particular to women -- include one high-incidence disease -- diabetes -- which systematically reduces the life expectancy of women in relation to that of men and which figures among the 10 main causes of death in all the countries of the region.

5. Maternal mortality

Among the causes of death affecting the female population, maternal mortality warrants special attention. This term is understood as designating the death of women during pregnancy or within 42 days after the termination of the pregnancy, regardless of its duration or site, due to any cause related to or aggravated by either the pregnancy itself or the medical care given in connection with it, but not those deaths due to accidental or incidental causes (PAHO, 1986a).

It is generally agreed that most of the deaths associated with pregnancy are preventable. As remarked in a document issued by PAHO, a maternity-related death in the world of today is as anachronistic and illogical as deaths by freezing (PAHO, 1986b).

Nonetheless, high levels of maternal mortality still exist in Central America. In fact, for women in their childbearing years, complications during pregnancy, the birth process and the puerperium are in many cases one of the five main causes of death of women in this age group.

Although maternal mortality did decrease during the period 1950-1980, even the lowest rates of maternal mortality existing in the region as of the period 1980-1984 were substantially higher than those found in the developed countries.

In many Central American countries, the proportion of such deaths is currently over 30 per 10 000 live births, whereas in Canada and the United States the figure is 0.5 and 0.8 per 10 000 live births, respectively.

The striking differences in the incidence of maternal mortality within the region correspond to the level of

modernization achieved by the various countries. Maternal mortality in the region is highest in: 1) countries having high levels of fertility, due to the high proportion of births occurring in high-risk age groups; 2) countries in which relatively few births take place in health care facilities; and 3) countries having high rates of abortion, which from a clinical standpoint, is regarded as one of the main causes of maternal mortality. Whereas maternal mortality rates in most of the countries that are at an advanced stage of modernization range between 3 and 6 per 10 000 live births, in countries where the modernization process is still incipient these levels vary between 20 and 50 per 10 000 live births.

In Central America the greatest decrease in maternal mortality has been seen in Costa Rica where the rate is now one-half of what it was two decades ago.

III. CHANGES IN THE FEMALE POPULATION'S AGE STRUCTURE

In designing policies geared towards women, it is important to consider the relative size of the female population in the various age groups. In the following discussion, reference is made to the relative size within the countries of the region of the female population from 0 to 19 years of age (equivalent to the pre-school and school-age population), from 20 to 59 years of age (the working-age population) and to those over 60 years of age (old people or the aged).

As a result of the decline in fertility, in particular, and, to a lesser extent, of the drop in mortality and the type of international migration which has taken place, Central America which has traditionally been regarded as a "young" region, has experienced a change in the age structure of its population, with the tendency being towards the aging of the population.

In terms of the course taken by the demographic transition process, the Central American countries can be classified as falling into one of the four following groups:

a) Countries with very young age structures. Guatemala, Honduras and Nicaragua are in this group. The proportion of the female population which is under 19 years of age is high in these countries, and the proportion of the female population between 20 and 59 years and over 60 years of age is low.

b) Countries with relatively young populations. In Central America, El Salvador is in this group. The size of the female population under 19 years of age is large in this country as

well, and the proportion of the female populations between 20 and 59 years of age and aged 60 or over is relatively low, but is slightly higher than in the countries in the first group.

c) Countries having relatively old populations. In Costa Rica, Mexico and Panama although the proportions of the female population under 19 years of age and from 20 to 59 years of age are still high and the proportion of the female population aged 60 years and over is relatively low, projections of the future course of the demographic transition process indicate that, unlike the countries belonging to the above two groups, the populations in this group of countries will be classifiable as "old" in the near future.

In this group of countries is thus clear the necessity to devote special attention to the status of older women, as was repeatedly emphasized during the United Nations Decade for Women, constitute one of the most vulnerable sectors of society.

IV. FEMALE MIGRATION

1. Internal migration

In Central America a great proportion of women who are now residing in the cities have migrated there from rural areas.

Most of the them have little schooling, are subject to substandard living conditions upon their arrival and face serious problems in adapting due to separation from their original family units and often from their own children, as well as to the fact that the prevailing cultural patterns in their new environment differ from those they incorporated during their socialization process.

These countries therefore have a societal duty to regard the women involved in internal migration as a group within the female population which deserves special attention. The relevant policies therefore need to be developed in order to help these large sectors of the female population to adapt to their new environment, to enter the labour market, to deal with the housing problems they face and thereby to improve their living conditions.

It is generally agreed that there were more women than men among the Central Americans women who migrated from the countryside to the cities during the period 1950-1970. This numerical predominance of women over men was even greater in the migratory flows towards the larger urban centres (Gatica, 1980).

Migration from rural to urban areas has slowed during the past decade. This overall change in the trend has been much less

marked, however, in the case of women.

It is difficult to ascertain the actual status of the women who have participated in internal migration, however, due to the limited statistical information existing in this connection.

One indication that the female population continues to migrate from the countryside to the cities is provided by the extremely high sex ratios of men to women, existing in rural areas, according to the information furnished by censuses taken around the year 1980: the ratios of men to women within all age groups in the rural areas of the countries of the region are far higher than what would be expected in a population not subject to migration.

In all Central American countries the sex ratios in rural areas are over 100.

An examination of this index by age group in rural areas shows that higher ratios exist in the older age groups. This could be an indicator of the migratory flows of earlier decades, but the fact that the male population is far larger than the female population in the younger age groups in rural areas as well lends greater plausibility to the hypothesis that women continue to emigrate to the cities.

In addition, rural-rural migration has become a particularly important phenomenon in the case of women during recent decades. This type of predominantly temporary migration involved men almost exclusively in the past. Now, however, women constitute a very sizeable proportion of temporary agricultural workers.

