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**A Five-Year Review of Progress towards the Implementation
of the Programme of Action of
the International Conference
on Population and Development**

A background paper prepared by
the United Nations Population Fund (UNFPA)
for
The Hague Forum
The Hague, Netherlands
8-12 February 1999

Note:

In the text of this paper, the designations "developed" and "developing" countries and "more developed" and "less developed" countries and regions are intended for convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process.

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LIST OF ACRONYMS AND ABBREVIATIONS

ACC	United Nations Administrative Committee on Coordination
AHD	Adolescents Health and Development Programme
AIDS	Acquired immunodeficiency syndrome
AVSC	Association for Voluntary Safe Contraception
BSSA	Basic Social Services for All
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CELADE	Latin American Demographic Centre
CIS	Commonwealth of Independent States
COPE	Client-Oriented, Provider-Efficient services
DESA	Department for Economic and Social Affairs, United Nations
DHS	Demographic and Health Survey
ECA	Economic Commission for Africa
ECE	Economic Commission for Europe
ECLAC	Economic Commission for Latin America and the Caribbean
ESCAP	Economic and Social Commission for Asia and the Pacific
ESCWA	Economic and Social Commission for Western Asia
FGM	Female genital mutilation
GNP	Gross national product
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IDA	International Development Association
IDB	Inter-American Development Bank
IEC	Information, education and communication
ILO	International Labour Organization
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
MCH/FP	Maternal and child health/family planning
NGO	Non-governmental organization
RTI	Reproductive tract infection
SIP	Sector Investment Programme
STD	Sexually transmitted disease
STI	Sexually transmitted infection
SWAP	Sector-Wide Approach
TFR	Total fertility rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund

WHO

World Health Organization

EXECUTIVE SUMMARY

1. This report has been prepared by the United Nations Population Fund (UNFPA) as a background document for the Hague Forum, to be held in The Hague, the Netherlands, 8-12 February 1999. The Forum will examine the progress made and the constraints encountered during the first 4-5 years of the on-going implementation of the 20-year Programme of Action of the International Conference on Population and Development (ICPD) held in Cairo, Egypt, in 1994. Adopted by 179 countries, the ICPD Programme of Action underscores the integral and mutually reinforcing linkages between population and development and endorses a new rights-based strategy which focuses on meeting the needs of individual women and men rather than on achieving demographic targets. Since the ICPD, several extensive reviews have been made of the first phase of the implementation of its recommendations. This report reflects the findings of those efforts, which include a series of round-table and technical meetings organized by UNFPA during 1998; consultations organized by United Nations regional commissions; and a global inquiry conducted by UNFPA in mid-1998, in which information was collected from 114 developing countries and countries with economies in transition through UNFPA Field Offices and to which 18 donor countries also responded.

2. Considerable progress has been made in implementing key areas of the ICPD Programme of Action, through policy reformulation, programme redesign, increased partnership and collaboration, and increased resource allocation. In particular, there has been encouraging progress since 1994 in promoting reproductive rights and implementing reproductive health as defined by the Programme of Action. As of mid-1998, many countries had made policy, legislative and/or institutional changes in the area of reproductive health and/or rights since the ICPD. Several countries are testing ways to integrate various reproductive health services, and others are exploring other means to ensure rights-based approaches.

3. Sector-wide progress in policy formulation is occurring in several countries, while work on improving specific aspects of policies has begun in others. The UNFPA Field Offices reported that 41 countries had made policy/legislative changes in reproductive health after the ICPD. Critical measures undertaken by countries more advanced in the implementation of the ICPD agenda have provided the right to have free and easily accessible reproductive health services as an overall health component, throughout the life cycle, including the voluntary choice of family planning methods.

4. As one of its key principles, the ICPD Programme of Action emphasizes that advancing gender equality, equity and empowerment of women, eliminating all kinds of violence against women, and ensuring women's ability to control their own fertility are cornerstones of population and development-related programmes and are central to the notion of sustainable development. The Programme of Action sets out as an important objective to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. These aims are important conditions for building a sustainable, just and developed society.

5. The incorporation of a gender perspective in population and development programmes has faced considerable constraints. Foremost among these has been the difficulty associated with operationalizing concepts related to gender equality, equity and empowerment of women in various social, cultural and political contexts. This constraint has slowed the integration of these concerns in a number of important planning and programming processes because of the absence of a consensus on what they mean. This problem is closely linked, in many countries, to the absence of data or research studies that would help in establishing clear operational definitions of these concepts. Most available data are based on quantitative methodologies and statistical analyses of only a few variables. Even in those countries where conceptual issues have been resolved, action plans have not always been accompanied by the necessary resource allocations, constraining the extent to which such plans can be effectively implemented.

6. The Programme of Action calls for the promotion of an effective partnership between all levels of Government and the full range of non-governmental organizations (NGOs) and local community groups in the design, implementation, coordination, monitoring and evaluation of population policies and programmes. Four years after Cairo, changing development paradigms are continuing to shift the roles of Government, civil society and the international community. Partnership has emerged as a basic element to support and advance the Programme of Action implementation process. It has become increasingly apparent that Governments alone cannot manage to provide the development services to meet the basic human and social needs and aspirations of their citizens. NGOs were genuine partners in framing the Programme of Action agreements and are now partners in its implementation. Effective and empowered women's movements and other mass movements are proving to be important in ensuring progress in policy development and implementation in many parts of the world.

7. A review of progress over the last few years on the scope of collaborative efforts with the civil society provides a basis for optimism. Major strides have been taken in procedural areas, such as positive changes in the concept of participation and the processes for consultation; recognition of the changing roles of civil society; increasing acceptance of innovative development approaches, including decentralized and community-based modalities; and improved partnership among United Nations organizations and bodies. Similarly, the context for substantive discourse and action by all parties has also changed, with increasing awareness of the societal dimensions of development and economic issues; growing recognition of the necessity for a human rights-based approach; expanding acceptance of reproductive and sexual health concepts and programmes; and deepening awareness and recognition of the need for gender equality and the empowerment of women.

8. All of the regional consultations and technical meetings held as part of the ICPD+5 process underscored, however, that if the ICPD goals are to be achieved, efforts to meet the funding levels specified in the Programme of Action will have to be intensified. Many countries have made impressive progress in realigning domestic budgets to address ICPD goals for improving the accessibility and quality of reproductive health programmes, reducing mortality and increasing attention to related social sectors. However, financial crises are affecting the ability of many countries, and especially developing countries and countries with economies in transition, to maintain the initial momentum towards achieving these goals. Donor countries are strongly encouraged to redouble their efforts to reach the \$5.7 billion target for international assistance by the year 2000 as was agreed to at Cairo.

Chapter I. INTRODUCTION

Background

Purpose and Framework

9. This report was prepared by the United Nations Population Fund (UNFPA) as a background document for the Hague Forum, to be held in The Hague, the Netherlands, from 8 to 12 February 1999. The Forum will assess the progress made and constraints encountered in the implementation of the Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994. A report on the outcome of the Forum will be sent to the March 1999 session of the Commission on Population and Development and will be taken into account in the preparation of the Report of the Secretary-General to the United Nations General Assembly Special Session on the Implementation of the ICPD Programme of Action, to be held from 30 June through 2 July 1999.

10. This report takes into account the findings of a series of extensive reviews, including:

- C A series of round-table and technical meetings organized by UNFPA during 1998;
- C Consultations organized by the United Nations regional commissions;
- C A global field inquiry conducted by UNFPA in mid-1998 in which information was collected from 114 developing countries and countries with economies in transition through UNFPA Field Offices, and to which 18 donor countries also responded;
- C Progress reports on the implementation of the ICPD Programme of Action from UN specialized agencies and other UN organizations; and,
- C Reviews, including case studies, conducted by international organizations, non-governmental organizations and academic institutions.

11. The ICPD Programme of Action, adopted by 179 countries, underscores the integral and mutually reinforcing linkages between population and development and endorses a new rights-based strategy focused on meeting the needs of individual women and men rather than on achieving demographic targets.¹ The ICPD Programme of Action sets out a number of time-bound population and development goals for a 20-year period, from 1995 to 2015, including: the provision of universal access to reproductive health services, including family planning and sexual health; a reduction in infant, child and maternal mortality; and the provision of universal access to education, especially for girls. It stresses the empowerment of women both as a highly important end in itself and as a key to improving the quality of life for everyone.

Organization of Report

12. Following the overview of the major themes presented in the ICPD Programme of Action and consideration of the population situation contained in this chapter, Chapter II discusses policy initiatives taken by countries since 1994 towards creating an enabling environment for the implementation of the Programme of Action. Chapter III focuses on reproductive health, including family planning and sexual health, and reproductive rights. Chapter IV discusses progress in the area of gender equality, equity and the empowerment of women. Chapter V examines partnerships between Governments and civil society and among United Nations organizations. Chapter VI examines issues pertaining to the resources required to implement fully the ICPD Programme of Action, including financial resource flows in both developing and donor countries. Each chapter analyses progress made in achieving the goals and objectives of the ICPD Programme of Action as well as the constraints and challenges in population and development. The chapters conclude with further actions required to accelerate progress in implementing the ICPD Programme of Action.

Global Population and Demographic Situation

13. In 1960, the world's population stood at 3 billion and the growth rate was 2 per cent; in 1980, the population was 4.4 billion and the growth rate was 1.7 per cent. World population today stands at 5.9 billion and is growing at 1.33 per cent annually. Favourable demographic trends give rise to the hope of an eventual stabilization of global population at a level the earth can support. However, the demographic momentum will continue to lead to large growth in numbers for at least the next two decades. According to United Nations global population and demographic estimates and projections, the world's population will exceed 6 billion for the first time in 1999. Of this total, some 80 per cent will be living in developing countries. Global population is expected to reach somewhere between 7.0 and 7.5 billion by the year 2015 and will continue to grow until at least the middle of the next century. Although the rate of population growth has declined, world population is currently increasing by some 78 million persons a year, compared with 63 million a year in 1960, because of the legacy of high fertility levels in the recent past. Approximately 97 per cent of the increase in world population is occurring in the least developed regions, which are growing at 2.6 per cent annually, and the less developed regions, which are growing at a rate of 1.7 per cent annually. The more developed countries are increasing by only 0.3 per cent annually, and in some of the more developed countries population is declining.

14. The available evidence suggests that reductions in infant and child mortality have continued in the 1990s broadly consistent with the goals of the ICPD. Average life expectancy at birth is projected to rise by 2 years between 1990-1995 and 1995-2000, that is, from 64 years to 66 years. However, the overall figures conceal wide disparities between regions and countries. For example, the average life expectancy at birth in 1995-2000 is 74.5 in the more developed countries, 63.6 in the less developed countries and just 52 in the least developed countries (LDC's). Moreover, at the country level, it is estimated that life expectancy has declined in parts of sub-Saharan Africa, where the impact of the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) pandemic has significantly affected mortality rates, and among a few of the countries with economies in transition. Average life expectancy at birth ranges from

70.6 for men and 78.4 for women in the more developed regions to 50.9 years for men and 53.0 years for women in the least developed countries (LDC's).

15. Overall improvements in mortality, coupled with advances in educational attainment and increased implementation of the right to reproductive choice, have resulted in women marrying at a later age and bearing significantly fewer children than in the past. Globally, women are now having an average of 2.8 children, compared with 3.0 five years earlier. However, as with mortality, the overall figures conceal wide disparities between regions and countries. For example, the average number of live births per woman in 1995-2000 is 1.6 children in the more developed countries, 3.1 in the less developed countries and 5.3 in the least developed countries (LDC's).

16. The age structure of the world's population is changing rapidly, particularly in the developing countries. As countries continue to reduce their birth rates, the relative share of children decreases and the population of working age increases. Increases in the proportion of persons of working age provide an excellent opportunity for countries who take advantage of it to increase saving and investment in productive assets, as well as to make greater human-capital investments in education and health. While the proportion of children is declining, the numbers and proportions of young persons are growing. Today's generation of young people between the ages of 15 and 24 is the largest ever, numbering more than 1 billion.

17. Over the past two decades or so, in all but the least developed countries (LDC's), the growth rate for the population aged 60 and over has been increasing at, or faster than, the growth rate for the total population. Worldwide, the growth rate for those aged 60 and over is double the overall rate. Even more noteworthy, however, is the rate of growth in the population aged 80 years and over. Rates for these ages worldwide exceed 3 per cent, reflecting increased life expectancy for the oldest ages. In much of Europe, Northern America and Japan, the proportion of older people is increasing more rapidly than any other age group.

18. Population ageing is thus becoming a feature of populations worldwide as fertility rates decline and life expectancy increases. This trend – evidenced, at first, in reduced proportions of children and enlarged groups of adults of working age – is rapidly extending its impact beyond the countries of established low fertility. By the year 2015, it will result in about 13 per cent of the world's population being aged 60 and over. A major feature is the increased speed with which this ageing will occur in developing countries compared with the earlier experience of more developed countries. Developing countries which currently account for 80 per cent of the world's population overall already have more than 60 per cent of persons 60 years or older. By 2015, this share is expected to increase to almost 70 per cent of older persons. Because of higher male mortality rates, females predominate at older ages, and the discrepancy between the sexes becomes greater with advancing age. This trend will result in a large proportion of older women spending many years without partners.

19. There remains a substantial gap in the data and research on the conditions among older persons, and the relationships between shifts in age structure and current and future social and economic development issues. These data and research provide the basis for policies and programmes addressing the particular needs of the elderly, including the economic and social security of the elderly, especially of older women and the frail; affordable, accessible and appropriate health care services; increased recognition of the

productive and useful roles the elderly can play; and support systems to enhance the ability of families to care for their older family members.

20. Continuing high levels of internal migration and urbanization are key issues in socio-economic development. The unprecedented movement of people within the borders of their own countries is one of the greatest transformations witnessed in the twentieth century. There continue to be large movements of people from rural to urban areas in most developing countries, with dramatic rates of urbanization, which have led to the creation of a growing number of mega-cities that have in many cases overwhelmed the social and environmental resources and spawned huge peri-urban slums. Many developing-country cities are growing far faster than economic opportunities are being generated. The high rates at which movements to urban centres are taking place are often due to the unsustainable growth of rural populations.

21. The international flow of people between countries is a complex result of economic, political and cultural interrelations and forces. Such movements of people affect, and are affected by, the developmental processes taking place in both the sending and the destination countries. International economic imbalances combined with the absence of peace and security, including gross human rights violations, exacerbated by the effects of widespread poverty and environmental degradation have led to rising numbers of international migrants.

22. Since the ICPD, the need to address the problems, issues and challenges raised by various forms of international migration have prompted Governments to increase cooperation at bilateral, subregional and regional levels. Some of the initiatives undertaken are beginning to show results. At the multilateral level, two processes merit mention: that initiated by the 1996 Regional Conference to Address the Problems of Refugees, Displaced Persons, Other Forms of Involuntary Displacement and Returnees in the Countries of the Commonwealth of Independent States and Neighbouring States (and its resulting Programme of Action); and the Puebla Process, which began in 1996 and which entails consultation between the countries of Northern and Central America. In addition, the international community has continued to consider the interrelations between international migration and development. The Technical Symposium on International Migration and Development, held in The Hague in 1998, under the auspices of the United Nations Administrative Committee on Coordination (ACC) Task Force on Basic Social Services for All (BSSA), served as a forum to discuss the many ways in which international migration interacts with development issues and to assess the effectiveness of policies in that regard.

Regional Population and Demographic Situation

23. Africa has a population of almost 780 million and a total fertility rate (TFR) of just over 5.3 compared with 282 million in 1960 and a TFR of 6.7. With an average annual growth rate of 2.6 per cent, the region is currently growing by 17 million a year and is expected to increase to just over 1.5 billion by the year 2025. Infant mortality is 86 per 1,000 live births, and overall life expectancy is 52.3 years for males and 55.3 years for females. However, regional figures mask great variations among individual countries. Notwithstanding their achievements in the area of population and development in recent years – primarily because an increased number of countries in Africa have formulated population policies and because collaboration has increased among Governments, NGOs, women and youth groups, and local communities

in population-related activities – most African countries continue to face high population growth rates, high levels of mortality and the spread of HIV/AIDS. Among the chief constraints to achieving the goals of the ICPD Programme of Action in the region are limited access to reproductive health services, insufficient numbers of trained personnel, inadequate financial resources and ineffective advocacy strategies.

24. Asia's population numbers almost 3.6 billion and currently has an average annual growth rate of 1.4 per cent. Excluding China, the growth rate stands at 1.6 per cent. Given the very large population base of the region, the annual increase in absolute numbers is staggering: over 50 million people are being added annually to the region's population. The countries of Asia are characterized by extreme diversity in the levels of fertility and mortality. In some countries in the region, fertility has declined to below replacement levels, whereas in others it remains high. Later female age at marriage, a decline in the age at menarche and a decline in the age difference between spouses raise important policy issues relating to the provision of reproductive health services for unmarried adolescents and young adults. Population is generally considered an integral component of government planning efforts, with most countries in the region trying to integrate population factors into their development plans. However, there are varying degrees of success in implementing the ICPD Programme of Action. The chief constraints include the lack of political commitment and limited human and financial resources. Moreover, the 1997/98 financial and economic crisis affecting a number of Asian countries continues to compound the challenges.

25. Europe has a population of just over 729 million and a zero average population growth rate. Its population is expected to decline to just over 700 million by the year 2025. The region's TFR, at 1.5, is the lowest in the world. Almost all countries in the region are at below replacement level of fertility. Within the region, infant mortality is highest in eastern Europe, at 17 per 1,000 live births, and lowest in northern and western Europe, at 6 per 1,000. Life expectancy in Europe is 68.3 years for men and 77.0 years for women.

26. Countries with economies in transition of the former USSR are experiencing simultaneous declines in fertility and life expectancy. Among the contributing factors are the political transformation and economic transition that these countries are undergoing, which to date has adversely effected the standard of living of large segments of the population, a deterioration of public infrastructure and a decline in the quality and range of health-care services. In addition, civil unrest and armed conflicts have contributed to a health crisis in a number of countries in the region.

27. Latin America and the Caribbean region has a population of almost 500 million and an average annual growth rate of 1.5 per cent. Although a rapid decline in fertility has been the distinguishing feature of demographic trends in Latin America and the Caribbean over the past three decades, major differences in fertility and mortality rates exist within the region, and the variations within countries themselves are considerable. This is due chiefly to the existence of social inequalities, which translate into high proportions of people living in poverty, exhibiting higher fertility rates and experiencing higher infant and maternal mortality rates. The decline in fertility has been especially noticeable among women over the age of 35; teen fertility has also declined, but at a slower rate. The region's TFR of almost 2.7 masks large differences between countries. Mortality levels and life expectancy also vary significantly across the region. Latin American and Caribbean countries have agreed on a strategy of offering access to high-quality safe motherhood services and family planning, taking into account the sociocultural identity of the users and giving priority to the most vulnerable groups in the population. To implement this strategy successfully,

countries will have to address such constraints as the lack of adequate human and financial resources and the lack of institutional experience in implementing integrated reproductive health services in a region where traditional family planning and mother and infant health programmes predominate. Further account will need to be taken of sociocultural barriers to the acceptance of reproductive health services, particularly those relating to sexual behaviour and fertility regulation.

28. Northern America, the most highly urbanized region, has a population of just over 304 million, which is expected to reach 369 million by the year 2025. It has an average annual growth rate of 0.8 per cent. Infant mortality stands at 7 per 1,000 live births and life expectancy is 73.6 years for men and 80.3 years for women. Low fertility and long life-spans have resulted in a rapid increase in the proportion of the population aged 65 and over.

29. Oceania, the smallest region, has a population of just under 30 million and an average annual growth rate of 1.3. The TFR for the region is almost 2.5. The infant mortality rate varies from 6 per 1,000 live births in the lowest mortality country to 61 per 1,000 in the highest.

Chapter II. CREATING AN ENABLING ENVIRONMENT

30. The ICPD greatly increased political action and public attention concerning population issues and heightened awareness of the many linkages between population and a country's social, economic, and environmental concerns. The paradigm shift that has been spoken of in public policy circles since 1994 refers to the movement away from the conceptualization and practice of top-down policy-making for population issues as numerical demographic concerns and towards a rights-based approach giving centrality to the meeting of reproductive health needs and to the fullest possible involvement of civil society in identifying and prioritizing those needs. The manifestation of this conceptual shift appears in the national development plans, population policies and programmes of action that have been formulated or revised in the wake of the ICPD.

31. The ICPD Programme of Action set out the following objectives and actions on population issues as they relate to development:

- C Population concerns need to be integrated into the formulation, implementation, monitoring and evaluation of all policies and programmes relating to sustainable development, and resource allocation at all levels and in all regions;
- C Governments, international agencies, NGOs and other concerned parties should undertake timely and periodic reviews of their development strategies, with the aim of assessing progress towards integrating population into development and environment programmes;
- C Governments should establish the requisite internal institutional mechanisms and enabling environment, at all levels of society, to ensure that population factors are appropriately addressed within the decision-making and administrative processes of the relevant government agencies responsible for economic, environmental and social policies and programmes;
- C Political commitment to integrated population and development strategies should be strengthened by public education and information programmes and by increased resource allocation through cooperation among Governments, NGOs and the private sector, and by improvement of the knowledge base through research and national and local capacity- building; and
- C To achieve sustainable development and a higher quality of life for all people, Governments should reduce and eliminate unsustainable patterns of production and consumption and promote appropriate demographic policies.²

32. This chapter first considers progress made since the ICPD in integrating population concerns into development strategies and policies. This is followed by a discussion of constraints and challenges encountered and finally provides operational and technical perspectives on further implementation of the ICPD Programme of Action.

Formulating or Revising National Population and Development Policies

33. A significant number of countries have formulated new, and in certain other cases revised existing national population policies or national social and economic development strategies incorporating population issues. Namibia, for example, launched its National Population Policy for Sustainable Development in August 1997. Mexico developed both a National Plan of Development and a Plan of Population for 1995-2000, which identifies the stated population policy as a tool and fundamental reference for the country's social and economic development. In line with the objectives of the ICPD Programme of Action, this programme emphasizes the linkages between population and development. Kenya formulated the Population Policy for Sustainable Development, based on the ICPD Programme of Action, to replace its 1984 population policy. Outlining the development goals that will guide the implementation of population programmes up to the year 2010, the policy incorporates issues addressed in the Programme of Action and emphasizes new concerns, such as population distribution and the environment.

34. Some countries translated the recommendations of the Programme of Action into a new population action plan and related sectoral action plans. In Mali, for example, the Government drafted the Action Plan on Population, 1995-2000, a strategic plan that focuses on the operationalization of the population strategy within the objective of making basic social services more accessible; in addition, the Government created action plans for HIV/AIDS, women's empowerment, adolescent reproductive health and poverty reduction, with programmes that promote the basic health needs of the population and emphasize the goals of the Programme of Action. Senegal adopted a National Plan after the ICPD. Because of the conclusions and recommendations of this plan, the Ninth Plan of Development (Economic and Social Development) 1996-2001 considers population issues in the formulation of its development strategy. In Bangladesh, a National Committee for the Implementation of the Programme of Action was formed, comprising policy makers from within the Government along with representatives of United Nations agencies and organizations, development agencies, national and international NGOs and researchers. The Committee developed a National Plan of Action and a strategic plan for family planning, as well as for the basic health and population sector. The Plan emphasizes human development, with specific developmental goals relating to mortality, education and health, with gender equity and women's empowerment as underlying themes, and also addresses financial sustainability, private-sector and NGO roles, and an examination and update of the National Drug Policy.

Establishing Institutional Mechanisms

Institutional Review

35. Progress made in areas of population policy since the ICPD has often been demonstrated in the establishment of a ministerial body or subcommittee charged with addressing population concerns, and, in particular, with integrating them into national development strategies and policies. Some countries, guided directly by the ICPD Programme of Action, established national commissions to help formulate policies and implement integrated population-related activities. These bodies, usually charged with following up the recommendations of the ICPD Programme of Action, often included representatives from sectoral ministries in social sectors as well as from civil society.

36. Nepal, for example, undertook an extensive response to population issues and concerns after the ICPD. In 1995, the Government established a separate Ministry for Population and Environment responsible for formulating an appropriate population policy, developing suitable programmes, conducting research and, in particular, coordinating population, family planning and related activities with various governmental bodies and NGOs. The Government also formulated and adopted a number of policies and programmes on population and health in line with the ICPD recommendations and objectives.

37. Brazil set up a National Commission on Population and Development in 1995, with representatives from civil society and social development sectors as well as several ministries. By acting as a focal point on both the domestic and international level and playing a key role in the development of policies and programmes, institutions like this commission are strategically situated to permit sufficient integration of population concerns into social and economic development plans and to ensure the monitoring and measurement of the ICPD goals and objectives.

38. In other instances, countries created population divisions or units operating within other ministries, such as within the Ministry of Interior or the Ministry of Planning. In these cases, the integration of population concerns into development strategy is well situated for programming and implementation. For example, Belize established a Population Unit within the Ministry of Human Resources to design and implement a national population and development policy.

39. Some countries updated their pre-ICPD population policies and institutions in response to the Programme of Action. At times, the process of revising the policies and institutions included input from other sectoral bodies. In many cases, the scope and planning of population activities were increased extensively when modified to take into account the goals and recommendations established at the ICPD. Often, this was an ongoing process in the modification and revamping of older institutions and policies. Peru, for example, developed an extensive infrastructure of institutional support in order to address many aspects of population issues raised at the ICPD. The Government dismantled the National Population Council (CONAPO) and transferred its duties to the newly formed Ministry for the Advancement of Women and Human Development (PROMUDEH), with a Human Development Division and a Population Programme Unit to deal directly with population issues. The Government integrated the goals of the ICPD Programme of Action into sectoral plans and programmes, particularly in the health and education sectors, in the course of implementing the National Reproductive Health and Family Planning Programme 1996-2000 and the National Sex Education Programme.

40. Other countries that had pre-ICPD institutional arrangements and mechanisms for addressing population issues modified their structures and/or responsibilities to ensure that they incorporated the goals and recommendations of the ICPD Programme of Action and could, thus, work intersectorally to integrate population concerns into other national concerns. In Egypt, for example, the Government's National Population Council was made responsible for population policy and reform; population strategy and multisectoral planning; population programme management, including monitoring and evaluation; and research studies on population concerns.

41. Indonesia, likewise, is an interesting case-study of how integrating population into development strategies changed after Cairo. Indonesia's Ministry of Population was merged into the National Family Planning Coordinating Board prior to the ICPD. The more substantive duties relating to population were

gradually shifted to the university-based Population Studies Centre (PSC). The Government was instrumental in facilitating this institutional shift, using both domestic and international resources to expand and strengthen PSC. More specifically, a collaborative UNFPA project transformed PSC into several newly established decentralized centres that deal with a variety of population and development issues, particularly those relating to family welfare and poverty alleviation.

Decentralization

42. In countries where moves towards decentralization of policy and programming have been taking place, a greater sense of progress has been noted in terms of awareness generated about population issues and their relevance to development. In India, for example, the state, district, and community level have all begun to receive much more information on population and reproductive health issues, which has helped them develop and implement appropriate population programmes for their respective districts and local areas.

43. Pre-existing civil-society institutions can also be valuable tools for decentralization. In some countries, for example, support for improving capacities of universities has proved successful in furthering the ICPD Programme of Action. Particularly in countries with economies in transition, where the Government may be preoccupied with conflict or economic crises, alternative channels for social development such as universities and other organizations of civil society have been important players.

Measurement and Monitoring

44. The integration of population issues into development strategies also requires mechanisms for monitoring and measuring progress towards meeting the goals and objectives set forth in Cairo. Most countries have continued to use traditional demographic and social-service indicators as part of their measurement process. Many augmented these indicators with more detailed reproductive health indicators, such as the proportion of births at which skilled attendants are present, access to contraception, and the adequacy of counselling and follow-up, as well as with wider social-service, environmental and economic indicators.

45. The countries that have been successfully monitoring their progress in integrating population concerns into development strategies have developed a comprehensive list of indicators and had charged specific ministries, subcommittees or departments with tracking them. Some countries planned to implement a computerized networking system for programme planning – an important area in which the full availability of data is crucial for the development and execution of appropriate programmes as well as for the tracking of domestic and international resource flows.

46. The accuracy and efficiency of monitoring and measurement have been increased in those countries that have expanded data collection to include a variety of sources, rather than relying on a single source, such as a Demographic and Health Survey (DHS). In Ghana, for example, key reproductive health indicators are tracked through the DHS but are also being gathered from the institutional reports of the Ministries of Health and Education as well as the reports of implementing agencies such as the National Council on Women in Development and academic and research institutions. Other countries have established coordinating committees on reproductive health and family planning policies that monitor all

relevant programmes executed by sectoral ministries. In the United Republic of Tanzania, the Government created four institutional structures for the coordination, monitoring and evaluation of the implementation of the national population policy and programme, including the integration of population issues into the development planning process.

Strengthening Information, Education and Communication Programmes

47. No other arena in development more clearly illustrates the importance of the capacity of people to communicate with one another than that of population and reproductive health. The placing of reproductive rights and sexual health at the heart of the population agenda is making the work of those concerned with such issues both more ethical and more politically and culturally complex. A whole range of reproductive rights and HIV/AIDS issues, from domestic violence to female genital mutilation to male sexual responsibility, have crystallized the need for a vigorous and public debate. Such debate depends fundamentally on communication within societies, within families, within communities, and on communication between societies, through political discourse and advocacy. Increasing the flow of information on population issues can have profound effects on many levels of society.

48. Information, education, and communication (IEC) strategies and training relevant to the implementation of the ICPD Programme of Action include the exchange of information on the effects of population on many other socio-economic issues, migration, urbanization and the macroeconomy. They incorporate population issues into educational curricula, public awareness campaigns, research, round tables, training and advocacy activities. The former and simpler strategies of education and persuasion where success was measured by the number of “acceptors” have been replaced by the complexities of choice and rights, where people themselves, and especially women and adolescents, are regarded as the main decision-makers and are entitled to determine what should happen to their bodies and their lives. Although much time and effort are required, IEC strategies can have far-reaching effects on social norms and behaviour and provide opportunities for furthering the gains made at Cairo by educating the public and policy makers about pertinent population issues.

49. The development of information and communications technologies (ICT) presents promising opportunities for addressing global population and reproductive health issues. The current information revolution has resulted in global communication links unprecedented in world history. E-mail for instance has transformed the opportunities available to advocacy NGOs and community organizations to network, lobby, and organize around many population and development issues, not the least in the field of reproductive health and rights. ICTs have great potential in the area of advocacy as well as in encouraging social interaction among all stakeholders and stimulating public debate of population issues.

50. New information and knowledge management technologies have been increasingly operational since the ICPD. For the last five years, key ICPD-related developments included such programmes as POPLINE, POPIN, the Development of On-line Information Service on Population and Environment Linkages, the development of new software, the use of websites and CD-ROMS for media materials, and the Global Knowledge Partnership. These activities have facilitated the systematic collection, analysis, dissemination and utilization of population-related knowledge and promoted information and experience exchange at the national, sub-regional, regional and global levels. At field level, powerful information and

communication technologies are being used to empower communities, couples and individuals to make informed decisions. For example, some countries in Asia and Africa are trying out the concept of “cyberbus” and electronic chatrooms, to educate young people on population and reproductive health issues. Many young people have also used telephone hotlines set up by NGOs and health institutions to obtain information and counseling on sensitive issues such as pregnancy, sexual relations, domestic violence, sexually transmitted diseases, including HIV/AIDs. In Bangladesh, mobile telephones have enhanced spousal communication and information on reproductive health among those involved in microcredit programmes offered by the Grameen Bank.

Advocacy Campaigns

51. Many countries have demonstrated their political commitment to integrated population and development strategies through the initiation of advocacy campaigns, either on population as a general issue or on specific reproductive health concerns as a response to the ICPD recommendations on promoting the general reproductive health of all members of society. In some countries, Governments have initiated multifaceted awareness-raising campaigns on these issues. In Brazil, for example, the Minister of Health established a National Day against Maternal Mortality as part of the Safe Motherhood Initiative, a multilateral effort involving the United Nations Children's Fund (UNICEF), Pan American Health Organization (PAHO), UNFPA and the Brazilian Federation of Gynaecology and Obstetrics. In addition, the Government organized "Cairo +5" events to further educate the public, politicians and the private sector on these issues.

52. Moreover, the impact of the personal commitment of political leaders to integrating population and development can be seen in countries such as Mexico, where the President publicly presented the National Programme for Sexual Health and Family Planning 1995-2000 through the mass media. This gave a clear message that reproductive health should be a basic part of health services, along with nutrition and vaccination. Some countries reported that presidential candidates included the ICPD Programme of Action in their campaign platforms.

Research/Training/Round Tables

53. Many countries have initiated studies on traditional population issues or initiated a revised national census that addressed the population and reproductive health concerns included in the ICPD Programme of Action. University and international organizations sponsored inquiries into specific population or reproductive health issues, and, in some cases, private-sector companies conducted research on population issues. For example, India's Energy Research Institute conducted a study on demographic concerns.

54. In Mali, an international NGO has been conducting research on migration and urbanization in West Africa and an analysis of the reproductive health situation. Likewise, in some Latin American countries, both the private and public sectors generated a significant amount of research and institutional knowledge about population and development issues. Both academic and governmental institutions analysed national development plans along with programmes on population and public-health sector reform as well as new policies on women and demographic issues.

55. In addition to the UN Regional Economic and Social Commissions meetings, many countries have held meetings or round tables on ICPD+5, or "Cairo in Action", to measure progress in implementing the Programme of Action and to garner continued support for integrating population issues into other sectors of policy planning and development. In Burkina Faso, for example, the Government has promoted the adoption of a wider development strategy, with a consideration of demographic trends particularly in regard to women and access to reproductive health services, by holding a round table on social-sector activities, including population and development.

Implementing Regional Initiatives to Promote Population and Development

56. Several regions, through their Economic and Social Commissions, have held meetings on the ICPD Programme of Action, drafted their own regional programmes of action, and developed, implemented, and strengthened regional networks for cooperation and coordination of population and development activities.

Africa

57. The Economic Commission of Africa (ECA) held a series of regional conferences as a follow-up to the ICPD and as a means of assessing benchmarks in the integration of population concerns into the various development plans of the region. ECA developed its own country inquiry for assessing national implementation of the Dakar/Ngor Declaration and the ICPD Programme of Action. At the most recent follow-up meeting in Addis Ababa in September 1998, ECA reviewed progress in the region as a whole and the trends and specific perspectives in the 36 countries that responded to the survey. Participants at the meeting, including Governments, international organizations, donors and NGOs, reviewed African experiences in the implementation of the ICPD Programme of Action and the Dakar/Ngor Declaration and arrived at 75 recommendations covering the full range of topics included in the ICPD+5 discussions.

58. The policy issues that emerged as those of prime importance to the region were related to strengthening support for policy development and programming of HIV/AIDS-prevention and related services, and recognizing and increasing the role of NGOs and the private sector in addressing population concerns. The meeting urged the adoption of appropriate population policies by those countries that have not done so and the establishment of adequate policy and programme coordinating mechanisms, in particular, those for South-South cooperation. The ECA regional recommendations also proposed policy development in regard to adolescents and youth in all aspects of reproductive health programming. The findings of the ECA questionnaire and recommendations will be formally reviewed at future regional ECA and African Population Commission meetings as well as at the Organization of African Unity (OAU) Summit of Heads of State in June 1999.

Arab States and Western Asia

59. The Economic and Social Commission for Western Asia (ESCWA) and the League of Arab States met in Beirut in September 1998 to review the ICPD Programme of Action, the Amman Declaration and activities surrounding their implementation and adaptation to policies and programmes in the region. Member States proposed future actions on population and development strategies and comprehensive reproductive health policies and programmes. The representatives reaffirmed their commitment to the goals

of the Programme of Action to integrate population into national development strategies and mentioned the importance of considering access to and the quality of reproductive health care and of addressing unmet needs resulting from age, gender and social status, all within the context of the economic restructuring occurring in the region. The recommendations call upon Governments to encourage the development of comprehensive reproductive health policies and programmes, paying attention specifically to STDs, violence against women and children, harmful cultural practices such as female genital mutilation (FGM), and male involvement in family planning and reproductive health. The report also calls for international and intersectoral collaboration to create reliable indicators and mechanisms to measure progress in implementing programmes of action, particularly the integration of population into development strategies and national social development plans.

60. Several of the countries of the region reported that comprehensive national strategies had been developed, including social development strategies that take into account equity and access to basic social services, create new economic opportunities, strengthen government awareness of issues such as poverty and catalyse efforts to rehabilitate social sectors. The ESCWA recommendations also emphasize advocacy for decision makers and officials in charge of programme implementation and the importance of intersectoral coordination among reproductive health service providers, including NGOs, the private sector and public health institutions.

Asia and the Pacific

61. The Economic and Social Commission for Asia and the Pacific (ESCAP) held a meeting in March 1998 to review the implementation of the ICPD Programme of Action and the Bali Declaration on Population and Sustainable Development. The forum gave the countries of the region an opportunity to demonstrate their commitment to fulfilling the goals of the Programme of Action and the opportunity to identify key actions that should receive urgent attention from all development partners. The meeting also considered the various structural reforms that countries of the ESCAP region were undertaking to adjust to and benefit from the opportunities posed by globalization. In all, the Asia-Pacific Regional Meeting generated 63 recommendations for future action and one resolution, which asserted the need for mobilization of human and financial resources for further implementation of the ESCAP regional population and development goals. The resolution endorses the utilization of South-South cooperation and NGOs as alternative mechanisms to governmental institutions.

62. The 63 recommendations for actions in the policy and institutional framework include addressing the issues of international migration, gender equality and equity, and the setting of explicit priorities within reproductive health care, adolescent health and the role of civil society. The ESCAP meeting concluded that progress had been made in implementing the ICPD Programme of Action but challenges remained, including that of balancing the role of government in the planning and provision of services with the private sector's capacity for the funding and provision of services. The ESCAP nations recognized that using the market mechanism for the provision of services would be an important step in further implementing the ICPD Programme of Action, particularly in terms of addressing inequities. The primary resolution calls for a report on the progress of the region in securing further human and financial resources for population and development policies and programmes to be presented at a follow-up conference in the year 2002.

Central and Eastern Europe and the Commonwealth of Independent States

63. The countries of the Economic Commission for Europe (ECE) considered in this discussion are primarily the countries of central and eastern Europe and the states of the former Soviet Union – the Commonwealth of Independent States (CIS). As a follow-up to the ICPD, the countries with economies in transition gathered for a UNFPA-sponsored workshop on population policy and programmes in the region, hosted by the Romanian National Commission for Statistics, in Romania in May 1995.

64. The population issues of most concern highlighted at the meeting were the high rate of abortion, low use of family planning, unsafe abortion as a leading cause of maternal morbidity and mortality, and the level of infertility among large proportions of the female population. Countries also reported extremely high levels of STDs especially among adolescents, and low levels of quality of care and of IEC on reproductive health care both within the service-provider community and the wider public. Most of the countries did, however, possess some key advantages in pursuing population and development goals, including high levels of literacy due to an emphasis on education, with equal access for women and men, and developing private-sector channels for health-service delivery. Although progress has been registered since 1995 in addressing many of these issues, significant obstacles still remain in many of these countries to fully implement the ICPD Programme of Action.

65. In December 1998, the ECE held a regional meeting in Budapest, Hungary, on ICPD+5 follow-up. The meeting provided an opportunity to review progress made in implementing the ICPD Programme of Action under five priority themes: fertility, family and gender issues; reproductive rights and sexual and reproductive health; mortality and health; population ageing; international migration. The conclusions of the meeting cover these themes, while briefly mentioning international cooperation.

Latin America and the Caribbean

66. In 1996, the draft Regional Plan of Action approved at the twenty-fifth session of the Economic Commission of Latin America and the Caribbean (ECLAC) became the Latin American and Caribbean Regional Plan of Action on Population and Development, after being further developed following the outcome of the ICPD. It describes activities, including round tables held in conjunction with UNFPA, on issues such as adolescent reproductive health, reproductive rights and the implementation of reproductive health programmes, and population and macroeconomic links. A follow-up conference in Aruba in May 1998 demonstrated the continuing political commitment of countries in the region to furthering the ICPD goals and recommendations through the establishment of national plans, declarations of principles concerning population and sustainable development, sectoral plans and programmes, and the creation of population units or commissions to formulate and coordinate policies and programmes.

67. The ECLAC subregional headquarters for the Caribbean is responsible for follow-up action and support with respect to the implementation of the Caribbean Subregional Plan of Action on Population and Development, which presents the contents of the Regional Plan of Action and the ICPD Programme of Action from the Caribbean perspective and which serves as a further guide to action for countries in the subregion. Technical assistance provided to countries of the subregion in areas such as applied research has been geared to the specific needs and concerns of these countries, which include international migration, the impact of immigration on small islands and coastal areas, the role and importance of family remittances

from abroad, return migration and adolescent health. Data for the policy and programmatic activities were systematically collected and disseminated as part of the regional socio-demographic data bank.

Constraints

68. Despite the progress observed, implementation of the Programme of Action has been uneven because of the many constraints and challenges countries face. They include limited financial and human resources, competing priorities, limited institutional infrastructure, insufficient intersectoral coordination, inadequate measurement/monitoring mechanisms, economic crises and civil unrest.

Limited Financial and Human Resources

69. One of the most widely recognized constraints encountered in the implementation of the Programme of Action was the limited amount of financial and human resources, including the lack of trained personnel to create and implement population and development policies. Human resource management limitations appeared in many ministries that were greatly overburdened due to an employee base that was insufficiently skilled and trained for the considerable work flow in the social and economic development sectors.

70. Countries that have made institutional and programmatic changes in the years following Cairo often mentioned dwindling resources as a reason for changes becoming less dynamic or even unsustainable. This constraint was illustrated by the countries in which population ministries or similar institutional bodies have no operational capacity, often due to a lack of funding.

Competing Priorities

71. The interdependence of population issues with macroeconomic, environmental and other development issues made the pursuit of the goals and recommendations of the ICPD Programme of Action essential. However, Governments often face priorities that compete with integrating population into development strategies. In some developing countries and countries with economies in transition, population issues have been seen as independent of, or secondary to, economic growth or poverty alleviation. Thus, there is a need for more awareness creation and advocacy activities on the links between population and other development issues.

72. Research studies conducted by independent international institutions show that up to 98 per cent of funds allocated for development activities are spent on sectors other than population.³ Population issues such as those discussed at Cairo – especially the empowerment of women, schooling of girls and, more generally, the integration of population into development strategies – can be overshadowed by more immediately pressing economic or environmental concerns.

Limited Institutional Capacity

73. A significant number of the countries covered by the UNFPA ICPD+5 Inquiry cited the limited institutional infrastructure or the lack of politically empowered sectoral bodies capable of addressing integrated population and development issues as constraints. For example, some countries reported that a national commission on population and development had been established, but it was created without the support of an overarching planning system or national development plan. In other cases, the governmental ministry or body established or charged with addressing population issues had no decision-making power or formal mechanisms to measure progress towards achieving the goals and objectives set forth at the ICPD.

74. Many countries in Africa and Asia reported that a lack of coordination between ministries or institutions had made incorporating the policy aspects of the Cairo agenda extremely challenging. In only a very few cases, did the countries surveyed mention that relevant sectoral agencies had either reviewed or actively participated in developing and implementing a new population or development strategy or action plan. This has also been reported in other regional and subregional reviews of post-ICPD activities aimed at implementing the Programme of Action.

Lack of Data and Monitoring Mechanisms

75. Many developing countries and countries with economies in transition reported that implementation of the ICPD Programme of Action was constrained both by a lack of data or information and by inadequate measurement or monitoring mechanisms. Many countries with economies in transition, especially the newly independent states, lack census data and the capacity to undertake a census.

76. Many countries cited as major constraints the lack of systematic mechanisms for monitoring ICPD goals, the difficulty in obtaining disaggregated reproductive health and basic social indicators, and/or inadequate or insufficient data and analytical systems. This challenge can arise in countries where DHSs or censuses are not conducted regularly, where they are carried out by different agencies, or where the data are collected and analysed by different agencies or organizations. In addition, the various bodies responsible for collecting and analysing the data may be constrained by limited resources and technical capacity.

External Factors

77. In countries where domestic markets were weak or experiencing recessions, the funding and maintenance of sufficient trained personnel in the relevant ministries became a central issue. This situation was often coupled with emigration of skilled personnel, causing further pressure on constrained ministries and sectoral agencies. Clearly, these situations cannot be corrected without attacking their root causes, making policy programming and implementation virtually impossible in the short term.

78. Many countries undergoing rapid structural changes and those in intense political and economic stress have witnessed a significant increase in the amount of civil and political unrest over the last few years. Wars related to ethnic strife, political conflicts and economic hardship have resulted in growing public health

problems and a breakdown in the infrastructure to deal formally with population and reproductive health issues.

Information Gap

79. The “information gap” between the rich and poor and between gender is stark and the distribution of new information and communication technologies is even less equal. Access for information means access to power and most societies continue to exclude women. The domination of Internet by men has also been a source of consistent criticism since its inception. Despite such lack of access, the Internet has had a major impact in enabling the civil society organizations to organize themselves and campaign. In developing countries, there is a race for harnessing technologies for knowledge, information and networking and for increasing participation of and interaction with the public. Women’s organizations are increasingly understanding and seizing the strategic importance of new technologies for exercising the full benefits of reproductive rights. “The freedom to have access to spaces other than the bedroom and the kitchen, and to fully and safely be able to act in other public spaces is key to women’s full participation in the world’s future” argues Marie-Helene Mottin-Sylla, of the NGO Enda Tiers Monde in Senegal. Furthermore, it is the private sector that is driving the information revolution and population advocates are often absent from the discussions in which key global and national communication policies are being shaped.

Further Action Required

80. Governments should fully acknowledge the linkages among population, reproductive health, macroeconomic and other sectoral issues and the need for national policy and programme planning mechanisms that take the interdependence of these issues into account.

Institutional Strengthening

81. Governments should elaborate strategic frameworks that encourage and support intersectoral collaboration and coordination as a way of expanding the depth and scope of the attention given to population issues.

82. Governments should continue or begin the process of decentralization in population and development programme planning and implementation and should provide the necessary support to carry out the process effectively. Many countries that have begun the shift to decentralization in sectoral programmes and policies cited the continuation of this trend as a key opportunity for beginning or continuing to carry out the goals of the ICPD Programme of Action.

83. All stakeholders in the population and development field need to define clearly their roles and responsibilities in implementing the goals and recommendations adopted in Cairo.

84. Governments should strengthen their collaboration with civil society, including NGOs, in population and development planning, implementation and monitoring and evaluation, taking into account their comparative advantages and complementarities.

85. Governments should allocate more resources to strengthen existing institutions or to create new ones that address population issues in order to ensure that the institutional framework is adequate to achieve the ICPD goals.

Technical and Human Resources

86. Governments should work together with NGOs and the private sector to ensure that the appropriate technical resources are present, i.e., skilled, trained personnel and adequately funded programmes, that will allow the full integration of population into development planning.

87. Governments, NGOs and other civil-society representatives should work to establish a sustainable base of well-informed and adequately trained personnel within the government and health sectors in order to support population and development policy and programmes.

IEC and Advocacy

88. Governments, as well as NGOs and private-sector actors, should initiate and increase awareness-raising activities that mobilize support for integrated reproductive health; women's empowerment; and economic, environmental and other social welfare programmes.

89. Governments should strengthen national networks and coalitions for advocacy, targeting multiple audiences ranging from national leadership to the grass-roots level, for the goals and recommendations of the ICPD Programme of Action, in cooperation with civil-society organizations. They should nurture networks that link senders and receivers, citizens and decision-makers, public and private sectors, communication professionals, community and mass media, and opinion leaders.

90. Governments, as well as NGO and private-sector actors, should avail themselves of the opportunities offered by the new participatory and open paradigm of the Global Information Society. ICTs offer new processes and tools for advocacy communication in support of the ICPD Programme of Action. State-of-the-art tools include inter-active and inter-linked websites, the production of localized, more attractive and interactive population data, electronic archives, distance learning systems, and electronic conferences.

Research and Data

91. Governments, as well as civil society organizations, should engage in strategically focused research to improve the effectiveness and efficiency of population and reproductive health programmes. Timely availability of research results and their effective application in programme design should be stressed.

92. Governments and civil society, including academic or technical institutions, should work together to provide and share integrated and comprehensive data that are manageable and sustainable.

Chapter III. GENDER EQUALITY, EQUITY AND EMPOWERMENT OF WOMEN

93. As one of its key principles, the ICPD Programme of Action emphasizes that advancing gender equality, equity and empowerment of women, eliminating all kinds of violence against women, and ensuring women's ability to control their own fertility are cornerstones of population and development-related programmes and are central to the notion of sustainable development (Principle 4). The Programme of Action also sets out as an important objective to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles (paragraph 4.25). These aims, goals and objectives are important conditions for building a sustainable, just and developed society.

94. The rationale for the promotion of gender equality, equity and empowerment of women population and development programmes is underscored by the fact that women's disadvantaged social position, which is often related to the economic value placed on familial roles, helps perpetuate poor health, inadequate diet, early and frequent pregnancy and a continued cycle of poverty. From infancy, females in many parts of the world receive less and lower quality food and are treated less adequately when sick than are males. In countries where women are less educated, they receive less information than men and have less control over decision-making and family resources. They are also less apt to recognize health problems or to seek health care.

95. Women's low socio-economic status also exposes them to physical and sexual abuse and mental depression. Unequal power in sexual relationships exposes women to unwanted pregnancy and STDs, including HIV/AIDS. With changing social values and economic pressures, girls are engaging in sexual relationships at earlier ages. Additional health risks for women also arise from the general level of underdevelopment that are reflected, for example, by poor roads and lack of transport. This may hinder women from receiving timely medical treatment for pregnancy-related complications. Inadequate water supply, lack of electricity and poor sanitation impose extra burdens on women because of their household responsibilities, such as fetching water and fuel wood.

96. Building on agreements from previous international conferences on population and on women, the consensus reached at the ICPD set the stage for two major strategic shifts in the formulation and implementation of population and development programmes. The first shift entailed adopting an even stronger gender perspective in programmes, such that the focus would no longer be on women separately, but rather on the social context in which they live. This includes the unequal gender and power relations that circumscribe their lives and enable or hinder them from benefiting from population and development programmes. The second shift involved the adoption of a rights-based approach to enable women to secure and safeguard their reproductive and sexual rights.

97. Promoting the ICPD goals of gender equality, equity and empowerment of women has, for many countries, meant the adoption of a dual strategy. On the one hand, activities focusing exclusively on women or men may be necessary in specific contexts where gender gaps are wide, provided that doing so does not promote gender stereotypes or inadvertently reinforce gender inequalities. Women-specific programmes are still considered important because of the biological and social burden that women carry, relative to men, in reproduction. Such programmes are, therefore, useful in implementing strategies for the

empowerment of women. On the other hand, many countries have also adopted the mainstreaming of gender concerns in all population and development activities as a means of achieving the commitments made at the ICPD. Gender mainstreaming entails, among other things, addressing issues related to equality between men and women in opportunities and access. This has meant careful planning both for the strategies used and for the outcomes expected to be achieved.

98. This chapter assesses the progress made to date in various countries in promoting gender equality, equity and the empowerment of women. The areas covered include the adoption of a gender perspective or gender mainstreaming; the creation of an enabling environment for gender equality; advocacy for the integration of a rights-based approach to population and development programmes; protection of the rights of the girl child; and the promotion of male responsibility, especially with regard to reproductive health. The chapter concludes with proposals for pursuing the goals of gender equality and empowerment of women.

Incorporating a Gender Perspective

99. The ICPD Programme of Action emphasizes the incorporation of a gender perspective in the development of population programmes. The PoA notes that while women are generally the poorest of the poor, they are also key actors in the development process. They are often omitted from policy dialogue, or their needs and priorities are defined on their behalf by others, too often in terms which actually reinforce preconceived roles and relationships which are normally characterized by inequalities and inequities.

100. In attempting to implement the agenda of ICPD on gender issues, many countries have promoted planning and policy formulation processes in which the definition of key stakeholders has widened to include previously excluded groups. At the policy level, the greatest challenge has been in promoting the legitimacy and, indeed, necessity, of gender equality as a fundamental value that should be reflected in all population and development choices and in institutional practices. In this respect, gender equality issues cannot be divorced from other fundamental challenges that countries face, such as democratization processes.

101. For many countries, an immediate action following the ICPD was to assess the extent to which the existing policy environment was conducive to mainstreaming gender concerns. In many cases, the absence of a conducive environment prompted countries to establish a policy framework in which gender concerns could begin to be addressed systematically and at all levels. The main strategy used was to develop gender and development policies and action plans to guide various sectors in this endeavour. The development of gender-disaggregated data played an important role in this respect. The process was accelerated considerably by the preparations for, as well as the aftermath of, the Fourth World Conference on Women held in Beijing in 1995.

102. The Marshall Islands, the Federated States of Micronesia, Namibia and Uganda are among the countries which developed comprehensive national policies on women or on gender following the ICPD. In these and other countries, national action plans indicating the areas needing action to promote gender equality were also developed. In Thailand, the Government prepared a comprehensive 20-year plan to ensure the adoption of a gender perspective in planning processes. This plan addresses women's concerns in the judicial system, in research and data collection systems, and in the health sector. Ecuador and

Paraguay adopted five-year plans for the promotion of equal opportunities for women. The creation of an enabling environment included other sectoral policies, such as in Venezuela, where the reforms of both the educational and the health sectors systematically incorporated a gender perspective.

103. The adoption of a gender perspective in reproductive and sexual health programmes is a benchmark for the achievement of the goals of the ICPD Programme of Action. It is now evident that gender relations and sexuality are intimately linked to issues such as effective use of contraceptives, unwanted pregnancy and STIs. This link is forged in a person's socialization into sexuality and gender roles. The process of socialization begins early in life in both the family and the community and is reinforced by basic social institutions, the mass media and other factors, and this often subsequently leads to the political, economic, legal and cultural subordination of women.

104. Many countries have begun to grapple with double standards regarding male and female sexual behaviour as well as certain beliefs and practices regarding women's bodies and sexuality which have negative health consequences. These include beliefs that women should be ignorant about sexuality —so that they will not be promiscuous— which exposes them to a high risk of STIs and unwanted pregnancy and may make them reluctant to seek health care. These and other social constructions of sexuality and gender relations are a denial of basic rights and an important determinant of reproductive and sexual ill-health.

105. To address this situation, countries have employed a number of strategies. For example, Zimbabwe established a reproductive health task force to ensure that gender concerns are reflected in reproductive health policies and services. El Salvador on the other hand developed a Family Law Code to streamline and clarify formerly ambiguous gender-related issues.

106. The incorporation of a gender perspective into population and development programmes has not been easy. One common problem has been the absence of a consensus on the best and most effective strategies to use to promote gender equality, equity and empowerment of women in different social, cultural and political contexts. This has slowed the integration of these concerns in sometimes vital planning and programming processes. Another difficulty has been posed by the lack of gender disaggregated data and research studies which use gender appropriate methodologies to evaluate the impact of strategies that are being used. Most available data are based on quantitative methodologies and statistical analyses of a few variables. Certain limitations thus arise in the extent to which such data and analyses can elucidate some of the emerging issues related to gender equality, equity and empowerment of women. