International Conference on
Population and Development

National
Progress in
Implementing
the ICPD
Programme
of Action
1994-2004

Investing in People

UNFPA

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Foreword

Imagine that all people in the world have the information and means to protect themselves from HIV/AIDS and other sexually transmitted infections, and to determine the number, timing and spacing of their children. Imagine that every woman can control her fertility and has adequate health services throughout her life. As a result, fewer mothers, infants and children die prematurely, and unnecessarily.

Imagine a world in which the interrelationships between population, resources, the environment and development are fully recognized, properly managed, and brought into balance, and governments are committed to achieving sustainable development and improving the quality of life of all people.

Imagine that women and men are recognized and treated as equal in dignity and rights, within the home and before the law, and wife beating, rape and other forms of violence against women and girls are considered unacceptable forms of behaviour, routinely condemned and brought to justice.

Imagine that all children, girls and boys, attend school and receive a high-quality education to help them reach their full potential as human beings. Imagine building partnerships to create an equitable and sustainable world in which respecting human rights, including the rights of women, meeting the needs of current and future generations, and ensuring universal access to education and health, including sexual and reproductive health, are considered urgent priorities.

Now imagine world leaders subscribing to this vision, and you will grasp the essence of the International Conference on Population and Development (ICPD), which took place in Cairo from 5 to 13 September 1994. The Cairo Conference was a tremendous success, shifting population policy away from human numbers to human lives and human rights.

In Cairo, leaders from 179 nations, with input from civil society, reached consensus on a set of important population and development objectives and mutually supportive goals. Among these goals and objectives are: sustained economic growth in the context of sustainable development; education, especially for girls; gender equality and equity; infant, child and maternal mortality reduction; and the provision of universal access to reproductive health services, including family planning and sexual health.

Ten years after the historic Cairo Conference, UNFPA is pleased to issue this report on the progress that has been achieved and the challenges that remain in implementing the ICPD Programme of Action. The over-arching conclusion is that the decade since the adoption of the Programme of Action has been one of significant progress. However, progress has not been consistent and constraints, including lack of funding, remain a critical concern at the midpoint of the 20-year agenda.

This report is based on a Global Survey that UNFPA conducted in 2003 to appraise national experiences. The Survey solicited responses from developing countries and countries with economies in transition as well as donor countries. Gratitude goes to the governments and civil society partners that replied, which resulted in a 92 per cent response rate among developing nations and countries with economies in transition, and an 82 per cent response among donor countries.

The Global Survey has been an integral component of the ICPD at Ten review process for which the Governments of Australia, Canada, Sweden, and the United Kingdom have provided financial support. We are grateful to them, and likewise to the Government of Switzerland, whose assistance also included support for activities related to the Survey. Appreciation also goes to the many UNFPA staff, both in the field and at headquarters, who worked on this worthwhile undertaking.

It is our hope that the findings of this Global Survey will accelerate implementation of the ICPD Programme of Action. This will contribute directly to the achievement of the Millennium Development Goals to dramatically reduce poverty, hunger, poor health, HIV/AIDS and gender inequality by 2015.

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent reproductive health
ARV	Anti-retroviral (therapy)
BCC	Behaviour change communication
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CARICOM	Caribbean Community
CIDA	Canadian International Development Agency
CIS	Commonwealth of Independent States
CRC	Convention on the Rights of the Child
DAC	Development Assistance Committee of the Organisation for Economic Cooperation and Development
DFID	Department for International Development (United Kingdom)
GIS	Geographic information system
GNP	Gross national product
GBV	Gender-based violence
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
ICPD+5	The five-year review of the ICPD
ICPD PoA	The Programme of Action of the International Conference on Population and Development
ICT	Information and communication technology
IDP	Internally displaced person
IDU	Injecting drug user
IEC	Information, education and communication
MDGs	Millennium Development Goals
MIS	Management information system
MTCT	Mother-to-child transmission
NGO	Non-governmental organization
ODA	Official development assistance
PLWHA	People living with HIV/AIDS
PRSP	Poverty reduction strategy paper
PMTCT	Prevention of mother-to-child transmission
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
SWAp	Sector-wide approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	United States Agency of International Development
VCT	Voluntary counselling and testing

Summary of Findings

BACKGROUND

The 1994 International Conference on Population and Development (ICPD) articulated a bold new vision about the relationships between population, development and individual well-being. At the ICPD, 179 countries adopted a 20-year forward-looking Programme of Action (ICPD PoA), which built on the success of population, maternal health and family planning programmes of the previous decades while addressing, with a new perspective, the needs of the early years of the twenty-first century.

As the ICPD is reaching its mid-point in 2004, it is fitting that countries take stock of progress that has been made so far in achieving the Cairo goals. UNFPA is mandated to assist countries in their review of operational experiences in implementing the ICPD PoA, and to that end, conducted a Global Survey in 2003 to appraise national experiences ten years after Cairo. An overall response rate of 92 per cent was achieved for developing and countries in transition. For donor countries, the response rate was 82 per cent.

The objectives of this report are to: (a) describe, from an operational perspective, the progress that has been made, and the constraints that have been encountered, by countries in their efforts to implement specific actions of the ICPD PoA and the MDGs; (b) present measures taken with some regional highlights; and (c) summarize the major conclusions arising from the 2003 Global Survey and assess the way forward. The various chapters of the report present the findings and conclusions emanating from the analysis of the Survey.

FINDINGS

To help readers obtain a quick overview of major findings of the survey, this section has been included in the report. It provides a summary of findings highlighting the significant results from each area covered by the Survey. References are included in each summary to guide the reader to the relevant chapter section for each topic covered. A comprehensive treatment of each topic area can be found in the respective report chapters. The implications of these and other findings for the way forward are presented in the final chapter.

A. POPULATION AND DEVELOPMENT

This chapter details progress made and actions taken to integrate populations concerns into selected aspects of the development process, including development strategies, decentralized planning, poverty-reduction strategies and environmental planning. It also presents details of policy actions on issues of internal migration, international migration and population ageing.

In reference to actions taken to integrate population concerns into development strategies, the Global Survey revealed that 79 per cent of reporting countries had adopted multiple measures (Section 2.2). This represents very good progress when compared to the 1994 survey, when only 52 per cent of developing countries had reported taking comparable action.

In the area of decentralization and integration of population factors into local development plans and local structures, 79 per cent of countries reported taking action (Section 2.3). In addition to incorporating population factors into local social, economic and, to a lesser extent, environmental plans, 52 per cent of countries established local governance structures. Continued action in this area includes strengthening the institutional and human-resource capacity of the local structures and encouraging countries that have not yet initiated population integration in the context of decentralization to do so.

On the issue of integrating population factors in poverty reduction strategies, 57 per cent of countries reported taking multiple measures (Section 2.4). This is a notable change from 1994, when only 13 per cent of developing countries had reported action. Analysis revealed that the countries with both the highest level of poverty (over 40 per cent) and higher population growth rate (≥1.47 per cent) had a higher action rate (65 per cent), as compared to 40 per cent for countries with lowest levels of poverty (< 20 per cent) and lower population growth rate (<1.47 per cent). These findings point out that national action is given higher priority in those countries most challenged.

Fifty per cent of countries reported taking strong action to address issues of population and environment, with most developing programmes, policies and/or laws on the

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issue (Section 2.5). An examination of the distribution of countries adopting at least two specific measures to address population and the environment is revealing. When the level of poverty and the rate of population growth are factored in, it is clear that countries with a higher level of poverty or a higher population growth rate are more likely to have adopted multiple measures. However, the joint effect of both a high level of poverty and a rapid population growth rate was even more significant: only 33 per cent of countries with lower levels of poverty (<20 per cent) and lower levels of population growth rate (<1.47 per cent) had adopted multiple measures, and the corresponding rate for the high poverty and high population growth group of countries was around 60 per cent — almost twice as high. It thus implies that national action is given higher priority in those countries most affected.

On the issue of addressing the special needs of the elderly, which is gaining in importance in all countries, 39 per cent of responding countries reported taking major action, compared to 21 per cent in 1994 (Section 2.6). A further analysis of responses for developing countries indicates that those with higher levels of population ageing (≥7 per cent — average for all developing countries) were almost twice as likely to have adopted major initiatives (58 per cent) than those with lower levels of ageing (30 per cent). This implies that not only the degree of ageing in a country is an important factor in taking action on the elderly issue, but also that many countries have initiated action, even at relatively lower levels of ageing.

In addressing internal migration, the Global Survey results show that 64 per cent of countries reported taking some action, as compared to 41 per cent in 1994 (Section

On the issue of integrating population factors in poverty reduction strategies, 57 per cent of countries reported taking multiple measures. This is a notable change from 1994, when only 13 per cent of developing countries had reported action.

2.7). A total of 39 countries had adopted multiple measures on internal migration. Fifty-two per cent of countries had adopted plans on migration; 51 per cent had created plans to distribute socio-economic and political activities to influence spatial distribution of the population; 15 per cent had initiated programmes to provide assistance and services to internally displaced persons, and 10 per cent had established special institutions on migration. Essentially, governments developed plans to promote resettlement schemes, redistribute population by creating new economic growth centres, decentralize social and economic planning as well as political activities, and formulated programmes and strategies to resettle and rehabilitate internally displaced persons, as appropriate.

According to the Global Survey findings, 73 per cent of countries had taken some action to address international migration issues, representing enormous progress, since only 18 per cent of countries had reported taking similar action in 1994 (Section 2.8). The most common measure adopted was the formulation of plans, programmes or strategies on international migrants and/or refugees issues (45 per cent), followed by the enactment of laws or legislation on international migrants and migrant workers (37 per cent), the adoption of a migration policy (33 per cent), the undertaking of efforts to enforce international conventions on refugees, asylum-seekers and migrants (11 per cent), and the passing of laws or legislation on the trafficking of humans, especially women and children (10 per cent). In addition, a growing number of countries have established coordination mechanisms of various types — coordination across agencies within government, coordination between governments, and coordination among

governments, non-governmental organizations (NGOs) and international donors and others.

The ICPD PoA emphasized that valid, reliable, timely, culturally sensitive, sex-disaggregated and internationally comparable data should form the basis for all stages of policy and programmatic action. Responding to a question on measures taken to strengthen national capacity for population data, 96 per cent of the countries stated that they had taken action (Section 2.9). Globally the measures adopted were: strengthening the capacity of institutions for data collection as well as for the processing, analysis and utilization of data (93 countries); supporting development of national databases and management information systems (75 countries); training of staff on database management (61 countries), and creation/strengthening of a national statistical service (61 countries).

Monitoring and evaluation of the implementation of international development frameworks, including the ICPD PoA and Millennium Development Goals, are crucial for assessing progress towards development targets and identifying best practices and constraints. The results of the Global Survey indicated that governments had started to take measures to create and strengthen mechanisms for monitoring and assessing progress in achieving ICPD goals and the MDG (Section 2.9). For example, on the question of mechanisms developed for monitoring and measuring progress in achieving ICPD goals, 131 (87 per cent) out of 151 countries responded to the question, and 82 countries (54 per cent) provided information on mechanisms used. Compared to the 1998 Survey, when 43 countries had reported taking significant measures to establish monitoring mechanisms for assessing the achievement of ICPD goals, demonstrated progress has been made in this area.

The most frequently mentioned constraints affecting policy development and implementation in population and development strategies were lack of financial resources;

> **At the global level, 99 per cent of responding countries reported that they had adopted measures to protect the rights of girls and women.**

lack of trained or qualified staff; insufficient institutional capacity; lack of awareness and understanding of the issues; lack of data; and insufficient coordination among institutions and ministries. Other constraints include religious opposition and lack of political will in some instances.

When asked about emerging issues in population and development, countries identified population ageing; poverty alleviation; internal and external migration; improving the situation of refugees/internally displaced persons; and the need to strengthen population-data collection, especially censuses, and improve overall quality of data.

B. GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN

The ICPD PoA defined a set of strategic objectives and spelled out corresponding actions to be taken by governments, the international community, non-governmental organizations and the private sector to remove existing obstacles to gender equality and to improve the lives of girls and women. The Global Survey posed a number of questions on gender-related issues in an attempt to track progress made by countries in implementing the PoA's gender component. The responses cover measures taken in five specific areas, namely: (a) protecting the rights of girls and women; (b) women's empowerment; (c) gender-based violence (GBV); (d) gender-based disparities in education; and (e) men's support for women's rights and empowerment. Cultural considerations reported by countries are also presented.

The Global Survey sought information on whether governments have taken any policy, legislative or administrative measures to protect the rights of girls and women. At the global level, 99 per cent of responding countries reported that they had adopted measures to protect the rights of girls and women (Section 3.2). The most common measure adopted was legislation and formulation

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of national laws on the rights of girls and women (71 per cent), followed by the ratification of United Nations conventions and the implementation of the ICPD PoA (45 per cent). More than a third of the countries (41 per cent) reported that they had formulated policies to remove gender discrimination, and less than a third (29 per cent) provided constitutional protection to girls and women.

The ICPD PoA underscored that the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. Thus, the Global Survey solicited information on the progress countries have made to promote the empowerment of women through policy, legislative or administrative measures (Section 3.3). Ninety-nine per cent of countries reported having taken measures to empower women. The most common measures included promotion of increased participation of women in governance (51 per cent); the provision of economic opportunities for women (46 per cent); the provision of education and training for women (38 per cent); adoption of laws and legislation for the empowerment of women (34 per cent); and promotion of increased participation of women in the political process (20 per cent).

The ICPD PoA, the Beijing Declaration and Platform for Action and other global conferences and instruments recognized gender-based violence as a major issue on the international human rights agenda. The country responses show that at the global level, 98 per cent of countries reported having taken action to address gender-based violence (Section 3.4). The most common measure taken in the legal and legislative category was the adoption of laws and legislation on GBV (66 per cent of countries). In addition, 16 per cent of the countries promoted enforcement of laws and legislation. Regarding programmatic and administrative measures, countries reported that they have provided support services for victims (40 per cent); conducted IEC and advocacy on GBV (37 per cent); established national commissions on GBV (37 per cent); and trained service providers and government officials on handling GBV cases (24 per cent). Another measure

reported was setting up institutional mechanisms for GBV monitoring and reporting (24 per cent).

The PoA called for universal primary education to be a reality in all countries before the year 2015. The Survey reveals that globally 93 per cent of countries have made progress in addressing the gender gap in education (Section 3.5). Of the 129 respondents who reported some progress, 22 per cent indicated that the ratio of girls to boys at the primary level was increasing. At the secondary level, 16 per cent of countries reported that concurred that the ratio of girls to boys was increasing. Measures initiated by governments to close the gender gap in education were: provision of incentives to poor families to send girls to school (21 per cent); provision of IEC and advocacy campaigns on gender equality in education (21 per cent); promulgation of laws and legislation for equal education of girls and boys (18 per cent); incorporation of gender issues into school curricula (17 per cent); and provision of an increased number of girls' schools at the secondary level (12 per cent).

The results obtained on access to primary and secondary education show that at the global level, 96 per cent of countries have taken measures to improve access to education. The most common measure was making schooling free to the public (40 per cent). This was followed by providing increased public spending for schools (41 per cent) and declaring compulsory primary education for boys and girls (32 per cent). Other measures taken were: providing incentives to poor families to send children to school (20 per cent); and providing free secondary education (19 per cent).

The PoA states that changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving a harmonious partnership of men and women. Responses to a question in the Global Survey indicated that some progress has been made in this area. Globally, 82 per cent of responding countries reported adopting relevant measures to ensure that attitudes respectful of women and girls are instilled in boys (Section 3.6). More than half (54 per cent) of the countries mentioned the development, review and revision of textbooks

and curricula to incorporate gender equality concerns; about a third (37 per cent) reported conducting IEC/advocacy campaigns on gender equality; 26 per cent advocated for gender equality in organizations; and 15 per cent developed reproductive health education plans and programmes for adolescents and youth.

In regard to actions taken to enable men to support women's rights and their empowerment, 70 per cent of countries reported having taken measures in this area. Reported actions included: IEC/advocacy campaigns on men supporting women (54 per cent); and the formulation of plans and programmes encouraging male involvement in reproductive health (42 per cent).

The Global Survey asked countries to describe whether the cultural context of the country contributed to or constrained the promotion of gender equality, equity and women's empowerment. Seventeen per cent reported that the cultural context supported the empowerment of women and 8 per cent reported that women were respected as mothers and that children were treated equally irrespective of gender. Twenty-six per cent of countries mentioned gender discrimination in the division of labour.

C. REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

The aim of ensuring universal voluntary access to a full range of reproductive health care information and services by 2015 is central to the ICPD Programme of Action. The PoA and the ICPD+5 *Key Actions* described a framework for providing reproductive health care within health systems, recognizing the importance of integrating family planning, maternal care and prevention services for sexually transmitted infections (STIs), including HIV/AIDS. This chapter provides a review of progress made in reproduc-

The responses to the 2003 Global Survey, particularly in comparison to the 1993 and 1998 Surveys, show that countries are making increasing progress in reproductive health services and information and in reproductive rights issues.

tive health and reproductive rights as reported by countries in the 2003 Global Survey.

Out of the 151 countries, 145 provided responses to the question on enforcement of reproductive rights, and of those 131 reported adopting policy measures, laws or institutional changes at the national level to enforce reproductive rights (Section 4.2). Many countries have reported formulating new policies, new national plans, programmes or strategies, or passing new legislation to enforce reproductive rights. This is a major step in implementation of the ICPD PoA. Fewer countries have reported IEC or advocacy strategies, or institutional changes, including training staff on reproductive rights, although these are essential to secure the full enjoyment of reproductive rights. Even though results on reproductive rights from the 1998 and 2003 Global Surveys are not exactly comparable, there appears to have been significant progress since 1998 in this area.

Countries reported using a variety of mechanisms to monitor reproductive rights and reproductive health services (Section 4.3). Some countries have established national human rights institutions, including national commissions to monitor the implementation of human rights. Others have human rights ombudsmen; and many rely on the monitoring procedures of legally binding international human rights treaties that their governments have ratified. Many countries stated that reproductive rights are included in their country reports to the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC) Committees.

The ICPD PoA recognizes that primary health care should include a minimum package of family planning, maternal health services, and prevention and manage-

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ment of STIs, including HIV/AIDS. Out of the 151 countries, 136 reported on measures taken to integrate reproductive health service components into the primary health care system, including 93 countries reporting multiple measures (Section 4.4). There has been considerable progress in integrating reproductive health into primary health care services over the last 10 years: of the 136 countries reporting such measures, 81 indicated that they began after the ICPD.

In the last decade many countries have embarked on health-sector reform to improve efficiency, affordability, quality and client responsiveness. Of 120 countries implementing health-sector reform, 106 reported including aspects of reproductive health as part of the package (Section 4.5). Some countries reported that their package recognized the needs of a specific clientele, for example adolescents and youth (73 countries); women, in particular pregnant women (58 countries); or women, men and youth (44 countries). A number of countries (20) reported that the package included information, education and communications on reproductive rights and reproductive health. Two countries said that the inclusion of reproductive health in the package allowed them to increase budget allocations for reproductive rights and reproductive health.

The Programme of Action recognizes the importance of access to a set of integrated reproductive health information and services. The Global Survey asked about key measures taken by governments to increase access to high-quality reproductive health services (Section 4.6). Out of the 151 canvassed countries, 149 responded to the question and 143 indicated the key measures they have taken to increase access to reproductive health services, including 115 coun-

tries reporting multiple key measures. Countries emphasized the need to correct shortages of trained staff, particularly in midwifery and essential obstetric care. A number of countries have introduced protocols for standardizing quality service delivery, and many countries have worked to upgrade their reproductive health facilities.

The 2003 Global Survey included a question on key measures taken by countries to expand contraceptive choice. Out of the 151 countries, 143 responded to this question and 126 indicated having taken key measures, including 88 having taken multiple measures (Section 4.7). Progress since 1994 and since the ICPD+5 are significant, both in the number of countries taking major measures and in the variety of measures taken to increase information on and access to contraceptives, as well as to increase the choice of contraceptives.

The Programme of Action and the *Key Actions* stressed the need to make quality services affordable and accessible to all who need and want them, including a reliable and adequate supply of a range of contraceptive methods and other reproductive health commodities. Responses to the 2003 Global Survey revealed that 119 countries reported taking one or more measures to improve reproductive health commodity security and 56 reported multiple measures, a significant improvement from the 1998 Survey (Section 4.8).

The ICPD recognized complications related to pregnancy and childbirth as among the leading causes of mortality for women of reproductive age in many parts of the developing world. The Global Survey asked countries to report on the key measures they have taken to reduce maternal morbidity and mortality; 146 out of 151 countries responded, with 144 reporting specific measures and a large number

> **Responses to the 2003 Global Survey revealed that 119 countries reported taking one or more measures to improve reproductive health commodity security and 56 reported multiple measures, a significant improvement from the 1998 Survey.**

(113 countries) reporting multiple measures (Section 4.9). These included: training of health care providers, improved prenatal and post-natal services, creation of a network of reproductive health/family planning clinics, provision of maternal health services for vulnerable groups or those in remote areas and improving data collection and record keeping.

Research, prevention and treatment of sexually transmitted diseases are among the reproductive health-related actions outlined in the ICPD PoA. Almost all countries responding said that they had taken key measures to prevent and manage sexually transmitted infections, and 135 reported multiple measures (Section 4.10). Measures taken included: STI prevention, treatment and management service provision, IEC/advocacy campaigns on prevention and treatment, national commission/agency/ministry/desk established by government, monitoring surveillance systems, educational initiatives that target vulnerable populations, and social marketing of condoms and STI medication.

The ICPD PoA encouraged countries to pay particular attention to the health impact of unsafe abortion as a major public health concern, including management of complications. Of the 151 countries that responded to the Global Survey, 117 countries reported that they had taken key measures to prevent and manage complications of unsafe abortion (Section 4.11). Some countries indicated that strengthening their family planning services was a key measure to preventing unsafe abortions. Others reported measures (guidelines, training, facilities) to improve access to post-abortion services, both to manage complications and to prevent repeat unsafe abortion.

Strengthening the voices of clients, especially women, and facilitating stronger partnerships between beneficiaries, providers and local officials, are at the heart of the ICPD agenda. In response to the a question about key measures to involve beneficiaries of reproductive health services, 124 of 137 countries indicated that they had taken key measures to involve beneficiaries, and 48 reported multiple measures (Section 4.12). Some countries have taken measures to assess the needs and opinions of the population by means

of public hearings or consumer surveys, or by involving the community and civil society in policy and/or programme formulation. Countries have also established action groups at the local level; trained community reproductive health workers to involve beneficiaries and meeting their needs; and conducted information and advocacy activities aimed at informing and involving beneficiaries.

The responses to the 2003 Global Survey, particularly in comparison to the 1993 and 1998 Surveys, show that countries are making increasing progress in reproductive health services and information and in reproductive rights issues. However, Survey results also underscore the challenges involved in integrating reproductive health services into the primary health care system, especially in the context of health-sector reform (Section 4.13). Constraints common to all regions included insufficient financing and lack of sustainability (64 countries); lack of trained health care providers (38 countries); lack of equipment and facilities (33 countries); difficulties in accessing services, particularly in remote areas, often due to insufficient decentralization (22 countries); and poor communications (19 countries). Countries also cited gender inequality, and problems in providing services for men and adolescents.

D. ADOLESCENT REPRODUCTIVE HEALTH AND YOUTH

Nearly half of the world's population is under the age of 25, the largest youth generation in history. Since 1994, countries have become more aware of the importance of ensuring that policies are in place to address the right to health and the reproductive health needs of adolescents; to introduce health education, including life skills for youth both in- and out-of-school; and to provide access to reproductive health information, education and services.

Ninety-two per cent of reporting countries indicated that they had taken at least one measure to address the reproductive health and reproductive rights of adolescents, including access to information on reproductive rights and reproductive health (Section 5.2). In terms of policy and legislative measures, 34 per cent of countries have devel-

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oped and implemented policies sensitive to adolescent reproductive health; 27 per cent of countries have developed and implemented laws and/or legislation on reproductive rights and reproductive health needs of adolescents; and 9 per cent have ratified United Nations conventions. In regard to programmatic and strategic measures, those reported by countries included: formulating national plans and programmes (62 per cent) including the reproductive rights and reproductive health needs of adolescents; utilization of information, education and communication (IEC) and advocacy campaigns on adolescent issues (33 per cent); integration of reproductive health education into school curricula (26 per cent); and establishment of a national commission on adolescents and youth (22 per cent).

In order to implement the ICPD PoA in terms of promoting the well-being of adolescents, enhancing gender equality and equity, and encouraging responsible sexual behaviour, attention is increasingly being given to formal and non-formal education on population and health issues (Section 5.3). The 2003 Global Survey results indicated that 140 (93 per cent) of the 151 countries have taken at least one measure to introduce health education, including life skills, into school curricula and programmes for out-of-school youth. The most common measures were: (a) provision of school curricula including reproductive health and life skills (89 per cent); (b) out-of-school programmes and clinics (39 per cent); (c) training on reproductive health for teachers and other school staff (26 per cent); and (d) peer education programmes (19 per cent).

Since the ICPD and particularly since the ICPD+5, there has been major progress in the provision of reproductive health information for adolescents and in the way that

> **Since the ICPD and particularly since the ICPD+5, there has been major progress in the provision of reproductive health information for adolescents and in the way that adolescents and youth are accessing services.**

adolescents and youth are accessing services (Section 5.4). Of the 151 countries responding to the 2003 Global Survey, 133 (88 per cent) reported taking action to provide access to information on reproductive health to adolescents. These measures included: (a) IEC/advocacy (54 per cent); (b) formulation and implementation of national education plans, programmes and strategies (35 per cent); (c) provision of peer education programmes (29 per cent); and (d) use of media such as TV and radio to convey reproductive health information (28 per cent).

The PoA of the ICPD provides a clear recommendation to countries to provide adolescents with access to affordable, confidential, gender-sensitive and youth-friendly reproductive health services. Of the 151 countries responding to the Global Survey, 136 countries (90 per cent) are taking action to provide adolescents and youth access to reproductive health services (Section 5.5). Of those, 78 countries (57 per cent) reported the establishment of youth-friendly services. Other notable measures reported were: plans and programmes for providing reproductive health services to adolescents (34 per cent); provision of counselling for adolescents on reproductive health (27 per cent); and IEC/advocacy on reproductive health services for adolescents (27 per cent).

Countries have also taken measures to provide life-skills training to adolescents and youth. One hundred and thirty (86 per cent) of the 151 countries are taking action to support the comprehensive development of young people (Section 5.6). The measures taken include: (a) provision of a relevant education system and education in vocational and entrepreneurial skills (61 per cent of the countries that took at least one measure); (b) provision of vocational and entrepreneurial education to out-of-school youth (55 per

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cent); (c) provision of jobs for youth by government (33 per cent); and (d) provision of entrepreneurial training for youth by NGOs (18 per cent).

The participation of young people in policy and programme development has been encouraged since the Cairo Conference. The ICPD PoA recommended that youth be actively involved in the planning, implementation and evaluation of development activities that have a direct impact in their daily lives, in particular activities concerning reproductive health, including the prevention of early pregnancies, and the prevention of HIV/AIDS and other sexually transmitted infections. Of the 151 countries responding to the Global Survey, 118 (78 per cent) were taking action to ensure the participation of youth in policy and programme development (Section 5.7). The measures taken in this regard included: (a) involvement of adolescents and youth in formulation and implementation of projects (64 per cent of the countries that took at least one measure); (b) involvement of adolescents and youth in policy development (47 per cent); (c) establishment of fora for youth to elicit information (28 per cent); and (d) promotion of youth organizations or associations as a channel for their participation (19 per cent).

When asked how the cultural context of the country contributed to the promotion of adolescent reproductive health, 70 countries (46 per cent) out of 151 responded (Section 5.9). Religion was reported as a factor contributing to the promotion of adolescent reproductive health in some countries. Reproductive health information is provided as part of religious teaching in some religions. When asked how the cultural context constrained the promotion of adolescent reproductive health within the country, 120

The findings of the 2003 Global Survey also indicated that an increasing number of countries have introduced a more multisectoral approach to the HIV/AIDS pandemic, involving a wide range of ministries complemented by the increasing involvement of NGOs.

countries (79 per cent) out of 151 responded. Many countries discussed the lack of information made available to youth and reported that open discussion of sexual behaviour and reproductive health issues with adolescents and youth is considered inappropriate or not done (43 per cent). In addition, it was reported that religious opposition can sometimes prevent youth from seeking reproductive health services (23 per cent).

E. HIV/AIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in the year 2003 alone three million people died from AIDS; in the same year, the number of AIDS orphans climbed to 14 million, 11 million of whom live in sub-Saharan Africa. Indications are that HIV infections are not leveling off. The number of people living with HIV and AIDS continues to increase, most markedly in sub-Saharan Africa but also within the expanding epidemics in Asia, the Pacific, Eastern Europe and Central Asia. In 2003, more than five million people became newly infected — half of them young people between the ages of 15 and 24 — and are now part of today's 40 million people living with HIV/AIDS across the globe. As HIV/AIDS is a key component of reproductive health and a critical factor influencing the achievement of ICPD goals and the MDGs, the 2003 Global Survey attempted to elicit information on measures and actions taken by countries to address the epidemic.

The 2003 Global Survey asked countries to describe successful strategies used to address the HIV/AIDS pandemic (Section 6.2). The collective findings are categorized into three distinct groupings: (a) plan, policy or strategy formulation; (b) adoption of prevention

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approaches; and (c) support activities. Of those countries responding to the Survey, 74 per cent reported the adoption of a national strategy on HIV/AIDS; 36 per cent stated that they had specific strategies aimed at vulnerable and high-risk groups; 18 per cent indicated having adopted a specific policy on HIV/AIDS; and 16 per cent reported having passed laws or legislation in support of HIV/AIDS efforts.

In the past decade, many developing countries have established national AIDS commissions and have developed policies and programmes to address the impact of the pandemic. In addition, there are many examples in developing countries where Heads of State are directly involved in leading the fight against HIV/AIDS. The findings of the 2003 Global Survey also indicated that an increasing number of countries have introduced a more multisectoral approach to the HIV/AIDS pandemic, involving a wide range of ministries complemented by the increasing involvement of NGOs.

Global statistics tell only a fraction of the story of HIV/AIDS. Epidemic dynamics can vary significantly among regions and even within regions or communities. It is therefore essential that HIV/AIDS strategy and programme development take into account specific driving factors and impediments to the implementation of effective prevention, care and treatment to better ensure effective action.

While the majority of those infected with HIV/AIDS live in Africa, the pandemic affects people living in all regions of the world. The second-highest regional rate of infection currently exists in the Caribbean, and HIV/AIDS has already become fully established in Latin America. In the CIS, Eastern and Central Europe region, numbers of new infections are soaring. While there are currently comparatively low prevalence rates in countries in Asia and the Pacific and the Arab States, the numbers of those infected could surge out of control. Even countries that have hardly any infections at present could suddenly face a serious problem.

Based on Global Survey responses, it is evident that a large proportion of countries are addressing prevention within their response to HIV/AIDS (Section 6.3). Programmatic measures reported include information, education and communication; blood safety; voluntary counselling and testing (VCT); prevention and treatment for HIV/AIDS and other STIs; promotion of condom use; surveillance (both epidemiological and behavioural); harm reduction; care, treatment and support of those infected and affected; capacity-building combined with strengthening of the health infrastructure; elimination of stigma and discrimination; increased involvement of people living with HIV/AIDS; advocacy and other supportive measures; and monitoring and evaluation.

It has become increasingly apparent that, given the limited resources of many of the countries affected by the HIV/AIDS pandemic, interventions should be aimed at those at highest risk of infection (Section 6.4). An attempt was made in the Global Survey to obtain information on the targeting of high-risk and vulnerable groups within national prevention strategies. A total of 131 countries reported targeted interventions referencing high-risk groups, vulnerable groups and others at risk of infection.

The data shows that among high-risk groups, the largest proportion of countries reported action targeting sex workers (73 per cent), followed by actions targeting injecting drug users (31 per cent) and long-distance truck drivers (24 per cent). Among vulnerable groups, the percentage of action reported is highest for adolescents and youth (62 per cent), followed by pregnant women and their spouses (28 per cent), women (14 per cent) and street children (5 per cent). Among other at-risk and

> **It has become increasingly apparent that, given the limited resources of many of the countries affected by the HIV/AIDS pandemic, interventions should be aimed at those at highest risk of infection.**

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vulnerable groups, soldiers and uniformed service personnel were targeted by 18 per cent of countries, and migrant workers were targeted by 12 per cent of countries.

The 2003 Global Survey results revealed that cultural practices and other country-specific factors can play a facilitating or constraining role in addressing the HIV/AIDS pandemic (Section 6.5). A total of 73 countries (48 per cent) reported that culture has had a facilitating role in their countries in their efforts to address various aspects of HIV/AIDS: 23 per cent reported that social and cultural attitudes promoted community involvement, 16 per cent stated that religious beliefs in their countries had the potential to reduce risky behaviours in the population, 14 per cent felt that culture promoted delay in the onset of sexual activity among their youth, and 8 per cent stated that the extended family system of their culture has helped in the care and support of HIV-positive individuals in their population.

A total of 121 countries (80 per cent) reported that social and cultural factors in their countries had a constraining influence on addressing HIV/AIDS pandemic. Thirty-two per cent stated that because of cultural constraints, there was a lack of open discussion and dialogue on HIV issues; 28 per cent stated that because of stigma and exclusion of people living HIV/AIDS, it was often difficult to reach those affected; 23 per cent stated that there was a lack of perception of the risk of HIV/AIDS in their countries; 19 per cent felt that traditional social and cultural practices were a hindrance, and 13 per cent cited the low status of women in their countries as an impediment.

F. ADVOCACY, EDUCATION AND BEHAVIOUR CHANGE COMMUNICATION

This chapter focuses on strategies countries have used to create an enabling environment for people to make respon-

> **Ninety-two per cent of countries reported having taken one or more successful advocacy strategies and other measures to promote responsible and healthy reproductive health behaviours.**

sible, healthy and voluntary choices about their sexual and reproductive health. Key actions identified in the Global Survey included efforts to influence the national development agenda to ensure attention to population, reproductive and sexual health, HIV/AIDS and gender issues and to create political commitment for programme and policy changes, resource allocation and programme implementation.

Ninety-two per cent of countries reported having taken one or more successful advocacy strategies and other measures to promote responsible and healthy reproductive health behaviours, especially among high-risk groups (Section 7.1). These measures include advocacy, IEC and behaviour change communication campaigns (68 per cent); activities targeting vulnerable groups of young people, women and men (32 per cent); and media campaigns using radio and television (23 per cent). In many instances, these strategies were complimented by educational efforts such as peer education on reproductive health issues (23 per cent) and the introduction of health education in school curricula (22 per cent).

When asked to describe advocacy strategies specifically related to implementation of the ICPD PoA, countries most commonly reported lobbying for legislative changes and new laws related to the ICPD PoA (60 countries), the establishment of local advocacy bodies (45 countries), and the development of national and regional advocacy strategies (37 countries).

In regard to the expansion of media coverage on reproductive rights and reproductive health issues aimed at attitude and behaviour change, the highest number of countries reported use of electronic media (radio, television and internet) to address reproductive health issues (81 per cent), followed by the use of print-media materials such as newspapers, magazines, posters and fact sheets (59 per cent). Messages were also conveyed through

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creative communication channels such as concerts, street plays, dramas and local seminars (32 per cent) as well as through the celebration of national awareness days (13 per cent). A significant number of countries (30 per cent) mentioned training national and local media practitioners on reproductive health issues.

Emerging information and communication technologies have been increasingly used to increase access to information and provide sensitive information on reproductive health and reproductive rights in a decentralized and interactive manner. A majority of countries reported having set up hotlines on reproductive health issues (59 per cent) or phone-in radio and television talk shows (58 per cent). Many countries also created web sites for individuals to access information on reproductive health-related topics (47 per cent). The establishment of village-level computer centres, reported by 14 per cent of countries, has enabled more people to access information on reproductive health matters, including HIV/AIDS. Communication technologies have also helped disseminate information on reproductive health issues during the course of national awareness days, and have been used to set up management information systems to support reproductive health programmes and the empowerment of women and youth.

Some 45 countries cited policy and funding constraints, programme-related issues and sociocultural factors as challenges to overcome in influencing attitude and behaviour and change. The most commonly reported constraint was limited financial resources (36 per cent). Other constraints included social and cultural attitudes (33 per cent); lack of political will (20 per cent); religious opposition (18 per cent); lack of human resources (18 per cent); lack of monitoring and evaluation mechanisms (13 per cent); lack of coordination between agencies (11 per cent); and lack of equipment and training (7 per cent).

> **Ninety-five per cent of responding countries reported at least one successful effort to strengthen partnerships with civil society organizations in implementing the ICPD PoA.**

G. PARTNERSHIPS AND RESOURCES

This chapter highlights initiatives at the country level to involve civil society and the private sector in carrying out the objectives and actions set forth in the ICPD PoA and *Key Actions*, as well as presents trends in resource mobilization aimed at achieving these goals. Since building partnerships between governments and civil society is also a key strategy and target of the Millennium Development Goals, efforts to achieve the ICPD PoA also contribute to the achievement of the MDGs.

Countries responding to the 2003 Global Survey were asked to describe at least one specific successful effort that had been made to involve civil society in population and reproductive health programmes. They were also asked to report on what mechanisms, if any, they had put in place to coordinate their own efforts in population and reproductive health programmes with those of NGOs and other members of civil society. Ninety-five per cent of responding countries (143 out of 151 countries) reported at least one successful effort to strengthen partnerships with civil society organizations in implementing the ICPD PoA (Section 8.2).

Partnership efforts that involved policy and programmatic measures included: development of population and reproductive health plans and programmes (38 per cent); capacity-building and training in population and reproductive health issues (22 per cent); the establishment of parliamentary caucuses (21 per cent); development of laws and legislation on reproductive rights and reproductive health (13 per cent) and population policy-making (11 per cent). Collaboration on the production of population research and census data was also cited by countries (3 per cent). The most common coordinating mechanisms for partnership efforts were: partnership between national population commissions and NGOs (39 per cent); national

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forums for NGOs (17 per cent); and partnerships between local governments and community-level NGOs (15 per cent).

A regional analysis of the findings demonstrates the cross-cutting prevalence and value of government and NGO partnership efforts on reproductive health and population issues. Partnership efforts were reported by over 90 per cent of responding countries in every region. This marks a notable increase from the 1999 ICPD+5 review, in which 49 of 114 countries (43 per cent) took actions to involve civil society.

One of the most common areas of partnership between governments and civil society is the involvement of NGOs in the design and implementation of population and reproductive health plans and programmes. One of the most commonly cited coordinating mechanism for partnerships in the design of plans and programmes was NGO representation in national population commissions, offices or ministries (39 per cent). In addition to direct representation of NGOs in government advisory bodies, 17 per cent of countries reported that they involve civil society in the formulation of population plans and programmes through national forums and associations for NGOs. Governments also reported involving community-level NGOs in local decision-making bodies (15 per cent).

Countries responding to the Global Survey also reported numerous successful partnership efforts with NGOs in the development of population and reproductive health policies, laws and legislation. Globally, almost one quarter (24 per cent) of responding countries indicated successful partnerships with civil society in the formulation and adoption of national population policies or laws. Many countries also reported partnerships with parliamentarian groups and with UN System partners.

Government partnerships with civil society organizations cover a wide variety of substantive issues. These include, but are not limited to: addressing the special needs of the elderly and internal and international migrants; protecting the rights of girls and women; monitoring human rights; increasing access to quality reproductive health information, services and commodities; reducing maternal morbidity and mortality; preventing HIV/AIDS; and monitoring country-level progress of the ICPD and the MDGs. Countries also reported partnerships with NGOs in IEC and outreach capacity building and training, and in commodity security.

In addition to building partnerships with civil society, governments have been actively increasing their collaboration with the private sector. The private sector can play an important role in such areas as reproductive health commodity security, service delivery, social marketing of contraceptives, and the promotion of reproductive health and reproductive rights for young people, women and other groups.

The 2003 Global Survey asked responding governments to report on what measures they have taken to include the private sector in population and reproductive health activities. Out of 151 countries, 113 (75 per cent) responded that they have taken actions to involve the private sector (Section 8.3). This figure underscores the rapid development of government partnerships with this sector in the last five years, especially when compared with the 1999 survey results, which indicated that only 8 per cent of countries responding had taken significant measures to involve the private sector in population and reproductive health activities.

The most reported partnership efforts with the private sector were: provision of contraceptives and reproductive health services (49 per cent); private sector sponsorship of social marketing campaigns and outreach programmes (47 per cent); private sector sponsorship of IEC and advocacy activities on reproductive health issues (42 per cent); and private sector representation in government coordina-

> **Globally, over 80 per cent of countries reported that available resources did not meet their countries' reproductive health needs.**

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tion bodies for population and reproductive health issues (30 per cent). A number of countries also reported private sector provision of financial assistance for reproductive health activities (12 per cent).

Resource mobilization is an important part of the Cairo agenda. The Global Survey asked governments to report on the level of domestic and international resources available in their countries for population and reproductive health programmes and to assess whether the resources were sufficient to meet their national reproductive health needs. Countries were also asked to report on cost-recovery approaches, absorptive capacity maximization, and other ways to fully utilizing available resources. Major constraints to maximizing available resources were also reported by countries.

Globally, over 80 per cent of countries reported that available resources did not meet their countries' reproductive health needs. They also indicated that their absorptive capacities were often inadequate to maximize the available resources. Despite these trends, 82 per cent of developing and countries in transition reported taking some action to increase domestic resources for population and reproductive health programmes, underscoring their commitment to achieving the ICPD PoA. However, by and large, most countries reported being able to make only incremental increases in funding due to the difficult economic circumstances in many countries.

Amidst these resource shortfalls, many countries are looking for innovative strategies to maximize and increase available resources, including strengthening partnership efforts and implementing cost recovery and cost sharing strategies.

Eighty–four per cent of countries responding to the global survey reported mobilizing international assistance for the implementation of population and reproductive

Several donor countries reported that they are using the MDGs as a basis for the development of programmes and policies that promote the ICPD agenda.

health programmes. Many countries reported efforts to maximize resources through partnerships with international agencies (including members of the United Nations system), development banks, bi-lateral government agreements and donor country development organizations.

The 2003 Global Survey also asked responding countries to report on the constraints they faced in maximizing the impact of available resources for population and reproductive health programmes. Over 67 countries reported constraining factors. The most prevalent constraints were: lack of financial resources (44 countries); lack of human resources and professional training (28 countries); and lack of materials, equipment or facilities (13 countries).

H. DONOR EXPERIENCES

As in the 1998 Global Survey, a separate, shorter questionnaire was prepared for developed countries belonging to the Organization for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC), referred to in this report as "donor countries". The Survey aimed to elicit their views and experiences regarding the implementation of the ICPD Programme of Action (ICPD PoA), including the challenges they have faced and the commitments they have made to further implement the ICPD PoA.

The responses from 18 countries cover: population issues and concerns faced by donor countries since the ICPD, as well as measures they have enacted to address them; actions they have taken relating to gender equality and women's empowerment; measures carried out to increase access to reproductive health services, including those to adopted to reduce the spread of HIV/AIDS; and partnerships between donor countries and civil society organizations, as well as issues related to international assistance, including problems and challenges faced by donor countries in mobilizing resources to support ICPD

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PoA implementation. It also describes how donor countries link ICPD goals with international development frameworks and processes. Several donor countries reported that they are using the MDGs as a basis for the development of programmes and policies that promote the ICPD agenda.

Nearly all donor countries that responded to the Survey (16 out of 18) cited population ageing as an important issue confronting them (Section 9.2). Donor countries recognize that a continuing challenge is the development of effective policies, programmes and strategies to respond to the special needs of the elderly. Since 1994, a number of major initiatives have been taken by donor countries to address this issue. These initiatives include developing policies, strengthening institutions, building capacity in the areas of continuing education and training, supporting research, and carrying out innovative projects, including ones promoting alternative living arrangements.

In regard to international migration, countries responding raised a number of issues and concerns, including the social and economic integration of migrants, family reunification, and issues relating to human trafficking, illegal immigrants, refugees and asylum-seekers (Section 9.2). Several countries mentioned the importance of immigrant integration in the receiving society. Measures that have been adopted include ones aimed at promoting equality of opportunities in access to jobs, housing, health and education, along with other social services and amenities. Also, since the ICPD, a number of donor countries have introduced changes in their family-reunification policies. Developed countries have recently been viewing migration as a response to medium-term labour supply shortfalls. The initiatives have been almost exclusively directed towards highly skilled immigrants, reflecting an increasing demand for skilled labour due to demographic changes and the increasing globalization process.

A major challenge to migration management mentioned by donor countries is the growing trafficking in human beings. Nearly all countries enacted laws and legislation to combat trafficking and many ratified international treaties. Half of responding countries developed programmes specifically to combat trafficking. Many countries examined the root causes of trafficking in order to address the issue more effectively. Fifty per cent of countries that responded to the Survey provided international aid to combat trafficking of women and children, while nearly all provided services to victims.

Although most receiving countries recognize the positive contributions of migration to the economic, social and cultural development of both migrant-receiving and migrant-sending countries, the growing levels of illegal immigration and the continuing flows of refugees and asylum-seekers remain major concerns. Many donor countries realize that more international cooperation is necessary to effectively manage migration.

In the area of gender equality and equity, donor countries reported that efforts have been made since Cairo to protect the rights of girls and women and to promote women's empowerment (Section 9.3). Twelve countries passed new laws and legislation for the protection of the rights of girls and women. These focused on the trafficking and exploitation of women; ensuring gender equality in society (including in education and in parliamentary representation); enforcing gender equality in the workplace (including parental work leave and equal wages); and laws against sexual harassment. Some countries have also established women's commissions or agencies within government structures.

Donor countries also reported that they have national strategies to address gender-based violence. Twelve countries have enacted laws and legislation on this issue, and many donor countries have established institutional mechanisms in their legal and judiciary systems. Almost half of responding countries provided services for victims of GBV. Seven countries are working to raise awareness and provide

> **There appears to be continued momentum for the implementation of the ICPD PoA in donor countries since Cairo.**

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behaviour change communication on GBV and are providing training for service providers and government officials.

Since the ICPD, donor countries have addressed a range of reproductive health issues. Priority issues identified in the 1998 Global Survey were also reported in the 2003 Survey. They include decreasing unwanted or unplanned pregnancies, the need for counselling and services for high-risk groups, and the prevention of HIV/AIDS and other STIs. Ninety-four per cent of donor countries have reported that the quality standards with regard to reproductive health service delivery have improved since the ICPD, especially in the areas of human capacity-building and institutional development.

Donor countries have also continued to address adolescent and youth reproductive health concerns, including adolescent fertility; the increasing incidence of STIs; and substance abuse. Measures taken to address these issues include making contraceptives available free or for a subsidized fee, and providing counselling and youth-friendly reproductive health information and services to adolescents and young people. Donor countries have also increasingly addressed the reproductive health needs of migrants and indigenous populations.

In reference to fighting HIV/AIDS, donor countries described a number of actions that have contributed to a comprehensive response to the pandemic, including the availability of funding for HIV/AIDS research and prevention programmes, access to care and treatment, organized support networks, human rights advances, and the use of new information technologies to raise awareness of HIV/AIDS and disseminate relevant information (Section 9.6). Donor countries have developed national strategies and policies that take into account the need for a multisectoral and comprehensive response. Many countries have also partnered with local authorities, NGOs, medical experts, and international organizations to combat the spread of HIV.

Donor countries targeted high-risk groups through information, education and communication campaigns and service-provision efforts. They also enacted laws and legislation to protect the rights of people with HIV/AIDS. Donor countries have integrated STI counselling and testing, family planning counselling, and antenatal care into HIV/AIDS programmes with the aim of reaching a greater number of people, reducing the stigma associated with HIV/AIDS, and increasing the efficient use of limited health care resources.

It is clear from the country responses to the Global Survey that donor countries, like their developing country partners, are increasingly partnering with civil society organizations to assist in the provision of reproductive health information and services (Section 9.7). Most of the donor countries (15 out of 18) reported that they have active partnerships with NGOs. This demonstrates a significant increase from the 1998 Global Survey responses on partnerships, where approximately half of donor countries indicated significant measures on partnerships. In addition, five countries reported that NGOs are playing more active roles in their partnerships with governments, specifically on reproductive health issues, since implementation of the ICPD PoA.

There appears to be continued momentum for the implementation of the ICPD PoA in donor countries since Cairo (Section 9.8). Nearly all the 18 countries that replied to the Survey have revitalized their reproductive health programmes, including increasing attention to the reproductive health needs of adolescents, young people, migrants and indigenous populations; availability of high-quality and comprehensive reproductive health services; and training of health-care providers. Donor countries, however, continue to be concerned with such emerging issues as: meeting the special needs of older persons; the growing levels of illegal immigration; the trafficking of human beings; and the continuing flows of refugees and asylum-seekers.

IMPLICATIONS

The 2003 Global Survey elicited a vast amount of information on the kinds of activities that countries had undertaken to implement the recommendations of the ICPD PoA and ICPD+5 Key Actions. The findings presented here and in the report chapters demonstrate the nature of progress made, and constraints faced, by countries. The implications of these and other findings for the way forward are presented in Chapter 10.

