

High Death Rate Among Russian Men Predates Soviet Union's Demise

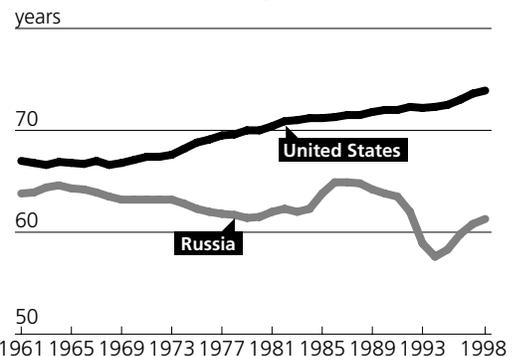
by John Haaga

There is good news and bad news for Russian men. The shocking increase in the mortality of Russian men has reversed in the last few years. But Russia would need years to catch up to levels of life expectancy that prevailed in that country in the early 1960s, let alone to reach the levels found in other industrialized countries now.

The increase in Russian death rates during the 1990s captured public attention. Nicholas Eberstadt, a scholar with the American Enterprise Institute, called it a "catastrophe of historic proportions," involving far more premature deaths than were suffered by the Russian army in World War I. Life expectancy for men fell abruptly from a high of 65 years in 1987 to a low of 57 years in 1994, then rebounded to 61 years in 1998.

Most commentators have put the decline in the context of the economic and social turmoil following the breakup of the Soviet Union in 1989. But a team of Russian and French demographers

Male Life Expectancy at Birth



Sources: State Committee of the Russian Federation on Statistics (Goskomstat), and the U.S. National Center for Health Statistics.

collected several decades of time-series mortality data for the former Soviet Union and dated the decline to the early 1960s, long before the breakup.

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Growth in U.S. Population Calls for Larger House of Representatives

by Margo Anderson

Controversy over the use of sampling in the 2000 census for reapportionment prompted a Supreme Court decision and protracted congressional deliberations. Interestingly, the controversy did not prompt Congress to investigate the nuts and bolts of reapportionment.

The formula for allocating seats in the House of Representatives among the states according to their population has gone fundamentally unchallenged since 1940.

The reason may be that few Americans know how the size of the House is set. Only since 1910 has the House of Representatives had 435 members. In 1792 there were only 106 members. And although the House generally expanded each decade, between

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Prohibition Under Gorbachev *Continued from page 1*

For the first 40 or so years of its existence, the USSR enjoyed a remarkable improvement in health conditions, despite civil wars, internal repression, and world war. By the early 1960s, life expectancy had caught up with that in the United States. During the 1960s, though, life expectancy in the United States rose rapidly, while life expectancy in the Russian republic faltered and began to decline. The gap between East and West in life expectancy, like the gap in economic performance, grew steadily wider.

This trend was already apparent by the early 1980s. In a 1982 *Population Bulletin* published by PRB, Murray Feshbach, former chief of the U.S. Census Bureau's research unit on the USSR's population, noted "the mortality rise of the last decade and a half" and cautioned that "[I]f the health sector is neglected, the adverse mortality trend which has resulted in a major reduction in the life expectancy of Soviet males may persist."

The story within the story came in the late 1980s, when then-President Mikhail Gorbachev instituted a vigorous antialcohol campaign as part of a wider effort to rescue Russian society, and the Soviet state, from self-destruction. The draconian, unpopular, and probably unsustainable campaign

produced a sharp but temporary improvement in mortality rates. The collapse of the public health campaign, the collapse of the Gorbachev government, and the breakup of the Soviet Union nearly coincided in 1988 and 1989. The progress quickly made since the mid-1980s was just as quickly lost, and the long-term decline continued until the mid-1990s.

Cause-of-death data are difficult to use for comparisons over long periods or across countries with very different medical and statistical systems, but several independent analyses have come to the same conclusion: The decline in life expectancy and the gap between levels in Russia and the rest of Europe can be attributed mainly to abnormally high rates of cardiovascular disease and injury, for both of which abuse of alcohol was a major risk factor.

But limiting the comparison to the last 10 or 12 years is misleading. Comparing the unusually good years of 1986 and 1987, when the antialcohol campaign was most effective, with the lowest points of the mid-1990s exaggerates the speed of decline. Any other choice of start and end dates would produce a more characteristic picture of steady, long-term decline.

This is not just a historian's quibble, since such comparisons

have political meaning in Russia today. Dating every bad trend from 1989 fits in with revisionist nostalgia for the old days under communism. It also fits with the arguments made about giving foreign aid and policy advice to Russia: The catastrophe shows either the need for more aid and advice or the mess that comes of accepting either, depending on one's point of view. Perhaps worst of all, the exclusive focus on the post-Soviet period obscures the achievement of the mid-1980s, which must rank as one of the most dramatic improvements in life expectancy ever induced by public policy. Surely there are some lessons from that experience, and an example of real accomplishment amidst the turmoil of the last days of the Soviet Empire, that could help Russians continue their recovery from their current troubles. ■

For More Information:

Vladimir Shkolnikov, France Meslé, and Jacques Vallin, "Health Crisis in Russia," *Population: An English Selection* 8 (1996).

Alexandre Avdeev and Alain Blum, "La population russe: des raisons d'espérer?" ("The Russian Population: Reasons for Hope?") *Population & Sociétés* 351 (November 1999). Available only in French on the INED Web site: www.ined.fr/publications/.

Nicholas Eberstadt, "Russia: Too Sick to Matter?" *Policy Review*, no. 95 (June and July 1999): 3-26.

José Luis Bobadilla, Christine A. Costello, and Faith Mitchell, editors, *Premature Death in the New Independent States* (Washington, DC: National Academy Press, 1997).

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Webwise

www.prb.org • www.ameristat.org • www.popnet.org • www.measurecommunication.org

The following were posted recently on PRB Web sites:

1999 World Population Data Sheet (French and Spanish versions) The *1999 World Population Data Sheet* contains the latest population estimates, projections, and other key indicators. (www.prb.org/pubs/wpds99.htm)

Building on Global Gains in Health, Education, and Rights: The Cairo Consensus

The Cairo Consensus, reached at the International Conference on Population and Development (ICPD) in 1994, focuses on improving health, educational opportunities, and individual rights as a way to stabilize population growth and

promote sustainable development. The five-year review of the ICPD provided an opportunity to evaluate national efforts and to identify actions needed for further implementation of the conference's goals. This policy brief presents highlights of the five-year review. (www.measurecommunication.org/policy_briefs)

Margaret Sanger, Birth Control Pioneer

by *Ellen Chesler*

The core agenda of international population policy has recently broadened beyond targeted demographic objectives to the relationship between women's status and reproductive outcomes. This historic shift returns the conversation to where it began at the turn of the 20th century, when Margaret Sanger first identified women's sexual and reproductive health and rights as a cause for social concern.

Sanger emerged on the American public scene before World War I, when it was fashionable to believe in the inevitability of human progress. She became politically active on behalf of the radical labor movement and was called to her life's mission by the tragedies of unwanted pregnancy and illegal abortion that she witnessed as a midwife among the immigrant poor in New York.

In 1917, Sanger went to jail for distributing an early version of the diaphragm from a makeshift clinic in a tenement storefront in Brooklyn. Her conviction, when appealed, won an interpretation of New York law that allowed doctors—though not nurses, as she intended—to prescribe contraception for medical purposes. Under those constraints, she built the modern family planning movement.

With the victory for women's suffrage finally achieved in 1920, she found new supporters among its adherents, many of them women from the middle and upper classes. Birth control, she argued, would liberate women in the bedroom, the home, and the larger community.

Through the 1920s and 1930s, Sanger took her thriving social movement abroad. In 1927, she sponsored the first world population conference in Geneva, which gave rise to the International Union for the Scientific Investigation of Population Problems (renamed in 1947 as the International Union for the Scientific Study of Population).

Meanwhile, Sanger's clinic in New York provided contraception and preventive gynecology, along with pioneering services in sex education, marriage counseling, and infertility counseling. The clinic even quietly made referrals for safe, illegal abortions. It was, in many ways, a model

for the comprehensive and integrated approach to service delivery that is today's reform mantra.

Yet the birth control movement stalled during the long years of the Depression and World War II, and in the decidedly pronatalist decades that followed in this country. The movement was stymied by the cost and complexity of trying to reach women most in need without any public funding. It was engulfed by internal dissension and overwhelmed by a barrage of opposition.

The always-fragile alliance Sanger tried to forge with the country's social, professional, and business establishment became a distinct liability. She resigned from the American Birth Control League because of the conservative, eugenic leanings of some of its leaders, who boldly advanced contraception as a means of slowing birth rates among the poor during the Depression. Yet Sanger also found no ally in her close friend Franklin Roosevelt for her democratic family planning message. Roosevelt was forced to capitulate to the furious opposition raised by the New Deal's coalition of northern urban Catholics and southern rural populists.

Embittered by birth control's failure to secure a place in America's social welfare and public health systems, Sanger turned her full attention abroad and founded the International Planned Parenthood Federation in London in 1948. For two more decades, until her death at the age of 87 in 1966, she struggled valiantly to build family planning associations in the developing world and to promote programs that would not lose sight of her concern for the precarious status of women. ■



Margaret Sanger (1879-1966) in a Brooklyn courtroom with her sister, Ethel Byrne (right), in 1917.

Ellen Chesler is a senior fellow with the Open Society Institute in New York City, where she directs the foundation's reproductive health and rights program. She is the author of *Woman of Valor: Margaret Sanger and the Birth Control Movement in America* (New York: Simon & Schuster, 1992).

Reapportionment by the Cube Root Rule *Continued from page 1*

1830 and 1840 Congress made the House smaller after a census and reapportionment.

The framers of the Constitution expected the House to grow with the population. Alexander Hamilton and James Madison, in Federalist no. 58, noted that the purpose of the census was to “readjust, from time to time, the apportionment of representatives to the number of inhabitants ... [and] to augment the number of representatives ... under the sole limitation that the whole number shall not exceed one for every thirty thousand inhabitants ...”

Since 1910, however, Congress has not increased the size of the House. In that year, the population was 92 million, and each House member represented about 210,000 people. Today the number is 572,000, and it will jump to about 630,000 after the 2000 census. Will that increase continue? What is the “right” number?

Rein Taagepera and Matthew S. Shugart, who analyze apportionment systems around the world, have found that the size of the largest legislative body of a national legislature today tends to be the

cube root of the population—a number that, when multiplied by itself twice, yields the voting-age population. For example, the voting-age population was 203,578,000 in 1990, and the whole number closest to being the cube root of that population is 588 ($588 \times 588 \times 588 = 203,297,472$). Although that formula tracked the size of the House fairly well between 1790 and 1910, the discrepancy between the current House size and the “cube root of population” rule is so great that restoring that relationship would require adding more than 150 members to the House (see figure above).

Taagepera believes that the cube root rule should prevail because it would maximize efficiency and reduce the influence of nonelected congressional staffs. If more representatives were added, he thinks that the number of communication channels per representative—both in assembly and toward constituents—would decline and that efficiency would increase. One aspect of that efficiency would, in his view, be a diminished need for large congressional staffs,

which Taagepera holds have mushroomed to compensate for the small size of the U.S. House. If Congress decided to enlarge its membership, it could at the same time limit or cut the size of support staff, he believes.

Shugart feels similarly. “My guess,” he said, “is that what would happen with a much larger House is that members would come to rely more on their parties to deliver the representation that constituents want ... There would be necessarily less ‘pork’ and more policy arising out of a larger House.”

Because such a change would unsettle politics as usual in undetermined ways, it is not surprising that few incumbent politicians talk about the issue. In 1996 and again in 1997, House members introduced bills to establish a commission that would make recommendations on the appropriate size of the House and the method by which representatives are elected. Neither bill made it to committee.

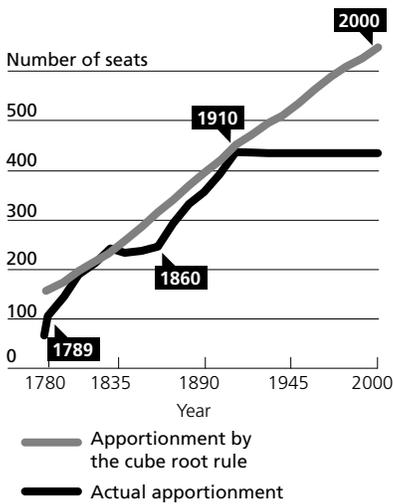
James Clyburn, D-S.C., current chairman of the Congressional Black Caucus, favors “alternative voting methods” such as proportional or cumulative voting in multimember districts, which might lead to or be paired with expanding the House of Representatives. But the Caucus has not taken a position on expanding the House.

Nonetheless, there are a number of potential supporters outside the political arena. Rob Richie, of the Center for Voting and Democracy, noted that, “In state legislatures, women do better in districts that are smaller,” and that there would be (with more House members) “more opportunities for districts drawn to facilitate racial minorities without contorting lines.” Richie speculated that enlarging the House would appeal to populists, because smaller House districts might elect more “ordinary folks.”

There are many ways for regions, parties, and factions to seek advantages in the decennial process of census-taking and reapportionment. Debates about the propriety of sampling are merely the tip of the iceberg. Perhaps in 2010, a full century after Congress last increased the size of the House, Americans will take a look at the issue. It may not be too soon to start the conversation now. ■

Margo Anderson is a professor of American history at the University of Wisconsin–Milwaukee. She is co-author, with Stephen E. Fienberg, of *Who Counts? The Politics of Census-Taking in Contemporary America* (New York: Russell Sage Foundation, 1999).

Size of House



Source: Author's analysis.

Leisure Gap

Calls for “equal work for equal pay” may now be joined by cries for “equal play.” In a recent book, *Time for Life: The Surprising Ways Americans Use Their Time*, researchers have documented a gap between the number of hours of free time enjoyed per week by men and by women.

The research, based on diaries kept by male and female subjects, shows that men have five hours more free time each week than women do: 43.6 hours vs. 38.5. The gap emerges from a comparison of free time for employed men and women and stems from a difference in the time each devotes to housework. Women reported doing about 15.6 hours of housework a week in 1995, while men reported doing nine hours a week.

Authors Geoffrey Godbey of Penn State University and John Robinson of the University of Maryland drew on findings from the University of Maryland’s Americans’ Use of Time Project. For more on the project, see the Web site of the University of Maryland’s Survey Research Center: www.bsos.umd.edu/src/timeuse.html. The book is available from the Penn State University Press: www.psu.edu/psupress.

Africa’s Brain Drain

In a global economy that places an increasing premium on scientific and technological knowledge, how can Africa compete when thousands of African professionals are emigrating to the West?

A recent conference in Addis Ababa, Ethiopia, examined the issue of brain drain, the departure for other countries of university graduates and others with specialized training, often at high cost to their country of origin. Participants at the conference, hosted by the Economic Commission for Africa and the International Organization for Migration, assessed the impact of the problem on Africa’s develop-

ment and considered how to slow out-migration and exodus.

The UN estimates that Africa lost 60,000 doctors, engineers, and other professionals between 1985 and 1990 and has been losing an average of 20,000 per year ever since.

For information on the conference, contact Sophia Deneke, Communication Team, Economic Commission for Africa, e-mail: ecainfo@un.org; Web site: www.un.org/Depts/eca. (See “Spotlight Statistic” on page 7 for more data on the brain drain.)

Point and Click for the World’s Hungry

Every 3.6 seconds, someone in the world dies of hunger, and children account for three-fourths of these deaths, according to a UN Web site that helps feed the hungry. Each time someone visits the site, corporate sponsors pay to give a hungry person a meal. The donated meals combine with more than 200 metric tons of food provided weekly to the United Nations World Food Programme and have reached recent highs of more than 1 million cups a day. Access the site at: www.thehungersite.com.

Sprawl Tops List of Concerns

A recent poll conducted on behalf of the Pew Center for Civic Journalism shows that Americans oppose sprawl. Eighteen percent of respondents identified sprawl—the complex of problems such as growth, traffic, poorly maintained roads, inadequate sewer and water infrastructure, and crowded schools—as the most important local issue. Rankings differed, however, by respondents’ demographics. Sprawl primarily concerns college-educated white Americans who live in the suburbs. Among African Americans, the top concern was crime, ranked first by 35 percent of respondents.

The results of the survey include findings from separate

surveys done in Denver, Philadelphia, San Francisco, and Tampa, Fla. The survey is available on the Pew Center’s Web site: www.pewcenter.org/doingcj/research/.

FDA Delays Approval of RU-486

Approval of the drug that many believe will change the abortion debate has again been delayed. On Feb. 18, the U.S. Food and Drug Administration (FDA) issued an “approvable letter” for mifepristone (better known as RU-486) used in combination with misoprostol. An approvable letter indicates that the FDA has found the drug safe and effective, but wants additional questions answered before granting final marketing approval.

The approvable letter went to the New York-based Population Council, which holds the rights to the drug. The Population Council received a similar letter on Sept. 18, 1996, and responded to issues that were outstanding at that time. According to a Feb. 19 article in the *Washington Post*, the current questions concern the manufacturing and labeling of the drug.

Finding and approving a manufacturer has been a contentious process, the article states, because of strong opposition from antiabortion groups. Mifepristone is used in combination with misoprostol to terminate pregnancies of up to 49 days. It has been widely used in Europe for more than a decade. It allows women to avoid the notice and controversy associated with surgical abortion.

For more information on mifepristone, see the Web site of the Population Council: www.popcouncil.org. (Click on “Publications,” then do a search for “mifepristone.”) ■

India Proposes Retooled Population Policy

by *O.P. Sharma*

Fifty-three years after independence, India is still looking for a viable policy to control population growth. Although it was the first country to adopt a family planning program, in 1952, the country is still growing by 15.5 million people each year and, if this trend continues, India may overtake China in 2045 by reaching a population of 1.5 billion.

As Indians contemplate becoming a population “billionaire” on May 11, the Minister of Health has just announced an ambitious new national population policy. The National Population Policy 2000—released on Feb. 15—aims to bring the total fertility rate (TFR) to replacement level by 2010 and to achieve a stable population by 2045, at a level consistent with sustainable economic growth, social development, and environmental protection.

Addressing unmet needs for basic health services and supplies is foremost among the policy’s goals.

Although these objectives are higher and the time frame to achieve them is shorter than with past programs, the 2000 policy may be more appealing to the public. It envisages achieving replacement-level TFR (about two children per woman) through “promotional and motivational measures” that emphasize quality of life, rather than through numerical targets for the use of specific contraceptive methods, which plagued previous programs. The proposed policy talks of better management of public health, education, and sanitation, and focuses on women’s employment.

Addressing unmet needs for basic reproductive and child health services, supplies, and infrastructure is foremost among the policy’s goals. Other goals are keeping girls in school longer, raising the age at which girls marry to 18 or 20, reducing infant and maternal mortality, and achieving universal immunization of children against vaccine-preventable diseases.

One well-publicized aspect of the National Population Policy 2000 concerns the allocation of seats in the Indian parliament. The policy recommends freezing the current number of seats for another 25 years to avoid penalizing states

that have complied with previous population policies. The last allocation of seats to states and union territories was undertaken on the basis of the 1971 census and was due to be revised following the 2001 census. But if it were revised then, according to one estimate, the number of seats allocated to the state of Tamil Nadu, which has reduced fertility, would have gone down from 39 to 33. Meanwhile, the number of seats allocated to the state of Uttar Pradesh, which has failed to curb its growth rate, would have risen from 85 to 120.

Another vital recommendation of the policy is the formation of a National Commission on Population to guide and review implementation. The policy also recommends formation of similar commissions by each state and union territory. This decentralized approach would extend to the village level, where local self-help groups would be counted on to implement program measures.

Although it has not taken effect—both houses of the Indian parliament first must ratify the legislation—many wonder whether this policy can be implemented. An additional budget of 64 billion rupees (\$1.4 billion) is needed to implement major portions of the policy.

In addition, some of the measures may be open to misuse. For example, an incentive of 500 rupees at the time of birth of a girl child and awards of 500 rupees to mothers who have their first child after they turn 19 appear to be unworkable given that registration of births and deaths in the country suffers from incompleteness. And offers of health insurance for couples below the poverty line who undergo sterilization could cast doubt on the government’s explanation that stabilizing population is needed for sustainable development “with more equitable distribution.”

The success of the population policy, if it is implemented, will depend on a judicious mixing of the roles of males and females. It is well known that women in India generally do not decide their reproductive behavior. Although most contraceptive methods are for women, many women have no say in limiting their family size or in adopting a particular preventive method. The proposed policy would focus information and education campaigns on men to promote small families and to raise awareness of the benefits of birth spacing, better health and nutrition, and better education. ■

O.P. Sharma retired as deputy director of census operations in India. He is PRB’s India consultant on the National Family Health Survey-2.

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Numbers You Can Use

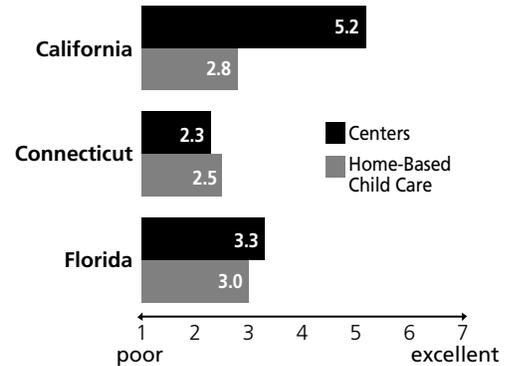
Latest data and estimates



Speaking Graphically

Child-Care Quality Rated Low for Welfare Leavers' Kids

A new study shows that the 1996 reform of the welfare system has had unforeseen consequences for children whose mothers participate in welfare-to-work programs. Many such mothers, often without the financial aid they are entitled to, have placed their children in poor-quality child-care centers. Researchers see low use of child-care subsidies as a strong disincentive to work, and the low quality of care to which children are exposed for more than 40 hours a week as unlikely to end the cycle of welfare dependence.



Note: Ratings are based on setting-specific scales.

Source: Growing Up in Poverty Project 2000, "Remember the Children: Mothers Balance Work and Child Care Under Welfare Reform" (Berkeley, CA: University of California's Graduate School of Education-Policy Analysis for California Education, 2000). For copies of the report, call 510/642-7223; for an excerpt, visit the Web site: www.gse.berkeley.edu/research/PACE/earlyed.html.



World Population

As of April 2000 6,045,000,000
Annual growth 84,000,000

Population of the United States

As of Nov. 1, 1999 274,114,000
As of Nov. 1, 1998 271,544,000



U.S. Population Update

12 Months Ending With February

	Number		Rate	
	1999	1998	1999	1998
Live births	3,968,000	3,906,000	14.7	14.6
Fertility rate	—	—	66.4	65.4
Deaths	2,323,000	2,319,000	8.6	8.7
Infant deaths	27,500	27,400	6.9	7.0
Natural increase	1,645,000	1,587,000	6.1	5.9
Marriages	2,256,000	2,386,000	8.3	8.9
Divorces	—	—	4.2	4.3

Notes: Fertility rate is given per 1,000 women ages 15-44; infant deaths per 1,000 live births; other rates per 1,000 population. Number of divorces not available.

Source: National Center for Health Statistics, *National Vital Statistics Reports*, vol. 48, no. 2 (2000).



Spotlight Statistic: Africa's Brain Drain Accelerates

Period	Number of Professionals Who Left Africa for Europe or the U.S.
1960-1975	27,000
1975-1984	40,000
1985-1990	60,000

Source: UN Economic Commission for Africa, ECA Press Release No. 01/2000 (Feb. 17, 2000). For more information on this topic, see "In the News," page 5.

Note: Additional information and sources for population estimates are available on the *Population Today* appendices page of the PRB Web site: www.prb.org/poptoday/ptappend.htm.

Mozambique's High Rate of Maternal Mortality

The floods in southern Africa have turned world attention and resources to Mozambique. International donors have flown in emergency shipments of food, medical supplies, and search and rescue personnel to lessen human suffering and minimize the death toll—500 confirmed and hundreds more expected.

A far deadlier but less obvious problem besetting the southeastern African country is maternal mortality. Maternal mortality, like the deaths from the floods, is difficult to measure; yet unlike a sudden natural disaster, the problem doesn't make international news.

Mozambique's ratio of maternal deaths to 100,000 live births—1,500—is among the world's highest. With the country's population of 19.6 million, the ratio translates into about 9,800 maternal deaths per year; roughly one in seven women die from pregnancy or childbirth complications. Often, the women who die leave behind other children, whose care may be jeopardized. In nearly every case, the deaths of women rob their families and societies of social support and productive workers.

Why is the toll so high? In fact, it could be higher. It's difficult to

measure maternal mortality because it requires accurate information about deaths of women ages 15 to 49. Few less-developed countries register births and deaths; fewer still record cause of death, which even in more-developed countries may elude health care workers if the women have tried to conceal or abort their pregnancies.

That is why the World Health Organization and UNICEF estimate maternal mortality rates and ratios for less-developed countries including Mozambique based on birth rates and the proportion of births that are assisted by a trained person. In the case of Mozambique, specialists use mathematical models to predict the proportion of all deaths of women of reproductive age that are maternal, and then apply this proportion to UN projections of adult female deaths.

There are three main reasons for Mozambique's high maternal mortality:

- Only 60 percent of the population has access to health services, which were destroyed during years of war and have not yet been rebuilt. Poor general health is common, prenatal visits are rare, and fewer than half of births are assisted by trained health workers.

Population: 19.6 million

GNP per capita, 1997: US\$140

Total Fertility Rate: 5.6

Maternal Mortality Ratio: 1,500 deaths per 100,000 live births

Infant Mortality Rate: 134 deaths per 1,000 live births

Source: PRB's *World Population Data Sheet*, 1997 and 1999.

- Illegal abortions are common and very often result in maternal deaths. Although hospitals interpret abortion laws liberally and offer abortions for a fee, many women are too poor to pay and so go to unsafe practitioners.

- Seventy-five percent of women are illiterate, and girls drop out of school early—sometimes marrying at age 10 or 11. Marrying young leads to early and risky childbearing; ignorance of family planning means little spacing between births.

These problems also help explain the country's high infant mortality rate (see table above).

As of March 3, USAID's total contribution to flood relief efforts amounted to \$12.7 million. The agency's fiscal year 2000 budget request for population and health programs in Mozambique totaled \$14.5 million. ■