2. International migration by women

While women who migrate from one location to another within

their own countries find it difficult to adjust to their new environment, the adaptation process is much more complex in the case of women who move from one country to another.

The Nairobi Forward-Looking Strategies for the Advancement of Women stressed the need to devote special attention to migrant women, who are often the victims of discrimination on two counts: as women and as migrants. In this connection, emphasis is placed on the need to take the necessary steps to safeguard and maintain family unity and to ensure that such women will have access to employment opportunities, health services and social security benefits in general on an equal footing with the rest of the population in the host country.

The formulation of policies for protecting the rights of migrant women is deemed necessary in view of the fact that these women are faced with especially serious problems due, firstly, to the often difficult process of assimilating the way of life prevailing in the host country and, secondly, to the loss of their customary environment when they leave their countries of origin.

The analysis of the most prominent features of international migration by women which is presented below is based on the information collected by the IMILA research project on international migration in Latin America conducted by CELADE. As part of this project, the data recorded in each country's census concerning the aliens present at the time of the census has been compiled.

This information indicates that during recent decades there has been both an intensification in population shifts within Central America and an increase in the number of Central Americans in the United States, Canada, Australia, and the European countries.

During the period 1970-1980, increases were recorded in the presence of foreign-born persons in Costa Rica and Mexico.

As part of these international population movements, there was a noticeable growth in international migration by women. Indeed, unlike the international migratory flows of earlier periods, which were made up primarily of men, in the 1970s and 1980s women have been a majority in many migrant groups.

The most noteworthy examples in this respect include the predominance of women in virtually all the groups of Central Americans currently residing in the United States and Canada.

This increase in international migration by women is associated with various types of quite different factors. In some cases, an important factor is the growth in demand in the labour markets of neighbouring countries for people to perform what are often thought of as "women's" work (one prime example being employment in the personal services sector), while in other cases such increases have been the result of adjustment policies which have motivated women (and often highly qualified ones) to seek better job opportunities in more developed countries. Finally, during the past few decades international migration has been strongly influenced by the existence of armed conflicts and emergency situations in various areas of the region.

The second factor mentioned above is illustrated by the case of the 1,951,742 Latin American women (mostly Mexicans, Cubans and Dominicans) who were residing in the United States in 1980. As of the time of census, all the various groups of Central American women residing in that country had high labour force participation ratios (with activity ratios of over 50% in most cases) and, with the exception of the female population from Mexico, were highly educated as well, with most of them having

over 12 years of schooling.

To women who have had to leave their countries as a consequence of armed conflicts or emergency situations represent a different case altogether. As stated in the Nairobi Forward-Looking Strategies for the Advancement of Women, "the international community recognizes a humanitarian responsibility to protect and assist... refugee and displaced women" who, as is noted in the same document, "are exposed to a variety of difficult situations affecting their physical and legal protection as well as their psychological and material well-being".

While acknowledging that a lasting solution for the problems of refugee women should be sought in the elimination of the causes of their displacement, the above document also underscores the need for programmes aimed at providing legal, educational, social, humanitarian and moral assistance to women in this situation.

Although these factors gave rise to migratory flows in the past as well, in some areas of the region such migration began to take place on a much larger scale in the 1970s and 1980s.

One example of this is pointed up by a analysis of the composition of immigrant women in Costa Rica, where the resident alien population as of 1984 was 93% larger than it had been in 1973. Obviously, this increase coincided with the intensification of armed conflicts in Central America: in 1984, 43,559 alien women were living in Costa Rica, of whom 22,533 were Nicaraguans and 4,674 were Salvadorians. The difference between the status of those women and those described in preceding paragraphs is reflected in the corresponding labour force participation ratios. Thus, for example, in 1984 the activity ratio for immigrant Nicaraguan women in Costa Rica was 18.2%,

which was far lower than that of the migrant women discussed earlier (Pellegrino, 1988).

The above-mentioned situations attest to the fact that international migration by women of the region is far from being a marginal phenomenon; therefore is needed the design of policies to safeguard these women's rights.

Notes

1/ "The average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of 'age-specific fertility rates'; also referred to as total fertility. It is frequently used to compute the consequence of childbearing at the rates currently observed", Manual X. Indirect techniques for demographic estimation (ST/ESA/SER.A/81), published by the United Nations in English and Spanish in 1983, Sales No.: E.83.XIII.2.

2/ This classification of countries according to their level of modernization is based on Germán Rama, "La evolución social de América Latina (1950-1980): transición y cambio estructural", a paper presented at the Seminar on Development Options in Latin America, Bogotá, 1984.

3/ The classification of Latin American countries in terms of their degree of social modernization proposed by G. Rama includes four categories:

a) Countries at an advanced stage of modernization: Argentina, Chile, Uruguay, Costa Rica, Cuba, Panama and Venezuela.

b) Large countries where modernization has been rapid and uneven: Brazil, Colombia and Mexico.

c) Medium-sized and small partially-modernized countries: Ecuador, Paraguay, Peru and the Dominican Republic.

d) Countries where the modernization process is incipient: Bolivia, El Salvador, Guatemala, Haiti, Honduras and Nicaragua.

4/ The system of classification proposed by J. Chackiel (1987) establishes the following rating based on the proportion of death certificates lacking information on the cause of death:

Under 15%	- very good
15%-24%	- fair
25%-39%	- unreliable
Over 40%	- poor

5/ John Pollard (1986) determined the ratios needed in order to calculate the impact of each cause of death in terms of changes in life expectancy.

6/ These are preliminary findings based on unadjusted data.

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