1 Introduction

The 1994 International Conference on Population and Development (ICPD) articulated a bold new vision about the relationships between population, development and human well-being. According to this vision, efforts to address population and reproductive health issues must play a key role in actions aimed at eradicating poverty and improving the quality of life of all people. The conference, which was held in Cairo, Egypt, also marked a paradigm shift, away from the population control measures and demographic targets promoted by traditional population policies and towards a social revolution centred on individual needs and aspirations and carried out within a human rights framework. At the ICPD, 179 countries agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are central to achieving sustainable development in its economic, social and environmental dimensions. The ICPD adopted a 20-year forward-looking Programme of Action (ICPD PoA) which built on the success of the previous decades while addressing the needs of the early years of the twenty-first century.

The eradication of extreme poverty and hunger cannot be achieved if questions of population and reproductive health are not squarely addressed.

The ICPD PoA recommended a set of interdependent goals and objectives to be attained by 2015.[1] These include: universal access to comprehensive reproductive health services, including family planning and sexual health; reductions in infant, child and maternal mortality; universal access to basic education, especially for girls; and gender equality, equity and women's empowerment.

In 1999, the United Nations General Assembly convened a Special Session (known as the ICPD+5) that examined the progress made in meeting ICPD goals. The review reaffirmed the ICPD PoA, sought to improve monitoring and facilitate the setting of priorities, and underscored the importance of tackling such emerging issues as HIV/AIDS, population ageing and adolescent reproductive health. The ICPD+5 adopted a set of *Key Actions* for the further implementation of the ICPD PoA. The *Key Actions* included a new set of benchmarks in four areas: education and literacy; reproductive health care and unmet need for contraception; maternal mortality reduction; and HIV/AIDS.[2]

Many of the ICPD goals and targets were incorporated into the Millennium Development Goals (MDGs), which were adopted at the Millennium Summit in 2000 (the exception being the goal of universal access to reproductive health services). This is logical, as the MDGs, particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. The attainment of reproductive health and reproductive rights are fundamental for promoting development, fighting poverty and meeting the MDG targets. Conversely, poor reproductive health undermines development in a number of ways, including by diminishing the quality of women's lives; weakening and in extreme cases threatening the lives of poor women in the primes of their lives; and placing heavy burdens on families and their communities.[3]

As the ICPD PoA is reaching its midpoint in 2004, it is fitting that countries take stock of the progress that has been made so far in achieving its goals. A comprehensive review and appraisal of the status of the ICPD PoA implementation, both individually and collectively, is essential to strengthen efforts and to help accelerate its further implementation until the end of the 20-year time frame in 2015. Furthermore, this review assumes greater relevance in the context of the development challenges laid out by the Millennium Declaration, which will undergo a five-year review in 2005.

As mandated in General Assembly resolution 49/128 on the ICPD, UNFPA is expected to assist countries in their review of operational experiences in implement-

ing the ICPD PoA. To that end, UNFPA conducted a Global Survey in 1998 and again in 2003 to appraise national experiences five and 10 years after Cairo. Both surveys focused on developing countries and countries with economies in transition (henceforth referred to as countries in transition), as well as on donor countries. As with the 1998 Global Survey, the 2003 Survey focuses on the operational dimensions of population and reproductive health programmes, assesses the progress countries have made in achieving ICPD goals, and highlights what challenges they still face.

1.1 ICPD AND OTHER UNITED NATIONS GLOBAL CONFERENCES

In the 1990s and more recently in the beginning of the twenty-first century, United Nations global conferences and summits provided a forum for world leaders to reach a global consensus on the interconnected goals and objectives of development. The 2003 Global Survey covers the goals that directly relate to those of the ICPD. For instance, the 1990 World Summit for Children embraced the goal of improving the lives of the world's children and adolescents and increasing respect for their human rights.[4] The ICPD PoA reaffirms this goal through four major areas, namely girls' education, adolescent reproductive health, HIV/AIDS prevention and maternal mortality. Each of these areas is addressed by the Survey.

The Vienna Declaration and Programme of Action adopted by the 1993 World Conference on Human Rights took historic steps to promote and protect the rights of women.[5] The rights to reproductive health, gender equality and freedom from sexual violence, which were all promulgated in the Vienna Declaration, were subsequently reaffirmed by the ICPD, which led to the strengthening of national laws and policies promoting these human rights.

Both the ICPD PoA and the Platform of Action adopted by the 1995 Fourth World Conference on Women in Beijing emphasized the fact that empowering women is not only a justifiable end in itself, but is also an essential component of sustainable development.[6] In Cairo and Beijing, governments agreed to enhance the social, economic and political empowerment of women, to advance their education, and to improve their health, including their reproductive health.

The 1995 Summit for Social Development in Copenhagen reaffirmed the ICPD PoA with a commitment to poverty reduction strategies that would meet basic human needs, reduce economic and social inequalities, and provide sustainable livelihoods.[7] Countries committed themselves to creating an enabling environment for social development and social integration.

The 2001 United Nations General Assembly Special Session on HIV/AIDS reaffirmed commitments previously made in the ICPD PoA and emphasized the central importance of gender equality to HIV prevention, care and treatment. The Special Session's Declaration of Commitment on HIV/AIDS established time-bound targets to which governments and the United Nations have committed to achieve.[8]

Most recently, the 2002 World Summit on Sustainable Development in Johannesburg, a follow-up to the 1992 United Nations Conference on Environment and Development held in Rio de Janeiro, reaffirmed the commitments made at the ICPD and other global conferences. The Summit Declaration validated the linkage between health care and human rights. The Plan of Implementation endorses strategic components of the ICPD. Among these components are access to family planning information and services, safe motherhood, the prevention of sexually transmitted infections (STIs), including HIV/AIDS, and the elimination of sexual coercion and violence against women.[9]

United Nations conferences deliberately linked themes and action plans in the last decade, creating a movement that led up to the Millennium Summit. These global conferences and world summits fuelled the momentum of the ICPD process and will continue to shape the development agenda for the next 15 years.

1.2 LINKING ICPD WITH THE MILLENNIUM DEVELOPMENT GOALS

A global consensus emerged at the Millennium Summit, where 189 world leaders adopted the Millennium Declaration that sets out a number of interconnected goals to create an environment conducive to development. The MDGs are not conceived of as a comprehensive end in themselves, but rather as a tool for achieving lasting sustainable development and poverty eradication.

Many of the goals contained in the ICPD PoA and the ICPD+5 *Key Actions* parallel those of the MDGs (Table 1.1). The ICPD PoA's focus on population-related efforts, such as increasing access to reproductive health services, promoting gender equality, and nurturing a better understanding of the linkages between population dynamics and poverty, are prerequisites to the achieve-

Table 1.1 ICPD Goals and Millenium Development Goals and Targets

ICPD Goals and Objectives	Millennium Development Goals and Targets
. . . raise the quality of life through population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in context of sustainable development . . . [para. 3.16]	**Goal 1: Eradicate extreme poverty and hunger** Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger
. . . countries should further strive to ensure complete access to primary school or equivalent level of education by girls and boys as quickly as possible, and in any case before 2015 [para. 11.6]	**Goal 2: Achieve universal primary education** Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes [Principle 4]	**Goal 3: Promote gender equality and empower women** Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015
By 2015, countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000 [para. 8.16]	**Goal 4: Reduce child mortality** Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Countries should strive to effect significant reductions in maternal mortality by 2015: reductions by one half of 1990 levels by 2000 and further one half by 2015 . . . [para. 8.21]	**Goal 5: Improve maternal health** Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
. . . by 2005, ensure at least 90 per cent, and by 2010 at least 95 per cent, of 15-24 age group has access to IEC and services to develop life skills required to reduce their vulnerability to HIV infection; that by 2005 prevalence is reduced globally, and by 25 per cent in the most-affected countries [ICPD+5 para. 70]	**Goal 6: Combat HIV/AIDS, malaria and other diseases** Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases
. . . population issues should be integrated into formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development [para. 3.5]	**Goal 7: Ensure environmental sustainability** Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers
. . . strengthen the partnership between governments, international organizations and the private sector in identifying new areas of cooperation [para. 15.15a]	**Goal 8: Develop a global partnership for development** Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system (Includes a commitment to good governance, development and poverty reduction — both nationally and internationally) Target 13: Address the special needs of the least-developed countries (Includes: tariff- and quota-free access for least-developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries and cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction) Target 14: Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly) Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth Target 17: In cooperation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

ment of the larger development goals of the MDGs, such as eradicating poverty and hunger.

Both the ICPD PoA and MDGs set targets for providing universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health and combating HIV/AIDS and other diseases. The ICPD PoA also supports the MDGs' focus on ensuring environmental sustainability by recognizing the linkages between the environment and internal and international migration, population growth rates, and resource consumption.

While the MDGs do not contain any specific goal or target on reproductive health, they do contain targets related to components of reproductive health, including maternal health and HIV/AIDS. Indicators for maternal health include the maternal mortality ratio and the proportion of births attended by skilled health personnel. For HIV/AIDS, the indicators are the HIV prevalence rate among pregnant women aged 15 to 24, and the rate of condom use.

1.3 OBJECTIVES OF THE REPORT

This report, from an operational perspective, aims to: (a) describe the progress that has been made, and the constraints that have been encountered, by countries in their efforts to implement specific actions of the ICPD PoA and to examine the specific issues that have been encountered; (b) presents measures taken, with some regional highlights and (c) summarize the major conclusions arising from the 2003 Global Survey and to assess the way forward.

More specifically, the 2003 Global Survey report highlights the various actions and measures that have been taken by countries to implement various selected aspects of the ICPD PoA. The report also provides an analysis the contextual environment within which these actions and measures have been taken, and presents an overview of the progress made and actions required to strengthen the further implementation of the ICPD PoA.

1.4 GLOBAL SURVEY METHODOLOGY

The aim of the 2003 Global Survey was to document the implementation of the ICPD PoA over the last 10 years, with due emphasis on achievements and success stories, as well as on constraints and difficulties faced in implementation. The questionnaires elicited information on the implementation of selected aspects of the

ICPD PoA. Such information included actions, measures or initiatives countries have taken to address particular issues or concerns as well as obstacles that were encountered.

Two types of questionnaires were sent to a total of 187 countries. One questionnaire was sent to 165 developing countries and countries in transition, and a shorter one was sent to 22 developed countries belonging to the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC), referred to in the present report as "donor countries".

The questionnaire for developing countries and countries in transition consisted of 47 questions, structured as well as open-ended, on nine topics: population and development; gender equality, equity and women's empowerment; reproductive rights and reproductive health; adolescent youth; HIV/AIDS; behaviour change and advocacy; data and research; partnerships and resources; and best practices and emerging issues.

The questionnaire for donor countries consisted of 23 questions on five topics: population concerns; gender issues; reproductive health (including HIV/AIDS); partnerships with civil society; and international assistance to population and reproductive health programmes. The questions were designed to elicit information on the challenges faced by donor countries in mobilizing resources to support implementation of the ICPD PoA and on how the countries link ICPD goals with international development frameworks and processes.

The questionnaires for developing countries and countries in transition were sent out through the UNFPA or UNDP Country Offices at the beginning of January 2003, and the completed questionnaires were received by UNFPA New York by April 2003. The questionnaire for donor countries were sent out in March 2003 through the Missions to the United Nations in New York and returned by August 2003. The questionnaire for each country was to be completed by a national multi-stakeholder group under the appropriate coordinating government institution, consisting of government, non-governmental organizations (NGOs), academia, UNFPA Country Office staff and other pertinent stakeholders who were familiar with the progress that had been made as well as the constraints that were faced.

The data from the questionnaires were manually coded and processed using the Statistical Package for Social Sciences (SPSS version 11.5). The open-ended

questions were coded using a limited number of fields that captured the main answers given to particular questions. The information entered was cross-checked to ensure accuracy in terms of consistency and coverage. The tabulations were produced using routines of SPSS.

1.5 STRENGTHS AND LIMITATIONS OF THE REPORT

An overall response rate of 92 per cent was achieved for developing and countries in transition, a figure higher than the 1998 Global Survey response rate of 82 per cent. The rates varied from region to region, ranging from 75 per cent for the Arab States to 100 per cent for Latin American and the Caribbean, sub-Saharan Africa and Central Asian Republics. For donor countries, the response rate for 1998 and 2003 was the same at 82 per cent. The list of countries that responded to the 2003 Global Survey is presented in Annex 1, following UNFPA regional groupings.

It is important to note, however, that the 2003 Global Survey is not an assessment or evaluation of programmatic or policy interventions in the countries. It does not provide any information on the very detailed nature of the measures adopted, problems with their specific implementation or their experience with that particular measure. Also, given the thrust of the Survey on measures adopted to implement the ICPD PoA and at the same time to remain brief, countries were asked to highlight key measures, successful strategies, major actions and the like. In order to stay faithful to the questions asked, the titles of the corresponding tables in the chapters are different and not uniform.

The formats of presentation followed in the report for presenting the substantive findings of the 2003 Global Survey require some explanation. There was a high degree of commonality in the approaches and measures taken by countries to implement the various recommendations related to population and development, gender, advocacy and behavioral communication, and partnerships. By contrast, the types of measures taken in the areas of reproductive health, HIV/AIDS and adolescent reproductive health were more varied and tend to be very specific to countries and sometimes even to communities within countries. Given this inherent diversity in the responses of the Survey, the format of presentation followed has not been totally identical in every chapter, with more extensive illustrations being given of country-specific measures in some chapters than in others.

Although the high rate of response reflects the high degree of importance attached by countries to the review of ICPD PoA implementation efforts, the 2003 Global Survey itself was subject to a number of limitations.

First, although countries were asked to mobilize a multi-stakeholder group to complete the questionnaire, countries adopted different approaches. These approaches ranged from allowing one focal individual to respond to the questionnaire to having an inter-institutional/multisectoral response committee or group. Depending on the approach taken, the responses to each question may vary from rich and informed to general and less informed.

Second, in a few cases, the responses to the questionnaire reflected the government's views, which may differ from those of NGOs and of civil society.

Third, the Survey was rather ambitious in its coverage of thematic areas, but limited in terms of the battery of questions used to elicit detailed information on critical dimensions of programmatic measures and their implementation. This limitation imposed a restriction on the type of analysis that could be made of the responses.

Fourth, many questions were not specific enough to reliably elicit information on details with regard to strategies, policies, plans or legislation adopted by countries. Most countries provided information on whether or not they had adopted any of those measures, but fewer countries gave specific details of measures adopted. This constraint handicapped efforts to comment on the nature of progress countries have made in implementing specific recommendations of the ICPD PoA and to identify existing gaps in programmatic interventions related to the thematic areas covered in the Survey.

Fifth, given the open-ended nature of many of the questions, the coding of responses was rather difficult. With a view to making coding simple, only a few categories of codes (generally not to exceed 10) were identified. This constrained the nature of analysis that could be undertaken on some issues.

Sixth, the largely open-ended questionnaire used in the Survey led to unevenness in the quality of responses.

Seventh, some countries may have inadvertently underreported the actions or measures they have taken by failing to include these efforts in more than one

response. In cases where the actions and measures were relevant to more than one question in the Survey, the responses should have reflected that fact but did not always do so.

Eighth, ten years is a long period in which to recall and measure all changes stemming from the ICPD PoA. Hence, only the changes most salient and maybe more recent to the respondents have likely been reported.

Finally, the Survey did not focus on the quality, reach or impact of programmatic interventions and their effects on the lives of vulnerable groups and individuals, especially those in need of information and services.

1.6 ORGANIZATION OF THE REPORT

The report is organized into ten chapters. This introductory chapter is followed by seven thematic chapters presenting the results from the Survey for developing countries and countries in transition on: population and development; gender equality; equity and empowerment of women; reproductive rights and reproductive health; adolescent reproductive health and youth; HIV/AIDS; advocacy, education and behaviour change communication; and partnerships and resources. The ninth chapter focuses on donor countries, and the final chapter summarizes the main conclusions pertaining to both developing and donor countries, drawing attention to actions required for the way forward to make the promise of Cairo a reality.

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2 Population and Development

2.1 INTRODUCTION

This chapter provides a broad overview of the changes that have taken place in population and development strategies since 1994. It views these changes within the context of the demographic, social, economic and health-related shifts of the 1994-2003 decade, and it considers the results within the framework of the objectives and actions proposed in the International Conference on Population and Development Programme of Action (ICPD PoA) and the ICPD+5 *Key Actions*.

The areas covered here are based on the relevant questions posed by the 2003 Global Survey. These areas include: actions taken to integrate population concerns into development strategies; the incorporation of population factors into local subnational planning in the context of decentralization; the inclusion of population in national poverty reduction strategies; and the incorporation of population and environment linkages into national and/or sectoral development plans. They also include initiatives taken to address the special needs of the elderly; measures adopted to influence internal migration; actions taken to influence international migration; and efforts made to strengthen data, research, monitoring and evaluation in population and reproductive health programmes. The chapter concludes with a discussion of the challenges that have been met and that must be faced in the future.

The demographic and other changes that took place from 1994-2003 affected the degree of programmatic progress that was achieved by the year 2003 and vice-versa. Likewise, the anticipated trends in socioeconomic, demographic and other situations in countries can be expected to influence the pace and extent of the changes that will be needed in policies and programmes if the goals of the ICPD are to be realized during the decade of 2005-2015.

According to the United Nations, the total population of the world, which stood at 5.7 billion in 1995, has grown to 6.4 billion in 2004, and is expected to become 7.2 billion by 2015.[1] Almost all of the increase during 1995-2003 occurred in developing countries, which is also where most of the projected increases during 2003-2015 are expected to occur. While the annual rate of population growth has declined and is expected to further decline in the next decade in all major regions of the world, the increment to the world population is expected to remain at over 70 million persons per year over the next two decades, due to the large sizes of current populations and the youthfulness of populations in developing and least-developed countries.

A quick examination of demographic trends indicates that the level of fertility is declining, as is the rate of infant mortality. Moreover, the contraceptive prevalence rate is increasing, and the level of life expectancy at birth is increasing in all regions. Many developing countries are also experiencing unprecedented increases in the number of elderly persons and unprecedented increases in the number of young people. A good number of countries are also facing the complex issues of internal and international migration, internally displaced persons (IDPs), international trafficking in women and children, and influxes of refugees. In addition, many countries continue to experience high levels of maternal mortality, and some are even experiencing increases in adult mortality due to the AIDS pandemic. Clearly, there is a growing demographic diversity reflecting national differences in social, gender and health situations as well as the divergent paces at which countries experienced their demographic transitions.

The ICPD PoA underscores the fact that integrating population concerns into economic and development strategies can speed up the pace of sustainable development and of poverty alleviation efforts, contributing to the achievement of population objectives and to an improved quality of life for all. The ICPD PoA promotes the full integration of population concerns into development strategies, development planning, decision-making and resource allocation. It promotes development at all levels and in all regions, with the goal of meeting the needs, and improving the quality of life, of present and future generations. The ICPD PoA also endorses

integration as a means of promoting social justice and eradicating poverty through sustained economic growth in the context of sustainable development. The *Key Actions* reaffirmed the importance of such actions, and called for an intensification of efforts.

A number of actions were proposed by the ICPD PoA. First, at the international, regional, national and local levels, population issues should be integrated into the formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development. Second, development strategies should reflect the short-, medium-, and long-term implications of, and consequences for, population dynamics, as well as patterns of production and consumption. Consequently, the 2003 Global Survey solicited information on actions taken to integrate populations concerns into selected aspects of the development process, including development strategies; decentralized planning; poverty reduction strategies; and environmental planning.

2.2 ACTIONS TAKEN TO INTEGRATE POPULATION CONCERNS INTO DEVELOPMENT STRATEGIES

Out of 151 countries canvassed in the Survey, 149 (99 per cent) provided responses to the question on integrating population concerns into development strategies, and 146 (96 per cent) had taken some action. Among them, 115 countries, or 79 per cent, had adopted multiple measures. The high percentage (96 per cent) of countries taking some action represents a marked improvement from the time of the ICPD+5 review, when 78 per cent of countries had taken or were about to take some action. In contrast, only 52 per cent of developing countries at the time of the ICPD in 1994 had reported taking comparable action. Overall, this represents significant progress.

Data on specific, multiple measures taken by countries to integrate population into development, presented in Table 2.1, indicate that 91 per cent of the countries that responded to the question had included population in the formulation of development plans and/or strategies. The other measures taken included: integrating population factors into the formulation and/or modification of policies (61 per cent); specifically using population data in planning (25 per cent); including population factors in laws and legislation (15 per cent); and incorporating population into the formulation of advocacy efforts and information, education and communication (IEC)

Table 2.1 Measures Taken by Countries to Integrate Population in Development

Measures Taken	Number and Percentage of Countries	
	No.	%*
Formulation of plans and/or strategies	133	91
Initiation and/or modification of policies	89	61
Utilization of population data in planning	36	25
Laws/legislation	22	15
IEC/advocacy	14	10
Total	**146**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

activities (10 per cent). A smaller number of countries have stated that they have incorporated population concerns into special programmes, including ones focusing on gender, HIV/AIDS, children, and adolescents and youth. However, most of those countries did not provide details on the measures taken.

Regional differences in the proportionate use of these measures show that integrating population into development plans and/or strategies is the highest (at 100 per cent) among the Arab States. The percentage of countries using the initiation or modification of policies as an entry point to integrate population is the highest in sub-Saharan Africa (at 71 per cent). The strategy of using data in the planning process has been most popular in the Caribbean subregion, where it was adopted by around 54 per cent of counties.

2.3 POPULATION AND PLANNING IN THE CONTEXT OF DECENTRALIZATION

Many developing countries have embraced the concept of decentralization, in which power is devolved to the subnational and/or local levels. In parallel with this process, there have also been efforts in many countries to decentralize development planning, programme development and service provision to subnational and other levels, both to promote the involvement of local beneficiaries and to better reflect the needs of local people. To facilitate the creation of an enabling environment for local development, including the provision of services, the ICPD PoA recommended that governments consider

decentralizing their administrative systems. Among the recommended measures was giving responsibility for revenue-raising and expenditure to regional, district and local authorities. The Survey obtained information on whether and how population factors were taken into account in local-level planning within the framework of decentralization of local government. Out of 151 countries, 145 (96 per cent) answered the question, and 119 (79 per cent) responded that they had taken action in this regard. This represents notable progress since 1994, when decentralization was a relatively new and still-evolving process.

Table 2.2 presents data on different measures taken by countries to take account of population factors in development in the context of decentralization. Sixty-two countries (52 per cent) established local governance structure, while 60 countries (50 per cent) integrated population factors into local social plans. Forty-seven countries (39 per cent) integrated population factors into local economic plans, and eleven countries (9 per cent) integrated them into local environment plans. These measures were supported by a number of activities, including ones that sensitized members of parliament and local leaders on population and development linkages; trained district planning officers on the integration of population into development; and encouraged and supported local administrative and planning organs to collect, analyse and utilize population and socio-economic data in development planning.

Regional variations in the percentage of countries adopting these measures indicate that integrating population factors into local social plans was universal

in the Central Asian Republics. Establishing local administrative structures was the most common measure in sub-Saharan Africa, the Arab States, the Caribbean and the Pacific, where 50 per cent of countries reported doing so. About half the number of countries in the regions of Asia, the Central Asian Republics and Latin America reported adopting the strategy of integrating population factors into local economic plans.

Clearly, progress has been made in the area of integrating population factors into local development plans and local structures in the context of decentralization. Now that the foundation has been established, it is crucial that the institutional and human-resource capacity of these structures be strengthened. At the same, countries that have not yet initiated population integration in the context of decentralization should be encouraged to do so. Only then will local communities and states be empowered to assume greater control and responsibility for their socio-economic development priorities and programmes.

2.4 POPULATION IN NATIONAL POVERTY REDUCTION STRATEGIES

The ICPD PoA states that widespread poverty remains the major challenge to development efforts. Poverty is related to unemployment, malnutrition, illiteracy, the low status of women, exposure to environmental risks and limited access to social and health services, including reproductive health and family planning. Poverty also contributes to high fertility, morbidity and mortality; low economic productivity; inappropriate spatial distribution of population; unsustainable use and inequitable distribution of such natural resources as land and water; and serious environmental degradation. Consequently, the international community and governments committed themselves in the ICPD PoA to "raise the quality of life for all people through appropriate population and development policies and programmes aimed at achieving poverty eradication, and sustained economic growth in the context of sustainable development".[2]

The persistence of poverty amid plenty has been a global challenge. Poverty, both in terms of income and social deprivation, continues to prevail in all regions of the developing world. According to the World Bank, about half the world's population lives on less than $2 a day, and about 1.2 billion people — a fifth of the world —

Table 2.2 **Measures Taken by Countries to Address Population Integration in the Context of Decentralization**

Measures Taken	Number and Percentage of Countries	
	No.	%*
Establishment of local structures	62	52
Integration into local social plans	60	50
Integration into local economic plans	47	39
Integration into local environmental plans	11	9
Total	**119**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

live on less than $1 a day.[3] During the last decades, poverty trends have varied in different parts of the world. In East Asia, the number of people living on less than $1 a day has been reduced by a third, but in Latin America, South Asia and sub-Saharan Africa, the number of poor people has been rising. In the Commonwealth of Independent States (CIS) countries and Central Asian Republics, the number of people living on less than $1 a day rose more than twenty-fold. In terms of non-income measures of poverty, there is a growing diversity much like the demographic diversity noted earlier.

The ICPD PoA underscores the need to give priority to poverty eradication, and the *Key Actions* asks governments to 1) ensure that poverty eradication programmes are targeted particularly at females, especially female-headed households; 2) develop innovative ways to provide more effective assistance to strengthen families in extreme poverty, such as providing microcredit for poor families and individuals; and 3) undertake policies and programmes that seek to ensure a level of consumption that meets the basic needs of the poor and disadvantaged. Given the potential linkages between population and poverty factors, the Survey elicited information on actions taken by countries to take account of those linkages in formulating poverty-reduction strategies.

Of 151 countries, 136 indicated that they had taken into account population-poverty interactions in some way, but only 71 countries, or 52 per cent, had taken multiple measures regarding the interactions. Yet this is a notable change from 1994, when only 13 per cent of developing countries reported action on this issue.

It should be noted that there has been significant progress regarding the handling of population-poverty linkages through various measures, including policy dialogue. The specific strategies adopted by countries in addressing the interactions presented in Table 2.3 have been diverse. They include the adoption of broad population and development measures in 115 countries (85 per cent); the establishment of special strategies for migrants, refugees, internally displaced persons and other vulnerable groups in 41 countries (30 per cent); and the instituting of measures and strategies for income generation and women's empowerment in 26 countries (19 per cent). In 14 per cent of the countries, strategies were formulated to lower the level of fertility. The same percentage of countries adopted strategies to reduce the rate of population growth. While the majority of countries did not provide details

on the types of priority measures or priority activities being implemented, many of them are targeting vulnerable groups.

The regional variations in specific measures taken to address population and poverty linkages show that all the countries of the Caribbean and all Central Asian Republics and 94 per cent of Latin American countries have adopted plans and strategies on population and development as entry points to take account of the linkages. Furthermore, over 40 per cent of countries in Asia, Central Asian Republics and Latin America and the Caribbean have reported adopting strategies on migrants, internally displaced persons and other vulnerable groups to address population-poverty linkages. Finally, the percentage of countries adopting strategies to empower women (and at the same time gaining entry points for addressing population-poverty linkages) is the highest for Arab States at 31 per cent.

Box 2.1 contains some examples of innovative approaches adopted by countries to address population factors in poverty reduction strategies.

Although the overall aggregate percentage of countries reporting actions aimed at addressing the linkages between population and poverty is rather high, this finding should be interpreted with caution. Many countries responding positively to the question may have done so because they had adopted either a population policy/programme or a poverty-reduction strategy or programme. Most developing countries have taken some

Table 2.3 **Measures Taken by Countries to Address Population in Poverty Reduction Strategies**

Measures Taken	Number and Percentage of Countries	
	No.	%*
Formulation of plans and/or strategies	115	85
Strategies on migration & vulnerable groups	41	30
Strategies on women's empowerment	26	19
Strategies to lower fertility	19	14
Strategies to lower growth rate	19	14
Total	**136**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

BOX 2.1 POPULATION AND POVERTY LINKAGES

The Millennium Development Goals recognize that poverty is not merely a matter of income; it also involves such factors as opportunity, choice and human dignity. Escaping poverty is not a purely individual achievement. It depends on the support of institutions — the family, the State, civil society, the private sector and the local community. It also depends on the political, economic and social milieus these institutions create, and on the support and opportunities they provide. The World Summit on Sustainable Development pointed out that environmental factors are also linked to poverty. Indeed, in many respects, the MDGs and the WSSD reinforced the aspirations regarding poverty expressed by the international community in the ICPD PoA and later reaffirmed in the *Key Actions*. The following are examples of some of the successful efforts made by countries to address population and poverty issues.

In **Tanzania**, the Government is undertaking a number of policy initiatives with the goals of reducing the number of people living in poverty by 50 per cent by 2010; eliminating poverty by 2025; and addressing population and reproductive health concerns as well as poverty's negative impacts on education, water, sanitation, agriculture, the environment and vulnerable population groups.

In **Cuba**, access to basic services, including ones focusing on education, housing and sexual and reproductive health, is considered a basic human right. By offering such services to people regardless of sex, age or socio-economic status, Cuba has enhanced the quality of life of its population. Life expectancy levels for both females and males are high, for example, and maternal mortality levels are low.

In **Jamaica**, the Government has set its priorities as follows: 1) eliminating poverty-related conditions (physical, social and economic) in the most deprived communities; 2) targeting interventions at specific groups, such as unemployed youth, low-income families with children, and the elderly poor; and 3) setting up social safety net/income transfer programmes, emphasizing a shift from a welfare approach to one focusing on development.

In **Armenia**, the Government addresses population and poverty issues by focusing its Poverty Reduction Strategy Paper on improving reproductive health, regulating migratory processes, providing social support to young couples, improving general health, and providing targeted social assistance to vulnerable groups, including IDPs and refugees.

In **Bangladesh**, the Government's poverty-reduction strategy visualizes that, by the year 2015, the nation will achieve the following goals: 1) reducing the level of poverty by eradicating hunger, chronic food insecurity, and extreme destitution; 2) reducing the number of people living below the poverty line by 50 per cent; 3) attaining universal primary education for all girls and boys of primary school age; 4) eliminating gender disparity in primary and secondary education; 5) reducing infant and under-five mortality by 65 per cent and eliminating gender disparity in child mortality; 6) reducing the proportion of malnourished children under the age of five by 50 per cent; 7) reducing maternal mortality by 75 per cent; 8) ensuring access to reproductive health services for all; 9) reducing/eliminating social violence against the poor and against disadvantaged groups, especially violence against women and children; and 10) ensuring comprehensive disaster risk management, environmental sustainability and the mainstreaming of these concerns into the national development process.

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action on either of these two fronts in the past decade, so it follows that the reported percentages would be relatively high. It does not unequivocally mean that the mutual linkages between population and poverty have been taken into account in policy dialogue or programme design.

An in-depth analysis of countries that had adopted measures to address population-poverty linkages shows that the "action rate with multiple measures" (the percentage of countries adopting two or more measures) was closely related to the level of poverty in the countries. For example, among those countries for which data on both the level of poverty and multiple measures taken were available, the action rate was 54 per cent among countries with a poverty rate of less than 20 per cent. It was 59 per cent among those with a 20-40

per cent poverty rate, and 67 per cent among the group with the highest level (over 40 per cent) of poverty. There was no significant difference in action rates by groups of differing annual rates of population growth. However, when both the level of poverty and the annual rate of population growth were jointly considered, the countries with both the highest level of poverty (over 40 per cent) and higher population growth rate (≥ 1.47 per cent) had a higher action rate (65 per cent), as compared to 40 per cent for countries with lowest levels of poverty (< 20 per cent) and lower population growth rate (< 1.47 per cent). These findings illustrate that national action is given higher priority in those countries facing the dual challenges of population growth and poverty.

Many countries have reported on constraints in taking measures to take account of population and poverty

linkages in development strategies. The response of Nigeria, which mentions its poverty reduction strategy paper (PRSP), is illuminating, and may be indicative of the situation in other countries as well. According to the response, "Population factors were recognized in the development of [the] PRSP and the National Poverty Eradication Programme (NAPEP). However, population and development factors are not sufficiently main-streamed into the strategies." Indeed, an in-depth analysis undertaken by UNFPA of many PRSPs showed that, while the number of countries taking account of population, gender and reproductive health in poverty strategies is progressively growing, the percentage of countries taking satisfactory action remains under 50 per cent.[4] Perhaps there is still a lack of proper under-standing regarding measuring linkages, incorporating them into poverty strategies, and promoting effective policy dialogue on the issue. In this context, the need for appropriate methodologies, trained specialists and collaborative planning assumes even greater importance.

2.5 POPULATION AND ENVIRONMENT INTERACTIONS

The outcomes of the World Summit on Sustainable Development (WSSD) further emphasized the need to consider linkages between population, the environment and sustainable development, linkages that had also been spotlighted by the ICPD PoA. Consistent with Agenda 21, the Rio Declaration on Environment and Development, the ICPD PoA set a number of objectives for governments to address population and environment interactions. These objectives aimed to ensure that factors related to population, the environment and the eradication of poverty were integrated into sustainable development policies, plans and programmes. They also aimed to reduce unsustainable consumption and production patterns, with a view towards reducing the negative impacts of demographic factors on the environ-ment in order to meet the needs of current generations without compromising the ability of future generations to meet their own needs. The ICPD PoA emphasized the need to "integrate demographic factors into environment impact assessments and other planning and decision-making processes, aimed at achieving sustainable development".[5] In the *Key Actions*, the need for such measures was reaffirmed.

The Survey thus elicited information on the extent to which countries had taken population and environmental

interactions into account in national and/or sectoral development plans. Globally, 145 (96 per cent) out of 151 countries answered this question, and 133 (88 per cent) gave a positive response. Among them, 66 countries (50 per cent) had adopted multiple measures to take account of the interactions. This is a major development, consid-ering that in 1994, most countries did not report having explicitly taken environmental issues into account when developing their population programmes. Similarly, they did not take population factors into account when devel-oping environmental programmes

An analysis of responses provided by 133 countries on the kinds of measures they had taken to address population and environment issues is presented in Table 2.4. Essentially, countries have reported adopting one or more of the following measures: the formulation of plans and/or strategies to take account of population and environment linkages (122 countries, or 92 per cent), followed by the creation of policies on population and the environment (40 countries, or 30 per cent) and the adoption of laws and legislation on population and the environment (22 countries, or 17 per cent). Although only a few countries gave detailed answers, it can be observed that their plans, programmes and strategies focused on the population-environment nexus. The countries' actions acknowledged the linkages between high population growth rates and deforestation, deserti-fication, health and environmental conservation, for example, as well as the relationship between popula-tion, available resources and possible threats to sustainable development. The countries also reported the adoption of policies incorporating issues related to population, gender and the environment into laws and

legislation covering environmental management and protection (including the safeguarding of forests, land and water).

Regional variations in the percentage of countries reporting adoption of these three specific measures indicate that plans and/or strategies have been used as the framework for incorporating population and environment linkages in all countries (100 per cent) of the Pacific and of the Caribbean subregion. By contrast, 40 per cent of countries in the sub-Saharan Africa region and in the Central Asian Republics had adopted policies on population and environment to take account of the linkages. Finally, laws and legislation have been used as entry points for incorporating the linkages in over one third of countries in Asia and in Latin America.

A further analysis was made of the responses to examine what role, if any, socio-demographic contextual factors played in the actions taken by countries. The findings of this analysis highlight the effects of poverty level and the population growth rate on government action. For example, countries with a higher level of poverty or a higher population growth rate were more likely to have adopted at least two specific measures to address population and environment linkages. The joint effect of a high poverty level and rapid population growth was more significant: only 33 per cent of countries with lower levels of poverty (< 20 per cent) and lower levels of population growth rate (< 1.47 per cent) had adopted multiple measures, and the corresponding rate for the high poverty and high population growth group of countries was around 60 per cent. It thus implies that national action is given higher priority in those countries most affected.

Box 2.2 presents some country examples of approaches adopted by countries in dealing with population-environment linkages.

2.6 MEASURES TO ADDRESS THE SPECIAL NEEDS OF THE ELDERLY

One of the important demographic changes that will characterize the early decades of this century will be the acceleration in ageing of human populations. Population ageing is occurring because of past declines in fertility and mortality. Currently, around 650 million persons, or one in every ten persons in the world, is aged 60 or over. While the proportion of the elderly in developed countries is presently around 20 per cent and will reach almost 33 per cent by 2050, the corre-

sponding proportion for developing countries is only around 8 per cent now and is projected to be around 20 per cent by 2050. However, the projected growth in the absolute number of older persons in developing countries is astounding. The number, which is around 415 million today, is expected to reach 1.514 billion by 2050. In contrast, in developed countries, the number of older persons will increase from 240 million to 394 million. Given that the social and economic aspects of addressing the population ageing issue in the developing countries are often even more complex than those related to high fertility or the population growth rate, the ICPD PoA and the World Assembly on Ageing in 2002 understandably underscored the urgency of addressing population ageing as a policy issue.[6]

In the ICPD PoA, governments set a number of objectives related to the welfare of the elderly. These goals aimed to foster self-reliance and enhance the quality of life for the elderly; to improve their access to reproductive health and social security services; and to develop a social support system that will facilitate the ability of families to take care of elderly people within the family. The proposed actions include: 1) taking into account the increasing number and proportions of elderly people in the population in medium- and long-term socio-economic planning; 2) enhancing the self-reliance of elderly people to facilitate their continued participation in society; and 3) strengthening formal and informal support systems and safety nets for elderly people and eliminating all forms of violence and discrimination against them, paying special attention to the needs of elderly women. The *Key Actions* reinforced the recommendations of the ICPD PoA and took note of the impact of HIV/AIDS on the elderly.

The Survey elicited information on actions taken by countries to address population ageing as both a long-term policy or planning issue and an immediate challenge involving meeting the special needs of older persons. In all, 140 (93 per cent) of the 151 countries responded to the relevant question, and 133 among them reported having taken some action. Major actions had been taken in 58 countries, representing 39 per cent. Additionally, a large number of countries had taken some minor action. In 1994, only 21 per cent of countries had reported taking any action. This clearly illustrates that important progress was made during the 1994-2004 period. While only 39 per cent of all countries reported major action on this issue, the regional differences were

quite significant. The "action rate" was the highest for the Latin America and the Caribbean region (60 per cent), followed by around 50 per cent for Asia and the Pacific, the Arab States, the Central Asian Republics and CIS, Eastern and Central Europe. The rate was lowest in sub-Saharan Africa (26 per cent).

These differences are similar to the demographic prevalence of population ageing by regions. A further analysis of responses for developing countries indicates that those with higher levels of population ageing (≥ 7 per cent — average for all developing countries) were almost twice as likely to have adopted major initiatives (58 per cent) than those with lower levels of ageing (30 per cent). This implies that national action is given higher priority in those countries most challenged.

Data on the number of countries reporting on the various measures taken to address population ageing is presented in Table 2.5. The formulation of plans and/or strategies was reported by 93 countries (70 per cent), while the provision of minimum living standards for the elderly was reported by 50 countries (38 per cent). Forty-four countries, or 33 per cent, either drafted or have implemented specific policies on population ageing, and 25 countries, or 19 per cent, carried out data collection focused on meeting the needs of the elderly. Twenty-two countries, or 17 per cent, supported civil society action, while 21 countries, or 16 per cent, adopted laws/legislation on the elderly. It is clear from the table that the various measures take into account both the long-term and short-term implications of population

Table 2.5 Measures Taken by Countries to Address Population Ageing

Measures Taken	Number and Percentage of Countries	
	No.	%*
Formulation of plans and/or strategies on ageing	93	70
Provision of minimum living standards	50	38
Policies on ageing either adopted /or being implemented	44	33
Data collection focused on elderly	25	19
Civil society action	22	17
Adoption of laws/legislation on elderly	21	16
Total	**133**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

BOX 2.3   **POPULATION AGEING AND THE ELDERLY**

The 1982 World Assembly on Ageing, the ICPD PoA, and the 1992 Second World Assembly on Ageing have all underscored the signifiance of population ageing and the importance of addressing the needs of the elderly. Developing countries, where ageing is an emerging issue, have adopted or are beginning to adopt a number of measures to address population ageing and to meet the needs of the elderly. Some of the best practices are:

In **Seychelles**, it has been the Government's policy since 1979 to address the needs of the elderly via a universal pension scheme for persons aged 63 years and older. Starting in 1997, a home care service provision programme has been available to help meet the needs of elderly people whose families are unable to assist them due to economic limitations. The Government is also providing home-care assistance through the Ministry of Social Affairs and Employment and is providing houses for the elderly who have no immediate family support. And finally, the Government is setting up a Council for the Elderly to provide information related to ageing and to provide support for the elderly.

In **India**, a comprehensive National Policy on Older Persons (NPOP) was formulated in 1999. The policy led to a number of actions, including: 1) the Ministry of Social Justice and Empowerment set up a body to provide legal, medical and social assistance to elderly people across the country; 2) over 8,000 NGOs and 516 district collectors and organizations were selected to establish voluntary action groups at local levels to provide help to the elderly; 3) the Government extended financial and other support to NGOs in the creation and operation of old-age homes; 4) a national project entitled "OASIS" (Old Age Social and Income Security) was started to enable young workers to build up savings during their working lives; and 5) the Ministry of Rural Development started providing pensions to destitute older people under the National Social Assistance Programme.

In **Nepal**, a national scheme of monthly old-age pensions was introduced for widows over 60 years, and to all persons who have reached 75 years of age. Since then, a policy of collaboration between the Government and NGOs has been adopted to enhance the socio-economic status of the elderly and to eliminate violence and discrimination against them, with special attention being given to the needs of the elderly women.

In **Bolivia**, a group of laws guarantees free access to health care, social services and medical insurance for persons aged 65 years and over, as well as a fixed annual income for people in the same age group.

In **Kazakhstan**, the various measures adopted include the registration of 1.6 million retired people in institutions of social welfare. Pensions and other measures of social welfare for the elderly are governed by such laws as Pension Payments in the Republic of Kazakhstan; State Social Payments for the Handicapped; Loss of Bread-winner in the Republic of Kazakhstan; (iv) Privileges and Social Welfare for Veterans and Invalids of the Great Patriotic War; and Special State Welfare in the Republic of Kazakhstan.

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ageing. The table also reflects the attempts that have been made to deal strategically with the population ageing issue by encouraging greater involvement of civil society organizations and examining other organized approaches to meet the needs of the elderly.

An examination of the types of initiatives taken indicates that for plans, programmes and strategies, the focus was on the social, economic and health aspects of ageing. These aspects include social and legal protections, health care, social welfare, and access to work and to social services. In the case of minimum living standards, governments explored ways of providing the elderly with housing, access to health facilities and services, and old-age pension schemes regardless of previous employment status. Governments also focused on institutional mechanisms and data collection efforts and worked in partnership with NGOs and international organizations to provide older persons with facilities and services such as accommodations and home visits. Data was generated and research on the elderly was carried out. Governments also supported the role of NGOs in advocating and promoting the special needs of the elderly. In fact, in the area of taking care of the elderly, beneficial partnerships between governments and NGOs were frequently cited.

Regional variations in the percentage of countries adopting these measures indicate that around 60 per cent of countries in Asia, in the Caribbean and in Arab States have reported adopting plans and/or strategies. Furthermore, the use of minimum living standards to meet the needs of the elderly was the highest in Arab States at 80 per cent, closely followed by 62 per cent in the Caribbean subregion. Both Asia and the Caribbean subregion are examining the most appropriate approaches to help meet concerns of the elderly. Finally, close to 30 per cent of countries in both the Arab region and in

Asia are supporting action in the realm of civil society on population ageing.

Box 2.3 presents selected examples of country experiences in addressing population ageing and the special needs of the elderly.

2.7 MEASURES TO INFLUENCE INTERNAL MIGRATION

From a developmental and planning perspective, the spatial distribution of population is important. Factors such as rural-urban residence and population concentration by administrative locations (state, district, regions, etc.) are examined by countries that seek to achieve a more balanced distribution of population. Governments may adopt specific strategies to deal with such issues as rural-urban migration, metropolitan concentration, the creation of small and/or medium cities, colonization or resettlement schemes of agricultural and rural land, and rural development. Unplanned or unregulated movements of population, in combination with other social and economic forces, can sometimes lead to undesirable consequences — a familiar occurrence in many developing countries. The issue of internal migration and its determinants and consequences is very diverse across regions. The ICPD PoA focused on internal migration with the aim of achieving a number of goals. These included fostering a more balanced spatial distribution of the population; reducing the role of the various "push" factors as they relate to migration flows; offering adequate protection and assistance to persons displaced within their country, particularly women, children and the elderly; and putting an end to all forms of forced migration.

The actions proposed included: 1) formulating population distribution policies; 2) adopting sustainable regional development strategies and strategies for the encouragement of urban consolidation, the growth of small or medium-sized urban centres and the sustainable development of rural areas; and 3) increasing information and training on conservation and fostering the creation of sustainable off-farm rural employment opportunities. The *Key Actions* reaffirmed the same actions and also pointed to the need to carry out research to better understand the trends and characteristics of internal migration and geographical distribution of the population, with a view towards formulating effective population distribution policies.

To examine the progress made so far, the Survey solicited information on policies and/or programmes on

internal migration aimed at promoting a more balanced spatial population distribution. A total of 147 (97 per cent) out of 151 countries answered the question, and 64 per cent, or 97 countries, reported having taken some action. This reflects notable progress, since only 41 per cent of developing countries had taken some action as of 1994.

Table 2.6 shows that out of the 97 countries that had reported taking some action, 50 (52 per cent) had adopted plans on migration; 49 (51 per cent) had created plans to distribute socio-economic and political activities to influence spatial distribution of the population; 15 (15 per cent) had initiated programmes to provide assistance/services to internally displaced persons (IDPs), and 10 (10 per cent) had established special institutions on migration. Governments developed plans to promote resettlement schemes and to redistribute population by creating new economic growth centres and by decentralizing social and economic planning as well as the political process of decision-making. They also formulated programmes and strategies to resettle and rehabilitate internally displaced persons, as appropriate. A total of 39 countries had adopted multiple measures on internal migration.

Regional variations in percentages of countries reporting adoption of these specific measures show that formulating specific migration plans was most common in sub-Saharan Africa at 69 per cent. The utilization of economic and/or political measures to influence internal migration was most common in the Caribbean subregion at 88 per cent, followed by over 70 per cent in Asia and in the Arab States. Finally, about fifty per cent of the Caribbean countries reported that they were imple-

menting programmes of assistance or service to internally displaced persons.

The data was analysed to examine whether countries with higher levels of urbanization were more likely to have adopted multiple measures to address the internal migration issue. The analysis indicates that the relationships were rather weak. While a slightly higher percentage of countries with higher proportions of urban population had taken action (26.2 per cent), the corresponding rate for countries with lower levels of urbanization was around 25 per cent. A similar analysis by the annual rate of urban population growth also failed to show any strong differences. For example, while 25 per cent of countries with lower rates of urban growth (< 2.8 per cent — average) had taken action, only 28 per cent of countries with more rapid urban growth had taken action on internal migration. This implies that the policy dynamics of internal migration issue is very divergent among the various countries of the world.

2.8 MEASURES TO INFLUENCE INTERNATIONAL MIGRATION

International migration can have positive impacts on both sending and receiving countries. In many countries, international migration has helped to shape societal patterns, promote cultural enrichment and enhance development prospects. According to the United Nations, the number of people residing outside of their country of birth was at an all-time high of about 175 million around the year 2000, more than double the number in the 1970s.[7] Sixty per cent of the world's migrants reside in the more developed countries, and 40 per cent live in the developing countries. During 1990-2000, the number of foreign-born migrants in the world increased by 14 per cent or by about 21 million persons. There was a 28 per cent increase in the number of migrants in developed countries, and a 2.6 per cent decline in developing countries. Countries with the largest number of international migrants include the following developing countries: Côte d'Ivoire, India, Iran (Islamic Republic of), Jordan, Kazakhstan and Pakistan.

The ICPD PoA proposed actions on international migration with a view towards achieving a range of objectives. These goals included: addressing the root causes of migration, especially those related to poverty; encouraging more cooperation and dialogue between countries of origin and countries of destination in order to maximize the benefits of migration; and facilitating the reintegration process of returning migrants. Recommendations were directed at finding ways to achieve sustainable economic and social development, ensuring a better economic balance between developed and developing countries, and defusing international and internal conflicts. Other recommendations included considering the use of temporary migration (for example, short-term and project-related migration) as a means of improving the skills of nationals of countries of origin; supporting the collection of data on flows and stocks of international migrations, and on factors causing migration; and strengthening support for international protection of and assistance to refugees and displaced persons and promoting the search for enduring solutions to the issue.

According to the Survey findings, 73 per cent or 110 countries had taken some action, representing enormous progress in dealing with the international migration issue, since only 18 per cent of countries had reported taking similar action in 1994.

Table 2.7 **Measures Taken by Countries to Influence International Migration**

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. POLICY OR PROGRAMMATIC MEASURES		
Plans/programmes/strategies on international migrants and refugees	50	45
Laws/legislation on international migrants and migrant workers	41	37
Adoption of policy on international migration	36	33
Enforcing conventions on refugees, asylum-seekers and illegal migrants	12	11
Law/legislation on trafficking of human beings	11	10
B. MECHANISMS FOR COORDINATION		
Intergovernmental policies on migration	36	33
Inter-institutional cooperation on migration (govt., NGOs, donors)	13	12
Intra-governmental	13	12
Total	**110**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Data on specific measures taken to address the issue of international migration is presented in Table 2.7. It indicates the use of a broad range of measures, ranging from the adoption of policies, the formulation of plans, strategies or programmes, the enactment of laws and legislation, efforts to enforce conventions, and the establishment of various coordination mechanisms, both intergovernmental and intra-governmental.

According to the findings, the most common measure adopted is the formulation of plans, programmes and strategies on international migrants and/or refugees (in 50 countries, or 45 per cent), followed by the enactment of laws/legislation on international migrants and migrant workers (in 41 countries, or 37 per cent), the adoption of migration policy (in 36 countries, or 33 per cent), the undertaking of efforts to enforce international conventions on refugees, asylum-seekers and illegal migrants (in 12 countries, or 11 per cent), and the passing of laws/legislation on the trafficking of humans, especially women and children (in 11 countries, or 10 per cent).

Countries are also paying attention to the important aspect of coordination in handling the complex issue of international migration. A growing number of countries have established coordination mechanisms of various types — including coordination across government agencies, coordination between governments, and coordination among governments, NGOs and international donors. As is clear from Table 2.7, thirty-six countries (33 per cent) are approaching the issue with inter-governmental policies on migration, while 13 countries, or 12 per cent, reported participating in inter-institutional cooperation and in intra-governmental networks on migration.

Regional variations in the percentage of countries reporting specific measures taken to address international migration show that adoption of plans, programmes and strategies on migration and refugees was most common in the Arab States (62 per cent) and the Central Asian Republics (60 per cent). Adoption of laws and legislation on immigrants and migrant workers was most common, at over 35 per cent of countries, in Asia, Arab States, the Pacific, and the Central Asian Republics. Formulation of policies on international immigration was most common in the Caribbean

Countries are also paying attention to the important aspect of coordination in handling the complex issue of international migration.

(64 per cent). Finally, the use of an intergovernmental policy approach was most common in the Central Asian Republics (60 per cent) and in the Caribbean (55 per cent). Given the broadness of the question asked in the Survey and the wide diversity of situations with regard to international migration, these observed differences are unsurprising.

Some countries also provided information on the main thrust of measures adopted. For example, emphasis was given to settling refugees in sub-Saharan African countries like Ghana and Tanzania. This emphasis was reflected in plans, programmes and strategies, as well as in policies on international migration. In Latin American and Caribbean countries, the focus was on providing incentives for returning nationals, while the emphasis in CIS, Eastern and Central Europe, the Arab States, and Central Asian Republics was on protecting labour markets. Combating drug trafficking and drug abuse was the thrust of actions in Eastern and Central Europe, the Arab States, and the Central Asia Republics. In most subregions, there was a focus on providing intergovernmental arrangements for the protection of workers/labour migrants in both sending and receiving countries.

Box 2.4 provides some illustrative examples of measures on international migration adopted by a few countries.

2.9 CAPACITY-BUILDING IN DATA, RESEARCH, MONITORING AND EVALUATION

The ICPD PoA emphasized that valid, reliable, timely, culturally sensitive, sex-disaggregated and internationally comparable data should form the basis for all stages of policy and programmatic action. The recommendations are aimed at strengthening national capacity to seek new information and at meeting the need for basic data collection, analysis and dissemination. They seek to ensure political commitment to, and understanding of, the need for data collection on a regular basis and to encourage the analysis, dissemination and full utilization of data. Specific actions were recommended to strengthen national capacity in the area of data; develop programmes on data collection, analysis, dissemination, utilization and research; establish and maintain data-

As a global phenomenon, international migration has continued to be at the fore-front of national and international agendas during the decade since the ICPD. Discussions and policy dialogue on such issues as human rights; the protection of migrant workers; the social and economic integration of migrants; labour force and worker remittances; human trafficking; refugees, internally displaced persons and asylum-seekers; and national security have led a number of countries to re-examine their policies and to devise various measures and programmes. For example:

In **Algeria**, the Government has coordinated institutional efforts on migration issues by creating a Secretary of State in charge of the needs of expatriates and their participation in the development process. The Government has also established a permanent commission for Algerian émigrés at the National Assembly, and has developed programmes to encourage the return of migrants and to stem the root causes of emigration. Finally, it has conducted research through the National Employment Ministry into the reasons behind economic emigration and has proposed strategies for fighting unemployment and for providing economic incentives for Algerian youth to remain in the country.

In **Belarus**, the Ministry of Labour has been discussing with its counterparts in other countries mutual agreements regarding matters relating to labour migration and the social protection of its citizens. These agreements include one with the Czech Republic relating to the temporary employment of the citizens of both countries; one with Poland on mutual employment; one with Germany on joint actions to prevent illegal labour migration and illegal employment; and one with Tajikistan on temporary labour activities and the social protection of citizens working outside their countries.

In **Slovakia**, a law was passed in the early 1990s that provides support to displaced persons from Bosnia and Herzegovina and Kosovo. An Act on Asylum adopted in 2002 provides new rules on the principle of non-repatriation and regulates in detail the procedures for granting asylum. It also covers the establishment of an independent review authority to reconsider negative decisions taken regarding asylum-seekers.

In **Bolivia** an inter-governmental policy was adopted (in collaboration with Argentina, Brazil, Chile and Uruguay) to deal with international migrants in the region. The policy allows nationals of member countries to work and obtain legal residency in any of the countries.

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bases (paying attention to gender disaggregating of data); and to strengthen training programmes in statistics, demography, and population and development studies. The Survey collected information from countries on actions taken to strengthen capacities in the areas of population data and research, in the development of consistent, high-quality indicators, and in the adoption of monitoring and evaluation mechanisms.

Capacity for Population Data

Responding to a question on measures taken to strengthen national capacity for population data, 96 per cent of the countries stated that they had taken action. Globally the measures adopted were: strengthening the capacity of institutions for data collection, processing, analysis and utilization (93 countries); supporting the development of national databases and management information systems (75 countries); the training of staff on database management (61 countries); and the creation/strengthening of a national statistical service (in 61 countries). Other measures mentioned, but less frequently utilized, were the training of professionals on the utilization of databases

(15 countries) and the mobilizing of donor support for capacity-building in data (13 countries).

An interregional comparison of data on the measures taken indicates that countries in Asia and the Pacific, Latin America and the Caribbean, the Arab States, Central Asian Republics, CIS, Eastern and Central Europe have emphasized strengthening data collection, analysis and utilization. The development of national databases has, however, been emphasized in all regions. While these represent useful developments, the extensiveness and comprehensiveness of action on the data issue across countries is inadequate, given that a large number of countries have underlined problems of data in addressing other specific issues, as will be seen in later chapters of this report. Data inadequacy is a significant recurrent problem.

Box 2.5 presents selected examples of country practices on strengthening national capacity for data.

Capacity for Research

Attaining national capacity for research is crucial to assess progress made in ICPD PoA implementation. According to the findings of the Survey, 90 per cent

The ICPD PoA stated that valid, reliable, timely and culturally relevant and internationally comparable data form the basis for policy and programme development, implementation, monitoring and evaluation. The *Key Actions* re-emphasized this point by identifying the need to strengthen national information systems to produce reliable statistics on a broad range of population, environment and development indicators in a timely manner. These indicators are relevant to all the international frameworks, including the MDGs and the 2002 WSSD. The following selected country experiences are examples of some of the actions being taken by countries in this area.

In **Kenya**, the use of national experts in the design and implementation of the 1999 census exercise contributed to national capacity-building. These experts assisted with data processing and analysis and the drafting of analytical reports, as well as with census advocacy. The national experts were backstopped by external experts, including ones from UNFPA Country Technical Services Teams (CSTs),

the U.S. Agency for International Development (USAID) and the United Kingdom's Department for International Development (DFID). UNFPA, DFID and USAID/Macro International Inc. also supported the work of Central Bureau of Statistics (CBS) professionals, local analysis consultants and external advisers of international repute. These joint efforts enabled the transfer of an enormous amount of skill and knowledge, culminating in a record-time release of nine in-depth census analysis reports and a host of statistical appendices. Procurement of an assortment of data processing and analysis equipment and materials also contributed to strengthening local capacity, as did the institutionalization of computer-assisted cartography (CAC) and Geographic Information Systems (GIS) equipment within the CBS and related institutions.

In **China**, the Government has strengthened the training of professionals involved in collection, management, research and analysis of population and development data. Higher education institutions have

trained a large number of professionals in the areas of population and development. In addition, a China Population Information Network has been set up and linked with the Asia-Pacific Population Information Network.

In **India**, the Government strengthened the data processing centre under the aegis of the National Sample Survey Organization. In addition, the Central Statistical Organisation (CSO) drew up a national training strategy for skills-upgrading and capacity-building in data collection, analysis and utilization. Short- and long-term courses were implemented regarding population censuses and surveys, data-processing and Management Information Systems (MIS). In addition, the central cabinet approved a national data-dissemination policy. Under this policy, data generated from the public exchequer will enter the public domain within three years of the date of completion of a survey or census. The same decision also approved the establishment of a national data warehouse.

of countries had taken some action in this regard. The most common measures taken were: supporting surveys and the generation of research reports (92 countries); supporting research by a national commission/secretariat/council (57 countries); supporting consultative and participatory research (38 countries); and supporting expansion of research to include "overlooked" groups (28 countries). These efforts often included the recruiting and training of human resources and the setting up of necessary infrastructure. Among the other actions identified were: the creation of a national centre for studies in population and development (27 countries); the provision of demographic training for civil servants (18 countries); and the creation/strengthening of regional population offices (11 countries). Capacity-building efforts included the provision of the equipment and human

resources needed to carry out interdisciplinary research (including socio-cultural research) in the field of population, gender, reproductive health and development, as well as training in research methods at national universities. Although none of the measures identified were reported by more than 60 per cent of the countries of any region, the strengthening of national capacity for research is nevertheless noteworthy.

Interregional comparison showed that all the regions emphasized supporting surveys and the generation of reports, as well as research by a national commission, secretariat or council. Additional emphasis was placed on supporting consultative and participatory research in the Asia and the Pacific region, and on supporting research on overlooked groups in Latin America and the Caribbean.

Consistent and High-Quality Indicators

Indicators are vital tools in determining the extent of success or failure in programme interventions. They can only be produced by mining and analysing data and by promoting quality research. In all, 79 per cent of countries in the Survey reported on measures taken regarding indicators. The most common ones were: assigning the role to a national commission/secretariat/institution to generate indicators (31 countries); establishing an inter-agency group on indicators (27 countries), involving the national statistical service to generate indicators (27 countries); enhancing collaboration (22 countries), setting up an integrated system to monitor social policies (19 countries); and finally, ensuring that core indicators are made available locally (17 countries). This represents progress on indicators, especially in view of mechanisms that are being established to help generate information for monitoring and evaluation. (These mechanisms are presented in the next section.)

Many countries also reported on the constraints they are facing in producing consistent, high-quality indicators. The most commonly mentioned ones include lack of financial resources (32 countries); lack of coverage in data collection and analysis for all population groups and/or topics (19 countries); lack of human resources (17 countries); lack of infrastructure/lack of coordination (15 countries); lack of technical training (14 countries); and the failure to collect and disseminate data and information in a timely fashion (15 countries). These responses point to the need for both governments and the international community to further strengthen the work on indicators.

Mechanisms for Monitoring and Evaluation

Monitoring and evaluation of the implementation of the international development frameworks, including the ICPD Programme of Action, play vital roles in assessing whether development targets have been achieved. Monitoring and evaluation efforts also help identify best practices and constraints. The Survey showed that countries are increasingly recognizing the importance of ICPD goals in achieving MDGs. The Survey also indicated that governments were beginning to create and strengthen mechanisms for monitoring and assessing progress in achieving ICPD goals and the MDGs. For example, on the question of mechanisms developed for monitoring and measuring progress in achieving ICPD goals, 131 (87 per cent) out

of 151 countries responded to the question, and 82 countries (54 per cent) provided information on mechanisms used. Compared to the 1998 Global Survey, when 43 countries had reported taking significant measures to establish monitoring mechanisms for assessing the achievement of ICPD goals, there is clearly demonstrated progress in this area.

A number of mechanisms were used by countries. Common ones included setting up a multisectoral coordinating body to monitor the achievement of ICPD goals (37 countries); conducting an annual national survey on the ICPD PoA implementation process (29 countries); and appointing focal point/desk officers to oversee the ICPA PoA implementation process (24 countries).

A similar question on the monitoring of the MDGs prompted responses from 124 countries, with detailed information on the mechanism used provided by 87 countries. Actions included setting up a multisectoral coordinating body to monitor the achievement of the MDGs (36 countries); conducting an annual national survey on the achievement of the MDGs (26 countries); and appointing focal point/desk officers for overseeing progress in achieving the MDGs (23 countries). This represents significant progress, especially since the MDGs were adopted only a few years ago. Clearly, countries are committed to helping achieve and monitor the MDGs and the ICPD goals.

2.10 CONCLUSION

Countries continue to face constraints now as they did at the time of the 1998 Global Survey. At that time, countries frequently mentioned such constraints as lack of financial resources, lack of trained or qualified staff, insufficient institutional capacity, and lack of awareness and understanding of the issues. They also cited a lack of data and insufficient coordination among institutions and ministries. Most of these constraints were reiterated in the current 2003 Global Survey. Newly identified constraints include in particular lack of political will. In some countries, such constraints have indeed affected the implementation of the Programme of Action's population and development aspects.

The countries also identified a number of emerging issues in population and development. These issues include population ageing, poverty alleviation, internal and external migration, the situation of refugees and internally displaced persons, and the need to strengthen population data collection (especially censuses) and

improve the overall quality of data. The Survey noted broad regional differentials. Sub-Saharan Africa, for example, identified poverty-alleviation issues, data quality/censuses and ageing, while Asia and the Pacific identified ageing, migration, refugees/IDPs, data and employment creation. The Arab States, the Central Asian Republics, CIS, Eastern and Central Europe singled out population policy, making poverty and ageing, while Latin America and the Caribbean pointed to ageing, poverty, migration, improving the situation of refugees/IDPs, and data quality/censuses.

The findings of this Survey show that countries have made progress since the 1998 Global Survey in implementing actions proposed in the ICPD PoA and *Key Actions*. Good progress has been made in integrating population concerns into development strategies and in addressing population issues within the context of poverty, environment and decentralization of the planning process. Significant progress has also been made in terms of actions taken vis-à-vis population ageing and internal and international migration. Moreover, there have been successes regarding the development of monitoring and evaluation systems. These mechanisms are essential for tracking the progress that has been made towards achieving ICPD objectives and the Millennium Development Goals.

Associations were observed between the severity of the specific population issue and the multiplicity of measures adopted to address it. These associations imply that countries are becoming more pragmatic in focusing resources and addressing priority needs. It also indicates that a working knowledge of the recommendations of the ICPD PoA regarding the role of population factors in development is growing rapidly in countries. However, the results also show that much more remains to be done to implement population and development measures in a more comprehensive, effective way, thereby helping to achieve ICPD goals.

Countries need to resolve the constraints and difficulties being encountered in implementation, and to adopt or strengthen programmatic interventions to address newly emerging issues. Continued progress on the population and development aspects of the ICPD PoA and *Key Actions* is essential to create the enabling environment necessary for achieving success in other aspects of the ICPD PoA, especially in the areas of gender empowerment, reproductive rights and reproductive health, partnerships and resource mobilization. In this context, the need for an integrated approach towards the formulation and implementation of population and development policies, plans, strategies and programmes is critical. There is a clear need for adequate and timely data, appropriately trained human resources, effective mechanisms for coordination and the existence of monitoring and evaluation structures. Although the ICPA PoA and *Key Actions* have recommended actions to help resolve these issues, countries need to further strengthen these aspects in their national efforts.

Addressing the newly emerging issues of population ageing, international migration and the spatial distribution of population (including internal migration) requires a high degree of coordination of different types. Without overburdening their policy- and programme- development machinery, countries need to promote effective coordination. This coordination should be intra-sectoral, intersectoral, inter-institutional, international and inter-functional (encompassing policies, programmes and strategies).

Finally, countries should move ahead rapidly to enhance the quality, relevance, reach and impact of the programmatic measures they have adopted with regard to population and development. Only then will they be able to achieve the goals of the ICPD.

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3 Gender Equality, Equity and Empowerment of Women

During the 1990s, global conferences sought to provide a vision of women's lives. The World Conference on Human Rights held in Vienna in 1993 asserted that women's rights are human rights.[1] In Cairo, in 1994, the International Conference on Population and Development (ICPD) built on this assertion and placed women's rights, empowerment and health, including reproductive and sexual health, at the centre of population and sustainable development policies and programmes.[2] At the Fourth World Conference on Women, held in Beijing in 1995, a consensus was reached that seeks to promote and protect the full enjoyment of all human rights and the fundamental freedoms of all women throughout their life cycle.[3]

Over the last ten years, various stakeholders have worked at every level to implement and incorporate the agendas of these conferences into national programmes for action. The ICPD Programme of Action (ICPD PoA), in particular, defined a set of strategic objectives and spelled out corresponding actions to be taken by governments, the international community, non-governmental organizations and the private sector to remove existing obstacles to gender equality and to improve the lives of girls and women.

The ICPD PoA called for actions to empower men and women and to eliminate inequalities between them. These actions include promulgating, implementing and enforcing national laws and international conventions relating to gender in such areas as eliminating gender discrimination in employment and guaranteeing women the rights to obtain credit and to buy, own, inherit, and sell property and land. It also recommended ensuring equitable representation of both

A number of countries reported undertaking measures over the last ten years to promote the fulfillment of women's potential through education, skills development and employment. They also reported establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life.

sexes in all programmes, including ones focusing on population and development.

The actions were aimed at achieving equality and equity based on a harmonious partnership between men and women. They were also directed at enhancing women's contributions to sustainable development by enabling their full involvement in policy- and decision-making processes and in all aspects of production, employment, income-generating activities and population-related activities, among others. Actions were recommended to ensure that all women, as well as all men, are provided with the education necessary for them to meet their basic human needs and to exercise their human rights.

It is also recognized that women can and must play a significant role in sustainable development and poverty-eradication efforts. When women are healthy and educated, their families, communities and nations benefit. Thus, the Millennium Summit envisioned a much-improved world by the year 2015, a world in which gender disparities in primary and secondary education have been eliminated and where women have been empowered. Moreover, it has become clear that gender equality is important not only as a goal in itself, but also as a path towards achieving the other Millennium Development Goals.[4]

Over the last ten years, considerable work has been done to produce and disseminate gender-sensitive data. However, much remains to be accomplished, as work on gender and women's empowerment continues to be fraught with conceptual, methodological and measurement difficulties. For example, the 2003 Global Survey findings reflect what is generally well known about a basic problem inherent in the area of gender: a persist-

ent lack of clarity regarding such concepts as "gender mainstreaming". This lack of clarity compounds the difficulty of analyzing data on gender and women's empowerment. Data may vary according to the source of information, the time periods to which data refers, and the respondents' understanding of nomenclatures and definitions. Furthermore, issues such as gender-based violence (GBV) and men's responsibilities are relatively new, having come into prominence since the Beijing Conference and the ICPD. As a result, few countries have collected sufficient reliable data on these subjects, though efforts to do so are currently under way with the assistance of United Nations agencies and donors.

The 2003 Global Survey posed a number of questions on gender-related issues in an attempt to track progress made by countries in implementing the ICPD PoA's gender component. This chapter looks at measures taken since 1994 in five specific areas, namely: (a) protecting the rights of girls and women; (b) women's empowerment; (c) gender-based violence; (d) gender-based disparities in education; and (e) men's support for women's rights and empowerment. Cultural considerations reported by countries are also presented. Examples of government and civil society partnerships on gender and women's empowerment issues are described in Chapter Eight.

3.2 PROTECTING THE RIGHTS OF GIRLS AND WOMEN

Since Cairo and Beijing, many national policies addressing population, reproductive health and the status of women have increased their focus on gender and human rights. A carefully constructed framework of gender and human rights exists, built on a strong ethical foundation and drawn from all cultures and traditions. This framework recognizes that all human beings have the same rights, and that women must be free to make their own choices and decisions concerning reproductive health. To do so, women must be free from discrimination, coercion and violence.

The ICPD PoA called for all countries to make greater efforts to promulgate, implement and enforce national laws and international conventions that protect women from economic discrimination and sexual harassment. Such conventions include the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The ICPD PoA also called for countries to fully implement the Declaration on the Elimination

of Violence against Women and the Vienna Declaration and Programme of Action. Countries were urged to sign, ratify and implement all existing agreements that promote women's rights. The ICPD+5 *Key Actions* called on governments to review all legislation and revoke any laws discriminating against female children and young women.

The 2003 Global Survey sought information on whether governments have taken any policy, legislative or administrative measures to protect the rights of girls and women. At the global level, of the 151 countries that responded, 150 (99 per cent) reported that they had adopted measures to protect the rights of girls and women.

Table 3.1 reveals that the most common measures adopted were legislation and formulation of national laws on the rights of girls and women (71 per cent), followed by the ratification of United Nations conventions (45 per cent). More than a third of the countries (41 per cent) reported that they had formulated policies to remove gender discrimination, and less than a third (29 per cent) provided constitutional protection to girls and women.

It is interesting to note that nine per cent of the responding countries reported instituting IEC and advocacy programmes for gender equality as a specific measure aimed at protecting the rights of girls and women – an important action in terms of influencing legislative and policy change, formulating gender-sensitive programmes, and promoting changes in behaviour and attitudes towards the rights of girls and women. The countries that have adopted such a

Table 3.1 Measures Taken by Countries to Protect the Rights of Girls and Women

Measures Taken	Number and Percentage of Countries	
	No.	%*
Formulation of national laws and legislation on women's rights	107	71
Ratification of United Nations conventions on rights of women	67	45
Adoption of policies to remove gender discrimination	61	41
Provision of constitutional protection to women	43	29
Total	**150**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

measure include Argentina, Bangladesh, Belize, Gabon, Grenada, Marshall Islands, the Republic of Moldova, Papua New Guinea, Paraguay, Philippines, Saint Kitts and Nevis, Syria, and the United Republic of Tanzania. On a regional basis, Latin America had the highest number of countries (88 per cent) that formulated legislation and national laws on the rights of girls and women.

On the establishment of a national commission for women, 88 per cent of countries in Latin America reported having taken this measure, compared to 20 per cent of countries in the Central Asian Republics. In Africa, Asia and the Caribbean, at least 50 per cent of the countries reported that they had established such a commission.

3.3 WOMEN'S EMPOWERMENT

The ICPD PoA underscored that the empowerment and autonomy of women and the improvement of their political, social, economic and health status is a highly important end in itself. It also noted that the full participation and partnership of both women and men is required in all aspects of productive and reproductive life. Such a partnership would include shared responsibilities for the care and nurturing of children and the maintenance of households. Moreover, the empowerment of women, as indicated in the Millennium Declaration, is an effective way to combat poverty, hunger and disease and to stimulate development that is truly sustainable. Sustainable development requires that women be fully involved in the development of environmental policies and programmes at all levels.

Women's empowerment includes extending them all civil, cultural, economic, political and social rights. It involves processes by which women gain the power to express and defend their rights and to gain greater self-esteem and control over their own lives and relationships. Male participation and acceptance of changed roles is an essential element of these processes.

Education was identified as one of the most important means of empowering women with the knowledge, skills and self-confidence they need to participate fully in the development process. A number of countries reported undertaking measures over the last 10 years to promote the fulfilment of women's potential through education, skills development and employment. They also reported establishing mechanisms for women's equal participation and equitable representation at all levels of the political process and public life.

The 2003 Global Survey solicited information on the progress countries have made in promoting the empowerment of women through policy, legislative or administrative measures. The results reveal that 99 per cent of countries reported having taken measures to empower women. Table 3.2 shows that the most common measures adopted by countries include (a) legislative measures and (b) programmatic and administrative measures. The former included promotion of increased participation of women in governance (51 per cent); adoption of laws and legislation for the empowerment of women (34 per cent); and promotion of increased participation of women in the political process (20 per cent).

On the other hand, the programmatic and administrative measures included the formulation of plans, programmes and strategies on the inclusion of women in development (59 per cent), the provision of economic opportunities for women (46 per cent) and the provision of education and training for women (38 per cent). Ten countries reported that they have formulated plans on the inclusion of marginalized women in development

Table 3.2 Measures Taken by Countries to Empower Women

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. Policy and legislative measures		
Inclusion of women in governance	74	51
Adoption of laws/legislation for the empowerment of women	49	34
Promotion of increased participation of women in the political process	29	20
B. Programmatic and administrative measures		
Formulation of plans/programmes/ strategies on the inclusion of women in development activities	85	59
Provision of economic opportunities for women	66	46
Provision of education and training for women	54	38
Sensitization of government officials on gender issues	18	13
Total	**144**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Empowering women is an important end in itself. Empowerment is a basic human right, and empowering women is a contribution to human well-being. Gender equality, equity and women's empowerment are essential to achieve economic, political and social development for all.

In March 2000, the President of **Azerbaijan** issued a decree "On the Implementation of State Policy on Women's Issues in Azerbaijan", which underlined the country's commitment to the principles of women's rights. It instructs the Government to ensure equal representation of women in the state administration, equal opportunities for women within the framework of ongoing reforms, and the provision of gender expertise in the national legislature. Furthermore, in each district, government institutions were directed to appoint a focal point on gender issues in their respective offices. Focal points from relevant ministries, along with representatives of leading NGOs and the media, sit on an inter-agency council charged with implementing the National Plan of Action on Women's Empowerment and Equality and instituting amendments to the national criminal legislation.

In **Gabon**, information and sensitization seminars are regularly organized for government administrators on gender- and equity-based strategies for development. In 2001, the United Nations office in Gabon organized an information session for cabinet members on gender issues. The Prime Minister presided over the session.

In **Indonesia**, the President issued Instructions on Gender Mainstreaming in National Development. As a result, focal points were established in 11 government institutions, including the Ministry of Education, the Department of Health, and the Ministry of Justice and Human Rights. At the regional/provincial level, women-in-development management teams coordinate empowerment activities. Teams, which have been established in all of the 30 provinces and 207 districts and municipalities, are made up of government personnel as well as representatives of local NGOs and university-based women study centres.

In **India**, institutional mechanisms have been set up to protect the rights of women and men and to promote gender equality. The Government created a National Human Rights Commission that has the power to inquire about and provide redress when the state or members of civil society violate a person's human rights. A National Commission for Women was also formed, with a mandate to ensure that women's rights legislation is promulgated and implemented. In addition, family courts and *mahila* (women's) courts were set up, along with special units in police stations to handle crimes against women. In addition, a law has been enacted to provide free legal aid and advice to all women, irrespective of their status. To ensure gender sensitivity among law enforcers and the criminal justice system, the Government has institutionalized gender-sensitization programmes for judges, police and prosecutors through pre-service and in-service courses on gender equality.

In **Mexico**, the Secretary of Health, within the Women's Health Programme, is carrying out sensitization and training activities of health-sector employees to promote gender equity in the formulation of policies in their areas of health specialization. The Government is implementing a strategy for the mainstreaming of a gender perspective in the budgets of the Secretary of Health.

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activities, namely, Angola, Bolivia, Chile, Costa Rica, Grenada, Mexico, Panama, Peru, Tunisia and Venezuela. Box 3.1 illustrates different institutional mechanisms utilized by countries to promote gender equality and women's empowerment.

The main policy and legislative measures carried out by regions were: promotion of increased participation of women in governance (75 per cent in Latin America and the Central Asian Republics) and adoption of laws and legislation for the empowerment of women (75 per cent in the Central Asian Republics). On the other hand, the main programmatic and administrative measures used by regions were the provision of economic opportunities for women (55 per cent in sub-Saharan Africa) and the provision of education and training for women (63 per cent in the Caribbean).

3.4 GENDER-BASED VIOLENCE

Violence against women is an ancient problem, occurring in every culture and social group. Violence against women and girls is often referred to as "gender-based violence" because it evolves in part from women's subordinated status in society. In many cultures, traditional beliefs, norms and social institutions legitimize and thereby perpetuate violence against women.

The ICPD PoA, the Beijing Declaration and Platform for Action and other global conferences and instruments recognized gender-based violence as a major issue on the international human rights agenda. By situating violence against women squarely within the discourse of human rights, these action plans affirm that women are entitled to equal enjoyment and protection of all human rights and fundamental freedoms.

Gender-based violence includes a wide range of violations of women's human rights, including trafficking in women and girls, rape, spousal abuse, sexual abuse of children, and harmful practices that irreparably damage the reproductive and sexual health of girls and women. The consequences of GBV are manifold — ranging from the denial of fundamental rights, to negative effects on reproductive and mental health, to threats to the well-being of women and children. In addition to its human cost, violence against women undermines their participation in public life, reduces their productivity and drives up costs, including the price of medical care.

While it is recognized that the roots of gender-based violence have to be identified, often the incidence and severity of violence cannot be adequately ascertained due to the culture of silence surrounding GBV and the attached social stigma.

The ICPD PoA stressed the need to eliminate violence against women. In the *Key Actions*, governments were urged to promote and protect the human rights of the girl child and of young women. Among these rights are economic and social rights as well as the right to be free from coercion, discrimination and violence (including sexual exploitation and harmful practices). Governments were further requested to develop programmes and policies that foster attitudes of "zero tolerance" towards violence against girls and women, including female genital cutting, rape, incest, trafficking, sexual violence and exploitation.

In line with the ICPD PoA and the *Key Actions*, a question was included in the 2003 Global Survey to provide information on measures taken by countries relating to violence against women. The results showed that at the global level, 98 per cent of countries reported having taken action to address GBV. Countries reported having adopted a set of measures to address the problem, including legal and legislative measures giving statutory authority for implementation and enforcement. They also reported taking programmatic and administrative measures to address the need for services for victims of violence, the provision of information on GBV, and monitoring of its incidence. These measures included training, IEC and advocacy strategies to both raise awareness of the problem and to counter the prevalence of GBV, as well as measures to take care of victims through counselling services.

As can be seen in Table 3.3, the most common measure taken in the legal and legislative category was the

adoption of laws and legislation on GBV (66 per cent of countries). In addition, 16 per cent of the countries promoted enforcement of laws and legislation. The number of countries having taken legal enforcement measures was only 24, indicating that more remains to be done in terms of addressing this issue.

Regarding programmatic and administrative measures, countries reported that they have provided support services for victims (40 per cent); conducted IEC and advocacy on GBV (37 per cent); established national commissions on GBV (37 per cent); and trained service providers and government officials on handling GBV cases (24 per cent). Other measures reported include setting up institutional mechanisms for GBV monitoring and reporting (24 per cent). Box 3.2 presents examples of measures taken by countries to address GVB.

At a regional level, 88 per cent of Latin America countries had the highest number of countries that adopted laws and legislation on GBV. Eighty-two per cent reported that they had programmes to provide services to the victims and 53 per cent had conducted IEC and advocacy campaigns.

Table 3.3 **Measures Taken by Countries to Address Gender-Based Violence**

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. Legal and legislative measures		
Adoption of laws/legislation on gender-based violence	97	66
Enforcement of GBV laws/legislation	24	16
B. Programmatic and administrative measures		
Provision of services to victims	59	40
Conduct of IEC/advocacy on GBV	55	37
Establishment of national commissions on GBV	54	37
Training of service providers/ government officials on handling GBV cases	36	24
Setting up of institutional mechanisms to monitor/report on GBV	36	24
Total	**147**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

BOX 3.2   ADDRESSING GENDER-BASED VIOLENCE

Since the ICPD Programme of Action, many countries have provided gender-sensitive training for government officials. A good number have also created new institutions or programmes that promote women's rights.

In **Brazil**, the Ministry of Health has formulated guidelines on violence and health, directed at the prevention and treatment of injuries derived from GBV. For example, the Technical Regulation, for the Prevention and Treatment of Injuries derived from sexual violence against women, was distributed among health teams, women's organizations and universities. In 2001, the Protocol for the Attention of Intra-family Violence and the Chart on Human Rights and Intra-Family Violence were adopted, as was the Protocol for the Prevention of AIDS in victims of sexual violence. Significant investments have been made to provide services for women in situations of violence. In 1997, there were only 17 Referral Services for Comprehensive Assistance for such women. Today, these services can be found in 85 hospitals and 113 ambulatories.

Since 1998 there has been a policy in **Colombia** called *Haz Paz* (Make Peace). It aims to prevent, monitor and detect domestic violence, and to provide assistance in the areas of justice, health and protection. As part of this policy, and with UNFPA's support, in 1999 the Project on Comprehensive Attention to Victims of Sexual Violence was launched. The project aimed to improve the quality of the attention provided to victims of sexual violence, while helping to reestablish their rights.

Iran established special centres for female police officers in metropolitan police departments to assist victims of violence against women. The Government also supported the creation of a hotline within police departments. Iran has hired 400 female police since October 2002.

Since 2000, the **Jamaican** chapter of the Caribbean Association of Feminist Research and Action (CAFRA) and a group called Woman, Inc. have carried out a "training of trainers programme" on domestic violence intervention for police personnel**.** As a result, domestic violence intervention was added to the syllabus of the Jamaican Police Academy and Probationer's basic training. Since then, 642 police officers and 384 probation officers have been trained on the handling of domestic violence. In 2002, the Bureau of Women's Affairs trained justice personnel on gender-sensitive approaches to violence against women. Workshop participants included judges, police, court clerks, lawyers, probation officers and social workers.

In **Sierra Leone**, the Government, in collaboration with NGOs and the police, has conducted sensitization and advocacy programmes on issues related to gender equality and gender-based violence. Telephone help lines have been established so that women who have experienced violence can be linked to a Family Support Unit within the Police Force.

In 1999 a Domestic Violence Act was passed in **Trinidad and Tobago**. The Government subsequently established a Domestic Violence Unit, which operates a toll-free, 24-hour hotline/referral service for victims. The hotline provides information on shelters, counselling, services and community-based drop-in centres. There are currently 16 counselling centres and 15 shelters for victims. The Government is also collecting and analysing data on domestic violence and conducting an extensive public awareness programme that includes the production and dissemination of procedural manuals, information booklets, posters and brochures. Community policing units have also been established to address domestic violence issues. Police personnel in these units receive extensive training on gender-sensitive approaches to policing. Because of the amended act, the training of police officers was modified regarding the handling of domestic violence.

3.5 REDUCING GENDER DISPARITIES IN EDUCATION

The ICPD PoA called for universal primary education to be a reality in all countries before the year 2015. At the same time, all countries were urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, bearing in mind the need to improve the quality and relevance of that education. In addition to recommending opportunities for girls' education, countries were asked in keeping with their commitment to eliminate all gender bias to encourage changes in the areas of teachers' attitudes and practices, school curricula and educational facilities.

The closure of the gender gap in education as specified in the ICPD PoA is re-echoed in the MDGs. Closing the gap is an important challenge for policy makers, particularly in sub-Saharan Africa and South Asia, where gender differentials in primary enrolment are largest. Questions were included in the 2003 Global Survey on progress made by countries to improve access to primary and secondary education, and to address gender disparities in education.

Addressing the gender gap in education

The 2003 Global Survey reveals that globally 93 per cent of countries have made progress in addressing the gender gap in education. Of the 129 respondents who

reported some progress, 22 per cent indicated that the ratio of girls to boys at the primary level was increasing. At the secondary level, 16.3 per cent of countries reported that the ratio of girls to boys was increasing.

Measures initiated by governments to close the gender gap in education included: provision of incentives to poor families to send girls to school (21 per cent); provision of IEC and advocacy campaigns on gender equality in education (21 per cent); promulgation of laws and legislation for equal education of girls and boys (18 per cent); incorporation of gender issues into high school and university curricula (17 per cent); and provision of an increased number of girls' schools at the secondary level (12 per cent).

At the regional level, countries reported that they had taken various measures to improve access to primary and secondary education. Most of the regions highlighted the provision of free primary education. In addition, 73 per cent of countries in the Caribbean and 56 per cent of Latin America countries increased public spending for education. In regard to addressing gender disparities in education, 50 per cent of the Arab States reported that they had promulgated laws and legislation for equal education for girls and boys. Many countries, however, recognize that much remains to be done to improve access to education, especially for the girl child.

Access to primary and secondary education

The results obtained on access to primary and secondary education show that at the global level, 96 per cent of countries have taken measures to improve access to education. The most common measure, as presented in Table 3.4, was providing increased public spending for schools (41 per cent). This was followed by providing free primary education (40 per cent) and assisting drop-outs (32 per cent). Other measures taken were: providing incentives to poor families to send children to school (20 per cent); and providing free secondary education (19 per cent).

The percentage of governments adopting measures to increase access to primary and secondary schooling did not exceed 41 on any identified measure, showing that progress has been low. Twenty-five per cent of countries reported that the level of progress had been low, 46 per cent reported that there had been some progress, and 29 reported a high level of progress. The fact that less than 30 per cent could state that progress was at a high level

suggests that much remains to be done if the ICPD PoA goals are to be achieved.

3.6 ENHANCING MEN'S SUPPORT TO WOMEN'S RIGHTS AND EMPOWERMENT

The ICPD PoA states that changes in both men's and women's knowledge, attitudes and behaviour are necessary conditions for achieving a harmonious partnership of men and women. This would open the door to gender equality in all spheres of life, including improving communication between men and women on issues of sexuality and reproductive health, and improving understanding of their joint responsibilities, so that men and women are equal partners in public and private life. One of the actions recommended was that parents and schools should foster in boys attitudes respectful of women and girls from the earliest possible age. In line with this recommendation, the 2003 Global Survey elicited information from countries on measures they had taken over the last 10 years.

Instilling respectful attitudes in boys

Responses to a question in the 2003 Global Survey on measures taken to ensure that attitudes respectful of women and girls are instilled in boys indicated that some progress has been made in this area. Of the 151 countries that responded, 123 countries (82 per cent)

Table 3.4 Measures Taken by Countries to Improve Access to Primary and Secondary Education

Measures Taken	Number and Percentage of Countries	
	No.	%*
Provision of increased public spending for schools	58	41
Provision of free primary education	57	40
Formulation of plans/programmes/ strategies to assist drop-outs	45	32
Provision of incentives to poor families to send children to school	28	20
Provision of free secondary education	27	19
IEC/advocacy campaigns for education of girls	14	10
Total	**142**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

reported that they had adopted relevant measures. In terms of specific measures adopted, more than half (54 per cent) of the countries mentioned the development, review and revision of textbooks and curricula to incorporate gender equality concerns; about a third (37 per cent) reported the conducting of IEC/advocacy campaigns on gender equality; 26 per cent advocated attitudes on gender equality in organizations; and 15 per cent developed reproductive health education plans and programmes for youth. Other measures used included the provision of civic education on gender roles and the instilling in boys of positive attitudes on gender equality through rooting them in family values. Nearly all the regions reported that they had reviewed and revised textbooks and curricula to reflect gender equality

Table 3.5 Measures Taken by Countries to Enable Men to Support Women's Rights and Empowerment

Measures Taken	Number and Percentage of Countries	
	No.	%*
Provision of IEC/advocacy campaigns on men supporting women	57	54
Formulation of plans encouraging male involvement in reproductive health	44	42
Adoption of laws and legislation for paternity	16	15
Total	**106**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

as a measure to instill respectful attitudes in boys towards girls. Many of the Arab States mentioned that they had undertaken IEC and advocacy campaigns on gender equality.

Enabling men to support women's rights and empowerment

On the question regarding actions taken to enable men to support women's rights and their empowerment, out of the 151 responding countries, 106 (70 per cent) reported that they had taken measures in this area. The reported actions included legal, legislative, programmatic and administrative measures.

Table 3.5 shows that fifty-four per cent of countries reported that they had undertaken IEC and advocacy campaigns on men supporting women; 42 per cent had formulated plans encouraging male involvement in reproductive health and 15 per cent had adopted laws and legislation for paternity leave. Countries that adopted laws and legislation for paternity leave were: Bahamas, Bhutan, Cape Verde, Cuba, Democratic Republic of Congo, Estonia, Guinea, Haiti, Latvia, Nicaragua, Papua New Guinea, Philippines, Senegal and Viet Nam.

Male-focused measures against gender-based violence were reported by several countries. For example, in Jamaica a number of women's NGO groups formed a Women's Manifesto Committee, which actively sought the participation of men and men's groups in addressing the increased rates of domestic and sexual violence towards women and girls.

In the various regions, all countries reported that they had taken measures to promote male contraceptive methods. All countries in the Central Asian Republics had carried out IEC and advocacy campaigns on men supporting women, while in the Pacific, 57 per cent reported doing so. Similar campaigns were undertaken in Africa (56 per cent) and the Caribbean (54 per cent). The formulation of plans encouraging male involvement in reproductive health was an additional important measure taken by countries in the Caribbean (62 per cent).

3.7 CULTURAL CONSIDERATIONS

The 2003 Global Survey asked countries to describe

Nearly all the regions reported that they had reviewed and revised textbooks and curricula to reflect gender equality as a measure to instill respectful attitudes in boys towards girls.

whether the cultural context of the country contributed to or constrained the promotion of gender equality, equity and women's empowerment. Of the 151 countries that responded, only 25 (17 per cent) reported that the cultural context was not discriminative towards women, and 12 (8 per cent) reported that women were respected as mothers and that children were treated equally irrespective of gender. Forty countries (26 per cent) mentioned cultural constraints as a result of gender discrimination in the division of labor. Unfortunately, countries did not elaborate on their responses, hence the difficulty of presenting an in-depth analysis of the cultural dimension relating to gender concerns. It is apparent from the responses that many countries had difficulty in responding to the question.

3.8 CONCLUSION

Since Cairo, gender has played an increasingly prominent role in population and development agendas.

However, countries trying to implement the gender component of the ICPD PoA have encountered a number of constraints. These include the lack of accurate, timely and cross-country comparable data that is necessary to provide benchmarks and to serve as the basis for monitoring ICPD PoA implementation.

Integrating gender into policies and programmes has been fraught with difficulties. A misunderstanding regarding the concept of gender mainstreaming seems to still persist. For instance, although gender mainstreaming is generally accepted as a principle and acknowledged in policy statements, to many policy makers and planners it still remains a rather vague concept. There is the mistaken notion that mainstreaming simply involves raising awareness of the basic disparities between women and men. A better understanding of the scope and practical applications of gender mainstreaming and the need for adequate technical skills remain a challenge.

Although the past decade has witnessed a proliferation of laws (regarding violence against women and gender discrimination, for example) and policies have been established relating to reproductive rights, the operation and implementation of these laws and poli-

cies remain inadequate. Mechanisms to monitor gender equality and equity should be strengthened to help track efforts in closing the gender gap. Also, many countries have yet to establish modalities for monitoring compliance of gender-related regulations and the gender-related aspects of the ICPD PoA.

Other challenges include carrying out advocacy and IEC activities to increase the involvement of women in administrative and political decision-making; the promotion of greater male responsibility in family and reproductive decision-making through public education campaigns; and strengthening national capacity in the areas of gender and human rights by fostering dialogues and forging productive partnerships between, among others, civil society, women's groups, governmental structures and other coordination machineries for women's affairs, religious organizations, local power structures and donors.

Countries in all parts of the world have made considerable progress toward closing the gender gap. However, it is clear from the present analysis that many will fall short of ICPD and MDG targets. This may be due to broader societal factors such as faltering long-term economic growth, increases in income inequality and socio-cultural constraints. Yet, there remains a need for concrete action and demonstrable outcomes. Governments and civil society must commit themselves to achieving gender mainstreaming in policies and plans, in the spirit of the ICPD PoA and the Millennium Declaration.

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4 Reproductive Rights and Reproductive Health

4.1 INTRODUCTION

Reproductive health is the cornerstone of the consensus reached at the International Conference on Population and Development (ICPD). The goal is to ensure universal voluntary access to a full range of reproductive health care information and services by 2015.

At the ICPD it was agreed that reproductive health is a human right, part of the general right to health. The ICPD Programme of Action (ICPD PoA) defines reproductive health and explains its content.

The ICPD PoA says that reproductive rights "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions free of discrimination, coercion and violence, as expressed in human rights documents".[1]

The ICPD PoA and the ICPD+5 *Key Actions* describe a framework for providing reproductive health care within health systems, recognizing the importance of integrating family planning and services aimed at preventing sexually transmitted infections (including HIV) into maternal care.

In the decade since the ICPD, countries have embraced the idea and the practice of reproductive health, broadening programmes to reach more people in need of services; integrating family planning with pre- and post-natal care, childbirth services, STI and HIV/AIDS prevention, cervical and breast cancer screening, and referral for treatment where appropriate. There has been an increasing emphasis on improving access for underserved groups, including the very poor and people living in rural areas, and on ensuring that the poor have a stronger voice in policy-making, to ensure that information and services are adapted for their special circumstances.

Countries are paying attention to integrating reproductive health, including family planning and sexual health, with primary health-care services, in the con-text of health-sector reform and far-reaching changes in organizational, administrative and financing arrangements.

The HIV/AIDS pandemic is focusing more attention and resources on prevention and treatment. The growing presence of HIV/AIDS should increase rather than diminish overall resources: reproductive health programmes should be an important conduit for HIV-prevention activities and voluntary testing. These elements are especially important for women, who are more vulnerable to the infection than men. Young people, married or unmarried, are an especially important group for reproductive health interventions, because they account for a substantial proportion of unwanted pregnancies and half of all new STI and HIV infections. The youngest mothers are also at greatly heightened risk for maternal mortality and morbidity, including obstetric fistula.

Chapter 4 provides a review of reproductive health and rights, Chapter 5 focuses on adolescent reproductive health and youth, and Chapter 6 discusses HIV/AIDS.

4.2 ESTABLISHING REPRODUCTIVE RIGHTS IN PRACTICE

The promotion of the responsible exercise of reproductive rights, as stated in the ICPD PoA, should be "the fundamental basis for government- and community-supported policies and programmes in the area of reproductive health, including family planning".[2] The *Key Actions* provide additional guidance to: "Ensure that policies, strategic plans and all aspects of the implementation of reproductive and sexual health services respect all human rights, including the right to development, and that such services meet health needs over the life cycle, including the need of adolescents, address inequities and inequalities due to poverty, gender and other factors and ensure equity of access to information and services".[3]

Ensuring the full enjoyment of reproductive rights calls for recognition of a number of parallel rights, namely the rights to personal autonomy; to marry and found a family; to exercise free and informed choice; to be free of coercion in any form; and to privacy.

Countries have agreed and ratified legally binding international human rights treaties in several of these areas, including the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of All Forms of Discrimination against Women. The ICPD PoA explicitly states that coercion has no part to play in the provision of any reproductive health services.

To review progress made since 1994, the 2003 Global Survey asked questions about:

- Policy measures taken, and legislative and institutional changes or other major measures taken at the national level to establish reproductive rights;

- Whether reproductive rights and reproductive health are included in the monitoring of the implementation of human rights;

- Whether reproductive rights and reproductive health are included in the country's reports to human rights treaty (monitoring) bodies, including CEDAW.

Out of the 151 canvassed countries, 145 provided responses to the question on enforcement of reproductive rights, and of those 131 reported taking policy measures, laws or institutional changes at the national level to establish reproductive rights. An analysis of the regional differences reveals that relatively more countries took measures to enforce reproductive rights in Latin America, the Central Asian Republics, Asia and sub-Saharan Africa than in the Caribbean, CIS, Eastern and Central Europe, the Pacific and the Arab States. Only 14 countries reported no major measure to enforce reproductive rights. Even though results on reproductive rights from the 1998 and 2003 Global Surveys are not exactly comparable, there appears to have been significant progress since 1998 in this area.

As indicated in Table 4.1, many countries have reported formulating and adopting new policies, new national plans, programmes or strategies, or passing new legislation on reproductive rights. This is a major step in implementation. Fewer countries have reported information, education and communication or advocacy strategies, or institutional changes, including training staff on reproductive rights, although these are essential to secure the full enjoyment of reproductive rights.

There is growing recognition of the importance of incorporating reproductive rights into the law. Some countries, such as South Africa and Venezuela, include reproductive rights in their constitutions as fundamental human rights. Argentina passed a national law on sexual health and responsible parenthood. Some CIS, Eastern and Central European countries, for example Albania and Armenia, have adopted laws on reproductive health and reproductive rights based on ICPD principles. Moldova guarantees citizens' right to make decisions freely on reproductive health information and services, including family planning, under a law passed in 2000.

Many countries have adopted policies based on the principle of free and informed choice for all couples and individuals; for example, Azerbaijan, the Bahamas, Bhutan, India, Iran, Lao People's Democratic Republic, Pakistan, Sri Lanka and Thailand. The Health Master Plan of the Maldives focuses on the rights of individuals and couples to protect their reproductive health. The Arab States of Oman, Egypt and Yemen have specifically recognized the right to choose an appropriate method of contraception.

Countries increasingly use quality of care as an indicator to measure progress towards the implementation of reproductive rights. In Bulgaria, for example, the practice of informed consent is one of the criteria used to assess health centres for accreditation. Chile established a charter of patients' rights in 1998, stressing quality of care and treatment. Indonesia has given high priority to providing quality reproductive health information and services accessible to the poor.

Table 4.1 Major Measures Taken by Countries to Enforce Reproductive Rights

Measures Taken	Number and Percentage of Countries	
	No.	%*
Adopted national plans/programmes/strategies on reproductive rights	75	57
Formulated new policy on reproductive rights	71	54
Passed new law/legislation on reproductive rights	49	37
IEC/advocacy on reproductive rights	24	18
Implemented institutional change/training in reproductive rights	23	18
Total	**131**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Experience shows the importance of informing citizens of recent changes in law and policies. Many countries have strengthened information campaigns on reproductive rights.

4.3 MONITORING AND REPORTING OF REPRODUCTIVE RIGHTS

Worldwide, countries use a variety of mechanisms to monitor reproductive rights and reproductive health services (Tables 4.2 and 4.3). Some countries have national human rights institutions, including national commissions to monitor the implementation of human rights. Others have human rights ombudsmen; and many rely on the monitoring procedures of legally binding international human rights treaties.

Many countries recognize that reproductive rights should be included in their country reports to CEDAW and the Convention of the Rights of the Child Committees. However, reports to CEDAW are often perceived to be the exclusive domain of the government departments responsible for women's affairs, with the result that relevant actions by other departments are not brought to CEDAW's attention.

A number of countries have oversight bodies; for example Estonia and Kazakhstan. Countries such as India, Mongolia, Nepal, Tanzania and Uganda have national human rights commissions for monitoring human rights. India's human rights commission has adopted a declaration on reproductive rights and issued directions to various state governments to promote and protect reproductive rights.

Most countries in the CIS, Eastern and Central Europe report a relatively strong awareness of reproductive rights. Reproductive rights and reproductive health are usually monitored within the human rights framework: in addition to their inclusion in the monitoring of CEDAW, they are included also in the reports to the Human Rights Committee, which monitors the International Covenant on Civil and Political Rights, and to the Committee on Economic, Social and Cultural Rights. Turkey monitors reproductive rights through the procedures of the European Social Charter and the European Human Rights Convention. A study by the Mongolian Women Lawyers Association, to define positive steps taken since the adoption of its 1992 Constitution to protect reproductive rights and women's rights, highlighted existing conflicts and constraints in the legal environment, and suggested a framework and directions for future activities.

El Salvador, Ecuador and Panama have included both reproductive rights and reproductive health in their reports. In Bolivia, the Ombudsman's Office has intervened in cases of alleged violations of reproductive rights. Trade unions in Antigua and Barbuda are becoming involved in monitoring acts of sexual harassment in the workplace, as a result of which the Government is considering adopting CARICOM model legislation on "Sexual Harassment in the Workplace".

Table 4.2 Specific Measures Taken by Countries to Include Reproductive Health and Rights in Monitoring of Implementation of Human Rights

Measures Taken	Number and Percentage of Countries	
	No.	%*
Monitoring through various national and regional monitoring institutions	49	58
Monitoring through international conventions and reporting mechanisms	35	41
Monitoring through cooperation with NGO reporting mechanisms	10	12
Total	**85**	**100**

*Based on multiple responses: therefore percentages may add up to more than 100.

Table 4.3 Specific Measures Taken by Countries to Include Reproductive Health and Rights in Reporting on Human Rights Treaty Bodies

Measures Taken	Number and Percentage of Countries	
	No.	%*
Country regularly submits country reports to CEDAW	71	72
Country is signatory of CEDAW	60	61
Country submits reports to other human rights treaty bodies	29	29
Total	**99**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Many sub-Saharan African countries, for example Nigeria and Uganda, include the monitoring of reproductive rights within their general monitoring of human rights, particularly in areas such as harmful traditional practices, including female genital cutting and cases of gender-based violence.

In Asia and the Pacific, Bhutan, the Cook Islands, the Maldives, Malaysia and Thailand include reproductive rights and reproductive health in their reporting procedures to CEDAW. Samoa has taken the leadership in the South Pacific by driving and coordinating activities in connection with CEDAW, and by hosting a regional meeting in 2003.

Twelve of the 15 countries in the Arab region report to human rights treaty monitoring bodies, including CEDAW. A "shadow" report to CEDAW prepared by a number of health, social and legal NGOs in Palestine included both reproductive rights and reproductive health indicators.

Countries have some way to go in understanding the full extent of rights affecting reproductive health, and how they can be used to strengthen provision of the relevant health information and services. In their answers to the Global Survey questionnaire, most countries concentrated on CEDAW and the Convention on the Rights of the Child, leaving aside the reproductive rights aspects of other legally binding treaties such as the International Convention on Economic, Social and Cultural Rights.

In some countries, including Ecuador, Ethiopia, Ghana, Kenya and Liberia, NGOs such as women lawyers' organizations promote and monitor the implementation of reproductive rights. A number of countries, including Afghanistan, Bhutan, Chad, Eritrea, Fiji, Papua New Guinea, Somalia and Timor-Leste, do not monitor reproductive rights, often because they lack the capacity to do so. For many countries the collection and disaggregation of data remains a major problem.

4.4 INTEGRATION OF REPRODUCTIVE HEALTH IN THE PRIMARY HEALTH CARE SYSTEM

The ICPD PoA recognizes the importance of access to a set of integrated reproductive health information and services. The *Key Actions* reaffirmed the need to improve facilities, equipment, staff and skills, to provide resources for this purpose and to ensure the commitment of both policy makers and programme managers.

Experience over the last decade and responses to the Survey reveal a mixed picture. On the one hand, services are more extensive and contraceptive use is going up. On the other hand, the ability to supply reproductive health services, including family planning, is lagging behind a rising demand driven both by population growth and growing acceptance. Unmet need for family planning remains high among the poorest people and countries. Maternal mortality and morbidity remain

Mark Edwards / Still Pictures

stubbornly high, though there are some hopeful signs. The incidence of sexually transmitted infections, including HIV/AIDS, is rising rapidly in many regions, and especially among young people. Screening and referral for cervical and breast cancer is unknown in many locations.

Integration of reproductive health services into the primary health care system is essential to the success of achieving the ICPD goals. In that context, health-sector reform has had an important impact on countries' ability to deliver reproductive health information and services. Despite the challenges of resource constraints, different understandings and approaches to primary health care, integrating dedicated or vertical programmes with each other, and integrating reproductive health into primary health care, many countries have made special efforts to ensure that reproductive health receives its full share of attention.

The ICPD PoA states: "All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015".[4]

Primary health care should include a minimum package of family planning, maternal health services, and prevention and management of STIs including HIV/AIDS, as defined in the Programme of Action. In addition there should be opportunities for referral to higher levels of care.

There has been considerable progress in integrating reproductive health into primary health care services over the last 10 years: of the 136 countries reporting such measures, 81 indicated that they began after the ICPD. Only three countries said that they had taken no measures, and 93 countries that they had taken multiple measures.

Table 4.4 illustrates the wide variety of countries' responses to this question. All countries in sub-Saharan Africa have integrated a minimum package of reproductive health services into primary health care. In South Africa, the concept of making all services available and accessible through "one-stop service centres" led to the inclusion of reproductive health services in such centres. Eritrea, which is still in the process of establishing primary health care services, recognize the importance of including reproductive health. Côte d'Ivoire and Zimbabwe have included essential obstetric care in primary health care services and some countries, such

as Liberia, Mozambique and Zimbabwe, included STI and HIV/AIDS prevention.

Some Asian and Pacific countries with well-established family planning programmes had already included them as part of primary health care before the ICPD, and have since expanded them to cover a broader range of reproductive health services. In Malaysia, for example, core reproductive health service components, including specific obstetric care, had already been integrated into the primary health care system before the ICPD; since then, other reproductive health components, such as the treatment of reproductive tract infections, the treatment of infertility, and screening for cervical cancer, have been added.

Sixty-five per cent of the countries in Latin America have begun to integrate some components of reproductive health into the primary health care system.

Table 4.4 **Specific Measures Taken by Countries to Integrate Reproductive Health in Primary Health Care**

Measures Taken	Number and Percentage of Countries	
	No.	%*
Primary health care services expanded to include family planning	62	46
National plans/programmes/strategies on reproductive health integration	48	35
Information on STIs and/or HIV/AIDS prevention integrated	43	32
Information on teenagers and youth integrated	31	23
Integration through reproductive health providers	27	20
Integration through institutional changes on reproductive health	25	18
IEC/advocacy campaigns on reproductive health integration	14	10
National policies to integrate reproductive health	14	10
Local plans/programmes/strategies on reproductive health integration	12	9
Information on treatment of infertility integrated	10	7
Total	**136**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Argentina, Ecuador and Panama have produced manuals and guides for health workers and students. Bolivia has begun training and awareness programmes for health care staff. Training staff in reproductive health services is a priority in Honduras, as part of efforts to lower maternal mortality. Brazil has adopted a decentralized approach. Services, including for sexually transmitted infections, are now included in primary health care in Ecuador. Mexico, in addition to providing family planning and maternal health care as part of primary health care, also includes screening services for cervical and breast cancers and for menopausal and post-menopausal women. All countries in the Caribbean include some reproductive health components as part of primary health care. Services offered in some of them include free counselling, screening for cervical and breast cancer and for STIs, and specialist referral services.

Even before the ICPD, various components of reproductive health had been integrated into primary health care systems in some countries of the CIS, Eastern and Central Europe, for example Belarus, Estonia and Lithuania. In others, integration took place immediately after 1994, when family doctors and general practitioners began to offer a wide range of reproductive health services, including regular reproductive health check-ups for women. Training, continuing professional development and retraining of health professional and other health service staff can often lead to the inclusion of reproductive health in primary health care. The Russian Federation has created 500 centres for reproductive health within the public health service, and ambulance services with staff trained in reproductive health provide assistance to women in remote rural areas.

All countries in the Arab region attach great importance to primary health care. Countries such as

Bahrain, Turkey and Morocco have taken measures to ensure that reproductive health is included in primary health care. In other countries, maternal and child health programmes already in place before the ICPD relocated in primary health care services together with programmes for the prevention and treatment of STIs, including HIV.

4.5 REPRODUCTIVE HEALTH AND HEALTH-SECTOR REFORM

In the last decade, many countries have embarked on health-sector reform to improve efficiency, affordability, quality and client responsiveness. Reform implies structural changes such as integration and decentralization, posing challenges to under-funded health care systems that have grown up piecemeal. Integrating vertical reproductive health programmes into a broader reform process calls for commitment and strong advocacy, which has sometimes been lacking. Safe motherhood initiatives call for multisectoral strategies.

There have also been far-reaching changes since 1994 in financing arrangements. Most countries now rely on a combination of public and private health care providers and a variety of financing approaches, including risk-sharing arrangements or insurance schemes. Some countries, like Bolivia, have included reproductive health components in their basic health insurance scheme. This too has had an impact on reproductive health programmes.

Despite the difficulties, countries have included reproductive health in the reform process, and report some success. Of 120 countries implementing health-sector reform, 106 reported including aspects of reproductive health as part of the package. Some countries reported that their package recognized the needs of a specific clientele, for example adolescents and youth (73 countries); women, in particular pregnant women (58 countries); or women, men and youth (44 countries). A number of countries (20) reported that the package included information, education and communications on reproductive rights and reproductive health, while two countries said that the inclusion of reproductive health in the package allowed them to increase budget allocations for reproductive rights and reproductive health. Only 12 countries reported no measures to recognize reproductive health in their health-sector reform package.

BOX 4.1   SECTOR-WIDE APPROACH IN MOZAMBIQUE

A strategic plan for the health sector in **Mozambique** sets out five principles: efficiency and equity; flexibility and diversification; partnership and community participation; transparency and accountability; and integration and coordination through a sector-wide approach. In addition, the Ministry of Health takes gender differences into account at the policy, planning and programme levels, in order to meet the health needs of both men and women.

Over two thirds of the countries in Africa have included reproductive health as part of the health-sector reform package. In some countries, such as Botswana, measures include reviewing the institutional structure of reproductive health services to strengthen their implementation. Mauritius has set targets for improving reproductive health indicators. Integration of the reproductive health needs of adolescents is recognized as important in Cape Verde, the Democratic Republic of the Congo, Ghana and also in Angola, where, despite the fact that the health-sector reform process has not yet been completed, counselling services for adolescents and young people are already integrated in health facilities at the community level. A number of countries, including Ethiopia, Ghana and Tanzania, have also introduced reproductive health programmes as part of sector-wide approaches, set up as a means of implementing health-sector reform.

Health-sector reform is an important component for improving reproductive health in nearly all the countries of the Asia and the Pacific Region. The Philippines has included it as a key component of its women's health and development programme, a health-sector priority. In Cambodia, the health-sector strategic plan recognizes the importance of the health needs of adolescents and of youths. The health and population ministries in Pakistan have jointly developed a reproductive health package.

More than half of the countries in Latin America specifically recognize the health needs of women, men and youth as priorities in their health-sector reform packages. Emergency obstetrical care is included in the reform packages of nearly all countries in the region. In Chile, the package includes screening programmes for breast and cervical cancer, as well as the needs of post-menopausal women. Adolescent health is recognized in countries such as El Salvador, Honduras, Mexico and Panama where strategies include providing teenage-friendly services.

Most Caribbean countries include the reproductive health needs of women, men, adolescents and youths as priority components of their health-sector reform packages. The Bahamas, for example, include adolescent health, family planning and male initiatives in the work of the Maternal and Child Health Unit of its Department of Public Health. Guyana offers reproductive health services at all health centres and district hospitals; they are fully integrated at clinics, public hospitals and health centres. The Trinidad and Tobago package includes services for some population groups not previously considered as priorities — men, young people and infertile couples. Decentralization of services is taking place with the cooperation of regional health authorities and partnerships with NGOs.

Not all of the countries in the CIS, Eastern and Central Europe have implemented health- sector reform, and those that have done so have not always included reproductive health. Others, such as Albania and Lithuania, have targeted reproductive health as a priority or are working to integrate it, including maternal health and the prevention and management of STIs/HIV/AIDS, into district primary health care services, as has Azerbaijan, which has included reproductive health as part of health-sector reform.

The Arab States widely adopted health-sector reform, and a number of countries, including Djibouti, Jordan, Lebanon, Oman, Palestine and Somalia, have included reproductive health in the package. The main emphasis

Table 4.5 Key Measures Taken by Countries to Increase Access to High-Quality Reproductive Health Services

Measures Taken	Number and Percentage of Countries	
	No.	%*
Increased staff and training	77	54
Increased in number of service delivery points	48	34
Introduction of quality standards for health delivery	45	31
Allocation of more resources, including equipment for reproductive health	36	25
Improvement of management and logistics in reproductive health	36	25
Partnership with NGOs, international organizations and the private sector	33	23
Free reproductive health services in all public health facilities	25	17
Decentralized health care and service delivery system	24	17
Affordable reproductive health services in all public health facilities	21	15
Provision of youth-friendly services	18	13
Total	**143**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

has been on the provision of maternal and child health services, although Algeria has also included health services for adolescents, and Yemen and Oman have included HIV/AIDS prevention.

4.6 ACCESS TO HIGH-QUALITY REPRODUCTIVE HEALTH SERVICES

The 2003 Global Survey asked about key measures taken by governments to increase access to quality reproductive and sexual health services. Out of the 151 canvassed countries, 149 responded to the question, and 143 indicated the key measures they have taken to increase access to reproductive health services, including 115 countries reporting multiple key measures. Only six countries reported having taken no key measures to increase access to quality reproductive health services. Data from the 1998 and the 2003 Global Surveys are not exactly comparable, but it is clear that progress during the last five years has been significant both in the number of countries taking measures and in the variety of measures taken. Table 4.5 shows the variety of key measures reported by countries.

Countries emphasized the need to address shortages of trained staff, particularly in midwifery and essential obstetric care. Ghana, for example, has scaled up the provision of antenatal, perinatal and post-natal care at all levels, including the training of midwives and other service providers. In Benin and Guinea, the emphasis has been on recruiting additional personnel, and South Africa is making additional resources available for both the training of health care workers and the deployment of additional staff. Bangladesh has introduced a wide range of training programmes, including midwifery and essential obstetric care.

Capacity building in Asia and the Pacific includes training in quality-of-care approaches to all components of reproductive health programmes (as in Indonesia), and the introduction of programmes to update the knowledge and skills of service providers at different levels (as in Iran). The Fiji School of Medicine provides a regional training programme for the Pacific Islands, and Kiribati opened a School of Midwifery. Palau has introduced ongoing continuing education for young local physicians. In some countries, such as Bhutan, training for service providers has focused on improving service to people in hard-to-reach rural areas.

Training programmes in Latin America include Honduras, where auxiliary nurses are being licensed

MAP 1 **Measures Taken by Countries to Increase Access to Quality Reproductive Health Services**

This map does not reflect a position by UNFPA on the legal status of any country or territory or the delimitation of any frontiers. The final status of Jammu and Kashmir has not yet been agreed upon by India and Pakistan.

to provide certain services, including the insertion of inter-uterine contraceptive devices, injectable contraceptives and cervical screening.

A number of countries have introduced protocols for standardizing quality service delivery. In Bangladesh, the Democratic People's Republic of Korea, and Mongolia, for example, protocols are now in place for providing a wide range of reproductive health services, such as contraceptives; maternal and child health care; prevention and treatment of STIs and prevention of HIV/AIDS; and the quality control of reproductive health services. Indonesia is updating the existing pro-

Many Measures

Some Measures

Limited Measures

Donor Countries

No Information

tocols. In Jamaica indicators are being established for assessing and monitoring the quality of reproductive health services.

Many countries have worked to upgrade their reproductive health facilities. In Botswana, 90 per cent of the population now lives within 15 kilometres of a health care facility. Measures include: certification or accreditation of facilities (Mozambique); strengthening infrastructure and ensuring that specialized follow-up care is available (Brazil); mobile health units (El Salvador, Armenia); and free or low-cost services for slums and urban squatter settlements (148 countries).

4.7 FAMILY PLANNING

Access to a full range of modern family planning methods appropriate to age, gender and circumstances is essential for everyone who is sexually active. Access must be purely voluntary. Abstinence (or, for young people, postponing the start of sexual activity) must always be an option. However, experience and research over the last decade both show that encouraging abstinence and providing family planning information and services are not mutually exclusive: in fact, the more young people know, the more responsible their attitudes and behaviour are likely to be. Many married women do not have

Table 4.6 Key Measures Taken by Countries to Expand Contraceptive Choice

Measures Taken	Number and Percentage of Countries	
	No.	%*
Availability of emergency contraception	68	54
Availability of female condoms	65	52
Improving logistics for contraceptive availability	43	34
Subsidized or free contraceptives and/or services	27	21
Sale of contraceptives through pharmacies/other non-conventional sites	19	15
Training providers in contraceptive management	19	15
Social marketing "campaigns"	15	12
Total	**126**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

the option to refuse sexual contact with their spouses, and need access to methods under their own control.

Most developing countries with available trend data for the past ten years show a substantial increase in contraceptive use.[5] In 20 countries with two surveys since the early to mid-1990s, contraceptive prevalence increased in every case, from a starting average of 28 per cent to 35 per cent. The increase averaged 1.39 per cent per year, a proportional increase of 46 per cent. The proportion of modern methods used also increased in 19 of these countries. The poorest groups often showed the largest increases, especially when prevalence increased from relatively low levels. Government support has been an important determinant of contraceptive use.[6]

Around the world over 600 million married women are using contraception — nearly 500 million in developing countries. Five modern contraceptive methods — female sterilization, oral contraceptives, injectables, IUDs and condoms — are the most widely used methods. It has been estimated that as of 2000, some 123 million women did not have ready access to safe and effective means of contraception. The percentage of currently married women who need family planning but who are not using any method of contraception is, on average, 24 per cent in sub-Saharan Africa and around 18 per cent

in Northern Africa, Asia and Latin America and the Caribbean. In sub-Saharan Africa, many women are simply not aware of any modern form of contraception.[7]

Fertility fell in almost all developing countries in the last decade, as use of modern contraception rose, though speed and scale varied by region and by country. Findings from more than 100 surveys since 1990 suggest that more and more people want smaller families and more are succeeding in having the size of family they want. This is attributable to progress since the ICPD in providing information on, and improved access to, a wider range of contraceptive methods.

The Survey included a question on key measures taken to expand contraceptive choice. Out of the 151 canvassed countries, 143 responded to this question: 126 indicated having taken key measure, including 88 having taken multiple measures, and 17 countries reported not having taken any key measures. Progress since 1994 and since the ICPD+5 are significant, both in the number of countries taking major measures and in the variety of measures taken to increase information on and access to contraceptives, as well as to increase the choice of contraceptives (Table 4.6).

Two new contraceptive methods have become widely available in the decade since the ICPD: emergency contraception (the "morning-after pill") and the female condom, which is the only female-controlled method currently available to prevent HIV infection. An increase in resources has brought new impetus to research on microbicides against HIV infection.

Countries have used a variety of ways to popularize the female condom. Azerbaijan began with a government pilot scheme; in some countries of the Caribbean, family planning associations took the lead. The female condom is available in nearly two thirds of the countries in sub-Saharan Africa, although a number of countries report that it is not often used, for both financial and cultural reasons. A number of countries in Asia and Pacific reported limited use of female condoms. In Bhutan, they are being introduced to help prevent STIs and HIV/AIDS in high-risk areas. Papua New Guinea and Mongolia have introduced them recently as part of the HIV/AIDS prevention programme. Female condoms are available through both social marketing and the public health system in Bolivia. Chile plans to carry out studies on acceptability.

Emergency contraception is a useful supplement to family planning services. It is now available in many

Table 4.7 Key Measures Taken by Countries to Achieve Reproductive Health Commodity Security

Measures Taken	Number and Percentage of Countries	
	No.	%*
Provision of logistics management systems or procurement plans	70	59
Assistance from international agencies in securing/supplying contraceptives	39	33
Sharing facilities/interagency coordination plans for commodity security	33	28
Government partnerships with NGOs, private sector and religious groups for reproductive health provision	22	18
Training of management, administration and staff in logistics management	13	11
Total	**119**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

countries in sub-Saharan Africa, though not widely, especially in rural areas. In Mozambique, it is included in the formal training curriculum, and health units cut up packets of contraceptive pills to avoid the high cost of the dedicated product.

In Asia and the Pacific, emergency contraception is most likely to be available around big cities and in urban areas, sometimes still as a pilot initiative, in some countries through the private sector and/or the public health system. Emergency contraception is available, for example, in Cambodia, China, India, Iran, Indonesia, Mongolia, Nepal, and Thailand.

In some countries of the CIS, as well as some in Eastern and Central Europe, emergency contraception is available in some countries on a limited scale. In Latvia, for instance, it is sold as a non-prescription drug by drugstores. In Moldova, family planning doctors and pharmacists have been trained in its use.

4.8 ACHIEVING REPRODUCTIVE HEALTH COMMODITY SECURITY

The Programme of Action and the *Key Actions* stressed the need to make quality services affordable, acceptable and accessible to all who need and want them, including a reliable and adequate supply of a range of contraceptive methods and other reproductive health

commodities. Increasing demand as the result of population growth and wider use of services has stretched countries' ability to meet that demand.

Commodity security depends on having adequate supplies of reproductive health commodities, including condoms for HIV prevention, and on being able to forecast and respond to demand as it arises. Countries need the capacity to collect, analyse and report data and to secure, store and distribute supplies.

Responses to the 2003 Global Survey revealed a significant improvement over 1994, with 119 countries reporting one or more steps to improve reproductive health commodity security; 56 reported multiple measures. Only 18 had taken no measures (Table 4.7).

In sub-Saharan Africa, nearly 70 per cent of countries have established logistics management systems or procurement plans. Most have received external technical assistance in securing or supplying contraceptives. In some countries, as in Botswana, the government takes responsibility for the provision of all reproductive health commodities.

A number of countries in Asia and the Pacific, including some Pacific Island Countries, and Bangladesh, have introduced measures to resolve transportation problems. Another important measure is the allocation of a budget line in many countries.

Latin American countries have also taken steps, including logistics management systems or procurement plans, as in Paraguay and Nicaragua, which use a computerized system. In the Caribbean, Jamaica has developed annual contraceptive procurement tables with direct distribution of contraceptive commodities on a quarterly basis. Mexico set up systems to evaluate the needs of users and to maintain a wide range of modern, reversible methods.

BOX 4.2   PACIFIC COMMITMENT TO COMMODITY SECURITY

The **Cook Islands**, **Fiji, Samoa, Solomon Islands, Tonga** and **Tuvalu** developed the Pacific Plan of Action for Commodity Security in response to a resolution passed by the Commonwealth Health Ministers Meeting in 2002. Emphasizing the need for political leadership, the plan provides an independent budget line for commodity security. It calls for the establishment of regional warehousing with coordinated and effective storage and distribution systems, as well as for appropriate mechanisms for cost recovery and sustainability.

India's Ministry of Health has a division dedicated to reproductive health commodity security, and has appointed two national agencies for procurement. India's manufacturers produce and supply the country's own reproductive health commodities, and also export them. Iran also supplies much of its own contraceptive needs, encourages imports to fill gaps, and is adopting a model for contraceptive quality control.

Albania now has a national commission for contraceptive safety, and Armenia has set up a pilot logistics management information system. Azerbaijan has included access to quality contraceptives and medicines in its programme for poverty reduction and economic growth for 2000-2005 and has translated its training manual on contraceptive commodity security into the Azeri language. There are, however, still a few countries in the CIS, Eastern and Central Europe with no reproductive health commodity security policy or strategy.

Nearly 70 per cent of the Arab countries have taken measures to improve the purchase, storage and distribution of commodities. Countries like Syria and Lebanon are already funding, or working towards funding, their own procurement. In Palestine, reproductive health commodities are now included in the main procurement list of the Ministry of Health.

Many countries rely on external assistance to fund reproductive health commodities. Twelve countries in sub-Saharan Africa have reported that they are receiving assistance from development partners for contraceptive supplies, with 100 per cent donor funding in some cases. Examples can be found in all regions. Several countries, including Bhutan, Guatemala, Guyana, Honduras, Indonesia, and Peru are working towards self-sufficiency and have introduced budget provisions for reproductive health commodity security or cost-recovery schemes.

In many countries in all regions, reproductive health commodities are provided in partnership with NGOs such as family planning associations, or with the private sector, and many of these have developed inter-agency coordinating committees to ensure the availability of quality commodities at affordable prices.

4.9 REDUCING MATERNAL MORBIDITY AND MORTALITY

The ICPD recognized complications related to pregnancy and childbirth as among the leading causes of mortality for women of reproductive age in many parts of the developing world. They result in the death of an estimated 529,000 women each year, 99 per cent of them in developing countries. At least twenty times this number suffer from debilitating injuries and complications, including between 50,000 and 100,000 from obstetric fistula. Many of these deaths and disabilities could be avoided if all women had access to prenatal care, a skilled person in attendance during delivery, and access to emergency medical care should complications arise. A proportion of women will develop complications in childbirth, but it is difficult to predict or effectively screen for complications though antenatal care. Emergency obstetric care is therefore essential.

In 1999 the *Key Actions* refined and strengthened the ICPD goal of reducing by 75 per cent the incidence of maternal mortality. Where maternal mortality is high, skilled attendants should attend at least 40 per cent of births by 2005; 80 per cent by 2010; and 90 per cent by 2015. One of the eight Millennium Development Goals is reducing maternal mortality.

Of the estimated 529,000 maternal deaths in 2000, 95 per cent were in sub-Saharan Africa and Asia, four per cent (22,000) in Latin America and the Caribbean, and less than one per cent (2,500) in the more developed regions of the world. The maternal mortality ratio was estimated to be 400 per 100,000 live births globally in 2000. By region, it was highest in sub-Saharan Africa (830); followed by Asia excluding Japan (330); the Pacific, excluding Australia and New Zealand (240), Latin America and the Caribbean (190) and the developed countries (20). In high-fertility settings, women face this risk several times during their lives and the cumulative lifetime risk of maternal death may be as high as one in 16, compared with one in 2800 in developed countries.[8]

Five medical causes account for 75 per cent of maternal mortality. Conditions such as eclampsia or haemorrhage, which together account for over a third of maternal deaths, can arise quite suddenly, calling for greater emphasis on prompt recognition and referral. In sub-Saharan Africa, the proportion of deliveries with a skilled person in attendance increased from 33 per cent to 41 per cent between 1985 and 2000. Approximately 65 per cent of women in developing countries have some care in pregnancy; 40 per cent of deliveries take place in health facilities and skilled personnel attend slightly more than half of all deliveries.[9]

Strategies to reduce maternal mortality also need the support of broader efforts to address women's health. These include better nutrition for women and girls to build resistance and avoid anaemia; combating infectious diseases such as malaria and non-communicable conditions such as rheumatic heart disease; and averting violence. Reproductive health interventions promote the health and survival of infants and provide an important link between goals for child and maternal health.

The Survey asked countries to report on the key measures they have taken to reduce maternal morbidity and mortality; 146 countries out of the 151 canvassed countries responded, with 144 reporting specific measures and a large number (113 countries) reporting multiple measures (Table 4.8).

Countries such as Malaysia and Sri Lanka have maintained a supportive policy environment and sustained political commitment. In addition to having professionalized midwifery and ensured skilled attendance during childbirth, they have strengthened health systems, introduced civil registration, and improved access to services and quality of care through rural midwives with closely linked backup emergency obstetric services. They have tried to find the appropriate mix of private versus public expenditures.

Maternal mortality can be reduced significantly in a single decade, as Bolivia, China, Egypt, Honduras, Indonesia, Jamaica, Mongolia and Zimbabwe have shown. These countries have proved that strong safe motherhood policies can have an impact. The common factor is the presence of a skilled birth attendant or the availability of a capable and acceptable referral system.

Costs of safe motherhood services can be substantial and a major deterrent to use. Bolivia's insurance programme has increased the use of maternal services, but many of the poor remain outside the system. In

Indonesia, on the other hand, one small study found that the social safety net employed there to reduce costs of services to the poor did not increase the use of health facilities at all.

A number of countries in sub-Saharan Africa have introduced training in essential obstetric care including Angola, Benin, Burundi, Cameroon, Chad, Côte d'Ivoire, Guinea, Kenya, Lesotho, Liberia, Mozambique, Niger, Namibia, Senegal, Swaziland and Zambia. Many countries in other regions have also reported having provided midwifery training. In Iran, for example, rural midwives receive both theoretical and practical training for six months and are required to have managed at least 20 deliveries before qualifying as midwives. In Panama, the provision of training for midwives working in rural areas and with indigenous populations is a priority. Lebanon has phased out the use of untrained traditional birth attendants, and Lebanon and Oman have strengthened their referral services for emergency obstetric care.

Table 4.8 **Measures Taken by Countries to Reduce Maternal Morbidity and Mortality**

Measures Taken	Number and Percentage of Countries	
	No.	%*
Training of health care providers	76	53
Plans/programmes/strategies on maternal mortality	68	47
Improved prenatal and post-natal services	66	46
Improving data collection and record keeping for monitoring	45	31
Provision of IEC/advocacy on reducing maternal mortality	40	28
Creation of a network of reproductive health/ family planning clinics	21	15
Provision of maternal health services for vulnerable groups/remote areas	19	13
Partnership with UN agencies/ NGOs on maternal health services	17	12
Provision of transportation for emergency obstetric care	12	8
All deliveries take place in hospital	10	7
Total	**144**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Some countries, including Fiji, are encouraging all mothers to deliver either in health facilities or with a trained health professional in attendance. Bhutan is taking steps to ensure that at least half of all normal deliveries are attended by trained staff. Argentina has re-organized health services to carry out essential obstetric care. Chile has reduced the risks of childbirth with the use of guidelines for perinatal treatment. El Salvador has developed quality obstetrical model services in hospitals and health units. Paraguay has improved emergency and neonatal obstetric care. Uruguay has relatively low maternal mortality, as a result of widespread antenatal care and highly qualified staff attending births.

Governments in the Caribbean have established maternal and child health committees or technical advisory groups, including medical practitioners, nurses and social workers. Other measures include improved data analysis, emergency obstetric care and the widespread provision by midwives of antenatal and post-natal care. In Jamaica access to emergency obstetric care, including special facilities for transportation and referral to higher levels of care, is provided in each district. There are also special high-risk antenatal clinics, which provide in-clinic education about warning signs

in pregnancy and the appropriate action. Saint Vincent and the Grenadines holds an annual perinatal morbidity and mortality conference to analyse national data.

Many countries in sub-Saharan Africa have taken measures to improve antenatal and post-natal care and to ensure better nutrition; early treatment of malaria; and the provision of vitamin A supplements. In Latin America since the ICPD, 73 per cent of the countries in the region have improved prenatal and post-natal services, and 70 per cent have developed strategies and programmes to reduce maternal mortality.

There has been a significant decline in maternal and infant mortality in Egypt, where the general health of women and adolescent girls has improved, and services have been provided for prenatal, perinatal and post-natal care.

Many countries have taken measures to improve data collection and record keeping for monitoring purposes, for example Angola, Argentina, Bolivia, Cambodia, Cuba, Namibia, Sri Lanka, the Philippines and Zimbabwe. Measures include maternal mortality audits.

The urgent need in countries with high maternal mortality is for affordable and accessible emergency obstetric care, communications and transport. Some countries are making ambulance and blood-transfusion services available in rural areas. Mongolia, with its great distances and harsh weather, has 316 maternal rest homes at which women herders can stay and receive essential prenatal care during the weeks before delivery. In Syria the number of maternity centres has been increased and ambulances are provided, particularly in underserved areas.

Although some countries, including very poor ones, have been successful in reducing maternal mortality, progress in many countries remains slow. Maternal mortality and morbidity remain unacceptably high in many countries.

4.10 PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

Research, prevention and treatment of sexually transmitted diseases are among the reproductive health-related actions outlined in the ICPD PoA. The Survey included separate questions on HIV/AIDS, which are analysed in Chapter 6.

There are some 340 million new cases of curable sexually transmitted infections each year, according to the World Health Organization.[10] A high proportion of

Table 4.9 Key Measures Taken by Countries to Reduce and Manage STIs

Measures Taken	Number and Percentage of Countries	
	No.	%*
National plans/programmes/strategies	114	77
STI prevention, treatment and management service provision	99	66
IEC/advocacy campaigns on prevention and treatment	80	54
National commission/agency/ ministry/desk established by government	49	33
Partnerships with NGOs and UN and other international organizations	43	29
Monitoring surveillance systems	35	23
Educational initiatives that target vulnerable populations	27	18
National policies on prevention/ control of STIs	23	15
Social marketing of condoms and STI medication	22	15
Intra-governmental agency partnerships for service provision	13	9
Laws/legislation on prevention of HIV/AIDS/STIs	10	7
Total	**149**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

these infections are among young people, and young women are especially vulnerable. STIs by themselves account for a significant proportion of the global burden of disease; they also increase the risk of HIV infection, greatly increasing their impact on lives and health.

In women especially, STIs may be asymptomatic, making them more difficult to detect and treat, yet they can lead to long-term problems such as chronic pain, infertility, ectopic pregnancy, adverse outcomes of pregnancy, and genital cancers. Relying on observation of associated conditions and symptoms (the "syndromic approach") can lead to over-diagnosis and over-treatment, but effective diagnostic tools are not yet widely available.

The relative difficulty of diagnosis and treatment, and the serious consequences of STIs, especially for women's health, makes effective prevention even more vital, especially among young people, whether married or not. Information, education and communication programmes can help young people understand the need for and practice of responsibility in their sexual behaviour, including abstinence where appropriate: but services, including male and female condoms, are also essential.

All but two of the 149 countries responding to this question said that they had taken key measures to prevent and manage sexually transmitted infections, and 135 reported multiple measures. Table 4.9 shows the variety of the key measures taken by countries.

Sixty per cent of sub-Sahara African countries have implemented key measures for the prevention of STIs, in many cases as part of the prevention programmes for HIV/AIDS. Over 51 per cent of countries are providing services for STI prevention, treatment and management. While only seven countries have national policies for the prevention and control of STIs, more than half the countries in the region are undertaking information and advocacy activities. Given the high incidence of HIV in the region, it is critical that countries be vigilant in monitoring and surveillance of STIs; yet only nine countries reported having such systems.

In their programmes for STI and HIV/AIDS control, a number of countries in the region are using the syndromic approach to the treatment of STIs. They include Burundi, Côte d'Ivoire, Eritrea, Ghana, Guinea, Liberia, Namibia, Nigeria, Swaziland, and Zimbabwe. Chad and Guinea report widespread promotion of condom use. Botswana is providing screening programmes for the general public. Other measures taken include promotion of screening for sex workers; voluntary counselling and testing centres; and partner follow-up. However, many countries do not yet have these services in place.

Over a fifth of sub-Saharan African countries have increased the number of reproductive health personnel trained in the management of STIs and HIV/AIDS and to work in partnership with NGOs.

A number of countries in Asia and the Pacific have national policies on STIs, including Afghanistan, Bangladesh and Mongolia, where reproductive tract infections as well as STIs are included in the reproductive health services. Nepal has developed a national HIV/AIDS strategy, which is also seen as a road map for the prevention and reduction of STIs.

The Philippines, as part of its national AIDS and STI prevention and control programme, is integrating the syndromic approach in public-sector outlets; collaborating with private clinics on STI diagnosis, treatment and surveillance; promoting 100 per cent condom use;

providing STI drugs through social marketing; and collaborating with NGOs on peer education for condom promotion and STI prevention. A National Reference Laboratory on STIs and AIDS has also been established with offices in strategic places in the country. In India, the prevention, early detection and effective management of reproductive tract infections/STIs is included as an important component of reproductive health care through the existing primary health care structure; the nation is strengthening STI clinics in district hospitals and medical college hospitals, and is improving referral services for STI treatment.

Sixteen countries in Latin America and the Caribbean have reported plans, programmes and strategies for the management of STIs. In Brazil, more than 1,300 health service centres provide prevention and also treatment for both STIs and HIV. Chile has prevention programmes for both STIs and HIV, with 203 projects involving 435 organizations. Activities may include STI treatment for pregnant women, as in Bolivia. Peru has decided that education programmes should include prevention of STIs and HIV/AIDS, sexual violence and issues related to gender.

The high incidence of STI and HIV infection in the Caribbean is a matter of great concern to all countries in the region, and they are carrying out programmes for prevention and treatment. In Antigua and Barbuda, a relatively small country, the primary health care centre in the capital is designated as a treatment centre for STIs. Jamaica is improving case management in the public and private sectors; strengthening the contact investigation programme and the infrastructure of STI laboratories and blood collection and transfusion services; and conducting research to enable policy development.

Throughout the region, countries are carrying out education and information activities on STIs and HIV for the general public and high-risk groups. The Bahamas, for example, has provided HIV and STI education through a mass-media campaign. Governments work closely with NGOs, particularly family planning associations, in the fight to prevent STIs and HIV/AIDS.

In the CIS, Eastern and Central Europe, high and increasing incidence of HIV infection has led countries to step up prevention strategies, and is spurring measures to prevent other STIs. Romania, for example, has specialized services for STI diagnosis and treatment and is expanding services within primary health care. Treatment for syphilis is provided free of charge.

Governments have introduced measures aimed at preventing the spread of HIV/AIDS and other STIs, such as voluntary counselling and testing. The Russian Federation has adopted a federal programme on "Prevention and control of socially dependent diseases", which includes subprogrammes on the prevention of STIs and HIV/AIDS. Estonia has introduced programmes for young people and high-risk groups. Other programmes targeting young people are found in Armenia (with condom social marketing) and Belarus. Kazakhstan, where levels of HIV are low but STIs are a cause for concern, has begun a programme by government decree for the prevention and control of STIs. Some countries have developed information materials and media campaigns as part of their prevention activities. Other countries, such as Poland, have set up confidential phone lines and web sites.

Sixty per cent of countries in the Arab region have taken measures for the prevention, treatment and management of STIs; they have intoduced IEC and advocacy campaigns; and have set up monitoring and surveillance systems.

4.11 MANAGEMENT OF COMPLICATIONS OF UNSAFE ABORTION

The ICPD PoA encouraged countries to pay particular attention to the health impact of unsafe abortion as a major public health concern, including management of complications. An estimated 46 million pregnancies end in induced abortion each year, nearly 20 million under unsafe conditions. About 13 per cent of pregnancy-related deaths have been attributed to complications, about 67,000 deaths each year. Complications of unsafe abortion contribute to serious consequences such as infertility and chronic pain.

Of the 151 countries that responded to the Survey, 117 countries had taken key measures to prevent and manage complications of unsafe abortion (Table 4.10). Some countries indicated that strengthening their family planning services is a key measure to prevent unsafe abortions. Others reported measures (training, facilities, guidelines) to improve access to post-abortion services, both to manage complications and to prevent repeat unsafe abortion. For example, 40 per cent of the Arab States provide post-abortion services. In Nepal, where about half of maternal deaths are the result of unsafe abortion, policies and programmes have been developed to prevent unsafe abortion and manage complications.

Table 4.10 Key Measures Taken by Countries to Prevent and Manage Complications of Unsafe Abortions

Measures Taken	Number and Percentage of Countries	
	No.	%*
Provision of post-abortion services	62	53
Family planning services and contraceptives available as a preventative measure	38	32
Training of health care providers to provide post-abortion services	24	21
Setting up of facilities for prevention and management of abortion complications	15	13
Provision of guidelines for post-abortion care developed in absence of a policy or formal programme	14	12
Total	**117**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Many countries report that they allocate resources and facilities to prevent and manage the complications of unsafe abortion. In the Philippines, a progress report on the Millennium Development Goals referred to the prevention and management of complications of unsafe abortion: the Department of Health's mandate includes "the provision of quality and humane post-abortion care by competent, caring, objective and non-judgmental service providers in a well-equipped institution, complemented by a supportive environment for the women concerned".

Health professionals in most countries in sub- Saharan Africa are trained to deal with the consequences of unsafe abortion. Viet Nam and Laos have issued national guidelines and standards for the management of complications of unsafe abortion. In Bolivia, nearly all maternity hospitals have post-abortion programmes. Ethiopia has introduced national guidelines on post-abortion care. In Nigeria, specific sites have been established at which family planning services are integrated. Botswana includes family planning in post-abortion counselling.

4.12 INVOLVEMENT OF REPRODUCTIVE HEALTH BENEFICIARIES THROUGH PARTNERSHIPS

The Programme of Action and the *Key Actions* adopted the goal of ensuring that reproductive health services, including family planning and sexual health, are universally accessible by 2015, and that they are safe, affordable, confidential, treat clients with respect, and consider their diverse needs in a way that is gender-sensitive as well as culturally sensitive. Strengthening the voices of clients, especially women, and facilitating stronger partnerships between beneficiaries, providers and local officials, are at the heart of the ICPD agenda.

In response to the Survey's question about key measures to involve beneficiaries of reproductive health services, 124 of 137 countries responding indicated that they had taken key measures to involve beneficiaries, and 48 reported multiple measures.

Some countries have taken measures to assess the needs and opinions of the population by means of public hearings or consumer surveys, or by involving the community and civil society in policy and/or programme formulation. Countries have also established action groups at the local level; some countries have reported training community reproductive health workers to involve beneficiaries and meeting their needs. Finally, some countries have reported on information and advocacy activities aimed at informing and involving the beneficiaries (Table 4.11).

Over 40 per cent of countries in sub-Saharan Africa have taken measures to involve the beneficiaries of reproductive health service. Countries like Ghana and Mauritius have created community or local action

Table 4.11 Key Measures Taken by Countries to Involve Beneficiaries in Reproductive Health

Measures Taken	Number and Percentage of Countries	
	No.	%*
Consultation/inclusion of community representatives/NGOs/ community-based organizations in policy/programme development	71	57
Creation of community/ local action groups	30	24
IEC/advocacy campaigns on reproductive health	27	22
Surveys to solicit consumer views	17	14
Peer counselling	12	10
Total	**124**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

groups, recognizing that reproductive health is part of primary health care. Other countries have aimed at involving beneficiaries at the district and higher levels. Some countries have also involved adolescents in the provision of information on reproductive health for young people. Other countries have also involved special groups: for example, Eritrea has involved sex workers in peer education and management of programmes aimed at their fellow sex workers; Kenya has included village chiefs and traditional healers as community resource persons.

Throughout Asia and the Pacific, governments have begun to develop strong links and involve a wide range of beneficiaries in the provision of reproductive health services. They include women's groups, civil society groups and NGOs. Some governments acknowledge the need to make a concerted action to involve beneficiaries. Beneficiaries are involved in community needs assessments when plans are being made to decentralize services. The Malaysian approach is to conduct dialogues with service providers on the interests of beneficiaries and then organize meetings with the beneficiaries themselves.

In Latin America, countries involve community-based organizations and NGOs in programme development and evaluation. Brazil has set up health councils at the national, regional and municipal levels involving patients, caregivers, advocacy groups and other groups. Women's groups are involved in monitoring and evaluating the national programme in Argentina. In Honduras all systems, from mother and child clinics to national associations for people living with HIV and AIDS, use questionnaires, focus groups and in-depth interviews to elicit feedback. In Ecuador, the law on consumer protection gives the right to claim and receive damages in cases of low-quality or badly administered services.

In the Bahamas, focus-group discussions and interviews were held, involving adolescents, parents and teachers in the development of materials. Jamaica and Suriname also involve adolescents in developing programmes.

Governments in the CIS and Eastern and Central Europe work with NGOs such as family planning associations in the design and implementation of reproductive health activities. NGOs are particularly involved in reaching populations in rural areas. Many countries involve youth organizations, medical students' associations and schools in their work on providing youth-friendly health services. In Romania, the Government has consulted a coalition of NGOs active in reproductive health to help decide which reproductive health services should be included in the package to be financed by the health insurance system. Latvia has a "Patients Rights Bureau" that carries out regular surveys to assure patient satisfaction with health care, including reproductive health care. In Moldova, the views of consumers on their needs are included in radio discussions; surveys have also been carried out to consider the gaps in the reproductive health system, and the Client Oriented-Provider Efficient (COPE) programme is used to assess client satisfaction with family planning services.

Nearly 80 per cent of Arab States have taken measures to involve beneficiaries such as community-based organizations, NGOs, and women's organizations. In Lebanon surveys have been used to evaluate reproductive health services and awareness programmes, again involving NGOs.

4.13   MAIN CONSTRAINTS IN THE IMPLEMENTATION OF THE REPRODUCTIVE HEALTH APPROACH

The challenges involved in integrating reproductive health services into the primary health care system, especially in the context of health-sector reform, should not be under-estimated. Vertical programmes have their own rationales, history, cultures and dedicated staff which resist integration, often with reason: many countries have found it difficult to maintain quality and extend the reach of services while cutting costs and effecting synergies through integration. Preventive programmes such as family planning may lack advocates within the integrated system, putting them at a disadvantage in the competition for funding.

Similar problems have held up integrating or adding to the components of reproductive health programmes, especially as HIV/AIDS has become a priority. Family planning services are well established and widely used, but adding STI prevention and treatment has been more of a problem, especially in the absence of good diagnostic tools for STIs. Programmes have given insufficient attention to reaching men or young people, partly because of lack of resources, and partly because prevention has taken a lower priority in health services oriented to curative care.

On the other hand, it is clear that countries have overcome restraints and have successfully integrated reproductive health into primary health care, and the

different components of reproductive health care into a single system for delivery of information and services.

Constraints common to all regions include insufficient financing and lack of sustainability (64 countries); lack of trained health care providers (38 countries); lack of equipment and facilities (33 countries); difficulties in accessing services, particularly in remote areas, often due to insufficient decentralization (22 countries); and poor communications (19 countries). Countries also cited gender inequality, and problems in providing services for men and adolescents.

Of the 62 countries mentioning lack of financial resources, 26 are in sub-Saharan Africa. In Kenya, for example, there is no identifiable budget line for reproductive health services, and in Benin funds are inadequate to secure the necessary equipment and commodities to provide comprehensive reproductive health services. Latin American countries' financial and economic problems have held back progress.

Lack of human resources is a major problem in sub-Saharan Africa. Proactive involvement of health professionals has posed significant challenges in some Latin American countries; Argentina, Guatemala and Honduras have undertaken staff workshops, training programmes and advocacy campaigns to deal with this problem. In many countries civil unrest produces a high turnover of medical personnel in rural areas. Shortage of technical expertise holds back delivery of reproductive health services in some Caribbean countries, but career uncertainty inhibits qualified people from applying. In many countries, lack of technical expertise is compounded by lack of data or indicators for analysis, planning, management and monitoring.

Some countries cite "unmet need" for contraception as a constraint, while others report underutilization of reproductive health services. One of the major constraints is the difficulty in reaching and contacting the poorest of the poor, especially in rural areas. There may be difficulties in reaching distant islands or remote highland areas, or in maintaining services in the absence of all-weather roads.

Several countries have taken steps to ensure that information about reproductive health is available to the poor and illiterate. Many countries, like South Africa, have been translating information materials into local languages.

Innovative measures to overcome constraints include Azerbaijan's reproductive health programme with the Police Academy of the Ministry of the Interior; the programme aims to target uniformed personnel and to deal with the difficulties of reaching internally displaced persons.

4.14 CONCLUSION

The 2003 Global Survey shows that despite constraints, countries are moving ahead on the basis of the Programme of Action and the *Key Actions* adopted in 1999. Despite the impact of HIV/AIDS, countries are continuing to expand and improve the quality of, and access to, reproductive health services. Progress has been noted in:

• Acceptance and use of modern family planning continues to expand;

• Countries are confronting the threat of sexually transmitted infections;

• Safe motherhood is moving up the policy agenda, with more emphasis on attended delivery and referrals in emergency;

• Screening for cervical and breast cancers is making its appearance;

• Countries are taking steps to guarantee a secure and steady flow of reproductive health commodities to those who need them;

• Stakeholders in the community and civil society, especially women's groups, are becoming part of the policy-making apparatus.

Most important, countries have embraced the ICPD as their own policy agenda. They recognize reproductive health care as something every woman and man has a right to expect, and they are moving to make it a reality.

Countries have adopted a wide range of policy measures; as a practical matter they have included reproductive health in health-sector reform and integrated reproductive health into primary health care. Most countries are improving the training and increasing the numbers of health professionals and other service providers. They have improved service facilities and are improving access for those who need services, particularly those living in remote and inaccessible areas.

Much remains to be done in this respect, however, and improving accessibility and affordability, especially for poor households, will be a major emphasis for the

decade ahead. Poor countries and poor people in all countries still bear a disproportionately high share of the burden of reproductive ill-health, but lack access to, and the means to afford, necessary services and information. While some progress has been made in reaching the poor, especially in the area of family planning, the differences between the poor and rich are still staggering. In countries in sub-Saharan Africa, for instance, women in the richest quintile of the population are five times more likely to have access to and use contraception than women in the poorest quintile. In South Asia, a woman in the richest quintile is more than nine times more likely to have a skilled attendant at birth than a woman in the poorest quintile.[11]

Strategies that have been shown to be effective in making services more accessible to the poor and that should be further investigated and pursued include decentralization of health services down to the community level, alternative financing schemes such as social health insurance, and raising people's awareness of their rights as consumers. Improving the motivation of service providers, a key factor in improving quality of care, is another important area that needs to be explored and addressed. Gender-based violence, a tragic phenomenon affecting the lives of millions of women (especially poor women), needs to be addressed in reproductive health programmes.

Services for men in particular are still inadequate; many young people, even those who are married, still cannot find appropriate information and services to protect reproductive health. Gender imbalance in the provision of information and services, and underlying gender inequity, still threaten the attainment of ICPD goals: stubbornly high figures for maternal mortality in some developing countries tell their own story.

Since the ICPD, many efforts have focused on the development of client-centred services, including education materials, improved counselling, and soliciting users' perspectives to improve the delivery of services. Recognizing the importance of the demand side, new approaches are directed primarily at increasing the capacity of individuals and groups to obtain quality care, through raising awareness of reproductive health needs and rights and improving provider-client interactions.

The human rights approach should continue to guide policy, programme design and service delivery. By placing reproductive health in a broader context, and by emphasizing fundamental values, most notably respect for clients and their reproductive decisions, the rights-based approach can provide tools to analyse the root causes of health problems and inequities in service delivery and shape humane and effective reproductive health programmes and policies.

Extending reproductive health care to all by 2015 remains a reachable goal; it will, however, require the wholehearted commitment of all members of the international community.

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5 Adolescent Reproductive Health and Youth

5.1 INTRODUCTION

Nearly half of the world's population is under the age of 25, the largest youth generation in history. About 20 per cent of them, a staggering 1.2 billion, are in the age group 10-19 years.[1] Of these 87 per cent live in developing countries. Ensuring that they will enter adulthood in good health depends in part on empowering them to negotiate effectively with others to achieve a healthy lifestyle, including reproductive behaviour as outlined in the International Conference on Population and Development Programme of Action (ICPD PoA). The ICPD PoA made a major contribution to recognizing the rights of adolescents to health, including access to age-appropriate reproductive health information, education and services. The ICPD+5 *Key Actions* subsequently reaffirmed the right of adolescents to attain high standards of health. It emphasized the need to provide appropriate, specific, confidential, user-friendly and accessible services to meet young people's reproductive health needs.

Since 1994, countries have become more aware of the need to ensure that policies are in place to address the right to health and the reproductive health needs of adolescents; to introduce health education, including life skills for youth both in and out of school; and to provide access to reproductive health information, education and services. Subsequently, they have begun to recognize that investing in young people is critical to facilitating the achievements of the Millennium Development Goals, most of which are closely related to meeting the needs of young people.

Countries increasingly recognize that adolescent reproductive health (ARH) must be addressed in the context of other aspects of young people's lives, including acquiring life skills and the necessary support in terms of their future livelihoods, particularly through vocational training and employment opportunities. Furthermore, the cultural context in which adolescents live, grow and develop can contribute to or constrain their future growth and well-being.

Awareness has increased about addressing the diversity of the adolescent and youth populations. The needs of younger and older adolescents, boys and girls, married and unmarried adolescents, and those living in urban and rural areas should be addressed.

Countries are beginning to understand the need to develop gender-sensitive programmes that protect girls and facilitate their empowerment so that social norms do not expose them to reproductive health risks. At the same time they recognize the need to develop strategies to work with boys and young men to promote gender equality as well as reproductive health and reproductive rights.

Countries realize that sexual and reproductive health programmes help enable young people to become agents of change and development through their full participation in, and leadership on, issues affecting their lives and communities. This can help break the intergenerational cycle of poverty.

It was therefore deemed appropriate to include questions on adolescent reproductive health and reproductive rights in the Global Survey to facilitate the tracking of progress achieved in these areas since the ICPD PoA was adopted in 1994. This chapter outlines major changes that have occurred during the course of the implementation of the ICPD PoA. Major areas covered include measures taken by countries to: ensure the rights of adolescents to reproductive health information and services; provide health education, including life skills in and/or out of school; promote livelihood opportunities for adolescents and youth; promote youth participation in policy and programme development; and report on culture as a facilitating factor or constraint in the promotion of ARH. Examples of government and civil society partnerships on adolescent reproductive health and rights issues are presented in Chapter 8.

5.2 ADDRESSING THE RIGHTS OF ADOLESCENTS TO REPRODUCTIVE HEALTH INFORMATION, EDUCATION AND SERVICES

Although they represent a large and potent force for positive change, today's adolescents and youth face multiple challenges. For many, a bright future is tarnished by

poverty, lack of opportunities, abandonment of schooling, HIV/AIDS, unwanted and early pregnancies, and abuse and exploitation. The ICPD PoA and *Key Actions* recognize that protecting and promoting the rights of young people is critical to their ability to meet these challenges effectively — and to the common future of countries. No longer children but not quite adults, adolescents have evolving capacities to make decisions, think critically about their life options and assume responsibilities.

The ICPD PoA and *Key Actions* recommended that in order to protect the right of adolescents to the enjoyment of the highest attainable standards of health, the provision of age-appropriate, gender-sensitive, specific, accessible and user-friendly services should be provided. These must effectively address ARH needs. They must ensure that adolescents who are either in or out of school receive the necessary information, including information on prevention, education, counselling and health services, to enable them to make responsible and informed decisions regarding their reproductive health. One goal among others is to reduce the number of adolescent pregnancies.

The Global Survey shows that a number of countries have taken measures to address adolescent reproductive health and reproductive rights. Of 151 countries, 139 (92 per cent) indicated that they had taken at least one measure to address these issues. Seventy-nine per cent had taken at least two measures, reflecting a comprehensive approach to the issues. The measures could roughly be divided into two groups: (a) policy, legal and legislative measures; and (b) programmatic and strategic measures.

Policy, Legal and Legislative Measures

Policy, legal and legislative measures included: (a) development and implementation of policies sensitive to the issue (34 per cent); (b) development and implementation of laws and/or legislation on the reproductive rights and reproductive health needs of adolescents (27 per cent); and (c) ratification and implementation of United Nations conventions (9 per cent). See Table 5.1 for more details.

Just over a quarter of the countries have enacted laws and put in place legislation, including international treaties and conventions. The Convention on the Rights of the Child, which addresses the rights of children, including adolescents up to the age of 18, is the most widely ratified of all human rights

instruments. Many countries have introduced and implemented legislative measures to ensure that the rights that they have agreed to respect, protect, and fulfill in ratifying this Convention are implemented in their respective countries. This is particularly important in ensuring that young people receive information as well as services, particularly those related to their reproductive health. Also, countries have learned from experience that before laws are adopted there is a need for full consultation with those affected, including young people and teachers.

Some countries have rescinded laws and policies that restricted access of adolescents and youth to reproductive health information and services, while others are entertaining public debates about how best to ensure the right of adolescents to reproductive health.

Programmatic and Strategic Measures

Most countries face challenges in institutionalizing rights-based programming, a relatively emergent concept. Building on the recognition of those needs, a rights-based framework is rooted in the concept that people have rights they are entitled to enjoy and exercise. It is a relatively new concept that some countries are beginning to operationalize and it is from this perspective that they have carried out a number of programmatic and strategic measures. (See Table 5.2).

Actions in this area included: (a) formulating national plans and programmes (by 62 per cent of

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Table 5.1 Specific Measures Taken by Countries to Address Reproductive Rights and Reproductive Health Needs of Adolescents

Measures Taken	Number and Percentage of Countries	
	No.	%*
Policies developed and implemented on reproductive rights and reproductive health needs of adolescents	47	34
Laws/legislation developed and implemented on reproductive rights and reproductive health needs of adolescents	38	27
Ratified United Nations conventions	13	9
Total	**139**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Table 5.2 Specific Programmatic and Strategic Measures Taken by Countries to Address Reproductive Rights and Reproductive Health Needs of Adolescents

Measures Taken	Number and Percentage of Countries	
	No.	%*
National plans/programmes/strategies on reproductive rights and reproductive health needs of adolescents	86	62
IEC/advocacy campaigns on reproductive rights and reproductive health needs of adolescents	46	33
Reproductive health education integrated into school curricula	36	26
National commission on youth established	31	22
Partnerships with national and international NGOs on reproductive rights and reproductive health needs of adolescents	28	20
Provision of government funding for youth services	28	20
National health care programme includes ARH	26	19
Provision of counselling for adolescents	25	18
Training those who work with adolescents on reproductive rights and reproductive health needs of adolescents	14	10
Total	**139**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

the countries that took at least one measure) including the reproductive rights and reproductive health needs of adolescents; (b) utilization of information, education and communication (IEC) and advocacy campaigns on adolescent issues (33 per cent); (c) integration of reproductive health education into school curricula (26 per cent); and (d) establishment of a national commission on youth (22 per cent). Table 5.2 shows that a number of other measures were taken, albeit by fewer countries, such as creating partnerships with national and international NGOs on the reproductive rights and reproductive health needs of adolescents; provision of government funding for youth reproductive health services; provision of counselling for adolescents;

formulation of national care programmes including ARH; research on adolescents; and social marketing.

Countries have progressively recognized that adolescents and youth have a disproportionate share of reproductive health problems and more adverse consequences from them. HIV/AIDS has had a disproportionately high impact on young people. Some 13 million children under 15 years of age have lost one or both parents. One young person becomes infected with HIV every 14 seconds. Adolescent girls are among the most vulnerable to infection, with an estimated 7.3 million living with HIV infection as opposed to some 4.5 million males of a comparable age. Other reproductive health problems that particularly affect adolescents include unwanted pregnancy and childbirth, which are leading causes of death, and sexually transmitted infections, which can increase both the risk of HIV infection and infertility among adolescent girls. Young people are also at increased risk of attempted suicide; mental health problems; violence, including violence against women and girls; and sex trafficking.

Analysis of the Global Survey information showed that there was regional variation in the four most important measures taken by countries on adolescent reproductive rights/reproductive health issues. (See Chart 1.).

Compared to the 1998 Global Survey, there has been a significant increase in the number of countries protecting the reproductive rights and needs of adolescents through national programmes.[2] In fact, the number of countries reporting having taken at least one measure increased from 55 (48 per cent) in 1999 to 139 (92 per cent) in 2003. Fifty-five per cent of countries took at least two measures within the same period. The increase is more significant for countries that took at least two measures. For example in Asia and sub-Saharan Africa, there has been a significant change from 54 and 38 per ent respectively in 1999 to 78 and 80 per cent in 2003. This may be due to the urgency required to address the varied needs of large youth and adolescent populations, especially with pressing and emerging health issues such as the HIV/AIDS epidemic. (By 2000, HIV/AIDS had become a disease of young people, disproportionately affecting adolescent girls.) The percentage of countries that have taken at least two measures provides an indicator of the comprehensiveness of efforts being made to meet adolescent reproductive rights and reproductive health needs.

Chart 5.1 **Important Measures on Adolescent Reproductive Health Taken by Regions and sub-Regions**

Regions/sub-Regions	1. Formulate national plans, programmes	2. Develop and implement policies	3. Use IEC and advocacy campaigns	4. Develop and implement legislation
Africa, Caribbean, and the Pacific	Yes	Yes	Yes	
Asia and Arab States	Yes			
Latin America	Yes			Yes
Central Asian Republics		Yes		Yes
The CIS, Eastern & Central Europe and Turkey	Yes			Yes

If we relate countries taking at least two measures on adolescent reproductive rights and reproductive health to indicators on the enrolment of girls in secondary schools and to adolescent fertility, we find some interesting results. Seventy-four per cent of countries that have female enrolment rates of less than 50 per cent took comprehensive measures, as opposed to 70 per cent with enrolment rates of 50 per cent or more. Eighty-six per cent of countries with adolescent fertility rates of 100 per thousand or more took comprehensive measures, as opposed to 73 per cent of countries with adolescent fertility rates below 100 per thousand. This supports the notion that countries with many problems facing adolescents and youths, such as low enrolment rates for girls and high adolescent fertility rates, made more concerted efforts to meet needs in the areas of adolescent reproductive rights and reproductive health.

This observed progress may be partly attributed to the fact that since 1994, programmes that have adopted a more comprehensive approach to young people's needs appear to have been more successful in improving their reproductive health. In many countries, however, adolescent reproductive health programmes are still predominantly small and need scaling up. This is one of the challenges countries will face in the next ten years of the ICPD.

In addition, countries have increasingly come to recognize that gender mainstreaming is a critical but largely neglected aspect of programming. Gender discrimination and roles are key factors in young people's reproductive health and lives, often severely limiting their options and choices. However, programmes have tended to treat young people as a homogeneous group. An additional future challenge is to design programme strategies specific to the profile of the intended beneficiaries.

5.3 PROVISION OF HEALTH EDUCATION, INCLUDING LIFE SKILLS, IN AND/OR OUT-OF-SCHOOL

To implement the ICPD PoA in terms of promoting the well-being of adolescents, enhancing gender equality and equity, and encouraging responsible sexual behaviour, attention is increasingly being given to providing formal and non-formal education on population and health issues. In the area of reproductive health, these issues include protecting adolescents and youth from early and unwanted pregnancy, sexually transmitted infections (including HIV/AIDS), and sexual abuse, incest and violence.

Creating comprehensive, gender-sensitive and age-appropriate sexual and reproductive health education programmes based on the concept of gender equality was one of the most important actions proposed by the ICPD PoA. Educational programmes designed for adolescents both in and out of school need to have a life-skills approach that helps young people develop self-esteem and a sense of their own identities. Moreover, the programmes should strengthen personal peer and mentoring relationships so young people can make responsible choices about their health, including reproductive health; promote gender equality in personal relationships; improve livelihoods and increase involvement in household work and family processes

(including pregnancy and childbearing); and foster mutual respect and love in relationships, which must reject all forms of gender-based violence and harmful traditional practices.

The Survey indicated that 140 (93 per cent) of 151 countries have taken at least one measure to introduce health education, including life skills, into school curricula and programmes for out-of-school youth. In Table 5.3, the four measures most applied were: (a) provision of school curricula including sexual and reproductive health and life skills (89 per cent); (b) out-of-school programmes and clinics (39 per cent); (c) training on reproductive health for teachers and other school staff (26 per cent); and (d) peer education programmes (19 per cent). Other measures include: IEC/advocacy; extracurricular activities on reproductive health and life skills; education for primary students in reproductive health and life skills; use of media channels such as TV, radio, Internet and hotlines to convey information on reproductive health and life skills; provision of training manuals and teaching guides on reproductive health and life skills; initiation of pilot projects on reproductive health and life skills; and expansion of reproductive health and life-skills education to more schools and more grades.

The measures taken by countries to provide education on health and life skills vary according to the cultural context, resources available, influence of religion, and other factors. The measures are primarily implemented at the secondary or tertiary level of education. Information on reproductive health is included in school curricula and out-of-school programmes at varying levels of depth. Nearly all countries now promote the teaching of life skills to youth and adolescents, and often this includes reproductive health education, at times achieved by building on the concepts of family life education.

While all regions put primary emphasis on the provision of school curricula including sexual and reproductive health and life skills (100 per cent for Asia; 98 for sub-Saharan Africa; 88 for the Caribbean and the CIS, Eastern and Central Europe; 85 for Arab States; 73 in Latin America; 58 in the Pacific; and 50 in the Central Asian Republics), they utilized the other measures in different magnitudes. The second most important measure for sub-Saharan Africa, Asia and the Pacific, and the Central Asian Republics was the provision of programmes and clinics for out-of-school youth, while for the Caribbean

and Latin America it was the training of school teachers and other staff. The Arab States applied both these measures. Asia and the Caribbean reported utilizing some innovative pilot projects, while sub-Saharan Africa, Asia and Latin America recognized IEC/advocacy as an important tool.

Twenty-two countries reported the introduction of health and life-skills education in primary schools. More than 36 countries globally, and nearly a third of countries in Latin America and the Caribbean, are providing training for teachers on how to reach youth concerning reproductive health and building life skills, and providing necessary education materials. Some countries mentioned that although teachers received training, they are still not competent or comfortable enough in teaching the subject to their students or in working with parents and community and religious leaders on these issues.

Countries still face the important challenges of providing gender-sensitive, comprehensive health and life-skills education and enabling teachers to talk openly and comfortably with their students. Countries have

Table 5.3 **Specific Measures Taken by Countries to Introduce Reproductive Health Education in and/or out of Schools**

Measures Taken	Number and Percentage of Countries	
	No.	%*
School curricula includes reproductive health and/or life skills	124	89
Out-of-school youth programme and/or clinics	55	39
Training on reproductive health for teachers and/or school staff	36	26
Peer education programmes	27	19
IEC/advocacy	26	19
Extracurricular activities on reproductive health and/or life skills	24	17
Primary student reproductive health/life-skills education	22	16
Use of media, including TV, radio, Internet, hotlines	10	7
Training manuals and/or teaching guides	10	7
Total	**140**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

also noted that life-skills education is not often introduced in schools until students are in secondary or tertiary levels of education, and that it is not always offered in all schools, despite the fact that it is recognized to be highly popular with students.

Religious leaders and parents sometimes erroneously believe that the introduction of sexual health education will lead to increased sexual activity and promiscuity. This creates resistance to its introduction. Some governments are taking proactive measures to work with religious leaders and involve parents in the development of the curricula in schools. Some countries face problems because of a lack of consensus on the importance of including life-skills education in the curriculum.

Additionally, programmes have also been introduced for out-of-school youth in 55 countries (39 per cent). These youth may be more difficult to reach due to insufficient human and financial resources as well as inadequate transport for extension workers to cover rural areas. Yet a number of innovative programmes have been developed to meet the specific needs of this target group, in particular with NGO support. Health and life-skills education, including components on reproductive health, is provided for out-of-school young people through specific programmes, including clubs, summer camps, workshops and seminars conducted by NGOs, particularly in rural areas. Mass media including radio, television and newspapers is also used in some countries. Peer education programmes are also being implemented by 27 countries (19 per cent) to reach youth both in and out of school.

5.4 PROVIDING ACCESS TO INFORMATION ON REPRODUCTIVE HEALTH TO ADOLESCENTS

During the past decade, there has been a major change in how information is made available to adolescents and youth. In addition to its inclusion in the school curriculum, the emphasis has historically been on the production and distribution of written materials (comics, posters and publications aimed at young people); street plays; dramas and popular songs. Countries now recognize that the provision of information through the mass media is not only cost-effective, but is also appealing to young people. When tailored to the tastes and language of young people, mass media outlets, including TV, radio, popular magazines, music concerts, and the Internet, have proved capable of capturing large audiences. Mass media is very cost-effective

per person reached. Therefore, government and NGO-supported programmes are experimenting with this approach on a larger scale. Examples of efforts in this area are presented in Chapter 7.

The mass media also helps expose taboo and neglected issues by encouraging more open and public discussion. This can be a first step in mobilizing public and political awareness about critical issues in young people's lives. Media such as telephone hotlines, web sites or call-in radio shows are popular and valuable sources of information and/or counselling for young people. They offer them anonymous access to valuable information, surpassing the common barriers and concerns of having to go through adults (e.g. teachers, service providers, parents, others) to gain access. They also provide important information about where to access services.

Of the 151 countries responding to the Global Survey, 133 (88 per cent) reported taking action to provide access to information on reproductive health to adolescents. Findings in Table 5.4 indicate the measures that countries took to provide information. These measures included: (a) IEC/advocacy (54 per cent); (b) formulation and im-

Table 5.4 Specific Measures Taken by Countries to Provide Access to Information on Reproductive Health, Including Life Skills

Measures Taken	Number and Percentage of Countries	
	No.	**%***
IEC/advocacy	72	54
National education plan/ programme/strategy on access to reproductive health information by adolescents	46	35
Provision of peer education programmes	38	29
Establishment of youth-friendly services	38	29
Use of media, including TV and radio	37	28
Provision of counselling to adolescents and youth	32	24
Establishment of youth association/organization	27	20
Promotion of youth focused NGOs	26	20
Provision of a hotline	15	11
Total	**133**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

plementation of national education plans, programmes and strategies taking in account access to reproductive health information by adolescents (35 per cent); (c) provision of peer education programmes (29 per cent); and (d) establishment of youth-friendly services (29 per cent). Other measures included: use of media such as TV and radio to convey reproductive health information; provision of reproductive health counselling to adolescents and youth; establishment of youth associations/ organizations; promotion of youth focused NGOs; and provision of hotlines.

The notable measures used by each region were: sub-Saharan Africa: IEC/advocacy, media, peer education, youth-friendly services. Asia: IEC/advocacy, plans and programmes, media. Latin America and the Caribbean: IEC/advocacy, plans and programmes, youth-friendly services. The CIS, Eastern and Central Europe: IEC/advocacy. Central Asian Republics and the Pacific: IEC/advocacy, media. The Arab States: IEC/ advocacy, peer education.

Innovative measures such as using hotlines were reported in sub-Saharan Africa (three countries), Asia (four), Latin America (two) and the CIS, Eastern and Central Europe (two). Youth associations were reported by sub-Saharan Africa and Asia; provision of counselling services by Africa, Asia, Latin America and the CIS, Eastern and Central Europe; and promotion of youth-focused NGOs by sub-Saharan Africa, Caribbean, Latin America and the Arab States.

A number of countries have produced video and audio spots and media programmes for adolescents. Many others are using web sites and audio-visual materials. Youth are able to use free telephone hotlines in many of the countries, though primarily in urban environments, and can also refer to newspaper columns specially designed to meet their needs. For example, in the Bahamas there is a newspaper supplement entitled *The Vibe and Youth Corner*. Most recently young people have been able to access web sites and e-mail in order to find out what they want, or need, to know. Obviously this type of information is limited as far as adolescents in remote rural areas are concerned. Therefore, a mixed approach combining traditional and modern methods has been implemented.

For many young people it is important to be able to ask for information face-to-face, and 32 countries have responded to this need by taking measures to provide places where adolescents can meet and receive infor-

mation and counselling. Also, 27 countries have established youth associations or organizations. In Trinidad and Tobago, youth groups and advocacy groups work with young people, as does Rapport, the youth arm of the National AIDS Programme. Thirty-eight countries have established youth-friendly services to create environments for youth to access information. Youth festivals are also held in many countries. In most cases the development of parental support has been recognized as important, as has the utilization of peer counsellors.

Governments recognize the important role that NGOs and civil society can play in making information available to young people. They therefore support the provision by NGOs of information on available services for young people, and work with service providers to ensure that they treat adolescents with respect when they seek information and services.

The main challenges faced by governments when considering mass media strategies concern the sustainability and continuity of motivational messages to achieve behavioural change, and to foster ongoing shifts in social norms governing gender and sexual and reproductive issues. In some countries, the Ministry of Youth and Sports collaborates with youth associations, community elders, sports clubs and civil society organizations working on youth issues. In some countries, teams of trainers on adolescent sexual and reproductive health have been established. At the same time, National Strategic Plans to Combat HIV/AIDS, which focus particularly on young people, include peer education activities.

Other constraints include lack of resources to provide appropriate materials, and problems in training peer educators where the emphasis is predominantly on training adults. In some countries, providing information to unmarried adolescents and young people still causes problems, as it requires an approach that is socially and culturally acceptable. Where there is a high percentage of married adolescents, special programmes are being developed to address their needs. Other constraints that have been identified are lack of resources and the provision of information for hard-to-reach adolescents.

5.5 PROVIDING ACCESS TO REPRODUCTIVE HEALTH SERVICES

The ICPD PoA provides a clear recommendation to countries to provide adolescents access to affordable, confidential, gender-sensitive, youth-friendly reproductive health services. This was also underscored at other

international conferences, including the Fourth World Conference on Women, the Special Session on HIV/AIDS and the Children's Summit. The urgency of providing services to adolescents is rooted in the fact that the benefits of adolescent sexual and reproductive health are far-reaching.[3] In addition, half of all those with HIV become infected before their twenty-fifth birthday. The fact that adolescent girls are being infected at a rate five to six times higher than boys suggests that gender-discriminating practices leave adolescent girls with fewer skills for self-protection. Biological, social and economic factors make young women especially vulnerable to HIV, occasionally leading to infection soon after the women have become sexually active.

Since the ICPD and particularly since the ICPD+5, there has been major progress in the provision of reproductive health services for adolescents and in the confidence with which adolescents and youth access these services. Youth-friendly services are being designed to enable adolescents to feel comfortable using them. They are being made more accessible because young people cannot or will not travel great distances to go to them. Adolescents also attach importance to confidentiality and privacy since they do not want their parents or others in their community to know that they are using the services. The training of health-care providers in providing counselling and care for adolescents is recognized as being important. The needs of adolescents, whether married or unmarried, are increasingly recognized as unique to their age group.

Of the 151 countries responding to the Global Survey, 136 countries (90 per cent) are taking action to provide adolescents and youth access to reproductive health services. Of those, 78 countries (57 per cent) reported the establishment of youth-friendly services. Other notable measures reported in Table 5.5 were: plans and programmes for providing reproductive health services to adolescents (34 per cent); provision of counselling for adolescents on reproductive health (27 per cent); and IEC/advocacy on reproductive health services for adolescents (27 per cent). Countries also utilized: provision of guidelines and standards on ARH; adoption of policies on reproductive health provision to adolescents; and laws/legislation on adolescent reproductive health.

Although a mix of measures were used by each region, the focus was on: plans and programmes for providing reproductive health services to adolescents in the Central Asian Republics (80 per cent); youth-friendly

reproductive health services in sub-Saharan Africa (77 per cent), Latin America (69 per cent), the CIS, Eastern and Central Europe (75 per cent), Caribbean (60 per cent), and the Pacific (42 per cent); a mixture of provision of counselling and IEC/advocacy in the Arab States (40 and 40 per cent respectively); and plans and programmes, provision of counselling, and IEC/advocacy in Asia (39 per cent for each of them).

The actions countries took vary significantly according to region and cultural context, but some common themes were evident. Often, countries reported that ARH care services are offered through the general health care system, family planning units, or local clinics and that anyone of any age is free to access reproductive health services from clinics and hospitals. However, 78 out of 151 countries recognized the importance of having youth-friendly services and reported the establishment of at least one youth-friendly service centre.

Among the challenges reported were that unmarried and rural youth, married adolescent girls and young men are especially underserved groups, and service providers have difficulty attracting them. Services still reach relatively few adolescents. They are often used primarily by older young people, rather than by those in greatest need for whom the services were intended. There are

Table 5.5 **Specific Measures Taken by Countries to Provide Adolescents with Access to Reproductive Health Services**

Measures Taken	Number and Percentage of Countries	
	No.	**%***
Establishment of youth-friendly reproductive health services	78	57
Plans/programmes/strategies on access to reproductive health services by adolescents	46	34
Provision of counselling on reproductive health	37	27
IEC/advocacy on reproductive health services for adolescents	37	27
Provision of guidelines and standards on ARH services	23	17
Policy on reproductive health provision to adolescents	14	10
Law/legislation on ARH services	10	7
Total	**136**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

also very few large-scale public-sector programmes on ARH in developing countries. Most youth-friendly services have been developed on a smaller scale by NGOs.

The availability of youth-friendly services does not necessarily mean that young people will use them. Also crucial is a supportive community environment that makes young people feel safe and comfortable in doing so. Governments report that negative community attitudes and psychosocial barriers may be a determining factor in why young people will not seek services, even when they are youth-friendly and conveniently located. Clinic services have been more successful when they combine youth-friendly service provision and outreach with community awareness-raising. Community sensitization efforts de-stigmatize services and make them more acceptable, thereby overcoming key barriers to access by young people.

Non-clinical settings and multiple service delivery points have been useful in providing services. Some governments report that this appears to increase access to services by young people.

Despite observed progress, a number of constraints remain. Countries are working to overcome these constraints with a view towards increasing access in the future. To address the cost of providing special services for youth, some countries are scheduling regular services with specific times for adolescents, or are providing these services in youth clubs or other venues where adolescents meet together. The full workloads of service providers combined with low salaries create resistance to the introduction of further commitments, such as youth-friendly services.

Adolescents may still experience stigma and discrimination and require consent for services when they go to youth-friendly clinics. For this reason, while contraceptive knowledge is high, this may not be reflected in contraceptive use among young people, despite the fact that young people may have a high number of sexual partners. However, the threat of the spread of HIV/AIDS among young people has made it easier for them to obtain condoms. Confidentiality is another issue that is considered important, particularly in countries with small populations.

Other constraints encountered include a lack of political will; inadequate resource allocation; attitudes of health providers and lack of training; non-involvement of youth in planning, implementation, monitoring and evaluation of programmes and the actual costs to the young people themselves. Further, the diversity among adolescents and youth is vast and may be difficult to take into account as a number of countries are in the early stages of taking action to address their needs. However, progress has been made in taking action to address the needs of subcategories of adolescents (Box 5.1).

BOX 5.1   **EXPERIENCES OF COUNTRIES WORKING TO IMPROVE ACCESS TO YOUTH-FRIENDLY SERVICES BY ADOLESCENTS AND YOUTH**

In sub-Saharan Africa, **Uganda** has recognized that the specific needs of the girl-child should be addressed, particularly within the context of HIV/AIDS. The country is also using youth groups to reach out-of-school youth. Urban youth were the targets of some HIV/AIDS programmes in **Côte d'Ivoire**.

In Asia and the Pacific, services are often available for married adolescents, but not for unmarried ones. For example, in **Bangladesh** there is a programme targeted specifically for youth garment workers. The needs of adolescents living in slums have been addressed in **India**. Efforts have been made in **Indonesia** to reach younger adolescents, while in **Malaysia** NGOs have introduced programmes for rural adolescents and for disabled youth.

In Latin America and the Caribbean, **El Salvador** has established services for young and older youth. NGOs and international agencies in the **Dominican Republic** are working with urban and rural young people. In **Honduras**, a programme is targeting youth in areas where indigenous people live. Countries such as **Saint Kitts and Nevis**, **Saint Vincent and the Grenadines** and **Suriname** are offering services for adolescents in rural and urban areas. A few countries, such as **Jamaica** and **Trinidad and Tobago**, have developed separate programmes for young adolescents and older adolescents. The former emphasizes abstinence, while the latter emphasizes abstinence and practicing safer sex.

In CIS, Eastern and Central Europe, the Arab States, and the Central Asian Republics, a number of activities have been undertaken, including specific programmes for boys/men and youth in rural areas in **Estonia**. Programmes in **Romania** target Roma youth, particularly those who have dropped out of school. **Jordan** provides pre-marriage medical services; and **Palestine** has developed programmes to respond to the needs of injecting drug users and victims of sexual abuse.

5.6 LIVELIHOODS FOR ADOLESCENTS AND YOUTH

Countries have also applied specific strategies in the area of livelihoods to fulfil and protect the rights of adolescents and youth to health and development. Although the majority of countries' policy efforts are in the area of education and health, increasing attention is emerging to strengthen livelihood capacities. Livelihoods are a primary concern for adolescents and parents. Life-skills training is linked to economic returns and can increase human capital in the long term. It is believed that increased human capital and potential for earning income can also have an impact on reproductive health outcomes.

Table 5.6 shows that 130 (86 per cent) of the 151 countries are taking action to support the comprehensive development of young people. The measures taken include: (a) provision of a relevant education system and education in vocational and entrepreneurial skills (61 per cent of the countries that took at least one measure); (b) provision of vocational and entrepreneurial education to out-of-school youth (55 per cent); (c) provision of jobs for youth by government (33 per cent); and (d) provision of entrepreneurial training for youth by NGOs (18 per cent).

Countries in all the regions provided a relevant education system and education in vocational and entrepreneurial skills, along with vocational and entrepreneurial education for out-of-school youth.

Table 5.6 Specific Measures Taken by Countries to Support Progress in Livelihood and Life Skills for Young People

Measures Taken	Number and Percentage of Countries	
	No.	%*
Provision of relevant education system and vocational/ entrepreneurial skills education	79	61
Provision of vocational/ entrepreneurial education to out-of-school youth	71	55
Provision of jobs for youth by government	43	33
Provision of entrepreneurial training for youth by NGOs	24	18
Total	**130**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Nearly all countries recognize the importance of supporting young people in terms of livelihood, including vocational training and employment and the provision of life skills such as critical thinking and decision-making. Seventy-three countries have set up a range of programmes to impart various skills (Box 5.2). NGOs made a significant contribution to such training, as reported by 24 countries. Countries also reported supporting young people in terms of providing tertiary education, where critical thinking and problem-solving skills are being stressed.

Several countries reported that while their governments recognize the importance of providing vocational training and employment opportunities for young people, they are experiencing varying degrees of success. Some countries have a disproportionate number of unemployed young people, who may make up 75 per cent of the total unemployed. Nevertheless countries are giving high priority to vocational training with financial incentives. A major success factor for young people in finding employment is their willingness and ability to change from one specialty to another and to develop new skills. While young people are gaining higher-level qualifications, they may misperceive the real needs of the labour market when choosing their area of study, which poses a challenge for securing employment post-graduation.

5.7 ADOLESCENTS AND YOUTH PARTICIPATION IN POLICY AND PROGRAMME DEVELOPMENT

The participation of young people in policy and programme development has been encouraged since the Cairo Conference. The ICPD PoA recommended that youth be actively involved in the planning, implementation and evaluation of development activities that have a direct impact in their daily lives, in particular activities concerning reproductive health, including the prevention of early pregnancies, sexuality education and the prevention of HIV/AIDS and other sexually transmitted infections. *Key Actions* reaffirmed the right of adolescents to participate.

Countries increasingly understand that involving youth may lead to significant progress. Such progress may include improved information and knowledge and a growing awareness and use of available services. In addition, it is recognized that the participation of adolescents and youth in reproductive health programmes tends to strengthen their participatory skills in the wider social, economic and political life of their soci-

MEASURES TO ENHANCE YOUNG PEOPLE'S LIVELIHOOD SKILLS

A high percentage of the global population is under the age of 25. Consequently there is an urgent need to develop programmes to increase the skills, and ensure the future livelihoods, of young people. Country efforts, which often focus on involving young people in their own businesses, include training and credit programmes. Vocational technical training courses are also provided.

In **Malaysia**, there are many programmes for youth development, the largest being Rakan Muda, or Young Friends, under the Ministry of Youth and Sports. There are many youth and youth-related NGO programmes, which promote livelihood, entrepreneur and social living skills.

In **Guyana**, there is vocational training for adolescents. The Ministry of Agriculture has launched a Youth Internship Programme involving some 200 young farmers from tertiary education in addition to those that have a practical exposure to farming.

In **Chile**, the Government has instituted a network of youth centres to 23 locations in the country. The centres offer free access to computers, the Internet, courses, workshops and printing services and also serve as a venue for cultural activities.

In **Pakistan**, unemployment is recognized as one of the major issues confronted by youth. The Government is addressing four major areas, including small and medium enterprises and infor-

mation technology. Soft loans for small and medium enterprises are being extended to young people to promote self-employment, and steps are being taken to provide greater access to women for micro-credit through the Women's Bank and Agricultural Development Bank.

In **Ghana**, the Government included special interventions targeted at youth within its Poverty Reduction Strategy, such as skills training for over 6,000 unemployed youth in vocational and technical skills and access to credit and other support services for self-employment.

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eties. Programme relevance and results are improved by providing support to increase the capacities of young people's organizations and networks, through initiatives to build their skills and leadership roles in advocacy, policy and legislative debates, media access, human rights, and community outreach. Service delivery across the programming cycle improves programme relevance and results. This starts with asking young people what support they need and where they would like to receive it. It continues by empowering them to ensure the programmes designed by adults are delivered properly.

Of the 151 countries responding to the Global Survey, 118 (78 per cent) were taking action to ensure the participation of youth in policy and programme development (see Table 5.7). The measures taken in this regard included: (a) involvement of adolescents and youth in formulation and implementation of pilot projects (64 per cent of the countries that took at least one measure); (b) involvement of adolescents and youth in policy development (47 per cent); (c) holding of forums for youth to elicit information (28 per cent); and (d) promotion of youth organizations or associations as a channel for their participation at a local level (19 per cent). At a regional level, all regions laid emphasis on the first two measures.

A few countries are institutionalizing youth participation. For example, in some countries there are youth representatives in legislative and executive decision-making positions, and in others, they are involved in planning industrial and agricultural human development.

There is also an emerging strategy to ensure the participation of youth through promoting the development

Table 5.7 Specific Measures Taken by Countries to Promote Participation of Adolescents and Youth in Policy and Programme Development

Measures Taken	Number and Percentage of Countries	
	No.	%*
Involvement of adolescents and youth in formulation and implementation of pilot projects	75	64
Involvement of adolescents and youth in policy development	56	47
Holding of forums for youth to elicit information	33	28
Promotion of youth organizations to serve as a channel of their participation at the local level	22	19
Total	**118**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

of youth networks. Training their members in leadership skills such as advocacy and management makes their participation more effective and their example more attractive to others to follow.

While in many countries there is support for the involvement of young people, usually through their organizations and groups, it tends to be piecemeal and on an ad hoc basis. Moreover, while young people are often involved in the development of policies and programmes aimed at youth, they are usually not consulted about other issues. Therefore, a great deal remains to be done if the goals of the ICPD PoA are to be achieved in the next 10 years.

5.8 CULTURE AS A FACILITATING FACTOR AND A CONSTRAINT IN THE PROMOTION OF ADOLESCENT REPRODUCTIVE HEALTH

All societies have norms that apply to people's behaviour based on age, life stage, gender and social class. These norms create a cultural context that influences, among other things, the promotion of adolescent repro-

ductive health. At the same time, young people are growing up in a sociocultural context, or "youth culture", which can often be in conflict with the norms and values of their own parents or communities. This is especially so in terms of gender roles and sexuality, including early sexual initiation. With regard to gender norms, the health, education and life options of girls are often abruptly curtailed by gender discrimination, violence, unwanted pregnancy, early marriage and early child bearing.

Therefore, in looking at the progress of the implementation of the ICPD PoA, the Global Survey asked countries to report on the ways culture contributes and constrains the promotion of ARH.

The depth of responses varied widely, though a number of common issues were reported. Some countries reported on both the facilitating and constraining influences of culture, while others reported on one or the other. The issue was therefore analysed as two separate questions, with one concerning cultural contributions to ARH and the other cultural constraints on ARH.

Cultural Contribution

When asked how the cultural context of the country contributed to the promotion of adolescent reproductive health, 70 countries (46 per cent) out of 151 responded. Some said that youth are valued as the future of the society; they are seen as an investment in helping to maintain and promote the culture. In a few countries, sexual activity among youth is more widely acknowledged and cultural values associate sex with being in love and being a partner of a stable union. Young people in these countries are likely to use contraception and avoid STIs. In the majority of societies, however, sexual activity is not encouraged among non-married youth and adolescents. But as a result of gender discrimination, girls are often victims of sexual abuse, violence and sexual trafficking. Because of cultural norms, many adolescent girls are married against their will, forcing them to exercise their sexuality with husbands who may be many years older.

The threat of the HIV/AIDS pandemic and increasing drug use has contributed to making parents, school principals and religious leaders more supportive of programmes for adolescents. In countries where the status of women has improved during the past decade, there has also been an improvement in attitudes to making information and/or services available to young people.

Religion was reported as a factor contributing to the promotion of ARH in some countries. Reproductive health information is provided as part of religious teaching in some religions. Some countries in the CIS, Eastern and Central Europe and the Central Asian Republics responded that there is little or no religious opposition to the provision of ARH services and that there is a high level of awareness among young people, which contributes to ARH.

Cultural Constraints

When asked how the cultural context constrained the promotion of adolescent reproductive health, 120 countries (79 per cent) out of the 151 responded (Table 5.8). Many countries highlighted the lack of information made available for youth on reproductive health issues as a major constraint. Countries also reported that open discussion of sexual behaviour and reproductive health issues is considered culturally inappropriate (43 per cent). In addition, it was reported that culture can act as a barrier for youth seeking reproductive health services (41 per cent); traditional practices prevent youth

from seeking reproductive health services (32 per cent); and adolescents and youth face religious opposition in seeking reproductive health services (23 per cent). Countries also said that providers, parents and religious leaders lack skills to appropriately discuss sexual and reproductive health topics with adolescents and youth (18 per cent). Such factors have major implications in regard to adolescents' ability and confidence to access information and services.

Other constraints on the promotion of ARH include customs such as early marriage, which especially if associated with early childbearing can have a major detrimental effect on the health of adolescents; traditions promoting large families; and harmful practices such as female genital cutting and some sexual initiation rites. In some societies, the adolescent stage of life is not recognized, since people in the age group 10-24 are considered either as children or adults, and this precludes them from receiving timely information on reproductive health issues during the critical years of physical, mental and emotional development. In some cases, children have limited independence from their parents or families, and this contributes to limited

Table 5.8 **Cultural Constraints in Addressing Adolescent Reproductive Health**

Measures Taken	Number and Percentage of Countries	
	No.	%*
Open discussion of sexual and reproductive health issues is considered culturally inappropriate	51	43
Culture acts as a barrier for youth in seeking reproductive health services	49	41
Traditional practices restrict youth from seeking reproductive health services	38	32
Adolescents and youth face religious opposition in seeking reproductive health services	28	23
Lack of skills among providers, parents and religious leaders to appropriately discuss reproductive and sexual health topics with adolescents and youth	22	18
Total	**120**	**100**

*Based on multiple responses; therefore percentages could add up to more than 100.

independent decision-making. Further, socio-cultural expectations lead to stigma and discrimination of teenage mothers while at the same time promoting machismo or male domination among boys.

5.9 CONCLUSION

Since the ICPD and particularly since the ICPD+5, countries have made significant progress in addressing the rights and reproductive health needs of adolescents. This suggests that the incremental approach rooted in the socio-cultural context, taken by most countries in implementing the ICPD PoA has been successful. While many countries are just beginning to implement programmes for adolescents and youths, others have made significant strides in this area. Countries have shown an increasing understanding of the strategies needed to improve the reproductive health of young people. Some have developed rights-based, gender-sensitive programmes that recognize the diversity of adolescents and address their development needs and rights. More and more countries are realizing the importance of life skills-based education that supports adolescents in their transition to adulthood and provides them with the knowledge they need to protect their reproductive health.

Youth participation is often recognized as a key to the success of programmes. Moreover, it is seen as a way of fostering the right of adolescents and youth to engage in their societies as dynamic forces of change. The need for NGOs and civil society to participate in programmes directed at youth is also being acknowledged.

The great challenge during the next decade will be to start up new projects or scale up and institutionalize existing rights-based, gender-sensitive projects serving adolescents. A few countries have already begun this trend, recognizing that this is the only way to improve the reproductive health of adolescents and youth, especially girls. It is also the only way to empower them to negotiate regarding their sexual behaviour and to reduce the increasing rates of HIV/AIDS infection among them. Many countries now recognize that adolescents and youth have legitimate reproductive rights and reproductive health needs that can only be met with increased national commitment. This recognition is an encouraging foundation for future progress.

References

1 United Nations Population Fund, *State of the World Population 2003: Making 1 Billion Count: Investing in Adolescents' Health and Rights* (New York, UNFPA, 2003), p. 1.

2 United Nations Population Fund, *Report of the 1998 UNFPA Field Inquiry: Progress in the Implementation of the ICPD Programme of Action* (New York, UNFPA, 1999), p. 34.

3 Singh, et al., *Adding it up: The Benefits of Investing in Sexual and Reproductive Health Care* (New York, the Alan Guttmacher Institute and UNFPA, 2004), p. 29.

6 HIV/AIDS

6.1 INTRODUCTION

At the time of the International Conference on Population and Development (ICPD) in 1994, HIV/AIDS was not an issue high on political agendas. In the ICPD Programme of Action (ICPD PoA) references to HIV/AIDS are mainly in the context of prevention of sexually transmitted infections. It was during the 1999 five-year review to assess the progress that had been made in implementing the ICPD PoA that targets were established in relation to HIV/AIDS. *Key Actions* paragraphs 67 through 72 provide the elements for a multisectoral response to HIV/AIDS while stressing that HIV/AIDS prevention should be an integral component of sexual and reproductive health programmes. According to targets delineated in paragraph 70, "HIV infection rates in persons 15 to 24 years of age should be reduced by 25 per cent in the most-affected countries by 2005, and by 25 per cent globally by 2010." "By 2005," the paragraph declares, "at least 90 per cent, and by 2010 at least 95 per cent of young men and women aged 15 to 24 years [should] have access to the information, education and services necessary to develop the life skills required to reduce their vulnerability to HIV infection." Today HIV/AIDS is part of the world agenda, as is evidenced by other international consensus documents and instruments such as the Millennium Development Goals; the Declaration of Commitment on HIV/AIDS issued by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS); and the establishment of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM).

The message emanating from the cumulative statistics on HIV/AIDS is clear: no country is immune from HIV/AIDS, as the epidemic continues to outpace efforts to halt it. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in the year 2003 alone three million people died from AIDS; in the same year, the number of AIDS orphans climbed to 14 million, 11 million of whom live in sub-Saharan Africa. Indications are that HIV infections are not leveling off. The number of people living with HIV and AIDS continues to increase, most markedly in sub-Saharan Africa but

also within the expanding epidemics in Asia, the Pacific, Eastern Europe and Central Asia. In 2003, more than five million people became newly infected — half of them young people between the ages of 15 and 24 — and are now part of today's 40 million people living with HIV/AIDS across the globe. In an alarming upward trend, women are increasingly becoming infected. In 1997, women between the ages of 15 to 49 years accounted for 41 per cent of adults living with HIV/AIDS, rising proportionately to 50 per cent by 2003. The trend is even more pronounced in sub-Saharan Africa, where women account for about 60 per cent of adults living with HIV/AIDS. This "feminization" of the epidemic is further exacerbated by the burden on women as primary caregivers and maintainers of the household and by the legal and social inequalities they often face in the areas of education, health care, livelihood opportunities, legal protection and decision-making.

The impact of HIV/AIDS goes far beyond the statistics both in economic and social terms. Infrastructures are often stressed beyond capacities, past development gains are quickly eroding, and families and communities are being destabilized. HIV/AIDS is assuredly one of the biggest challenges facing today's global community, yet the recent *Report of the Secretary-General on Progress towards implementation of the Declaration of Commitment on HIV/AIDS* notes that "despite the growth in political commitment and resources for HIV/AIDS, globally it is estimated that,

(a) Fewer than one in four people at risk of infection are able to obtain basic information regarding HIV/AIDS;

(b) Only one in nine people seeking to know their HIV serostatus have access to voluntary counselling and testing services;

(c) Less than one in 20 pregnant women presenting for antenatal care are able to access services to prevent mother-to-child transmission of the virus;

(d) Less than 5 per cent of those who could benefit from anti-retroviral treatment are currently able to access such treatment;

(e) In the majority of countries where the sharing of equipment among injecting drug users is a major mode of HIV transmission, coverage for prevention and treatment programmes for drug users is under 5 per cent." [1]

As HIV/AIDS is a key component of reproductive health and a critical factor influencing the achievement of ICPD goals, the 2003 Global Survey attempted to elicit information on measures and actions taken by countries to address the epidemic. Relevant dimensions of the pandemic have been also been discussed in several other chapters of this report, most notably in Chapter 4 on the issue of HIV/AIDS in the context of STIs; in Chapter 5 on adolescent reproductive health and youth; in Chapter 7 on behavioural change communication; in Chapter 8 on partnerships; and in Chapter 9 on donor countries. This chapter relates to three important aspects of the epidemic that were examined in some depth within the Survey: first, an analysis of main strategies being followed relative to current prevalence rates of the infection in various regions of the world; second, a presentation of vulnerable and high-risk groups exposed to the infection and the kinds of inter-

ventions adopted to reach such groups, and finally, an examination of the influence of cultural factors. Given the essential role of prevention in halting and reversing the epidemic, the analysis primarily focuses on the prevention measures adopted in countries.

6.2 HIV/AIDS EPIDEMIC AND STRATEGIES TO ADDRESS IT

Global Overview

The global overview of the pandemic, aspects of which are noted in the introduction, presents a collective picture of both action and inaction. At the beginning of 2004, the number of people estimated to be living with HIV around the world was 40 million — about 50% more people than was predicated a decade ago. While progress has been made on many fronts, much still needs to be done in the fight against HIV/AIDS. Effective prevention strategies and technologies are available, political will and leadership is mounting, funds are being made available — the wheels are beginning to turn — what is urgently needed is an unprecedented mobilization of all sectors to take to scale HIV/AIDS

prevention, treatment and care activities that are commensurate with the magnitude of the threat posed by the epidemic.

To make the greatest impact on the crisis, however, actions should be based on the more specific driving factors of individual epidemics at the regional, country or community levels. While it is widely acknowledged that the majority of those infected with HIV/AIDS live in sub-Saharan Africa, it is important that this acknowledgement not overshadow the fact that HIV/AIDS is also spreading and having an impact in other regions of the world. The situation requires effective and decisive action.

The 2003 Global Survey requested countries to describe successful strategies currently in use; to confirm the utilization of selected approaches; and to describe approaches used to target difficult-to-reach populations. The collective findings summarized in Table 6.1 are similarly categorized into three distinct groupings: (a) plan, policy or strategy formulation; (b) adoption of prevention approaches; and (c) support activities. As noted in the table, of those countries responding, 74 per cent reported the adoption of a national strategy on HIV/AIDS; 36 per cent said they had specific strategies aimed at high-risk groups; 18 per cent indicated having adopted a specific policy on HIV/AIDS; and 16 per cent reported having passed laws or legislation in support of HIV/AIDS efforts.

In the past decade, many developing countries have established national AIDS commissions and have developed policies and programmes to address the impact of the pandemic. In addition, there are many examples in developing countries where Heads of State are directly involved in leading the fight against HIV/AIDS. The findings of the Global Survey also indicate that an increasing number of countries have introduced a more multisectoral approach, involving a wide range of ministries complemented by the increasing involvement of NGOs. This is a positive step away from the early response, in which HIV/AIDS was perceived as predominantly or solely a health issue, to be addressed only within the Ministry of Health.

Regional Overviews

Global statistics tell only a fraction of the story of HIV/AIDS. Epidemic dynamics can vary significantly among regions and even within regions or communities. It is therefore essential that HIV/AIDS strategy and programme development take into account specific driving factors and impediments to the implementation of effective prevention, care and treatment to better ensure effective action. Below, regional dynamics of HIV/AIDS are outlined followed by illustrative examples of action being taken. While there is some commonality of approaches adopted in different regions, there are also considerable differences.

Sub-Saharan Africa

Sub-Saharan Africa, the region hardest hit by HIV/AIDS, was home to an estimated 26.5 million people infected with the virus by the end of 2003. Within the region, women are approximately 1.2 times more likely to be infected than men. Among young people aged 15-24, young women are 2.5 times more likely than their

Table 6.1 **Strategies Taken by Countries to Address HIV/AIDS**

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. Plan/Policy/Strategies		
National strategy on HIV/AIDS	109	74
National strategy targeting high-risk groups	53	36
Policy on HIV/AIDS	26	18
Laws/legislation on HIV/AIDS	23	16
B. Prevention Approaches		
IEC/advocacy	98	66
MTCT Prevention of mother-to-child transmission	70	47
VCT Voluntary counselling and testing	69	47
Blood screening	46	31
Social marketing	27	18
C. Support Activities		
Creating a conducive environment	46	31
Inter-agency coordination (within govt.)	40	27
Management information system	23	16
Health-care provider training	22	15
Mobilizing resources	15	10
Total	**148**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

male counterparts to be infected.[2] While national prevalence rates vary, three southern African countries show rates among adults reaching or exceeding 30 per cent: Botswana (39 per cent), Swaziland (39 per cent) and Lesotho (30 per cent). In countries such as South Africa, Nigeria and Ethiopia, the combination of large population size and the rapid spread of infection is a recipe for explosive epidemics.

Figures alone, however, do not reflect the devastating impact that HIV/AIDS has had on development in Africa. During the past decade life expectancy has been drastically reduced in the worst hit countries. In Botswana, life expectancy has dropped from 65 years in 1990-1995 to 56.3 years in 1995-2000 to 39.7 in 2000-2005. Without AIDS, life expectancy would have reached 68.1 years for males and 76.2 for females by 2045-2050. In Zimbabwe life expectancy for 2010-2015 is 31.8 years. Without HIV/AIDS it would have been projected at 70.5 years. By 2050 the numbers are 45.7 and 76.2 respectively. AIDS-related deaths can translate into a strategic loss of human resources across all sectors of society; already-weakened sectors of government, including health and education, are often further stressed. However, HIV/AIDS is a problem with a solution. Uganda, for example, shows that concerted action, including awareness campaigns and preventive measures, can be successful in turning an epidemic around. Declines in prevalence rates have also been seen in Addis Ababa, Ethiopia; in Uganda; and most recently in South Africa. Early efforts made in Senegal have kept prevalence levels low.

One of the lessons learned over the past two decades is that the commitment of leaders plays a pivotal role. The 2003 Global Survey responses indicate that all governments in sub-Saharan Africa have taken measures to control the HIV/AIDS pandemic and to mitigate its impact on their populations and on the development and security of their countries. Nineteen African countries report having national AIDS commissions or councils set up at a high level, frequently directly under or within the office of the President or Head of Government. Some 40 countries in the region note the development of national strategic plans on HIV/AIDS covering programmes of prevention, treatment, care and support; many report using a multisectoral approach. However, more needs to be done to enable the 90 per cent of Africans who are free from infection to remain so.

Asia and the Pacific

While the prevalence rate in Asia and the Pacific is relatively low at the present time, the potential for catastrophic consequences is enormous, given that 61 per cent of the world population lives in the region. Over one million people in the region acquired HIV in 2003, bringing the total number of people living with HIV and AIDS to approximately 7.4 million. While national adult prevalence rates are still under 1 per cent in most countries, these low figures often mask or obscure serious epidemics, especially among groups practicing high-risk behaviours. Drug use and sex work are so pervasive in some areas that even countries with low infection levels could experience sudden surges of infection. The highest prevalence rates in the region are found in Myanmar (3.5 per cent), Cambodia (about 3 per cent), Thailand (around 2 per cent), India (0.8 per cent) and Papua New Guinea (almost 1 per cent). However, in terms of real numbers, the picture looks different. For example, in India, which has a vast population, between 3.8 and 4.6 million people are living with the virus, placing it second in the world behind South Africa in terms of actual numbers of infections. Similarly, in China, there were about 840,000 people living with HIV/AIDS by the middle of 2002.[3]

Most countries in Asia and the Pacific have developed national HIV/AIDS strategies. The main focus varies from country to country depending on the size and impact of the HIV/AIDS epidemic. However, analysis of government replies to the 2003 Global Survey suggests that there are gaps in the response. For example, while a number of countries refer to the prevention of mother-to-child transmission (PMTCT) of HIV, many do not address other important gender aspects of HIV/AIDS, despite considering women as a target group most vulnerable to infection. HIV prevention efforts among adolescents and young people have been predominantly focused on those who are in school, presenting a gap in addressing out-of-school youth. Commendably, most countries have moved to a more multisectoral approach after initially utilizing a medical approach based in the Ministry of Health.

Latin America and the Caribbean

By the end of 2003, between 1.3 and 1.9 million adults and children in the region were living with HIV/AIDS. Disturbingly, national prevalence has reached or exceeded 1 per cent in 12 countries within the Caribbean basin.

All the main modes of HIV infection coexist in most countries within the region amid significant levels of risky behaviour, including early sexual debut, unprotected sex with multiple partners and use of unclean drug-injecting equipment. Sex between men is an important yet often neglected factor in Latin America's epidemic. Brazil has the majority of people, including children, living with HIV in the region, and countries such as Honduras, Guatemala and Panama have rates of around 1 per cent. Of note is that of the 53 countries most affected by HIV/AIDS around the globe, eight are in Latin America and the Caribbean (Bahamas, Belize, Brazil, Dominican Republic, Guyana, Haiti, Honduras and Trinidad and Tobago).[4] Stigma and discrimination remain major obstacles within the region, especially as related to programming action targeting high-risk, often marginalized groups, further fuelling the apparent trend of increasing rates of infection among the socially and economically disadvantaged groups in the region.

According to the 2003 Global Survey, nearly all countries in Latin America have national plans and strategies to combat the further spread of HIV. Approaches and implementation methods differ among countries, however, including the extent to which they are multisectoral. Of note is the strategic plan in Brazil guaranteeing free, public and universal access to any kind of methods used for prevention, and to treatment.

About half of the region's countries have enacted laws, including legislation against discrimination and promoting equal treatment for those infected with HIV. Panama, for example, introduced a law in January 2000 that not only recognizes HIV/AIDS and STIs as affecting the national interest (therefore requiring a multisectoral response), but also prohibits discrimination against people living with HIV/AIDS (PLWHA) in education, the community or the workplace.

Despite the economic problems of the region during the past decade, middle-income countries in Latin America have directed a substantial proportion of their resources towards the fight against HIV/AIDS, including Brazil ($US 750 million in 2002). Argentina, while simultaneously dealing with its own economic crisis, spent an estimated $US 75 million in 2002.[5] Poorer countries have encountered more difficulties in funding their HIV/AIDS prevention and treatment activities, and many have submitted applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria to bolster

action. Box 6.2 provides an illustration of preventive measures taken by Mexico.

The Caribbean

The Caribbean has the second-highest regional rate of HIV infection in the world after sub-Saharan Africa. Governments recognize that the disease is entrenched in the region, with 350,000 to 590,000 adults and children infected. The region's two most serious epidemics are in Haiti and the Dominican Republic. Prevalence rates in Haiti have stood at 5 to 6 per cent since the late 1980s; within the Dominican Republic prevalence rates of selected populations have ranged from less than 1 per cent to a high of 12 per cent. In addition, national prevalence rates among pregnant women are over 2 per ent in the Bahamas, Belize, Guyana, and Trinidad and Tobago.

According to responses to the Survey, some Caribbean countries utilize a multisectoral approach, while others maintain programmes developed under the Department of Health. For example, Cuba's Prevention and Control Programme was established in 1986, when the Group to Control and Fight AIDS was set up under the leadership of the Ministry of Health. The Caribbean Community (CARICOM) is also leading important initiatives within the subregion.

CIS, Eastern and Central Europe and Central Asia

Eastern Europe and countries of the Commonwealth of Independent States have the world's fastest-growing HIV/AIDS pandemic. At the end of 2003, UNAIDS estimated that 1.5 million people were living with HIV and AIDS within Eastern Europe and Central Asia. The worst affected country was the Russian Federation, with an estimated 1 million people living with HIV/AIDS in 2003. Next are Ukraine, Belarus and Kazakhstan; in 2001 Ukraine had 25,000 HIV infections, while Belarus had 15,000 and Kazakhstan had 6,000.[6]

The epidemics in the region are being driven by widespread high-risk behaviour, predominantly injecting drug use and to a certain extent unsafe sex, especially among young people. The situation has been exacerbated by social and economic changes. HIV infection is correspondingly high among young people in the region; 80 per cent of people living with HIV/AIDS are under 30 years of age. The increasing number of women as a percentage of newly diagnosed infections (33 per cent in 2002, up from 24 per cent in 2001) further characterizes the region. The most recent HIV outbreaks are found in Central Asia, where the five republics straddle major drug trafficking routes into the Russian Federation and Europe.[7]

According to the Survey, 61 per cent of the countries in CIS, Eastern and Central Europe, and Central Asia have adopted strategies to deal with the HIV/AIDS pandemic. National AIDS Commissions or Committees have been established, and programmes to combat HIV/AIDS have been developed throughout the region. The interventions are multisectoral to varying degrees at both the national and sub-national levels. However, in the majority of cases, the primary responsibility remains with the Ministry of Health — although a number of other ministries may be involved. The Global Survey further suggests that countries with low prevalence rates are aware of factors that could lead to increased infection rates, such as the existence of a young and mobile population and low knowledge levels of sexual and reproductive health and reproductive rights.

The Arab States

In the Middle East and North Africa, with some exceptions, the epidemic appears to be nascent. UNAIDS estimates that, at the end of 2003, about 600,000 people in the region were living with HIV/AIDS. The predominant mode of HIV transmission is sexual, accounting for 82 per cent of the total reported cases. Injecting drug use accounts for an additional 4 per cent of infections. However, scant surveillance in the region may be masking serious outbreaks within certain population groups. In some countries within the region, blood transfusions retain a risk of infection. Within the region, there has also been widespread denial surrounding HIV/AIDS, combined with ignorance among many sectors of the population regarding HIV prevention and the protection of sexual health. In Djibouti, 11.7 per cent of the population aged 15-49 is HIV-positive, which places the country among the 10 most seriously affected by HIV/AIDS in the world. In Sudan, where national prevalence rates are over 2 per cent, ongoing conflict in the southern part of the country has hampered service delivery as well as HIV surveillance and response efforts.

According to the Survey results, some countries in the region are promoting a multisectoral approach to the pandemic; and many have developed strategic plans for combating the disease. For example, Djibouti's National Strategic Plan includes measures for reducing the socio-economic impact of HIV/AIDS and other STIs on individuals, their families and communities.

6.3 PROGRAMMATIC MEASURES TO IMPLEMENT STRATEGIES

The 2003 Global Survey asked countries to identify major programmatic measures taken in support of the strategies previously delineated. Based on Survey responses, it is evident that a large proportion of countries are addressing prevention within their response to HIV/AIDS. Programmatic measures reported include information, education and communication; blood safety; voluntary counselling and testing (VCT); prevention and treatment for HIV/AIDS and other STIs; promotion of condom use; surveillance (both epidemiological and behavioural); harm reduction; care, treatment and support of those infected and affected; capacity-building combined with strengthening of the health infrastructure; elimination of stigma and discrimination; increased involvement of people living with HIV/AIDS; advocacy and other supportive measures; and monitoring and evaluation. Table 6.2 summarizes data according to the type of prevention measures and approaches adopted within the responding countries.

The country-specific information provided on programmatic measures being implemented was in many cases quite extensive. The following is a sampling of the various kinds of interventions adopted by countries.

- **Promotion of condom use**. While many countries in all regions are promoting condom use, the scale of interventions remains inadequate. For example, although countries such as Cambodia, Pakistan and the Philippines have effectively promoted the consistent and correct use of condoms, only 24 per cent of people in Asia and 28 per cent of those in the Pacific have access to these types of programmes.

- **Voluntary counselling and testing (VCT)** is also an approach utilized in many countries and regions. In Iran, VCT centres have been established as "triangular" clinics and have been integrated into the primary health care system, providing VCT together with education, care, prevention and treatment for sexually transmitted infections, including HIV/AIDS. Primary target populations include injecting drug users and their families, including women and children.

- **Information, education and communication**. Most countries of the world have IEC programmes. The choice of "messengers" can be key; effective conduits for IEC communications often include respected leaders, celebrities and peers within the target populations. In Jamaica, for example, well-known personalities, including singers, entertainers, journalists, broadcasters and business personalities, present educational mes-
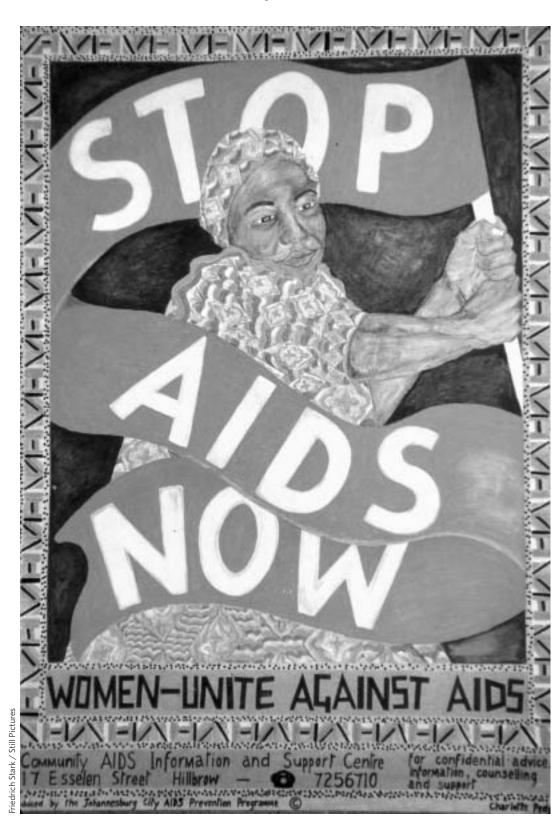
sages on HIV/AIDS. In Trinidad and Tobago, "Rapport", the youth arm of the National AIDS Programme, has introduced several interventions, including programmes for church youth groups, Rotary clubs, YWCA, YMCA and other NGOs. Messages are also important. Information programmes in Egypt are emphasizing the importance of consulting medical practitioners at the first suspicion of exposure to HIV infection. Other programmes include enlisting religious leaders to promote safer sexual behaviour.

- **Blood safety**. Many countries, including Somalia, Tunisia and Turkey, undertake blood screening as part of their programmes to reduce transmission in health-care settings.

- **Prevention of mother-to-child-transmission (PMTCT)**. Preventing transmission to children involves preventing pregnant women from becoming infected and providing anti-retroviral therapy for pregnant women who are HIV-positive. The "Retroviral Introduction Policy — Principles to Prevent MTCT", which is being implemented by the National Health Service, has been appended to the Government Gazette in Mozambique. There is, however, a great need to "scale up" these initiatives. A case in point is sub-Saharan Africa, where only an estimated 5 per cent of women have access to PMTCT programmes.

- **Elimination of stigma and discrimination**. Stigma and discrimination remain major problems in all regions. While many countries, including Ghana, South Africa and Uganda, have initiated programmes against stigma and discrimination, further action is still needed in all regions. NGOs, often including PLWHA, have taken the lead in driving measures to eliminate stigma and discrimination. One example can be seen in the Bahamas, where the Employment Act 2002 prohibits discrimination against HIV- infected persons in the workplace. In Trinidad and Tobago, workshops have been carried out on legal and ethical issues of HIV/AIDS through the national AIDS programme.

- **Programmes for support for PLWHA, home-based care and support for vulnerable groups.** It is important to note that PLWHA can be valuable resources providing substantive inputs into the design and implementation of effective programmes. In South Africa programmes

Table 6.2 Measures Taken by Countries on HIV Prevention

Measures Taken	Number and Percentage of Countries	
	No.	%*
Condom availability	109	83
Behaviour change communication	106	81
Voluntary counselling	103	79
Voluntary testing	102	78
Prevention in pregnant women	100	76
Strengthening capacity of service providers	96	73
Total	**131**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

have been developed for PLWHAs, including the provision of social grants and expanded community-based home care. In Zambia, in addition to programmes for home-based care, care and support services are provided for orphans and vulnerable children.

- **Harm reduction.** HIV transmission can occur at an extremely rapid rate among injecting drug users primarily through the sharing of injecting equipment but also through sexual transmission. Most regions have some level of programming targeting this high-risk population. In Asia, over 55 per cent of countries have harm-reduction programmes. In Viet Nam, programmes aim to stop injecting drug users from sharing of needles and syringes. Harm-reduction strategies, including programmes for needle exchange, are being promoted in many countries in Eastern and Central Europe and Central Asia, including Bulgaria, Estonia, Kazakhstan and Kyrgyzstan.

- **Reaching young people**. More than half of all the new infections occur in young people between 15-24 years of age. In Uganda, HIV/AIDS programmes have been developed to recognize the specific needs of the girl child and to reach out-of-school youth. Urban youth were the targets of some HIV/AIDS programmes in Côte d'Ivoire. However, the reluctance of parents, the community and religious leaders to recognize young people's rights to reproductive health information and services hinders the participation and empowerment of youth in many countries.

- **Surveillance.** Surveillance, both epidemiological and behavioural, is being carried out in a number of coun-

Friedrich Stark / Still Pictures

tries. In the Lao People's Democratic Republic, activities and data and information have been upgraded. In the Philippines, periodic surveillance is carried out through serologic testing for HIV1 and 2, Hepatitis B and syphilis among groups with high-risk behaviours such as sex workers.

• **Training of health professionals**. Health care professionals often possess the same beliefs and taboos as the community in which they work and therefore require training and sensitization so they can effectively provide HIV/AIDS-related services. It is not uncommon for providers to be reluctant to address HIV/AIDS or to attend HIV/AIDS patients. Trinidad and Tobago conducts workshops for second- and fourth-year medical students, providing a good example of mainstreaming the training of health professionals into a national AIDS programme. Workshop components include: a medical approach to understanding the disease; counselling and communication skills; legal and ethical issues; and addressing stigma and discrimination.

6.4 APPROACHES TO INVOLVE DIFFICULT-TO-REACH AND VULNERABLE POPULATIONS

The ICPD PoA and *Key Actions* did not specifically address the need to reach subgroups at higher risk of infection with specific interventions. They did, however, recognize the vulnerability of certain groups such as women and girls in danger of becoming involved in sex work, and of young people in general. In countries with limited resources yet affected by the epidemic, implementing interventions aimed at those at highest risk of infection may prove the most effective strategy. At the same time, the provision of information and services to those who are not in high-risk groups should not be neglected.

An attempt was made in the 2003 Global Survey to obtain information on the targeting of high- risk and/or vulnerable groups within national prevention strategies. A total of 131 countries reported targeted interventions referencing high-risk groups, vulnerable groups and others at risk or vulnerable to infection. Table 6.3 provides data on the percentage of countries with targeted strategies. The data shows that among the high-risk group category, the largest proportion of countries reported action targeting sex workers (73 per cent), followed by actions targeting injecting drug users (31 per cent), long-distance truck drivers (24 per cent), and cases involving male intimacy (24 per cent).

Among the vulnerable groups category, the percentage of action reported is highest for adolescents and youth (62 per cent), followed by pregnant women and their spouses (28 per cent), women (14 per cent) and street children (5 per cent). Among other at-risk and vulnerable groups, soldiers and uniformed service personnel were targeted by 18 per cent of countries, and migrant workers were targeted by 12 per cent of countries.

The Survey also sought to elicit information from countries on the approaches developed to provide reproductive health information and services to difficult-to-reach populations (e.g., sex workers, migrant workers, truck drivers, street children and drug users). The responses, as outlined in Table 6.4, indicate that in addition to adopting strategies or plans, countries have embraced three approaches: advocacy and IEC on the preventive aspects of the epidemic; advocacy for and distribution of condoms and strengthening health centres to provide services; and the provision of voluntary counselling and testing services and the development of harm-prevention programmes. Of note is that NGOs are playing a significant role in this regard in all regions. Illustrative examples of measures taken

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Table 6.3 Target Groups for HIV/AIDS Prevention

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. High-risk Group		
Commercial sex workers	95	73
Intravenous drug users	40	31
Long-distance truck drivers	32	24
Male Intimacy	31	24
B. Vulnerable Group		
Adolescents and youth	81	62
Pregnant women and their partners	37	28
Women	18	14
Street children	6	5
C. Others		
Soldiers/uniformed service people	24	18
Migrant workers	16	12
Total	**131**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Table 6.4 Measures Taken by Countries on HIV Prevention to Involve Difficult-to-Reach Groups

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. Adoption of broad strategies		
National plans/programmes/ strategies for subgroups	36	27
B. IEC and Advocacy Programmes		
IEC/advocacy to reach subgroups	88	67
NGO-sponsored peer group training	39	30
C. Advocacy for Condoms and Strengthening Services		
Condom advocacy and distribution programmes	53	40
Health centre/services targeted to specific subgroups	33	25
D. Voluntary counselling and testing, and others		
Voluntary counselling and testing services	26	20
Development of harm-prevention programmes	26	20
Total	**131**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

by countries in addressing the various subgroups are summarized below.

Sex workers: The risk of infection to sex workers and their clients makes them a common target group in nearly all regions. Over two thirds of the sub-Saharan countries report having developed strategies and interventions to reach sex workers in their respective countries, many involving NGOs. Kenya has implemented a project reaching 15,000 sex workers and their clients. The project offers education and counselling on responsible sexual behaviour and promotes condom use. It also has an economic empowerment component aimed at providing alternatives to women involved in commercial sex. In Côte d'Ivoire, a *Clinique de Confiance* (Trust Clinic) has been established for sex workers; efforts include the introduction of female condoms. In a number of countries, condoms are made available at places where sex workers operate. In Tanzania, research has been carried out focusing on women in so-called "stop over" towns. Findings have shown that the majority are poor, young, unmarried, have little post-primary education and work as brew sellers, bar and guesthouse attendants or in other unskilled jobs.

In Vanuatu, Wan Smol Bag is carrying out a survey of sex workers and their clients to gather baseline data and information on services for them. In Bangladesh, there are currently 29 sites where different organizations provide sexual health services to sex workers. In Dhaka, awareness programmes have targeted hotel and residence-based sex workers. When sex work is illegal, sex workers are likely to operate underground, creating a major challenge in delivering prevention and treatment programmes. The Iranian Ministry of Health is preparing a protocol of care and treatment and strategies to reach them. In Bhutan, the Health Department ensures confidentiality for sex workers seeking HIV testing and other services concerned with STIs.

Some countries in Latin America and the Caribbean require periodical medical check-ups for work permits for sex workers and carry out campaigns to promote condom use. El Salvador has a programme called "The Little Fig Tree", featuring counsellors who talk with sex workers at their places of work. In Antigua and Barbuda, condoms are distributed free of charge through programmes aimed at sex workers based in "houses of entertainment". Programmes in Haiti provide sex workers with information on HIV-prevention measures, including the use of condoms.

In Algeria, sex workers are provided with services in specialized clinics. In Djibouti services are also provided for sex workers and their clients to increase awareness of HIV/AIDS.

Truck drivers: Separation from partners and family contributes to vulnerability and increased risky behaviour, making truck drivers a commonly targeted group, and trucking routes a common setting for interventions. In Angola, mobile clinics are provided at truck stops and checkpoints to reach drivers as well as migrant workers. In Botswana, education campaigns have been introduced for truck drivers, and male and female condoms are made available at border posts and points of entry. In West Africa, a regional project called "Corridor" is being implemented on the main highway from Abidjan, Côte d'Ivoire, to Lagos, Nigeria. In Senegal, kiosks located at truck stops on the main highways offer information and provide services.

Popular artists in Bhutan have recorded IEC messages as songs for distribution to truck drivers and taxi drivers. In Pakistan, in an effort to involve truck drivers in HIV/AIDS programmes, several NGOs are approaching truck owners and visiting truck stops and roadside hotels.

In several Pacific Island countries, seafarers and in some cases their wives are being targeted as high-risk groups.

Drug users: HIV infection can increase explosively, especially among injecting drug users; however, social marginalization can make it difficult to reach them. Nevertheless, many countries have programmes addressing this high-risk group. In Venezuela, a joint programme with the Jose Felix Ribas Foundation targets young addicts who have dropped out of school. As in other regions, the availability of information and services is much better in urban than in rural areas. In the Bahamas, all drug users attending government clinics are offered STI education, counselling and voluntary testing (including for HIV).

Eastern and Central Europe and CIS countries have introduced harm-reduction/HIV prevention programmes targeted at different subgroups. In Belarus and Bulgaria health professionals working with drug users are trained, and anonymous testing centres and mobile clinics have been established to provide information, condoms, diagnosis and treatment of STIs and HIV/AIDS for injecting drug users (IDUs) and other vulnerable groups. Data from Latvia indicates that between 1997 and 2003, 37 per cent of IDUs were reached through harm-reduction programmes. Programmes in Saudi Arabia provide HIV counselling and testing for IDUs, for whom free-drug rehabilitation treatment is also provided. The Human Resources Development Foundation, an NGO in Turkey, has implemented a small number of projects for IDUs including free syringes and needle cleaning.

Migrants: Despite the importance of this group in HIV prevention, action is still limited. A good example of action in this area is Mexico, where the Department of Health's innovative programme "Go Healthy and Come Back Healthy" conveys health education messages to migrant workers. In addition, a document called the Traveler's Permit provides an important tool, helping the health service provide migrants and their families with services related to health education and the prevention, early detection and treatment of HIV/AIDS. Itinerant workers are at higher risk of infection, and they may put their partners at risk when they return home. The migrant Haitian population is considered a high-risk group in the Bahamas, where Creole-speaking health care providers have been trained to provide information and services to non-English-speaking Haitians. There are other subpopulations that are at high risk but are difficult to reach, including miners in remote rural areas in Suriname. An NGO, Medical Mission Suriname, provides these miners with information and services. Refugees — also highly vulnerable to infection — are targeted by programmes in Yemen.

Street children: Street children are at high risk of HIV infection. Activities have been undertaken in some countries around the world to address this vulnerable group. GOAL, an international NGO, is working in Nairobi, Kenya, targeting children on the streets as

well as those who were previously living on the streets. Its main activities include distributing information on HIV/AIDS and STIs; offering peer education; promoting and distributing condoms; and providing health care services, including treatment for STIs and management of opportunistic infections. GOAL also offers life-skills education and referral services, including for VCT, to health institutions. Referral fees are provided.

In Asia, the Bangalore Oniyawara Seva Coota Organization has initiated interventions aimed at street and working children with the help of Karnataka State AIDS Control Society since January 1, 2000. To date, 1,000 street children have been provided with interpersonal counselling, and all STIs cases have been referred to local hospitals for treatment.

Armed forces: Countries in the Latin American region have been particularly active in addressing this critical group. Box 6.3 provides a summary of efforts undertaken by some of them.

6.5 ROLE OF CULTURAL FACTORS IN ADDRESSING THE HIV/AIDS PANDEMIC

Cultural practices and factors can play a facilitating or constraining role in addressing the HIV/AIDS pandemic and should be taken into consideration in the formulation and implementation of programmes. Analysis of Survey responses provides an interesting picture of how specific cultural factors are influencing the planning and programming at the country level. A synthesis of those findings follows in the text below.

Culture as a Facilitator

Seventy-three countries (48 per cent of those responding) reported that culture has facilitated their efforts to address various aspects of HIV/AIDS. Twenty-three per cent reported that social and cultural attitudes promoted community involvement; 16 per cent stated that religious beliefs in their countries had the potential to reduce risky behaviours in the population; 14 per cent felt that cultural norms promoted the delayed onset of sexual activity among their youth; and 8 per ent were of the view that extended family systems contributed to the care and support of people living with HIV/AIDS, orphans and vulnerable children.

Positive cultural norms and traditions can strongly influence individual behaviours as well as foster community action to combat HIV/AIDS. In sub-Saharan Africa, many traditions encourage chastity before

marriage and fidelity during marriage, including Swaziland's traditional "Umcwasho" ritual for girls and the "Lusekwane" ritual for boys. "Lutsango", a cultural grouping made up of adult women, has held workshops on HIV/AIDS prevention. The ability to have open dialogues about sexual health, including discussions on preventing HIV infection, is considered beneficial in many societies. Many countries stated that HIV/AIDS has helped bring issues such as sex work, and "machismo" out from hiding, and in others, culture has played an important role in encouraging open talk at all levels of society about sexual health, the use of condoms and other important aspects of HIV prevention. Young people can also help create a more accepting environment for discourse on HIV/AIDS and the use of condoms for prevention. In Eastern and Central Europe and the CIS, societies have become much more open in a number of countries, facilitating the response to the epidemic. Estonia is ensuring that information has been made available in Russian as well as Estonian to better reach the Russian-speaking minority, which initially showed higher infection rates.

Several countries also report that religious leaders have played a positive role in reducing potential exposure to HIV through promoting abstinence before marriage and encouraging fidelity. Such leaders have worked to sensitize the population about the importance of avoiding unsafe sexual contact. Muslim leaders have also been influential in promoting greater fidelity among men as well as increased condom use. In Indonesia, most of the community and religious leaders are now sensitized to the impact that HIV/AIDS can have on society and on development. In Cambodia and Thailand, monks provide care for people infected or otherwise affected by HIV/AIDS. In Bangladesh, it is believed that its conservative social and religious milieu acts as a deterrent to high-risk sexual behaviour. In the Arab States, religion and religious teaching are being used to support efforts to combat HIV/AIDS. The role of religion is very powerful in Algeria, Mauritania, Morocco and Saudi Arabia and acts as a deterrent to premarital and extramarital sexual relations, which are prohibited under Islamic law.

Culture as a Constraining Factor

A total of 121 countries (80 per cent of those responding) reported social and cultural factors as constraining

influences in the response to the epidemic. Thirty-two per cent reported a lack of open discussion and dialogue on HIV issues; 28 per cent said that because of stigma and the exclusion of people living HIV/AIDS, it was often difficult to reach affected people; 23 per cent reported a lack of risk perception; 19 per cent mentioned that certain traditional social and cultural practices hindered action; 13 per cent cited the low status of women; and 10 per cent reported the practice of polygamy as a constraining factor.

When communications are closed, sexual partners do not discuss their sexual health, and young people's questions about their reproductive health and sexuality may go unanswered. In many countries, while it is recognized that appropriate language use for discussing HIV/AIDS with different age groups is an imperative, vocabulary limitations make translating HIV/AIDS educational materials into the local languages difficult.

In countries where religious leaders do not accept condom use, promoting only abstinence and faithfulness, this may be a contributing factor to a low rate of condom use and, inadvertently, to an increased risk of infection for those who are sexually active outside of marriage. Machismo culture often discourages condom use even if condoms are widely available. In the Latin American region, despite open discussion of issues such as reproductive health, family planning and sexuality education, the perpetuation of machismo and male domination has contributed to the high infection rates in many countries. In some countries, it is customary for men to have more than one sexual partner. Although polygamy by itself may not put those in the union at higher risk, where there are high levels of sexual promiscuity, especially among men, there is an increased risk. In some countries in Africa and Asia "wife inheritance" or "widow cleansing", whereby a widow is married to another man in the family, increases risk of infection if either party is HIV-infected. Similarly "wife sharing" can increase risk, as does the belief that HIV infection is the result of people not adhering to certain taboos (such as not having sexual intercourse with a woman during her menstrual period, or a widow/widower having sexual relations before he or she has properly observed the mourning period).

Gender inequities and male domination in sexual relationships can increase a woman's risk of infection, as she may have little control over decision-making concerning her sexual and reproductive health. In many countries there are also examples of older men enticing young girls and young boys with gifts to have unprotected sex. Too often, women are unable to negotiate safer sex in structured relationships because of religious constraints, economic circumstances or low self-esteem. A high level of denial about HIV and STIs and ignorance about women's sexual health exacerbates the problem. The belief that having sex with a virgin will cure HIV/AIDS increases the risk of infection for adolescent and young girls. Female genital cutting, scarification, tribal marks and tattooing can be predisposing factors to HIV infection. So can such practices as the use of herbal insertions in the vagina for dry sex — considered by some to increase sexual satisfaction for the male partner.

Stigma and discrimination preclude people from disclosing their HIV status. Stigma and discrimination against persons living with HIV/AIDS are reported as constraints in many countries. In communities where there is a strong association between HIV/AIDS and high risk behaviours, stigma accentuates the HIV crisis. In such communities, fears about modes of transmission can affect employment possibilities for those who are (or are perceived to be) infected, leading to social exclusion or even financial ruin. Ethnic minorities are often economically disadvantaged, less educated, and more prone to stigma and discrimination and a lack of access to information on sexual and reproductive health than the general population, and therefore more vulnerable to HIV/AIDS. In many countries, health providers and communities are so frightened by HIV/AIDS that they discriminate against those who are infected and avoid being near them.

6.6 CONCLUSION

Since the ICPD PoA was adopted in 1994, HIV/AIDS has had a devastating impact in countries around the world. While some progress has been made, as evidenced by the often-noted success stories of Brazil, Senegal, Thailand and Uganda, and by the recent efforts to increase access to anti-retroviral treatment for those who are infected, much more needs to be done. Action around the world varies, with some countries following a multisectoral approach and other continuing to use a predominately health-centred approach. Unfortunately, there are some countries that continue to deny HIV/AIDS and take little or minimal action to halt it. A truly effective response requires committed leadership, scaled-up

action, and a multisectoral response with prevention as the mainstay. As a majority of HIV transmission occurs through the sexual mode, improving access to sexual and reproductive health information and services provides an important entry point and should be made an integral component of HIV-prevention programming. Reproductive health should be utilized as a key conduit to and potential delivery point of care and treatment.

The 2003 Global Survey has shown how many countries have successfully reached out to groups at highest risk of infection, while striving to meet the needs of adolescents, street children and orphans. However, many challenges remain to be overcome if all who are at risk of infection are to be reached. To be successful communities must build on lessons learned and find innovative ways to ensure prevention, care and treatment services reach those who need them. The replies to the Survey have underscored the importance of responding to HIV/AIDS based on the dynamics and stage of the epidemic as well as the cultural context within which action is to be taken. The way forward to defeat HIV/AIDS requires scaled-up programmatic responses that are tailored to meet the needs of individual countries and regions and which recognize the important contributions that can be made through addressing sexual and reproductive health and rights.

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7 Advocacy, Education and Behaviour Change Communication

7.1 INTRODUCTION

Advocacy efforts have been instrumental in building a global consensus on the goals and objectives of the International Conference on Population and Development (ICPD) and in fostering national and international commitments for the implementation of its Programme of Action (ICPD PoA). Combined with education and behaviour change communication, advocacy has also fostered a favourable climate for reproductive and sexual health programmes, which have been carried out throughout the world.

The ICPD vision is a world where all individuals have access to comprehensive reproductive health information and services throughout their life cycle by 2015. At the ICPD, reproductive health was envisioned as a basic human right: it was recognized that women, men and young people all have the right to make informed choices and to have access to safe, effective and affordable reproductive health services and commodities. Such a vision implies the importance of communication and advocacy efforts, which help increase political and resource commitments to support policies and programmes while promoting socio-cultural norms that enable individuals and couples to make informed choices on reproductive health matters.

Specifically, the ICPD PoA articulates the following communications objectives: (a) to increase awareness, knowledge, understanding and commitment at all levels of society so that families, couples, individuals, opinion and community leaders, non-governmental organisations (NGOs), policy makers, Governments and the international community appreciate the significance and relevance of population-related issues and take the responsible actions necessary to address such issues within sustained economic growth in the context of sustainable development; (b) to encourage attitudes in favour of responsible behaviour in population and development, especially in such areas as environment, family, reproduction, gender and racial sensitivity; (c) to ensure political commitment to population and development issues by national Governments in order to promote the participation of both the public and private sectors at all levels in the design, implementation and monitoring of population and development policies and programmes; and (d) to enhance the ability of couples and individuals to exercise their basic right to decide freely and responsibly on the number and spacing of their children, and to have the information, education and means to do so.[1]

Over the years, more countries have become aware of the unique contributions that policy-oriented advocacy efforts as well as behaviour change communication and education interventions can play in the promotion of the ICPD agenda. To clarify their interrelated functions, the following definitions may prove useful. Advocacy aims to promote or reinforce a change in policy, legislation, resource allocation or socio-cultural norms. Rather than directly addressing individual beneficiaries, advocacy aims at winning support from influential people and groups to promote a cause or an issue. Behaviour change communication (BCC) is the process of understanding people's situations and influences, and using communication processes and media channels (both modern and traditional) to increase knowledge and to bring about changes in attitudes and behaviours. In the past, this type of intervention has been commonly referred to as information, education, and communication (IEC). BCC however puts emphasis on much needed behaviour change as an outcome of cummunication efforts.

This chapter focuses on strategies countries have used to achieve the above-mentioned objectives and to create an enabling environment for people to make responsible, healthy and voluntary choices about their sexual and reproductive health. Key actions identified in the 2003 Global Survey included efforts to influence the national development agenda to ensure attention to population, reproductive health, HIV/AIDS and gender issues; to create political commitment for programme and policy changes, resource allocation and programme implementation; to strengthen intersectoral collaboration, especially between the public and private sectors, NGOs and civil society; and to enhance the capacity of

partner organizations to support programme delivery and community empowerment in support of ICPD goals.

Many governments have adopted strategies and tools to influence behaviour and change attitudes with a view towards preventing HIV/AIDS and promoting responsible and healthy reproductive health behaviours. Both traditional and modern mass media have been extensively used for awareness creation and for campaigns aimed at increasing the demand for high-quality reproductive health services.

7.2 ADVOCACY

Advocacy Strategies to Promote Responsible and Healthy Reproductive Health Behaviours

Advocacy has played a key role in the promotion and adoption of the ICPD PoA at the national and community levels. Vigorous public debate and discussions have taken place on issues related to population and development, reproductive health, human rights, gender and HIV/AIDS. The discussions, which have taken place at different levels of society, are in part a direct result of the ICPD. The Survey results illustrate that such political discourse has increased awareness, consensus and social mobilization on population issues. It has also increased resource and political commitments in support of the ICPD PoA. Progress has been made in promoting and changing legal frameworks, policies and programmes, as well as social and cultural norms and traditions. As a result, issues related to population, reproductive health, HIV/AIDS and gender are increasingly being addressed in national development strategies, plans and programmes.

Globally, of the 151 countries responding to the Survey, 139 (92 percent) reported having adopted one or more successful measures to promote responsible and healthy reproductive health behaviours, especially among vulnerable groups (Table 7.1). These measures include advocacy and IEC/BCC campaigns (68 percent), activities targeting vulnerable groups of young people, women and men (32 percent), and campaigns using media like radio and television (23 percent). In many instances, the strategies involved educational efforts such as peer education on reproductive health issues (23 percent) and the introduction of health education in school curricula (22 percent). Successful strategies have likewise been characterized by an emphasis on broadening partnerships between governments and

NGOs, multilateral institutions, foundations, community groups and social networks (20 percent). Capacity-building and training on advocacy and BCC, as well as provision of free reproductive health services, were also cited as important aspects of successful strategies adopted by governments.

When asked to describe a successful ICPD-related advocacy strategy, countries most commonly reported lobbying for legislative changes and new laws related to the ICPD PoA (60 countries), the establishment of local advocacy bodies (45 countries), and the development of national and regional advocacy strategies (37 countries). China, Georgia and Syria also stated that supervision of law enforcement contributed to the success of their advocacy strategies. Inter-institutional cooperation, dialogue, partnerships and alliances were common threads in strategies that helped advance ICPD-related policies, legislation and programmes in Armenia, Bolivia, Cuba, Dominican Republic, Ecuador, Guatemala, Mexico, Peru, Tunisia, Uganda and Venezuela. New or revised national policies on a whole range of ICPD-

Table 7.1 Measures Taken by Countries to Promote Healthy and Responsible Reproductive Health Behaviours

Measures Taken	Number and Percentage of Countries	
	No.	%*
IEC/advocacy campaigns on reproductive health issues	94	68
IEC/advocacy campaigns for targeted vulnerable groups	45	32
Media campaigns (e.g. TV, radio)	32	23
Peer education on reproductive health issues	32	23
Health education introduced into school curricula	30	22
Broadening Government-NGO partnerships for advocacy	28	20
Provision of free reproductive health services/products	15	11
IEC/advocacy capacity-building	14	10
Training health professionals in reproductive health	11	8
Total	**139**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

related issues resulted from advocacy efforts in Cambodia, Costa Rica, Gambia, Lao People's Democratic Republic, Lebanon, Malaysia, Mozambique, Myanmar, Nigeria, Palestine, Papua New Guinea, Sao Tome and Principe, Sri Lanka, Sudan, Tajikistan, and Viet Nam. For example, in Viet Nam changes in the population policy relating to gender equality and reproductive health (especially for adolescents) were introduced through education and advocacy activities in the mass media and in schools. Box 7.1 presents examples of successful advocacy strategies used in various countries.

There were regional differences in the proportionate use of these measures. The use of IEC/advocacy campaigns on reproductive health behaviours was most prominent in the Caribbean subregion (100 per cent of countries), in the Arab States (80 percent) and in Asia (71 percent). A significant percentage of countries (30 to 50 percent) in the Central Asian Republics focused on specific strategies such as partnerships and networking, especially between governments and NGOs. The use of peer education programmes on reproductive health issues were commonly reported by countries in sub-

Saharan Africa and the Caribbean. IEC campaigns for vulnerable groups were prevalent in Asia, sub-Saharan Africa and the Caribbean, while mass media campaigns were used in Latin America. In CIS, Eastern and Central Europe and parts of Asia, health education was included in school curricula, and campaigns in support of service provision were used in the Pacific region.

Constraints Encountered by Countries in the Promotion of Responsible and Healthy Reproductive Health Behaviours

The Survey asked countries to describe constraints encountered in facilitating behaviour changes in support of reproductive health choices. Some 45 countries cited policy and funding constraints, programme-related issues and socio-cultural factors as challenges inhibiting efforts to influence attitudes and change behaviour (Table 7.2).

The most commonly reported constraint was limited financial resources (36 percent). Other constraints included social and cultural attitudes (33 percent); lack of political will (20 percent); religious opposition

Countries responding to the Global Survey provided examples of advocacy strategies that have been successful in advancing the ICPD PoA. Such strategies have helped promote and reinforce changing social and cultural norms and traditions. They have also facilitated legislative, policy and programmatic changes to support such ICPD issues as reproductive rights, reproductive health, adolescent reproductive health and gender equality. The following are selected examples of successful strategies:

In **Romania,** the Romanian NGO Coalition for Reproductive Health, a non-governmental, non-profit and non-governmental, non-profit and non-political organization that represents and defends women's rights, advocated for reproductive health rights and facilitated the inclusion of reproductive health services in the basic benefits package funded though the health insurance system.

In **Eritrea,** a range of social and economic development actions were taken with the goal of eliminating female genital cutting. Actions focused on women's empowerment and included emphases on girls' education, women's literacy and women's right to own and inherit land and other property. IEC programmes were also implemented to address harmful traditional practices.

In **Egypt**, mass media programs resulted in mobilizing public support to address the issue of early marriage. This led to a law preventing health units in villages from issuing estimated age certificates for very young girls. This task was undertaken by a committee of medical consultants at the governorate level.

In **Panama,** advocates mobilized groups to protect the rights of adolescent girls, leading to the enactment of a 2002 law that guarantees pregnant adolescents the rights to receive complete health services, to remain in school and to be provided legal protection when necessary.

(18 percent); lack of human resources (18 percent); lack of monitoring and evaluation mechanisms (13 percent); lack of coordination between agencies (11 percent); and lack of equipment and training (7 percent).

In terms of specific constraints in various regions, it was reported that lack of monitoring and evaluation was a major concern in Asian countries. Religious opposition was a major constraint in CIS, Eastern and Central Europe, as well as in the Arab States. A lack of political will was reported by many Asian countries, while a lack of financial resources hampered efforts in sub-Saharan Africa, Arab States, CIS, Eastern and Central Europe and in the Pacific. Lack of coordination between agencies was cited in many Central Asian Republics. Socio-cultural attitudes towards reproductive health and reproductive rights were mentioned as a constraining factor by a significant number of countries in the Caribbean, CIS, Eastern and Central Europe, Arab States and the Pacific region.

Table 7.2 Constraints Encountered by Countries in the Promotion of Healthy and Responsible Reproductive Health Behaviours

Measures Taken	Number and Percentage of Countries	
	No.	%*
Lack of financial resources	16	36
Social and cultural attitudes limit efforts	15	33
Lack of political will	9	20
Religious opposition	8	18
Lack of human resources	8	18
Lack of monitoring and evaluation mechanisms	6	13
Lack of coordination between agencies	5	11
Lack of equipment and training	3	7
Total	**45**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

7.3 INFORMATION, EDUCATION AND BEHAVIOUR CHANGE COMMUNICATION

Increasing Access to Information on Reproductive Health and Reproductive Rights

The ICPD PoA called on countries to ensure access to comprehensive information on reproductive health and rights by the year 2015. Although countries indicated that sexual behaviour and reproductive health remain sensitive topics, particularly in relation to adolescents, many countries mentioned using IEC/BCC and advocacy strategies to reduce socio-cultural and religious barriers to addressing such issues. The Survey found that progress has been made since the ICPD in providing

more comprehensive information, communication and education to address attitude and behaviour issues in key areas related to the ICPD PoA. In most cases, BCC was employed to influence socio-cultural norms and practices on reproductive health, to develop messages that respond to individual and community concerns, to promote behaviours that reduce risk of STIs (including HIV/AIDS), and to provide people with life skills and opportunities to cope with their situations and conditions of vulnerability.

When countries were asked what measures were taken to address key topic areas of the ICPD PoA, BCC strategies were often reported as key interventions. Nearly every country responding to this question reported adopting behaviour change communication strategies. These strategies were aimed at achieving a number of ICPD goals, including preventing HIV transmission; increasing male involvement in reproductive health; providing information to adolescents and youth; managing STIs; involving hard-to-reach groups; and addressing gender-based violence and maternal mortality.

Strategies for Bringing About Attitude and Behaviour Change

The ICPD PoA calls for countries to "enable and support responsible voluntary decisions about childbearing and methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law and to have the information, education and means to do so".[2] Information campaigns and education programmes were aimed at providing facts and facilitating understanding so that individuals could make informed choices about their health, including sexual and reproductive health. Responses from countries seem to indicate a paradigm shift away from broad awareness campaigns and towards strategies directed at influencing attitudes and behaviour change.

The 2003 Global Survey asked countries to describe successful strategies in the area of attitude and behaviour change. Responses were largely grouped in terms of (a) measures that expanded coverage of reproductive health and rights issues in the mass media (Table 7.3); and (b) innovative programmes that used emerging information and communication technologies to increase access to information on reproductive health and rights (Table 7.4).

Table 7.3 Measures Taken by Countries to Expand Mass Media Coverage of Reproductive Health and Reproductive Rights Issues

Measures Taken	Number and Percentage of Countries	
	No.	%*
Use of electronic media (Internet, television, radio)	115	81
Use of print media (newspapers, magazines, posters, fact sheets)	84	59
Support for community events (seminars and forums, concerts, street actions, dramas)	46	32
Training media practitioners on reproductive health issues	43	30
Celebrations of national awareness days	19	13
Total	**142**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

Expanding Reproductive Health and Reproductive Rights Through the Mass Media

Building a consensus on reproductive health and rights requires the involvement of multiple and diverse stakeholders. The ICPD PoA calls on countries to meet the changing reproductive health needs of the life cycle and to do so in ways sensitive to the diversity of circumstances of local communities. The mass media has the capacity to provide information in a sensitive manner and to contribute to people's perception of a supportive environment for behaviour change. The mass media has popularised reproductive health issues since the ICPD by including a "human face" on statistical reports. Media coverage of ICPD-related issues has increased over the last ten years.

Of the 142 countries that cited concrete BCC strategies, most reported using electronic media (radio, television and the Internet) to address reproductive health issues (81 percent). The second-most popular measure was using print-media materials such as posters, journals, magazines and fact sheets (59 percent). Messages were also conveyed via such creative communication channels as community events like concerts, street plays, and dramas (32 percent), as well as through the celebration of national awareness days

Table 7.4 Measures Taken by Countries to Use Emerging Information and Communication Technologies (ICTs) to Increase Access

Measures Taken	Number and Percentage of Countries	
	No.	%*
Established hotlines on reproductive health issues	81	59
Created phone-in radio and television talk shows that cover reproductive health issues	80	58
Created web sites with reproductive health information	64	47
Established village-level computer centres to provide access to information	19	14
Supported national awareness days activities	15	11
Total	**137**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

(13 percent). A significant number of countries (30 percent) mentioned training national and local media practitioners on reproductive health and family planning issues.

Countries reporting the use of electronic mass media referred to the use of local languages to address behaviours and attitudes towards reproductive health and rights and gender issues. For example, Mozambique reported that radio programmes incorporating information on such issues had been written in local languages and produced in the rural communities in which they were broadcast. Entertainment-education methodologies are being applied in creative and innovative ways through serial radio and television dramas in many countries. Print media, used in 84 of the 142 responding countries, took a wide variety of forms, including posters, newspaper articles, magazine stories, pamphlets, brochures and billboards (Table 7.3).

Countries responded that traditional folk media and community media, including celebration of national awareness days, dramas, music, tea ceremonies and other creative approaches, are being used to expand coverage of information related to reproductive health and reproductive rights. In Zambia, for example, media campaigns have used testimonies by people living with HIV/AIDS. These real-life stories have been very effective

in advocating for HIV/AIDS programmes and policies.

When asked to describe successful attitude and behaviour change strategies, as earlier described in Table 7.1, countries mentioned efforts to increase IEC/BCC capacity, including linkages to services and commodities. Ten countries took measures to build technical capacity and to involve stakeholders, including religious leaders, in the development and implementation of IEC/BCC programmes to improve results and to increase the sustainability of such programmes. Countries partnered with NGOs (28 countries), local networks (20 countries) and international organizations (10 countries). Countries also trained community health workers in IEC/BCC skills (11 countries). Thirty-four countries reported that they have adopted national IEC/BCC strategies. Thirty-two countries adopted mass media campaigns to facilitate attitude changes and promote responsible reproductive health behaviours.

The ICPD PoA also highlights the central role of education in promoting gender equality and equity and enhancing the well-being of adolescents and women. Education can be used to help prevent early or unwanted pregnancies, sexually transmitted infections (including HIV/AIDS), and gender-based violence. Educational measures taken by countries include peer-education programmes (32 countries) and formal education programmes (30 countries) including components on life skills and/or reproductive health. Linking IEC/BCC messages with corresponding reproductive health counselling, services and/or commodities is an important part of IEC/BCC strategies, as it can facilitate behaviour change and increase demand for services.

Countries also mentioned the participation of stakeholders in the development of IEC/BCC messages that are sensitive to religious and socio-cultural factors. For example, in Yemen, the "National Strategy for Youth" concentrates on training religious leaders to communicate reproductive health messages to youth and on teaching parents how to convey information about puberty to their children. The strategy also promotes the spread of knowledge regarding laws concerning girls' and women's rights in education, employment, inheritance and ownership.

Regional differences in terms of media use were also significant. The use of both print and electronic media was very prominent in all regions, with at least a majority of countries reporting this in the Survey.

BOX 7.2   **USING EMERGING INFORMATION AND COMMUNICATION TECHNOLOGIES TO INCREASE ACCESS TO REPRODUCTIVE HEALTH INFORMATION**

In **India**, radio programmes are used to deliver information on reproductive health to the country's diverse populations. "Kalyani" is a programme that encourages debate through quizzes, discussions and real-life stories on reproductive health themes. Folk music and drama-based serial programmes are also broadcast in 13 languages.

In the **Philippines**, a communication and advocacy information system stores population-related IEC and advocacy materials in a digital format for easy retrieval and access via the Commission on Population's web site. At the local level, the community-based management information system helps local governments determine unmet need for family planning and other maternal and child health services.

In **Ethiopia**, traditional associations and traditional ceremonies are used to increase citizens' access to information on reproductive health and rights, HIV/AIDS and gender issues.

In **Zimbabwe**, hair salons are used to convey reproductive health messages to women, and mobile clinics are accompanied by "road shows" presenting reproductive health information.

Community events were widely reported by Pacific Island countries and by Arab States, while training of media personnel in reproductive health and family planning was widely reported by countries in sub-Saharan Africa, the Central Asian Republics, and CIS, Eastern and Central Europe.

7.4 USE OF EMERGING INFORMATION AND COMMUNICATION TECHNOLOGIES TO INCREASE ACCESS TO REPRODUCTIVE HEALTH INFORMATION

The ICPD PoA calls for the participation of diverse stakeholders and for sensitivity to local cultural contexts. Emerging information and communication technologies (ICTs) have been used to increase access to information and to provide sensitive information on reproductive health and reproductive rights in a decentralized and interactive manner. Table 7.4 summarizes country responses to the Survey on the use of innovative programmes employing ICTs to address reproductive health issues.

A majority of the 137 countries that responded to this question reported having set up hotlines on reproductive health issues (59 percent) or phone-in radio and television talk shows (58 percent). Many countries also created web sites for individuals to access information on reproductive health-related topics (47 percent). The establishment of village-level computer centres, reported by 14 per cent of countries, has enabled young people to access information on reproductive health matters,

including HIV/AIDS. Communication technologies have also helped disseminate information on reproductive health issues during the course of national awareness days, and have been used to set up management information systems to support reproductive health programmes and the empowerment of women and youth.

The provision of education and information represents a large part of ICPD implementation efforts. Countries are using emerging technology in innovative and creative ways to reach populations, and to complement the use of traditional forms of communication in promoting reproductive health-related information.

The use of the Internet was reported as an ICT to increase access to information in 64 countries. Many countries have established Internet-based projects that primarily target youth and are interactive in design. Village-level computer centres were established in a number of countries, including Benin, Congo, Côte d'Ivoire, Ethiopia, Guinea-Bissau, Madagascar, Malaysia, Mali and Senegal. The centres helped to provide clients, including young people, with access to reproductive health information at the local level. Box 7.2 presents examples of ICT use in various countries.

Innovative programmes and strategies using emerging information and communication technologies were reported in almost all the regions. Use of the Internet, web sites and hotlines to promote reproductive health was reported by 33 to 74 per cent of countries in the

Pacific. The use of radio and TV shows was consistently popular in all regions.

7.5 CONCLUSION

Many countries have initiated actions, adopted strategies and implemented activities to promote the ICPD PoA and to bring about changes in attitudes and behaviour. If the ICPD PoA is to be fully implemented, such efforts need to be intensified.

As they have over the past ten years, behaviour change communication and education should be used to help clients make informed and educated choices about their sexual and reproductive health. Service providers and community stakeholders, who play important roles in enabling such choices, must also be targeted. Future efforts in the area of behaviour change will require the support of peers, families, communities and the society at large.

Advocacy, which has been used to help create a more favourable environment for behaviour changes among individuals, couples and communities, is essential. Advocacy must continue to be used to address environmental constraints that impede the adoption of healthy reproductive health behaviours. It is essential that advocacy efforts address these barriers and constraints by working with social networks to ensure their full support, to improve the socialization process for young boys and girls, and to address gender disparities in

health and education. Moreover, greater attention must be given to the prevailing cultural milieu. A rights-based approach to reproductive health should be firmly anchored in respect for cultural and religious diversities, traditions and sensitivities.

Specific policy and programme measures should be designed to enable or reinforce positive behaviour. These measures include building health and education infrastructures; enforcing standards and positive norms for quality of care in health settings; ensuring adequate reproductive health commodities security; and validating gender equity laws and norms. For instance, when a new national policy promotes the provision of reproductive health education in schools, it may empower adolescents with negotiation skills to delay the onset of sexual initiation. If these interventions are supported by policy and legislation, their impact can be greater and more long-lasting. Another issue that needs to be addressed is the paucity of effective monitoring and evaluation systems to measure the impact of these combined measures. An integrated approach to communication programming in the areas of advocacy education and behaviour change requires concrete and measurable indicators of results. It also requires that adequate attention be paid to make sure that interventions can be replicated and sustained.

References

1 United Nations, *Programme of Action adopted at the International Conference on Population and Development*, Cairo, 5-13 September 1994 (New York, United Nations, 1995), ST/ESA/SER.A/149, para 11.15a-d.

2 United Nations, *op. cit.,* para 7.5b.

8 Partnerships and Resources

8.1 INTRODUCTION

In the last two decades, the contributions of non-governmental organizations (NGOs) and the private sector to population and reproductive health programmes have gained increasing recognition in many countries. The International Conference on Population and Development Programme of Action (ICPD PoA) and the *Key Actions* from the ICPD+5 Special Session were far-reaching in their recommendations for promoting government partnerships with these sectors. They also specified the financial resources, both domestic and donor funds, necessary for successful implementation. These recommendations have created a number of challenges and opportunities, as governments, NGOs and the private sector begin to view themselves more as collaborators than as competitors. The introductions of health-sector reform, poverty reduction strategy papers and sector-wide approaches have also changed the dynamics of these partnerships.

Many civil society organizations possess comparative advantages in programme design and implementation due to unique relationships with their constituencies. Because of these relationships, they can serve as important voices of the people. Their associations and networks can provide governments with effective and efficient means of focusing local and national initiatives on pressing population concerns. Since building partnerships between governments and civil society is also a key strategy and target of the Millennium Development Goals, efforts to achieve the ICPD PoA also contribute to the achievement of the MDGs.

It is clear from the replies submitted by countries to the 2003 Global Survey that most countries are partnering with a wide variety of civil society and private sector groups on a broad range of issues related to the implementation of the ICPD PoA. These groups include national and international non-governmental organizations, particularly family planning associations, women's associations, community groups, human rights organizations, trade unions, universities, private firms and the media. Partnerships have also been forged with parliamentarians, intergovernmental agencies and government departments. Collaboration tends to be in areas in which governments require assistance in accessing hard-to-reach groups or in providing services that they are unable, for financial or other reasons, to provide themselves.

This chapter highlights initiatives at the country level to involve civil society and the private sector in carrying out the objectives and actions set forth in the ICPD PoA and *Key Actions*, as well as presents trends in resource mobilization directed at achieving these goals.

8.2 PARTNERSHIPS WITH CIVIL SOCIETY

Overview

Non-governmental organizations, particularly family planning associations, have traditionally partnered with governments to promote family planning activities. Since the ICPD, they have also been partners in the promotion of reproductive health and reproductive rights. Over the past decade, governments have partnered with a wider group of NGOs, many of which are outside of the traditional population and family planning field. This collaboration has primarily taken place in areas in which NGOs have proven to be effective at reaching underserved populations and at achieving successful results. These areas include: promoting gender equity; combating gender-based violence; encouraging male responsibility; working with adolescents; and reaching groups at higher risk of infection from HIV/AIDS. Some governments have also begun initiating innovative South-South partnership efforts to share knowledge and build capacity in population and reproductive health areas. Box 8.1 highlights examples of South-South cooperation activities.

The ICPD refers to civil society as non-state institutions, including, among others, NGOs, community groups, professional associations, religious communities, labour and trade unions, political parties, foundations, academic and research institutions, the media and women's, men's and youth groups, as well

as individual members of society. The wide array of organizations that comprise this sector is evident in the range of partner institutions mentioned by countries in their Survey responses.

The ICPD PoA promotes effective partnership, between all levels of government and the full range of non-governmental organizations and local community groups, in the discussion and decisions on the design, implementation, coordination, monitoring and evaluation of population and reproductive health activities.[1] Countries responding to the 2003 Global Survey were asked to describe at least one successful effort that had been made to involve civil society in population and reproductive health programmes. They were also asked to report on what mechanisms, if any, they had put in place to coordinate their own efforts in population and reproductive health programmes with those of NGOs and other members of civil society.

Ninety-five per cent of responding countries (143 out of 151 countries) reported at least one successful effort to strengthen partnerships with civil society organizations in implementing the ICPD PoA (Table 8.1). Partnership efforts that involved policy and programmatic measures included: development of population and reproductive health plans and programmes (38 per cent); capacity-building and training in population and reproductive health issues (22 per cent); the establishment of parliamentary caucuses (21 per cent); development of laws and legislation on reproductive rights and reproductive health (13 per cent) and popula-

Table 8.1 **Measures Taken by Countries to Involve Civil Society in Population and Reproductive Health Activities**

Measures Taken	Number and Percentage of Countries	
	No.	%*
A. Policy or Programmatic Measures		
Development of population and reproductive health plans and programmes	54	38
Training and capacity-building efforts on population and reproductive health issues	31	22
Establishment of parliamentary caucuses on population and reproductive health issues	30	21
Development of population and reproductive health laws and legislation	19	13
Development of population and reproductive health policies	16	11
B. Mechanisms for Coordination		
Partnership between national population commission and NGOs	56	39
National forum for NGOs	25	17
Partnerships between local governments and community-level NGOs	21	15
Total	**143**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

tion policy-making (11 per cent). Collaboration on the production of population research and census data was also cited by a number of countries (3 per cent). The most common coordinating mechanisms for partnership efforts mentioned by countries were: partnership between national population commissions and NGOs (39 per cent); national forums for NGOs (17 per cent); and partnerships between local governments and community-level NGOs (15 per cent).

A regional analysis of the findings demonstrates the cross-cutting prevalence and value of government and NGO partnership efforts on reproductive health and population issues. In every region, partnership efforts were reported by over 90 per cent of responding countries. This marks a notable increase from the 1998 Survey, in which 49 of 114 countries (43 per cent) took actions to involve civil society. This improvement demonstrates how governments increasingly view NGOs and other civil society organizations as important partners in efforts to achieve population and reproductive health goals. The extent of the involvement of civil society organizations was also evident in the number of countries that included NGO inputs in the completion of their surveys.

Partnerships by Functional Area

Partnerships in the Design and Implementation of Plans and Programmes

One of the most common areas of partnership between governments and civil society is the involvement of NGOs in the design and implementation of population and reproductive health plans and programmes. Thirty-eight per cent of countries responding to the Survey indicated that they had adopted measures in this area.

Partnerships involving NGOs in the formulation and implementation of population plans, programmes or strategies were most prevalent in the Asia and Pacific region, where over 60 per cent of responding countries indicated that they had taken this measure. Bangladesh, China, India, Indonesia, Mongolia, Nepal and the Philippines reported partnerships with NGOs in developing their national population plans and programmes. The other regions also reported high rates of NGO involvement.

One of the most commonly cited coordinating mechanism for partnerships in the design of plans and programmes was NGO representation in national popu-

lation commissions, offices or ministries (39 per cent). For example, the Steering Committee of the Commission on Population in the Philippines includes NGO representatives. Among other contributions, the NGOs provide input into the direction of the Philippines Population Management Programme. In Malaysia, members of government ministries and agencies, NGOs and the private sector are included in the Central Coordinating Committee on Reproductive Health.

Countries in other regions have also made efforts to partner with NGOs in the development of plans and programmes through NGO representation on national advisory committees. In Ghana, the National Population Commission, the highest advisory body to the Government on population issues, has representatives from NGOs, including religious organizations. In Ethiopia, the Government, the Family Guidance Association of Ethiopia and the Consortium of Reproductive Health Associations have collaborated in developing and implementing population activities. The Government has formed a coordinating committee consisting of relevant stakeholders, UNFPA field office representatives, and implementing partners.

In addition to direct representation of NGOs in government advisory bodies, 17 per cent of countries responding to the Survey also reported that they involve civil society in the formulation of population plans and programmes through national forums and associations for NGOs. This coordinating mechanism was most prevalent in the CIS and Eastern and Central Europe and in sub-Saharan Africa. For example, in Benin, the Centre for the Promotion of Associations and NGOs partnered with the Ministry of Health in HIV/AIDS prevention efforts. In Albania, an NGO Directorate has been created under the Ministry of Labour and Social Affairs to coordinate NGO involvement in relevant population-related issues.

In Ghana, a national coalition of NGOs was established to foster closer collaboration in the fields of population and reproductive health. NGOs working in the country have been involved in the planning and implementation of programmes, and quarterly programme management team meetings have been held to share ideas and exchange experiences on the management of population and reproductive health activities. In Mongolia, the NGO Network on Human Development, Reproductive Health, Gender and Human Rights has partnered with the Government to promote and strengthen NGO involvement in population and development programmes.

Governments also reported involving community-level NGOs in local decision-making bodies (15 per cent). For example, in Angola, provincial-level committees on population and development help coordinate population programme development in conjunction with provincial family and youth councils. Ethiopia reported that it has created regional population offices that interface with regional health bureaus. In the Philippines, community-level NGOs and local government officials serve as representatives in the Regional Population Executive Board and the Regional Population and Development Coordinating Committee.

Partnerships in the Formulation and Adoption of Population Policies and Laws

Countries responding to the Survey also reported numerous successful partnership efforts with NGOs in the development of population and reproductive health policies, laws and legislation. Globally, almost one quarter (24 per cent) of responding countries indicated successful partnerships with civil society in the formulation and adoption of national population policies or laws. This action was highest in Latin America, where over 50 per cent of countries reported partnerships on these activities.

Chile, Costa Rica, Guatemala, Nicaragua, Panama, Uruguay and Venezuela reported successful partnerships with NGOs in the passing of laws and legislation on population and reproductive health issues. Albania,

Armenia, Azerbaijan, Bulgaria and Georgia also reported partnering with NGOs and other civil society organizations in the formulation and adoption of new population and reproductive health laws. For example, the formulation and adoption of the Law on Reproductive Health and Reproductive Rights in Armenia is a good illustration of collaboration between the Government, parliamentarians, local NGOs, UNFPA and other donors. Before being adopted, relevant stakeholders had an opportunity to review and discuss the law at a national forum organized by the Armenian Ministry of Health.

The Governments of Cameroon, Guinea, Kenya, Liberia, Rwanda, Swaziland and Zimbabwe have collaborated with NGOs in the area of population policy-making. For example, in Swaziland, the Government involved multiple stakeholders, including NGOs, in the formulation of national policies on development, population, gender and reproductive health.

Partnerships with Parliamentarians

Since the ICPD, an increasing number of countries have recognized the importance of sensitizing parliamentarians to reproductive health issues. The ICPD PoA states that members of national legislatures can have a major role to play, especially in enacting appropriate domestic legislation for implementing the PoA, allocating appropriate financial resources, ensuring accountability of expenditures and raising public awareness of population issues.[2]

One of the most commonly reported tools for the formulation and adoption of national population policies and laws was the establishment of parliamentary caucuses for lobbying and advocacy efforts. Globally, over 20 per cent of responding countries indicated that NGOs, parliamentarians and other government officials had formed partnerships to work on population and reproductive health concerns. Regionally, over 35 per ent of countries in sub-Saharan Africa reported having partnered with NGOs in developing parliamentary caucuses to advocate population and development issues. Many countries in Asia and the CIS, Eastern and Central Europe regions also reported this action.

Ethiopia, for example, organized a two-day conference on population issues for parliamentarians. Similarly, the Indian Department of Family Welfare has organized seminars for the Indian Association of Parliamentarians on Population and Development and the Press Institute of India to sensitize members of these groups to pressing population concerns. Indonesia has organized a forum for parliamentarians, and Nigeria has established committees on population and development in both the upper and lower houses of government.

Strengthening and expanding such efforts during the coming decades would be beneficial, as informed politicians are more likely to support the provision of reproductive health and reproductive rights. Box 8.2 contains further examples of partnership efforts involving parliamentarians.

Partnerships with UN System Partners
The ICPD PoA states that donor partnerships have become more prevalent in a variety of configurations, so that it is no longer unusual to find Governments and multilateral organizations working closely together with national and international nongovernmental organizations and segments of the private sector.[3] The Survey results demonstrate that UN System partners are actively involved in partnerships with governments, NGOs and the private sector in implementing the ICPD PoA and in supporting the achievement of the MDGs by countries. UNFPA serves as the lead United Nations organization for ICPD-related activities, but many other UN agencies are contributing either directly to, or in support of, the implementation of the ICPD PoA.

For example, United Nations agencies, including UNDP, UNFPA and UNICEF, are collaborating in Cameroon for the provision of reproductive health services and commodities. In Jamaica, representatives of UNFPA and UNICEF took part in the Ministry of Health's Adolescent Policy Working Group. In Burundi, the World Bank has assisted the country in updating equipment and providing training for reproductive health services in hospitals. Also, the International Labour Organization (ILO) is working with the Guyana Ministry of Health and Ministry of Labour to develop a policy on HIV/AIDS in the workplace for the country. UN System partners are also collaborating at the country level in various theme groups, including those on gender, reproductive health and HIV/AIDS, among others, and in the design and implementation of various planning and programming frameworks, including SWAps, UNDAF, and PRSPs.

Partnerships by Substantive Area
Government partnerships with civil society organizations cover a wide variety of substantive issues. These include, but are not limited to: addressing the special needs of the elderly and internal and international migrants; protecting the rights of girls and women; monitoring human rights; increasing access to quality reproductive health information, services and commodities; reducing maternal morbidity and mortality; preventing HIV/AIDS; and monitoring country-level progress of the ICPD and the MDGs. In addition to the partnerships by substantive area described here, the report chapters contain further examples of the numerous ways in which civil society is involved with governments in implementation of the ICPD PoA goals.

Partnerships on Gender Equality, Equity and Women's Empowerment
While countries recognize the importance of promoting gender equality, equity and the empowerment of women, they also recognize that it is sometimes difficult for them to work directly with women in the community. Accordingly, women's NGOs in countries such as Jamaica, Malaysia and Mozambique have been working to assist governments on this issue. Gender-based violence (GBV), in particular, is an area in which NGOs have been effective partners for governments, as victims of GBV may perceive them as being more sympathetic and trustworthy. Many NGOs have been involved in training police officers, judges and others in the area of GBV in many countries.

In Ethiopia, for example, the Women Lawyers Association is focusing on gender-biased violence, including domestic violence and sexual abuse, while the National Committee on Traditional Practices of Ethiopia and NGO partners in the country are working to eradicate harmful practices against women. In the Philippines, NGOs have established Women's Crisis Centres for women and children who are victims of domestic violence. In Jamaica, a group of NGOs, including the Association of Women's Organizations in Jamaica, Fathers' Incorporated and the Bureau of Women's Affairs, undertook a project on GBV from 1999 to 2002. The project aimed at increasing media coverage of gender-based violence, sensitizing the police force, members of the judiciary, and health and legal professionals regarding violence against women, and encouraging the development of support systems for victims of violence.

Angola developed a women's network, "Rede Mulher Angola", comprised of a consortium of NGOs that promote gender equality. In Tanzania, NGOs supplement the Government's efforts on women's issues. Participating NGOs include the Tanzania Gender Networking Programme, the Women's Legal Aid Centre, the Tanzania Women Lawyers Association, and others. These NGOs have collaborated on media campaigns and education efforts geared towards ensuring the equality of men and women in the political, economic, social and civil realms.

NGOs are also often effective in the area of encouraging men to take responsibility for their reproductive health and for their social and family roles. In the Philippines, a number of NGOs are working to increase male support for women's empowerment and for women's rights with respect to reproductive health. In the Caribbean, the Women's Centre of the Jamaica Foundation is counselling young male parents and training male peer educators through its "Young Men at Risk" programme.

Partnerships on Adolescent Reproductive Health and Rights

Providing reproductive health information and services for adolescents is highly controversial in many countries, despite the fact that they need them to protect themselves from unwanted pregnancies and sexually transmitted infections, including HIV/AIDS. Countries such as Indonesia recognize that NGOs are often more effective in providing information and services to adolescents. Youth centres developed by the Indonesian Planned Parenthood Association are partly managed by the adolescents themselves. In Ethiopia, NGOs collaborate with Government institutions in such areas as conducting training for youth; providing reproductive health services for adolescents through youth centres and community-based programmes; and encouraging young people to undertake income-generating activities with the help of small-scale loans.

In Jamaica, an international NGO has worked with the Ministry of Health to carry out a mass-media campaign on responsible reproductive health behaviours targeted at adolescents. In Nigeria, the National Working Group on Adolescent Reproductive Health coordinates the efforts of the Government and others in reproductive health programmes for youth. In the Philippines, the Foundation for Adolescents has established teen centres, reaching youth through innovative approaches such as Dial-A-Friend programmes and peer counselling.

Partnerships on HIV/AIDS Prevention and Treatment

The rapid spread of HIV/AIDS during the past decade has had a major impact on the way in which governments work. Many are now responding to the pandemic with a multisectoral approach, and have placed their HIV/AIDS programmes under the direct leadership of the Head of Government. In addition, governments have reached out to find partners to help combat the disease.

NGOs are particularly effective in working with high-risk groups such as sex workers, truck drivers, and injecting drug users (IDUs). In Bangladesh, NGOs have established 15 sites to reach injecting drug users, and 29 sites where they work with sex workers. In Cambodia, a NGO has set up a male health centre that provides a place to share information and access services. In Nigeria, the Government collaborates with NGOs in providing IEC materials, condoms and voluntary counselling and testing for high-risk groups.

Street children are also at higher risk of HIV infection in many countries. In India, a NGO has initiated interventions aimed at street and working children with the help of local government HIV/AIDS agencies. In Kenya, an international NGO targets children who live on the streets and in rehabilitation centres. Its activities include awareness creation on HIV/AIDS and

STIs; peer education involving the promotion and distribution of condoms; health care services for treatment of STIs, and management of opportunistic infections. The programme also offers life-skills education, basic health care services and referrals to health institutions.[4]

Partnerships between governments and NGOs in the area of HIV/AIDS prevention and treatment are also prevalent in other countries in sub-Saharan Africa. In Botswana, a Parliamentary Committee on HIV/AIDS includes NGO representation. In Burundi, NGOs were active in lobbying private-sector firms to address the issue of HIV/AIDS prevention among their employees and were successful in getting many firms to take into account the health needs of their staffs. In Zimbabwe, the Government developed its HIV/AIDS policy through a consultative process involving parliamentarians, NGOs, and other members of the community.

Partnerships for Capacity-Building on Information, Education and Communication Efforts

The contribution of NGOs to the formulation and development of population and reproductive health programmes, policies, and laws is only one facet of their partnerships with governments. They are also active in capacity-building, particularly in the area of information, education and communication efforts. Responding to the question on successful partnership efforts between governments and NGOs, 22 per cent of countries reported cooperation aimed at providing capacity-building opportunities in population and reproductive health. These opportunities included training; research and management information systems (including censuses); and conferences and symposia.

The capacity-building efforts have brought together government officials, NGO staff, members of academia and research institutions, and representatives of civic groups, including faith-based organizations. Training efforts have involved government agency and NGO staff alike. On a regional level, many countries in the Arab States, Latin America and the Pacific reported taking significant measures to strengthen population and reproductive health capacity-building initiatives, including training.

For example, the Government of Yemen has conducted a number of conferences, seminars and national gatherings on population-related issues, attracting a wide range of political, social and religious leaders. The Government has also organized training workshops for

planners and executives in various state and civic institutions. In Papua New Guinea, the Department of National Planning and Rural Development coordinated a project to educate and train representatives from the Government and civil society organizations on issues of population, gender and development planning. In Kenya, a national steering committee was established to coordinate efforts for the country's census. The committee was staffed by government officials, as well as representatives from NGOs, religious organizations and the private sector.

Partnerships in Commodity Security

Increasing importance has also been given to the role of civil society organizations in reproductive health commodity security. NGOs can help governments ensure that individuals and couples are able to access the commodities they need to choose the number and spacing of their children and to protect themselves from HIV/AIDS and other STIs. For example, the Cambodian Government has included NGOs in its Contraceptive Working Group. Other governments across all regions have also reported taking similar measures to include civil society groups in their contraception planning bodies.

In Cambodia, a non-governmental organization provides emergency contraception in three provinces under the supervision of the Ministry of Health and has been supporting training in the use of IUDs. In the Philippines, NGOs work with the Government, the private sector and religious groups in reaching underserved segments of the population. In Guyana and Botswana, Population Services International has worked with the Governments to set up condom social marketing campaigns.

In Mongolia, a social marketing campaign for male condoms was launched in May 2000 and over 2 million condoms have been distributed to drugstores, kiosks, bars and hotels throughout the country. Since October 2002, female condoms have also been supplied. Also, revolving drug fund projects have been established in most of the country's rural provinces through support from international aid organizations.

8.3 PARTNERSHIPS WITH THE PRIVATE SECTOR

Overview

In addition to building partnerships with civil society, governments have been actively increasing their collab-

oration with the private sector. The private sector can play an important role in such areas as reproductive health commodity security, service delivery, social marketing of contraceptives, and the promotion of sexual and reproductive health and reproductive rights for young people, women and other groups. The ICPD PoA states that governments and non-governmental and international organizations should intensify their cooperation with the private, for-profit sector in matters pertaining to population and sustainable development in order to strengthen the contribution of the sector in the implementation of population and development programmes, including the production and delivery of high-quality contraceptive commodities and services.[5]

The Survey asked responding governments to report on what measures they have taken to include the private sector in population and reproductive health activities. Out of 151 countries, 113 (75 per cent) responded that they have taken actions to involve the private sector (Table 8.2). This figure underscores the rapid development of government partnerships with this sector, especially when compared with the 1999 survey results, which indicated that only 8 per cent of countries responding had taken significant measures to involve the private sector in population and reproductive health activities.

The table shows that globally, the most commonly reported partnership efforts with the private sector were: provision of contraceptives and reproductive health services (49 per cent); private sector sponsorship of social marketing campaigns and outreach programmes (47 per cent); private sector sponsorship of IEC and advocacy activities on reproductive health issues (42 per cent); and private sector representation in government coordination bodies for population and reproductive health issues (30 per cent). A number of countries also reported private sector provision of financial assistance for reproductive health activities (12 per cent).

Regionally, Latin America, the Caribbean and the Central Asian Republics report the highest levels of partnership efforts with the private sector. In almost all regions however, over three quarters of responding countries described at least one measure taken to involve the private sector, underscoring the consensus on the private sector's increasing value as a partner in population and reproductive health activities.

Partnerships for the Provision of Reproductive Health Services and Commodities

Government partnerships with the private sector for the provision of reproductive health services and commodities, including condoms, was most frequently reported in the Asia region, where 75 per cent of responding countries described measures taken. Other regions also took actions in significant numbers to involve the private sector in the provision of reproductive health commodities.

In many countries, the provision of sexual and reproductive services extends beyond the capacity of public health services alone, and sometimes there is a great reliance on private health care. In Indonesia, for example, the Government is concerned with ensuring that the private sector provides reproductive health services to the poor and to those living in rural and remote areas. Jamaica trains private medical providers, physicians, nurses and pharmacists in reproductive health services, and collaborates with private pharmaceutical companies and pharmacies to increase access to contraceptives. The Jamaican Government is also working with the private sector to achieve reductions in the cost of anti-retroviral drugs for people living with HIV/AIDS, and to increase their availability.

Government efforts to ensure access to reproductive health care and commodities also focus on the work-

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Table 8.2 Measures Taken by Countries to Involve the Private Sector in Population and Reproductive Health Activities

Measures Taken	Number and Percentage of Countries	
	No.	%*
Private sector supplies contraceptives and/or reproductive health services	55	49
Private sector sponsors social marketing and outreach	53	47
Private sector sponsors IEC/ advocacy activities	47	42
Private sector represented in reproductive health coordination bodies	34	30
Private sector provides financial assistance for reproductive health activities	14	12
Total	**113**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

place. For example, the Governments of Botswana and Côte d'Ivoire have partnered with private firms to develop initiatives on reproductive health at work. In Indonesia, the Government and private sector firms have established partnerships to expand the coverage of reproductive health services for employees. The Government provides contraceptive methods as well as provider costs, while private sector firms are responsible for operational and infrastructure costs. In Pakistan, two private companies are providing family planning information and contraceptives through their networks.

India, Lao People's Democratic Republic, Malaysia, the Philippines, Sri Lanka, Viet Nam and Zimbabwe have also forged partnerships with private sector organizations to supply contraceptives. For example, private sector firms in the Philippines provide free or subsidized contraceptives and other family planning services, especially in remote areas. In Zimbabwe, the Government has reviewed legislation to allow private sector participation in the importation and distribution of reproductive health commodities.

Partnerships in Social Marketing Campaigns and IEC/Advocacy Efforts

Another frequently reported partnership activity involving the private sector is the sponsorship and promotion of reproductive health IEC campaigns and social marketing and outreach activities. Countries in CIS, Eastern and Central Europe, the Caribbean and sub-Saharan Africa reported taking significant measures to involve the private sector in information and education initiatives on reproductive health behaviours and issues. In regard to social marketing and outreach initiatives, countries in Asia and Latin America have reported the most significant action.

In Kenya, for example, the private sector is a partner in reproductive health programmes for the social marketing of condoms and other reproductive health commodities. Supermarkets, shops and pharmacies sell condoms and other contraceptives. The Ghana Employers Association is involved in reproductive health advocacy, IEC and behaviour change activities at workplaces in the country. Trade unions can also play an important role. For example the "Reproductive Health in the Workplace" campaign of the Associated Labour Union and Trade Union Congress of the Philippines encourages male workers to take responsibility for their reproductive health needs and those of their partners.

Partnerships Involving Private Sector Representation on Government Bodies

A limited number of countries have also reported involving private sector organizations as representatives in government population and reproductive health coordination bodies. The regions where this partnership activity was most prevalent were the Caribbean, sub-Saharan Africa and the Pacific.

For example, in Cameroon, the Third Country Programme on Population and Reproductive Health is chaired by a steering committee comprised of government officials, NGO staff and members of private-sector firms. Also, the Government of Nigeria established a Private Sector Forum on HIV/AIDS, which is chaired by leaders of private-sector firms.

The inclusion of private sector firms in government planning bodies demonstrates how this sector is playing an increasingly important role in population and reproductive health. In many countries, private firms have been developing cost-efficient, effective methods to achieve the financial, managerial and technological capacities necessary for programme development and implementation. These capacities are useful to governments and NGOs alike. These shared capacities are helping governments to provide safe, affordable and accessible reproductive health information and services for all their people.

8.4 RESOURCE MOBILIZATION

Overview

Resource mobilization is an important part of the Cairo agenda. Without adequate financial resources, the population, reproductive health, gender and other goals of the ICPD PoA will not be met. The consequences of resource shortfalls include significant increases in unintended pregnancies, maternal morbidity and mortality, infant and child mortality, as well as an increase in AIDS-related morbidity and mortality and the resulting social and economic impact on individual families, communities and countries. Resource shortfalls in the population and reproductive health area also impede progress towards achieving the Millennium Development Goals.

The ICPD specified the financial resources, both domestic and donor funds, necessary to implement its 20-year Programme of Action. It estimated that in developing countries and countries with economies in

transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of STDs, as well as programmes that address the collection and analysis of population data, will cost (in US 1993 dollars) $17 billion by the year 2000, $18.5 billion by 2005, $20.5 billion by 2010 and $21.7 billion by 2015. Approximately two thirds of the projected costs were expected to come from domestic sources and one third from the international donor community. For the year 2005, this would mean $6.1 billion from donors.

Current levels of resource mobilization are inadequate to fully implement the Cairo agenda. The ICPD goal of mobilizing $17 billion by the year 2000 was not met and the gap between the target level of resources required and that actually made available is widening. During the 1994-2003 period, resources directed to the implementation of the ICPD PoA increased in the early years but there has been only very modest progress in resource mobilization since 1999. The lack of adequate funding remains the chief constraint to the full implementation of the ICPD PoA and to attaining the goals of the Cairo agenda.

The 2003 Global Survey asked governments to report on the level of domestic and international resources available in their countries for population and reproductive health programmes and to assess whether the resources were sufficient to meet their national reproductive health needs. Countries were also asked to report on cost-recovery approaches, absorptive capacity maximization, and other ways of fully utilizing available resources. Major constraints to maximizing available resources were also reported. The review of progress presented on domestic and international resources takes into account the findings of other UNFPA analyses.[6]

Globally, over 80 per cent of countries reported that available resources did not meet their countries' reproductive health needs. They also indicated that their absorptive capacities were often inadequate to maximize the available resources. In fact, all responding countries in Latin America, the Central Asian Republics and the Arab States indicated that their need for population and reproductive health programmes greatly exceeded the available resources. Most countries is all other regions responded similarly. These results underscore that most developing countries still face a pressing need for funding for population and reproductive health programmes.

Domestic Resources

The ICPD pointed out that domestic resources of developing countries provide the largest portion of funds for attaining development objectives. Domestic resource mobilization is therefore one of the highest priority areas for focused attention to ensure the timely actions required to meet the Cairo objectives.

Developing countries are making efforts to mobilize domestic resources for population activities. But they have not met the Cairo target of $11.3 billion by 2000. According to UNFPA estimates, domestic expenditures for population activities averaged annually around $8 billion in the years 1997-2000 and declined to $7 billion in 2001. Resource gaps are especially large in low-income countries. While the global total shows real commitment on the part of developing countries and countries with economies in transition, it conceals the great variation that exists among countries in their ability to mobilize resources for population activities. Most domestic resource flows originate in a few large countries. Many countries, especially those in sub-Saharan Africa and the least developed countries, are simply unable to generate the necessary resources to finance their own population programmes and rely almost entirely on donor assistance.

Despite these trends, 82 per cent of developing and countries in transition reported taking some action to increase domestic resources for population and reproductive health programmes, underscoring their commitment to achieving the ICPD PoA. However, by and large, most countries reported being able to make only incremental increases in funding due to the difficult economic circumstances in many countries. Amidst these resource shortfalls, many countries are looking to innovative strategies to maximize and increase available resources.

Many countries reported that the partnerships they have forged with civil society, the private sector and the international community provided opportunities to reduce costs and optimize available resources and capacities. Key NGOs and foundations continually aid countries in developing the most cost effective and efficient population and reproductive health programmes.

Other countries reported optimising the utilization of available domestic resources through multi-year costing plans and monitoring and evaluation schemes for population and reproductive health programmes. For example, in Cambodia, the Ministry of Health developed

a Health Sector Strategic Plan that includes a Medium Term Expenditure Framework to coordinate multi-year public expenditures based on sectoral financing needs and protections for the total resources available from domestic and external resources. Also, the Government of the Philippines formulated the Population Investment Plan (PIP) to estimate the budgetary requirements for population programmes over multiple years, and determine budget allocations for each program components as well as strategic action areas, including service delivery, IEC/advocacy and capacity building. These strategic planning initiatives help countries to increase absorptive capacity and avoid duplication of efforts and resource waste.

Many countries responding to the survey also reported that they sought to maximize their domestic resources for population and reproductive health programmes through cost-recovery, cost sharing and cost containment strategies. Recovered costs enable countries to multiply the services and supplies they can provide to their citizens. The most common cost-recovery approaches reported by countries included: minimal fees for services (35 countries); minimal fees for products (17 countries); cost recovery through a contributory health care system (9 countries); and cost recovery through social marketing initiatives (8 countries). For example, Indonesia introduced a self-reliance family planning programme to educate clients to be more responsible for their reproductive health through subsidies for contraceptives. The country reported that the number of clients obtaining contraceptives from private sources increased significantly. As part of the programme, fees for services are applied to reproductive health services in health centres, but the government provides a health card system for the poor to obtain these services for free. Cambodia, Romania and South Africa also reported establishing fee for services cost recovery systems.

International Resources

The pre-Conference process and the immediate post-ICPD period saw an increasing flow of resources in the form of donor and international community assistance for ICPD-related activities. Several members of the international donor community demonstrated their commitment to achieving the goals and objectives of the ICPD PoA through increased donor funding. International assistance for population activities increased 54 per cent between 1993 and 1995, from a total of $1.3 billion to $2.0 billion. The increased level of funding supported population programmes that benefited millions of people in developing countries. However, the momentum of Cairo did not last and population assistance hovered near the $2 billion mark from 1995-1999, with funding levels actually decreasing for the first time since the ICPD in 1997.

Although population assistance peaked at $2.6 billion in 2000, the ICPD financial goal of $5.7 billion by the year 2000 was not met; the resources mobilized represented roughly 46 per cent of the target agreed upon as the international community's share in financing the Programme of Action. And in 2001, population assistance decreased to $2.5 billion, about 44 per cent of the target. The gap between actual assistance and ICPD targets is widening.

Despite this gap, 84 per cent of countries responding to the Survey reported mobilizing international assistance for the implementation of population and reproductive health programmes. Many reported efforts to maximize resources through partnerships with international agencies (including members of the United Nations system) and bilateral agreements. Section 8.2 contains descriptions of government partnerships with UN System Partners.

Countries reported receiving international assistance in the form of resources for population and reproductive health activities from a vast number of agencies, organizations and governments. These included multi-lateral organizations, including UN agencies, development banks, bi-lateral government agreements and donor country development organizations. Countries also reported participating in debt forgiveness and debt swap arrangements.

International development assistance is increasingly targeted to particular concerns, e.g., maternal health, adolescent reproductive health and HIV/AIDS; and for specific functions, e.g., developing infrastructure or increasing human resources. For example, in Uzbekistan, a German funding agency (KfW) contributed funding to the Ministry of Health to develop the 'Protection of Women's Reproductive Health Programme.' Funds were donated to purchase contraceptives, equip reproductive health centres around the country with audio-visual equipment and computers and produce information materials for various client populations. Also, the government of Burundi was able

to undertake a national socio-demographic study of reproductive health in 2002 in part through funding contributions by the Government of Switzerland.

The Survey also asked responding countries to report on the constraints they faced in maximizing the impact of available resources for population and reproductive health programmes. Over 67 countries reported constraining factors. The most prevalent constraints were: lack of financial resources (44 countries); lack of human resources and professional training (28 countries); and lack of materials, equipment or facilities (13 countries).

8.5 CONCLUSION

In regard to increasing partnerships and resources for population and reproductive health activities, the 2003 Global Survey revealed many accomplishments and some areas for improvement. Most countries understood the importance of partnerships with a wide spectrum of stakeholders and have reported increased partnerships with NGOs, other civil society organizations and the private sector. Most countries have increased domestic and international resources for population and reproductive health programmes, although these remain insufficient to meet the needs of all people and absorptive capacities remain low.

The Survey results demonstrate that government partnerships with civil society organisations have ranged across numerous functional areas, including programme development and implementation; policy and law formulation and adoption; strengthened partnerships with parliamentarian groups; and innovative South-South cooperation efforts. They also cover a diverse set of substantive areas, such as gender and women's empowerment; adolescent reproductive health; HIV/AIDS prevention and treatment; and commodity security. However, a greater degree of direct involve-

ment and strengthened coordinating mechanisms are necessary to fully maximize the comparative advantage of these partnerships in programme design and implementation.

The responses from countries to the Survey also reveal that partnerships with the private sector have increased substantially since the ICPD. They show that private firms are not only involved in social marketing and commodity security efforts, but they are increasingly taking on programme and project financing, service delivery components and advocacy efforts. Countries will be challenged in the coming decade to further increase the number and diversity of private sector partners, to further delineate the respective roles and contributions of the public and private sectors, and to maximize the contribution of the private sector to resource mobilization in support of the ICPD PoA.

Although there is clear evidence from the Survey results of broad, multisectoral involvement of many actors in implementing the ICPD PoA, current levels of resource moblisation are inadequate to make the Cairo vision a reality. Full implementation calls for greater collaboration and partnership between donor and developing countries to increase resources and capacities. One of the key priorities is to continue to build national human and financial resources. While some recent trends in international population and reproductive health assistance are encouraging, financial commitments do not meet either the 2000 or the 2005 funding targets.

The challenge before the international community is to meet the agreed commitments for Official Development Assistance (ODA). Strengthening political will and commitment to implement the financial targets of the ICPD will further the aim of providing safe, affordable and accessible reproductive health information and services to all people and is also an integral part of the implementation of the Millennium Development Goals.

References

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9 Perspectives of Donor Countries

9.1 INTRODUCTION

As in the 1998 Global Survey, a separate, shorter questionnaire was prepared for developed countries belonging to the Organisation for Economic Cooperation and Development's (OECD's) Development Assistance Committee (DAC), referred to in this report as "donor countries". The 2003 Global Survey aimed to elicit their views and experiences regarding the implementation of the International Conference on Population and Development Programme of Action (ICPD PoA), including the challenges they have faced and the commitments they have made to further implement the ICPD PoA. The responses from 18 countries (Annex 1) underline the importance that these countries place on ICPD priority issues, including population, gender, reproductive and sexual health and HIV/AIDS.

This chapter is divided into four sections. The first section describes population issues and concerns faced by donor countries since the ICPD, as well as measures they have enacted to address them. Section two focuses on actions they have taken relating to gender equality and women's empowerment. The third section discusses measures carried out to increase access to reproductive health services and the challenges that lie ahead. This section also includes strategies and measures countries have adopted to reduce the spread of the HIV/AIDS pandemic. The fourth and final section describes partnerships between donor countries and civil society organizations, as well as issues related to international assistance, including problems and challenges faced by donor countries in mobilizing resources to support ICPD PoA implementation. It also describes how donor countries link ICPD goals with international development frameworks and processes.

Donor countries are using various international development frameworks and processes, such as the Millennium Declaration, PRSPs, SWAps and sector reforms to promote the ICPD agenda in international cooperation.

9.2 POPULATION ISSUES AND CONCERNS

Population Ageing

Nearly all donor countries responding to the Survey (16 out of 18) cited population ageing as an important challenge. Population ageing is seen as a complex issue that not only impacts upon the well-being of older persons, but also affects the overall population in such areas as health, labour markets and public finances. Indeed, population ageing affects all communities, all levels of government and all sectors of society. At the start of the twenty-first century, several developed countries are facing significant challenges due to the ageing of their populations, as the proportion of older persons is increasing more rapidly than all other age groups. In 2001, for instance, one Canadian in eight was aged 65 years or older. By 2026, one Canadian in five will have reached age 65. Within the next 45 years or so, there will be a five-fold increase in the number of people aged 85 and over.

Donor countries recognize that responding to the needs of the elderly is a continuing challenge. Since 1994, a number of major initiatives have been taken by donor countries to address this issue. These initiatives include developing policies, strengthening institutions, building capacity in the areas of continuing education and training, supporting research, and carrying out innovative projects, including ones promoting alternative living arrangements.

To ensure that the perspectives and needs of older persons are considered, a subcommittee was established in the United Kingdom consisting of representatives in key government departments to develop, coordinate and advance actions concerning the welfare of older

persons. Similarly in Sweden, the Government appointed a Parliamentary Commission of Inquiry on Elderly People that was charged with the task of examining three areas in particular: older persons in the employment sector, healthy retirement, and the needs of older persons in health and social care. In 2002, the Danish Parliament adopted legislation introducing free choice in relation to the care of elderly people and people with disabilities. The legislation ensured choice in the areas of housing and home-based providers of personal and practical help.

The status of older persons as a valuable human resource has been strongly emphasized, and measures are being taken to ensure their greater integration into the workforce. Special retraining programmes have been set up for older workers to ensure that their labour skills remain relevant and marketable. Some of these programmes provide older women with easier access to education and further training. A key factor for participation in an increasingly knowledge-driven world is the ability to acquire, evaluate and apply new knowledge; hence, access to lifelong learning opportunities for older persons has become increasingly important. In Austria, for example, the Federal Ministry for Social Security and Generations supports numerous educational opportunities to strengthen the information, communication and technology (ICT) competence of older persons. The Netherlands has likewise actively promoted the use of computers and the Internet among older persons.

In some donor countries, including Australia, efforts have been made to build research and capacity on population ageing with a view towards developing the evidence base necessary to inform decision makers on ageing policy. In other countries, research institutions focus on advancing knowledge with respect to improving understanding of the ageing process, promoting healthy ageing, preventing and treating age-related diseases and disabilities, improving health policies and systems and understanding the social, cultural and environmental factors affecting the life and health of older persons. In the United States, the "Healthy Aging Project" identifies strategies that have been successful in promoting healthy ageing, and it passes this knowledge along to health care providers to improve the delivery of preventive services.

Some donor countries have initiated new living arrangements for older persons in addition to independent living arrangements supported by professional caregivers. In Austria, multigenerational housing promotes cohabitation among several generations not only within the family but also among people who are not related. Projects with houses for three generations help counter the increasing isolation and loneliness facing older people, especially in rural areas where the single-family dwelling is the predominant form of housing.

Some donor countries, like Germany and Canada, mentioned their participation in the adoption of the Madrid International Plan of Action on Ageing 2002. Canada noted its role in advancing issues related to - gender equity, the abuse and neglect of older persons, the diversity of older persons' interests, recognition of the special needs of indigenous and disabled older persons, "ageing in place" environments and technologies and human rights. Germany mentioned that in line with the Regional Implementation Strategy (RIS) adopted in Berlin in September 2002 by the United Nations Economic Commission for Europe (UNECE), a National Plan of Action for the elderly is being developed with the support of the Government.

International Migration

Since the ICPD, international migration has continued to be at the forefront of the international policy agenda. The ICPD PoA recognizes that orderly migration can have positive consequences on both sending and receiving countries.

Countries responding to the 2003 Global Survey raised a number of concerns, including the social and economic integration of migrants, family reunification, and issues relating to human trafficking, illegal immigrants, refugees and asylum-seekers.

Several countries mentioned the importance of integrating immigrants into the receiving society. In Switzerland, for example, a Federal Commission on Alien Affairs has been established to address issues related to the integration of immigrants. In Finland, a law was passed in May 1999 regarding the social and economic integration of immigrants into Finnish society. Measures that have been adopted include ones aimed at promoting equality of opportunities in access to jobs, housing, health and education, along with other social services and amenities.

Since the ICPD, a number of donor countries have introduced changes in their family reunification policies. The responses show that while family

reunification continues to be pursued by receiving countries on compassionate grounds, some have added restrictive policies. Since July 2002, for instance, Denmark no longer offers a statutory right to reunification with a spouse, and in most cases does not grant reunification with a spouse if one of the spouses is younger than 24 years of age. Moreover, the spouses' aggregate ties with Denmark must be stronger than their ties with another country. In New Zealand, although the policy has been changed to recognize a wider range of family structures, it has also strengthened the legal obligations of sponsors to ensure that they take more responsibility for the family members they bring to the country. In Canada, on the other hand, the policy has become less restrictive, as the age for dependent children has been raised from under 19 to under 22. Moreover, sponsored spouses, common-law partners, conjugal partners and dependent children will not be refused simply on the grounds that they represent an excessive medical demand.

Developed countries have recently been viewing migration as a response to medium-term labour supply shortfalls. The initiatives have been almost exclusively directed towards highly skilled immigrants, reflecting an increasing demand for skilled labour due to demographic changes and the increasing globalization process. In 2002, for example, the United Kingdom introduced the Highly Skilled Migrant Programme (HSMP), which has enabled highly skilled individuals to seek and take up work in that country. In Germany, a "Green Card" scheme was introduced in August 2000 to induce highly trained computer-related workers to join the German workforce for a limited period of five years. Similarly, France established a system in January 2002 to attract highly skilled workers from outside the European Union to work in the country. In February 2003, Portugal adopted a new migration policy that gives permission to nationals from outside the European Union to legally reside in that country as long as they have a job authorization.

In a number of donor countries, there is an increasing tendency to attract and retain students from developing countries. In Australia, for example, policy changes have been made to enable highly skilled foreign students who

Donor countries perceive that over the last ten years there has been considerable progress in implementing key areas of the ICPD PoA in developing countries.

are studying there to apply for and be granted permanent residence without leaving the country.

A major challenge to migration management mentioned by donor countries is the growing trafficking of human beings. Countries have noted that increased efforts to tighten border controls and increased restrictions in asylum policies have inadvertently made the trafficking of human beings more profitable. To address this problem, some countries have introduced severe penalties for people-smugglers and those caught in trafficking in humans. Since January 2001, the United States has charged, convicted or secured sentences for 92 human traffickers in 21 cases. Over $15 million has been awarded to NGOs over the past 10 years to provide needed services to victims. These measures are consistent with the 2000 Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children.

Although most receiving countries recognize the positive contributions of migration to the economic, social and cultural development of both migrant-receiving and migrant-sending countries, the growing levels of illegal immigration and the continuing flows of refugees and asylum-seekers remain major concerns.

Many donor countries realize that more international cooperation is necessary to effectively manage migration. Norway, for example, has joined international cooperation efforts aimed at curbing the growing phenomenon of human trafficking and reducing the number of illegal immigrants, as well as asylum-seekers lodging ill-founded applications, through information campaigns carried out in the countries of origin. Also notable is the increased cooperation among countries seeking to improve the effectiveness of information-sharing. Such exchanges of information are taking place between immigration authorities and the police in both receiving and sending countries.

Other Population Concerns

Several donor countries noted other population-related concerns, while others mentioned important activities they have carried out since Cairo. Portugal reported that its 2001 census, which collected information about persons with disabilities, was the country's most

important statistical operation during the last decade. Portugal also carried out a Fertility and Family Survey, which focused on fertility issues and reproductive health.

Since the ICPD, Australia has invested significant resources in research and policy development in a range of population-related areas. Research has been carried out on fertility, the causes of fertility decline, and the impact of population change on the environment. The Government is disseminating the research findings as widely as possible, through such means as seminars and conferences. This approach is seen as vital to lay the foundation for a future that is economically, socially and environmentally sustainable.

Family-friendly policies were discussed by a number of countries. Apart from the high level of financial transfers, the Austrian family policy is focusing on improving the compatibility of work and the family. Similarly, in Norway steps have been taken to better reconcile family life with participation in the labour force, with a view towards enabling parents to spend more time with their children.

In the United States, disparities in minority health and education remain a significant concern. The disparities are being addressed by the Government, which is committed to providing underserved communities with improved quality and access to health care and to ensuring that every child receives a high-quality education.

Some countries mentioned post-Cairo initiatives in the area of population and health. To reduce population- and AIDS-related problems within the context of comprehensive and reproductive health care, Japan implemented "Global Issues Initiative on Population and AIDS". In Australia, disease prevention and health promotion are fundamental pillars of the health system. Preventive health services include child and adult immunization programmes and family planning services. Australia is also strengthening national capacity to deal with the management of new and emerging diseases, including Severe Acute Respiratory Syndrome (SARS), as well as threats related to bio-terrorism.

9.3 GENDER EQUALITY AND WOMEN'S EMPOWERMENT

Donor countries reported that efforts have been made since Cairo to protect the rights of girls and women and to promote women's empowerment. Twelve countries passed new laws and legislation for the protection of the rights of girls and women. New laws or legislation focused on the trafficking and exploitation of women; ensuring gender equality in society (including in education and in parliamentary representation); enforcing gender equality in the workplace (including parental work leave and equal wages); and laws against sexual harassment. Some countries have established women's commissions or agencies within government structures. Several countries — Australia, Canada, Finland, Germany, New Zealand, Spain and Sweden — have policies that promote the empowerment of women and prevent gender discrimination. Austria, Japan, the Netherlands, Spain, Switzerland and the United Kingdom have strategies on gender mainstreaming, while Australia, Japan, New Zealand, Sweden and Switzerland have IEC/advocacy programmes on promoting the empowerment of women.

The trafficking of women is condemned by both the ICPD PoA, which calls for the prohibition of harmful practices, and the Millennium Declaration, which calls for intensified efforts to fight trans-national crime. Since the ICPD, all donor countries responding to the Survey have taken actions to address the trafficking of women and girls. Nearly all countries enacted laws and legislation to combat trafficking, and many ratified international treaties. Half of responding countries developed programmes specifically to combat trafficking. Many countries examined the root causes of trafficking. Fifty per cent of the countries that responded to the Survey provided international aid to combat the trafficking of women and children, while nearly all provided services to victims.

The ICPD PoA states that countries should take comprehensive measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children. This implies both preventive actions and the rehabilitation of victims. Donor countries reported that they have national strategies to address gender-based violence and have taken measures to address it. Twelve out of the 17 countries have enacted laws and legislation. For example, Luxemburg (2000) and the Netherlands (1994) have enacted legislation requiring employers to protect their staff from sexual harassment. In order to monitor and report on GBV, many donor countries have established institutional mechanisms in their legal and judiciary systems. Almost half of responding countries provided services for victims of GBV. In Australia, for example,

Family Violence and Prevention Legal Service Units are being funded to work with victims and communities in a holistic manner and to prevent family violence. Denmark circulated a tool kit containing rules, legislation and advice related to GBV. Designed for professionals, the kit are working to raise awareness and provide behaviour change communication on GBV and are providing training for service providers and government officials.

9.4 REPRODUCTIVE HEALTH AND HIV/AIDS

Reproductive Health

Since the ICPD, donor countries have addressed a range of reproductive and sexual health issues. Priority issues identified in the 1998 Global Survey were also reported in the 2003 Survey. They include unwanted or unplanned pregnancies and the need for counselling and services for high-risk groups and HIV/AIDS and STIs.

Donor countries have also continued to address adolescent and youth reproductive health concerns, including adolescent fertility; early, unwanted or unplanned pregnancies; the increasing incidence of STIs, particularly chlamydia; and substance abuse. Measures taken to address these issues include making contraceptives available free or for a subsidized fee, and providing counselling and youth-friendly reproductive health information and services to adolescents and young people.

Several donor countries reported taking specific measures since the ICPD to increase access to a variety of reproductive health services. In Japan, for instance, oral contraceptives, intrauterine devices and female condoms have been legalized. Finland addressed the issue of infertility by co-financing 70 per cent of the cost of in-vitro fertilization by individuals. In Denmark, free medical services, including a full spectrum of reproductive health services, are available. In Sweden, STI treatment and contraceptives are provided free for young people. In New Zealand, free and low-cost contraceptives are provided for youth under 22 years of age.

Over the last 10 years, donor countries have increasingly paid attention to the reproductive health needs of migrants. Almost all responding countries have taken some actions to address their particular needs. Portugal, for example, has established mobile reproductive health services to reach migrants. Finland has conducted training specifically for migrant-population health care providers, while Sweden has provided additional training for midwives serving migrant women. Denmark is reaching out to migrant groups to provide them with reproductive health information and services, including counselling. In Spain, language barriers, cultural differences and the legal residency status of migrants have made the provision of reproductive health services to migrants even more challenging.

Since the ICPD, the needs of indigenous populations have been increasingly recognized by donor countries. Canada, for instance, has conducted a study on aboriginal peoples and their specific needs, while Australia has developed primary health care programmes, including ones focusing on reproductive health, for indigenous peoples.

Ninety-four per cent of donor countries have reported that the quality standards with regard to reproductive health service delivery have improved since the ICPD, especially in the areas of human capacity-building and institutional development. A few countries mentioned challenges in the provision of reproductive health services. For example, Switzerland stated that there are still regional and rural/urban discrepancies in terms of access to quality reproductive health services, while Sweden reported that youth clinics face challenges related to increasing the involvement of boys in the area of reproductive health.

HIV/AIDS

The 2003 Global Survey asked donor countries to describe successful strategies that are being used in their own countries to reduce the spread of HIV, address the gender and age dimensions of the pandemic, eliminate discrimination against persons infected with HIV and their families, and integrate relevant reproductive health components into HIV/AIDS programmes. Donor countries described a number of actions that have contributed to a comprehensive response to the pandemic, including the availability of funding for HIV/AIDS research and prevention programmes, access to care and treatment, organized support networks, human rights advances, and the use of new information technologies to raise awareness of HIV/AIDS and disseminate relevant information. Donor countries have developed national strategies and policies that take into account the need for a multisectoral and comprehensive response. Many countries have also partnered with local authorities, NGOs, medical experts and international organizations to combat the spread of HIV.

HIV prevention strategies adopted by donor countries acknowledge the living situations and day-to-day challenges of women, men, youth and children. Targeted mass media campaigns were created to raise awareness and prevent the spread of HIV among youth, men and women. Austria, Denmark, Finland, Germany, Ireland, Luxembourg, the Netherlands, Norway, Portugal, Sweden and the United States reported the adoption of school-based sexual health and life-skills education programmes that disseminated a wide range of information. Some countries provided such benefits as early pensions for people living with AIDS, free volunteer counselling and testing for HIV and other STIs, and free anti-retroviral (ARV) drugs and STI treatment.

Donor countries targeted high-risk groups through information, education and communication campaigns and service-provision efforts. They also enacted laws and legislation to protect the rights of people with HIV/AIDS, primarily through disability discrimination acts and laws protecting those who are homosexual or are involved in sex work. Donor countries also launched IEC and advocacy campaigns to discourage discrimination, reduce the stigma associated with HIV/AIDS, and to create awareness of the modes of HIV transmission. In Portugal, for instance, the National AIDS Commission (CNLCS) published a book recounting the life stories of people infected with the AIDS virus. Targeted at the general public, the book aims to dispel social stigma and to clarify myths, beliefs and values that surround HIV infection and people living with HIV/AIDS.

Donor countries have integrated STI counselling and testing, family planning counselling, and antenatal care into HIV/AIDS programmes with the aim of reaching a greater number of people, reducing the stigma associated with HIV/AIDS, and increasing the efficient use of limited health care resources. A case in point is Norway, where the Government issued a strategic plan called "Responsibility and Consideration: A Strategy for the Prevention of HIV and Sexually Transmitted Diseases" in December 2001. The plan calls for cooperation between those working with HIV/AIDS issues and those working with the prevention of other STIs. The goal of such cooperation is to provide education, prevent high-risk behaviour, survey the epidemic, ensure that HIV-infected persons are diagnosed and counselled, combat the discrimination against those who are HIV-infected, and ensure that health care and social welfare workers have sufficient expertise.

9.5 MEASURES TAKEN BY DEVELOPING AND DONOR COUNTRIES IN POPULATION, REPRODUCTIVE HEALTH, HIV/AIDS AND GENDER

Both the questionnaire sent to developing countries and the one sent to donor countries included questions relating to population and development, reproductive health, HIV/AIDS and gender. An underlying objective of the questionnaires was to facilitate the sharing, where appropriate, of the strategies and approaches used by donor countries and developing countries.

It is useful to compare measures taken by donor countries and developing countries on specific issues relating to population ageing, international migration, access to reproductive health, HIV/AIDS, the protection of the rights of girls and women, and the promotion of women's empowerment.

In addressing the special needs of older persons, both developing and donor countries have adopted plans, programmes and strategies, and have provided minimum living standards through social welfare programmes. However, donor countries have established pension systems, undertaken more research and data collection activities and have forged partnerships with civil society organizations (Table 9.1).

In the area of international migration, while both developing and donor countries have taken measures to manage the influx of migrants and refugees, donor

Table 9.1 Measures Taken by Donors to Address the Special Needs of Older Persons

Measures Taken	Number and Percentage of Countries	
	No.	%*
Plan/Programme/Strategies on ageing adopted	14	88
Provision of minimum living standards through social welfare programmes targeted at the elderly	9	56
Committee/commission on ageing formed	8	50
Pension systems established	8	50
Law/legislation on ageing	7	44
Civil society action (organizing older persons)	7	44
Research/data collection on ageing	7	44
Total	**16**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

countries have also focused on issues relating to the trafficking of human beings and to the economic and social interests and rights of migrant workers.

On gender issues, measures taken by both developing and donor countries are similar. High on the agenda are laws and legislation to protect the rights of girls and women, the establishment of national commissions, efforts to increase the number of women in governance, and policies that promote the empowerment of women.

Both developing and donor countries have taken measures to address the issue of access to reproductive and sexual health services. However, the focus has been different. While developing countries have been concerned with increasing staff and training, increasing the number of service delivery points and the introduction of quality standards, donor countries have concentrated on the provision of a greater variety of services, the offering of youth-friendly services and free reproductive health services in all public facilities and the reduction of inequalities in access to health services for vulnerable groups (Table 9.2).

In their attempts to reduce the spread of HIV/AIDS, both developing and donor countries have adopted similar measures. They have created laws, legislation and policies, drafted strategies, targeted high-risk groups, and worked to create an enabling environment for people living with HIV/AIDS and their families. Donor countries, however, have also introduced free or insurance-paid treatment, established management

Table 9.2 Measures Taken by Donors to Address Access to Reproductive Health

Measures Taken	Number and Percentage of Countries	
	No.	%*
Greater variety of services available (contraceptive options, infertility, counselling, etc.)	7	44
Provision of youth-friendly services/school-based services	7	44
Provision of free RH services in all public health facilities	6	38
Reducing inequalities in access to health services for vulnerable populations	6	38
IEC/advocacy	6	38
Total	**17**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

information systems, and conducted more research.

On gender issues, measures taken by both developing and donor countries are similar. High on the agenda are laws and legislation to protect the rights of girls and women, the establishment of national commissions, efforts to increase the number of women in governance, and policies that promote the empowerment of women.

9.6 VIEWS OF DONOR COUNTRIES ON THE IMPLEMENTATION OF THE ICPD PROGRAMME OF ACTION IN DEVELOPING COUNTRIES

Achievements

Most donor countries indicated that in the 10 years since Cairo, many developing countries have made substantial progress in the implementation of the ICPD PoA. Progress has been made in key areas relating to: (a) population; (b) reproductive health, including family planning; (c) gender and the empowerment of women; (d) increased collaboration and partnerships between governments and civil society in population and reproductive health; and (e) a human rights-centred approach to population that emphasized policies based on meeting the needs of individuals rather than on demographic targets.

Denmark noted that as a result of the ICPD, population issues in general seem to have been placed higher on the political agenda. Most countries, as observed by Australia, have used the ICPD PoA in the formulation of population and reproductive health policies and in the implementation of health and other development programmes, including poverty reduction, achieving universal education, empowering women and reproductive health service delivery within their public health programmes. Also, as mentioned by the Netherlands, many developing countries have shifted from top-down family planning programmes to more broad-based reproductive health programmes and policies. Moreover, family planning and reproductive health programmes have moved away from target-driven approaches to the voluntary, quality-of-service approach endorsed by the ICPD PoA. Developing countries have made great strides in expanding the availability of affordable reproductive health and family planning at the local level. Increasingly, family planning programmes are offered as part of a package of reproductive health, which includes, for example, screening and management of STIs, including HIV/AIDS; prenatal and post-natal care

and assistance at delivery; information, education and communication efforts; and family planning commodities and service delivery.

The ICPD agenda, as noted by Sweden, has served in many developing countries as an entry point for dialogues revolving around sexual and reproductive health and rights. It has also helped increase openness with regard to sexual and reproductive health.

Donor countries have also noted that since Cairo and the Fourth World Conference on Women held in Beijing, many developing countries have increased their focus on women's empowerment. Switzerland mentioned an increase in gender awareness and in the development of gender-sensitive policies and strategies. CEDAW and the CRC are instruments that are increasingly viewed as being complementary to, and supportive of, the ICPD. However, while the rights of women are now discussed more and more in many developing countries, there is a need to continue this discussion and for other countries to follow suit.

Donor countries have noted the increased collaboration between governments and civil society, including the latter's role in facilitating the growing influence of parliamentary groups in population and reproductive health since the ICPD.

The United States noted that the single greatest impact of the ICPD PoA and the ICPD+5 *Key Actions* on population and reproductive health programmes in developing countries has been the increased focus on the individual as a human being with needs to be met. Increasingly, developed countries are designing family planning and reproductive health programmes to address the needs of women and men while preserving their dignity. The so-called "top-down" approaches of the past, which placed demographic concerns ahead of individual needs, have largely been abandoned.

Constraints Identified by Donor Countries

Donor countries responding to the Survey identified three groups of constraints that hinder developing countries from fully implementing the ICPD PoA. First, limited resources were sometimes overwhelmed by competing priorities and demands for those resources. The situation has not been helped by the general declining trend in official development assistance (ODA). Second, donor countries mentioned the institutional limitations in many developing countries, including the lack of trained human resources and the weaknesses of existing vertical organizational structures involved in the delivery of reproductive health services. Third, several respondents referred to such constraining factors as the sensitive nature of reproductive health issues in many developing countries; religious and cultural opposition; a lack of political commitment towards gender equality and environmentally sustainable development; and resistance on the part of governments to greater NGO and private-sector participation in population and reproductive health programmes.

9.7 PARTNERSHIPS AND RESOURCES

It is clear from the country responses to the Survey that donor countries, like their developing country partners, are increasingly partnering with civil society organizations to assist in the provision of reproductive and sexual health information and services. Most of the donor countries (15 out of 18) reported that they have active partnerships with NGOs. This demonstrates a significant increase from the 1998 Global Survey responses on partnerships, where approximately half of donor countries indicated significant measures on partnerships. Ten countries stated that NGOs have already been playing an active role in the policy-making and/or delivery of reproductive health services before the ICPD. In addition, five countries reported that NGOs are playing more active roles in their partnerships with governments, specifically on reproductive health issues, since the ICPD.

Donor countries have provided technical and financial assistance to developing countries to address the HIV/AIDS crisis at the global level. They have also contributed to the creation of the necessary policy and programmatic environments for developing countries to address and slow the spread of the pandemic. One example is Japan, where the Japan International Cooperation Agency (JICA) held seminars on reproductive health and HIV/AIDS, sponsored capacity-building workshops for NGOs in developing countries, provided technical experts to work in developing countries, and contributed to international funds to combat HIV and other infectious diseases. Donor countries also continued to support research and the monitoring of trends in HIV/AIDS and reproductive health, particularly STIs. For example, the United States develops a transnational AIDS research plan each year, involving various National Institutes of Health. The collaborative, inclusive process involves government and non-government

experts from academia, foundations, and the industry, as well as community representatives.

Civil society organizations are increasingly responding to donor requests for partnerships and have even initiated some of them. Eight donor countries reported that NGOs have taken measures to assist in advocating ICPD goals and objectives in their respective countries. Other important areas where NGOs have taken measures to assist governments include: improving access to reproductive health services, addressing the special reproductive health needs of adolescents, protecting the rights and empowerment of girls and women, and protecting the rights of migrants/refugees/IDPs and combating trafficking (Table 9.3).

Donor countries have also taken measures to strengthen their partnerships with the private sector in population and reproductive health. Seven donor countries reported that they have established strong cooperation with the private sector in the provision of reproductive health services. Another seven countries reported that they have partnered with the private sector to strengthen reproductive health commodity security.

A particularly strong area of government/civil society collaboration has been the role of NGOs in facilitating the growing influence of parliamentary groups in population and reproductive health since the ICPD. Nearly all countries (16) reported that there has been a growing influence of parliamentary groups. Most of this influence has been gained through an increase in parliamentary

caucuses/committees and legislators' groups on population and reproductive health issues (10 countries) and through the drafting and ratification of new laws/legislation supported by the parliamentarian groups (four countries).

Donor countries are also working on ways to further strengthen their work with NGOs in key emerging priority areas. Over half of respondents (nine countries) indicated emerging opportunities for partnerships with NGOs on such issues as life skills/sexual and reproductive health education programmes for youth, HIV/AIDS prevention and treatment, GBV, and promoting the ICPD agenda and the MDGs.

Resource Mobilization and Development Cooperation

In their efforts to implement the ICPD PoA, donor countries and their partners are employing international development frameworks and processes to the extent possible. Most of the countries have reported using such frameworks as the MDGs, PRSPs, SWAps and other processes to support their work on population and reproductive health issues (Box 9.1). Several donor countries reported that they are using the MDGs as a basis for the development of programmes and policies that promote the ICPD agenda. Eleven countries reported promoting the ICPD agenda through PRSPs, while seven countries are advancing it through the use of SWAps. Donor countries have also indicated that these interrelated development frameworks have been useful in planning for IEC activities and NGO partnerships on population and reproductive health issues relating to the ICPD PoA.

The pre-ICPD process and the immediate post-ICPD period saw an increasing flow of resources in the form of donor assistance. Several members of the international donor community demonstrated their commitment to achieving the goals and objectives of the ICPD PoA by increasing their assistance for population activities. International assistance for population activities increased 54 per cent between 1993 and 1995, from $1.3 billion to $2.0 billion. The increased level of funding supported population programmes that benefited millions of people in developing countries. However, in the years from 1995-1999 population assistance did not increase, but continued to hover near the $2 billion mark. In 1997, funding levels actually decreased for the first time since Cairo.

Although population assistance peaked at $2.6 billion in 2000, the ICPD financial goal of $5.7 billion

Table 9.3 **Areas of Partnerships between Donor Governments and NGOs**

Measures Taken	Number and Percentage of Countries	
	No.	%*
Improving access to RH services	15	83
Addressing the special RH needs of adolescents	12	67
Protecting the rights of, and empowering, girls and women	12	67
Advocating ICPD goals and objectives	8	44
Protecting the rights of migrants/refugees/IDPs and combating trafficking	4	22
Total	**18**	**100**

*Based on multiple responses; therefore percentages may add up to more than 100.

by the year 2000 was not met; the resources mobilized represented roughly 46 per cent of the target agreed upon as the international community's share in financing the ICPD PoA. However, after declining in 2001, international assistance increased in 2002 to almost $2.8 billion. Nevertheless, a wide gap remains between actual assistance and ICPD targets.

Donor countries reported that they have faced constraints in mobilizing resources in their own countries to support international assistance programmes, including ones related to implementation of the ICPD PoA. They have indicated that a major constraint in supporting the ICPD PoA is the high and competing demands for donor funds, coupled with financial constraints on their international aid budgets. Over 65 per cent of responding countries indicated this as the most pressing constraint. They also reported that donor country citizens' lack of understanding of international assistance (20 percent) and partner governments' low priority or negative attitudes towards the ICPD PoA (20 percent) were significant constraints.

Although the constraints to ICPD implementation pose significant challenges, donor countries indicated that the ICPD PoA has been a useful tool for framing their development strategies. Many donor countries (15) reported that there have been changes in their development assistance strategies in support of population and reproductive health. In particular, donor countries altered development assistance strategies to include gender issues, HIV/AIDS prevention and treatment, and increased dialogue with beneficiaries and civil society. Moreover, in support of the further implementation of the ICPD PoA, particularly in strengthening international assistance in population and reproductive health, several donor countries have reviewed their policies and priorities and/or have modified their development assistance strategies (Box 9.2).

9.8 CONCLUSION

Donor country responses to this Survey reveal that they face many of the same population challenges that their developing country partners face, most specifically pop-

SUPPORT FOR THE FURTHER IMPLEMENTATION OF THE ICPD PROGRAMME OF ACTION

In support of the further implementation of the ICPD Programme of Action, particularly in strengthening international assistance in population and reproductive health, several donor countries have reviewed their policies and priorities and/or have modified their development assistance strategies. For instance:

In **Australia**, the Government published a revised policy on family planning assistance in 2001. Regarding the design and implementation of family planning projects overseas, the policy declares that "All family planning programmes must recognize the importance of the cultural, familial and religious context in which projects occur." Australia will continue to monitor its programmes and, where appropriate, will apply lessons learned to improve the quality of outcomes.

In **Denmark**, the Government has prepared a proposal for policies and priorities for its development assistance from 2004 to 2008. Increased emphasis is being placed on health and population issues, including additional funding for activities in these areas.

In **Finland**, the Government has proposed giving more support to HIV/AIDS-related activities and to MDG implementation. The Government is currently preparing a white paper on development cooperation that highlights the implementation of the MDGs.

In **Germany**, the Government has developed a new policy on sexual and reproductive health, which has been placed at the centre of the German poverty-reduction strategy. Sexual and reproductive health projects will be integrated into broader programmatic approaches for health system development and health sector reforms.

In the **Netherlands**, the implementation of the ICPD PoA is being broadened through more explicit attention to the sexual and reproductive rights of women in particular. Reproductive health policies are likewise being broadened to include political and human rights aspects.

In **New Zealand**, the Government committed itself to moving towards the DAC target of 0.7 per cent of GNP spent on official development assistance. The central policy focus of its ODA programme is poverty eradication, which has clear implications for reproductive health. It is likely that population and reproductive health and HIV/AIDS will continue to be priorities within the health policy and strategic frameworks of the New Zealand Agency for International Development (NZAID), and they may be given enhanced emphasis in the future.

The Government of **Sweden** has expanded and strengthened its support to the ICPD agenda. The Government's bill on global development, presented to the Parliament in May 2003, underscored population and development issues, especially those relating to gender, sexual and reproductive health and rights, HIV/AIDS, migration, development and the needs of young people.

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ulation ageing, migration, and adolescent reproductive health. Greater collaboration and partnership between donor and developing countries would be mutually beneficial and provide increased resources and capacities for full implementation of the ICPD PoA.

ICPD implementation efforts are continuing to gain momentum in donor countries. Nearly all of the 18 countries replying to the Survey have revitalized their reproductive health programmes. They have done so via such measures as increasing their focus on the reproductive health needs of adolescents, young people, migrants and indigenous populations; increasing the availability of high-quality comprehensive reproductive health services; and enhancing training for health-care providers.

Donor countries have also improved their responses to the HIV/AIDS pandemic. They have increased funding for research and prevention programmes; improved access to care and treatment; organized support networks; and employed new information technologies to raise awareness of, and to disseminate information on, the disease. They have also adopted measures to protect the rights of girls and women and to promote women's empowerment. These measures include the enactment of new laws and legislation to address gender-based violence and to combat trafficking in women and girls.

Donor countries continue to be concerned about a number of issues. Areas of concern include meeting the needs of older persons; the growing levels of illegal immigration and the continuing flows of refugees and asylum-seekers; and the trafficking of human beings. More recently, they have recognized a need to strengthen national capacities to address new and emerging diseases as well as bio-terrorism threats.

Donor countries perceive that over the last 10 years there has been considerable progress in implementing key areas of the ICPD PoA in developing countries. There has been progress in reorienting and strengthening reproductive health policies and programmes, including those focusing on family planning. There has also been increased recognition that gender concerns, including the empowerment of women, are vital to the

development process. Moreover, donor countries report increases in the number of partnerships and collaborative efforts between governments and civil society on population and reproductive health matters and increased acknowledgment of the need to place human rights and individual needs (rather than demographic targets) at the centre of population policies.

Although donor countries have mobilized resources to assist developing countries in implementing the ICPD PoA, financial resources remain insufficient. This is a particular point of concern for the least-developed countries, where population size will triple over the next 50 years. Donor countries recognize that to further implement the ICPD PoA, they will need to strengthen and intensify their international assistance in the areas of population and reproductive health. They will need to sustain partnerships and collaboration with relevant stakeholders. And finally, they must be proactive in using international development frameworks and processes to promote the ICPD agenda.

10 Overview of Progress and the Way Forward

10.1 OVERVIEW OF PROGRESS

The findings of this Global Survey call for a celebration of the implementation of the International Conference on Population and Development Programme of Action (ICPD PoA) and the *Key Actions*. National progress since Cairo is clearly visible at policy, operational and programmatic levels. This Survey shows:

- A considerable increase in the awareness of, familiarity with, and ownership of the ICPD agenda by countries of all regions;

- A confirmation that countries are implementing the ICPD PoA in a pragmatic manner by adopting an incremental approach and focusing first on priority concerns;

- Clear evidence of broad multisectoral interventions in implementing the ICPD PoA;

- A notable increase in institutionalized ways of addressing population, gender and reproductive health issues, as evidenced by the formal adoption of policies, legislation, strategies or programmes in so many countries;

- A clear adoption by countries of the concepts of reproductive health and reproductive rights as their own;

- A significant effort to integrate family planning services into reproductive health, resulting in greater use of modern family planning methods;

- A trend towards safe motherhood moving up the policy agenda, with greater emphasis on attended delivery and referrals in cases of emergency;

- A strong move towards involving stakeholders in the community and civil society, especially women's groups, as part of the policy-making and programming apparatus;

- An emerging recognition that the attainment of ICPD goals is critical to achieving the MDGs and that much can be gained from pursuing an integrated and coordinated approach to the formulation, implementation and monitoring of programmes to achieve these two sets of goals.

The reported progress, however, is not uniform across countries, regions or the various programme areas of the Cairo agenda. Wide variations exist in national action with respect to the extensiveness of action taken, the intensity of measures adopted, the scale and reach of interventions being implemented, and the amount of resources allocated. The Survey also indicates some important programmatic and operational gaps that point to the way forward. In the following section, a short description by selected programme areas of the progress achieved, programmatic issues encountered, and actions required for the way forward are presented. The final section of the chapter presents actions to address the operational issues and ends with a conclusion.

10.2 THE WAY FORWARD BY PROGRAMME AREA

Population and Development

The Survey results demonstrate that since Cairo a significant number of countries have taken actions to integrate population concerns into social development plans, economic development plans, poverty-reduction strategies and local-level planning. Analysis reveals that countries have focused actions on priority issues in population and development, including poverty reduction, population ageing, and internal and international migration. Appropriately, countries with the highest levels of poverty were more likely to develop poverty-reduction strategies. Countries with higher levels of population ageing were almost twice as likely to have adopted major initiatives on the special needs of the elderly. Many countries are also increasing efforts

in the areas of internal and international migration; most of them are specifically taking actions to handle the issues of internally displaced persons and the trafficking of women and girls. According to the Survey, there is still a need to:

- Intensify advocacy activities targeted at governments and NGO leadership on the linkages between population and poverty;

- Strengthen data collection and analysis for monitoring the living conditions of the poor; for contributing to the formulation of social development polices; and for designing programmes targeted at poverty reduction, especially for vulnerable groups;

- Strengthen capacity, at the national level, for robust analyses of the causes and consequences of emigration and immigration, as well as of internal migration in individual country contexts, with a view to helping countries develop appropriate migration polices. At the international level, studies need to be undertaken on the levels and trends, as well as the macro and micro implications, of international migration;

- Conduct national and subnational policy studies of changing age structures and of population ageing by incorporating structural and societal changes associated with ageing into the formulation of social development policies; and

- Further promote and strengthen protection of and respect for human rights, individual dignity and ethical values, with sensitivity to cultural differences, in the implementation of the ICPD agenda.

Gender Equality and Women's Empowerment

As the survey results show, a large percentage of countries reported having addressed gender as a priority concern since Cairo. Almost all countries reported having taken at least one policy, legislative or administrative action to protect the rights of girls and women and to support women's empowerment. Numerous countries reported they had formulated policies to remove gender discrimination or provided constitutional protection to women and girls. Many countries also reported efforts to increase the participation of women in governance and to provide economic, education and

training opportunities for women and girls. The results also illustrated areas of lesser action that need more attention. Overall, there is a need to ensure the effective implementation of laws and policies. Gender-based violence, gender mainstreaming, trafficking in women and girls, and national capacity-building remain major gaps to be addressed in many regions of the world, highlighting the need to:

- Strengthen national capacity in the areas of gender and human rights by fostering dialogues and forging productive partnerships between, among others, civil society, women's groups, governmental structures and other coordination machineries for women's affairs, religious organizations, local power structures and donors.

- Develop strategies to reduce and eliminate gender-based violence, including: building capacity at national and subnational levels for collecting and analysing GBV data; undertaking evidence-based advocacy and media campaigns for the prevention of GBV; and devising strategies for prevention, especially in conflict and post-conflict situations;

- Undertake conceptual and methodological work related to incorporating gender perspectives and gender equality into development policies and programmes by defining gender mainstreaming in non-technical terms and promoting its understanding among policy makers and planners. Establish mechanisms for the integration of gender equality, equity and women's empowerment perspectives into national, regional and international development planning and programming frameworks (e.g. Common Country Assessments/United Nations Development Assessment Frameworks, PRSPs, SWAps);

- Strengthen activities to eliminate the trafficking in young women, girls and boys, as well as strengthen existing facilities, especially in trafficking-prone areas, to enable such facilities to provide information, counselling and referral services to victims and potential victims through both in-house and outreach programmes; and

- Advocate for and ensure women's participation in local, municipal and national decision-making bodies, including those involved in reproductive health.

Reproductive Rights and Reproductive Health

The survey shows that countries recognize reproductive and sexual health care as something every woman and man has a right to expect and are moving to make that expectation a reality. Countries are making significant strides to empower women in their reproductive health choices and to encourage male involvement in reproductive health and family planning. Since Cairo, a majority of countries have taken measures to include reproductive health as part of the health-sector reform package, and to increasingly integrate reproductive health service components into the primary health care system. Progress is also significant both in the number of countries taking major measures and in the variety of measures taken to increase information on and access to contraceptives and contraceptive choice. Much remains to be done to improve the accessibility and affordability of services, especially for poor households. Male involvement in reproductive health progress remains inadequate. The way forward requires stakeholders to:

- Promote reproductive health as an essential component of poverty-reduction strategies and as critical to reduce high fertility, high and stubborn maternal mortality and morbidity, and the spread of HIV/AIDS and other sexually transmitted infections;

- Make reproductive health services even more accessible to the poor by decentralizing services down to the community level and exploring alternative financing schemes;

- Promote further the use of a human rights framework for guiding policies, programme design and service delivery to shape a humane and effective reproductive health and reproductive rights strategy;

- Integrate activities to address gender-based violence into reproductive health programmes;

- Promote high-quality, client-centred services by including education materials, improving counselling and soliciting users' perspectives to enhance the delivery of services; and help increase demand for and utilization of services by raising awareness of reproductive health needs and reproductive rights and improving provider-client interactions and motivation and skills of service providers; and

- Ensure reproductive health commodity security with a commitment of larger resources, as well as its integration into national resource allocation and budgeting systems.

Adolescent Reproductive Health and Youth

Adolescent reproductive health has emerged as a priority issue throughout the world in the last decade, and the Survey findings demonstrate that countries increasingly recognize the importance of this issue. Most countries responding to the Survey reported taking action since Cairo to address the reproductive health and reproductive rights of adolescents, including the provision of youth-friendly services. Many countries also report greater efforts to decrease gender disparities in education, to provide comprehensive health and life-skills education to in- and out-of-school youth and to increase employment opportunities for young people. Despite the achievements of countries in addressing adolescent reproductive health issues, the Survey reveals the need to:

- Raise the political commitment of governments to design rights-based, comprehensive programmes for adolescents and youth;

- Ensure the full participation of adolescents and youth in the design, implementation and monitoring of programmes addressing their concerns;

- Coordinate IEC efforts aimed at adolescents and youth with an expansion of services to improve access, particularly for the most disadvantaged;

- Increase investment in human capital development by incorporating youth-focused, high-quality public education, livelihood training and health services (including reproductive health) into national development and investment strategies; and

- Involve parents, communities and cultural leaders in efforts to promote adolescent reproductive and sexual health.

HIV/AIDS

The HIV/AIDS pandemic is one of the greatest threats to human development and security. The Survey demonstrates that countries have responded

through measures such as the establishment of national HIV/AIDS commissions or committees and the development of multisectoral policies and programmes. A great number of countries reported developing prevention programmes that are specifically focused on targeted interventions among high-risk groups, including sex workers, drug users and truck drivers. However, much remains to be done to strengthen preventive and curative measures, particularly by increasing IEC activities, voluntary testing and counselling and treatment programmes, and by addressing the linkages between HIV/AIDS and poverty and gender discrimination and violence. Actions for the way forward would be to:

• Incorporate HIV prevention within various sectoral policies and programmes to minimize the adverse impact of HIV/AIDS and promote a coordinated, multisectoral response by having one national AIDS coordinating body, one national AIDS strategy and one national monitoring system;

• Develop and strengthen the integration of reproductive health information and services, STI and HIV prevention, treatment and care, and sexual health education;

• Advocate for the highest feasible levels of access to an appropriate balance of prevention, treatment, care and support;

• Address the specific needs of women and girls, who suffer a disproportionate negative impact from HIV/AIDS, and ensure that laws, policies and programmes are gender-sensitive and that they effectively reach women and girls; and

• Break the cycle linking poverty and HIV/AIDS and accelerate progress towards the MDGs by simultaneously taking more aggressive action to address HIV/AIDS and attacking poverty with interventions to assist the most vulnerable.

Advocacy, Education and Behaviour Change Communication

Countries responding to the survey reported numerous advocacy strategies to promote responsible and healthy behaviours, especially among high-risk groups, including women and young people. Countries reported achievements since Cairo in developing national and subnational advocacy programmes, as well as lobbying for laws and legislative changes that support the ICPD PoA. A great number of countries also reported having taken significant actions to expand coverage on reproductive rights and reproductive health issues to influence attitude and behaviour change through the creative use of traditional and folk media, as well as through increased use of emerging information and communication technologies. There is still a need to:

• Ensure that the social and cultural environment is taken into account in the formulation and implementation of behaviour change communication strategies to maximize their positive reception and effectiveness and to facilitate the application of a rights-based approach to gender issues and reproductive health; and

• Enhance coordination and linkages between IEC/BCC programmes and service delivery in reproductive health to increase effectiveness and to address unmet needs and underserved populations.

Partnerships

In regard to increasing partnerships and resources for population and reproductive health issues, the Survey results revealed many accomplishments since Cairo and some areas for improvement. Most countries put a high premium on partnerships with a wide spectrum of stakeholders and have reported increased partnerships with NGOs, other civil society organizations, United Nations system partners and the private sector. The types of partnerships have ranged from programme development and implementation, to staff training and capacity-building efforts, collaboration with parliamentarian groups, and innovative South-South cooperation. They also cover numerous substantive areas, such as gender and women's empowerment; adolescent reproductive health; HIV/AIDS prevention and treatment; and commodity security. The way forward would be to:

• Encourage the evolution of these partnerships from a consultative and advisory nature to a more genuine sharing of power and authority in the design, planning and implementation of policies and programmes;

• Reaffirm commitment to even more comprehensive and inclusive partnerships with civil society and, particularly, the private sector;

- Create partnerships that include multisectoral approaches and a broader range of partners, as well as cover a larger number of policy and programmatic areas of population, gender and reproductive health issues; and

- Strengthen further cooperation and collaboration among the United Nations system partners, at both country and other levels, to ensure that ICPD goals and issues are well integrated into efforts to attain the MDGs.

Resources

In the area of resource mobilization, while some recent trends in international population and reproductive health assistance are encouraging, the current financial commitments are unlikely to meet the 2005 funding targets as agreed at the ICPD and the ICPD+5, and current levels of resources are inadequate to make the Cairo vision a reality. The way forward would be to:

- Protect funding for population and reproductive health in the face of a number of new and competing priorities, as well as in the context of international funding modalities; and

- Ensure that the Official Development Assistance (ODA) target of 0.7 per cent of GNP is met and that appropriate resources are allocated to population and reproductive health in the new funding and/or programming frameworks such as MDGs, SWAps and PRSPs.

Issues Reported by Donor Countries

Donor country responses to the Survey reveal that they face many of the same population and reproductive health challenges that their developing partners face, most specifically in reproductive health, adolescent reproductive health, population ageing and migration. Greater collaboration and improved partnerships between donor and developing countries would be mutually beneficial and would increase resources and capacities for full implementation of the ICPD PoA. Efforts by donor countries in this regard with beneficial impact would be to:

- Continue and strengthen their assistance efforts to developing countries through the transfer of technical advice, programme expertise and resources for population and reproductive health activities;

- Remove barriers to donor harmonization in support of the national priorities of programme countries and facilitate efforts to devise and implement coordinated programme activities; and

- Enhance methods of knowledge sharing and exchanging insights on lessons learned and good practices with their developing country partners.

10.3 THE WAY FORWARD FOR OPERATIONAL ISSUES

The findings of the Survey point to operational issues with regard to the need for the integration of the ICPD agenda into new perspectives and the need to strengthen programme implementation.

Integrating the ICPD Agenda into New Perspectives

The Survey results clearly indicate that countries are aware of the relevance of the MDGs as a unifying framework for recommended actions on the sectoral dimensions of development emanating from the global conferences of the 1990s. Adopted at the dawn of the 21st century, the MDGs have helped both individual countries and the international community to pursue a more holistic approach to development policy, dialogue, programming and cooperation. Many of the ICPD goals are included in the MDGs and thus the attainment of the former is essential for the achievement of the latter. To forge coherence between the two, the way forward requires developing countries and development partners to:

- Take advantage of national capacity-building efforts to achieve and monitor the MDGs for implementing and monitoring the ICPD PoA; and

- Infuse ICPD issues into policy dialogues in such areas as poverty eradication, women's empowerment, social policies, human rights, environmental sustainability, macroeconomic polices, SWAps, PRSPs and other development frameworks and programming processes.

Strengthening of Implementation

The Survey contains important information from countries on the constraints they face in the implementation of the ICPD PoA. Most notably, resource mobilization,

resource utilization, capacity development, institution-alization, systems of monitoring and evaluation and the absence of adequate data systems were highlighted by nearly all countries. To address these issues, the way forward would be to:

- Augment the allocation of domestic resources for reproductive health, the prevention of HIV/AIDS, and gender and youth programmes by generating the commitment of policy makers, engendering the political support of stakeholders (government, civil society and the private sector) for additional resource allocations, maximizing investments within available budgets, urging the international community to commit additional external resources (especially to low-income and least-developed countries), and making serious efforts to increase the effectiveness and efficiency of investments;

- Promote capacity-building in countries by assessing capacity needs, identifying capacity results to be achieved, adopting appropriate capacity-development strategies, monitoring progress and encouraging all partners, including governments, international donors, multilateral agencies, and civil society to coordinate their support and actions;

- Ensure the continuity, upscaling and future sustainability of programme efforts;

- Strengthen management capacities in various functional areas, including programme management, financial management, information and data management and human resources management;

- Strengthen and/or establish an effective monitoring and evaluation mechanism in countries to address constraints in programme implementation and to assess programme success. The same mechanism could be used in tracking the achievement of ICPD goals, the MDGs and other international development targets; and

- Address urgently and comprehensively the lack of data systems in countries by strengthening or establishing institutions with mandates for data collection, analysis, utilization and dissemination; launching

training and other skills-development programmes to improve the quality of human resource capacities; and enhancing institutional support for equipment, supplies and other materials to enable those institutions to function effectively.

10.4 CONCLUSION

It is clear that much progress has been achieved in implementing the Cairo Programme of Action, and much has been learned about the successes and constraints of putting the agenda into practice. Most importantly, this Survey demonstrates that countries have made the ICPD PoA their own by designing and implementing various components in a vigorous and committed manner. Achieving the Millennium Development Goals will depend on the attainment of the goals elaborated in Cairo: that by the year 2015 all governments will ensure universal access to reproductive health services; reduce infant, child and maternal mortality; and open the doors of education to every citizen, most particularly to girls and women. The consensus achieved in Cairo addresses some of the world's most pressing issues. The ICPD Programme of Action acknowledges that investing in people, broadening their opportunities and enabling them to realize their potential as human beings is the key to sustained economic growth and sustainable development, enhanced reproductive health, and strengthen reproductive rights, as well as to population stabilization. Governments' rising commitments to population-related concerns reflect the importance they attach to these vital crosscutting issues. Yet in many ways, the promise of Cairo remains unfulfilled. As a result, lives are being lost, future generations are being put at risk and the development prospects of entire nations are placed in jeopardy.

This Survey demonstrates that a solid foundation has been built in the first 10 years of ICPD for the implementation of the Cairo agenda. To achieve the goals and objectives of the ICPD Programme of Action, continued efforts and commitment are needed to mobilize sufficient human and financial resources, to strengthen institutional capacities, and to nurture stronger partnerships across sectors and all stakeholders.

With renewed vigor, it is possible to make the promise of Cairo a full reality.

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Annex

Countries that Responded to the Global Survey Questionnaire (listed according to UNFPA Regional Groupings)		
Region/Subregion	**Number**	**Countries**
Sub-Saharan Africa	45	Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Democratic Republic of Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Mozambique, Namibia, Niger, Nigeria, Rwanda, Sao Tome and Principe, Senegal, Seychelles, Sierra Leone, South Africa, Swaziland, Tanzania (United Republic of), Togo, Uganda, Zambia, Zimbabwe.
Arab States	15	Algeria, Bahrain, Djibouti, Egypt, Jordan, Lebanon, Morocco, Oman, Palestine, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, Yemen.
Central Asian Republics	5	Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan.
Asia	21	Afghanistan, Bangladesh, Bhutan, Cambodia, China, Democratic People's Republic of Korea, Timor-Leste, India, Indonesia, Iran (Islamic Republic of), Lao People's Democratic Republic, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Sri Lanka, Thailand, Viet Nam.
The Pacific	13	Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia (Federated States of), Niue, Palau, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu.
Latin America	17	Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela.
The Caribbean	16	Antigua and Barbuda, Barbados, Belize, Cuba, Dominica, Dominican Republic, Grenada, Guyana, Haiti, Jamaica, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Saint Lucia, Suriname, the Bahamas, Trinidad and Tobago.
CIS, Eastern and Central Europe and Turkey	19	Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Slovenia, Turkey, Ukraine.
Donor Countries	18	Australia, Austria, Canada, Denmark, Finland, Germany, Ireland, Japan, Luxembourg, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom of Great Britain and Northern Ireland , United States of America.
TOTAL COUNTRIES	169	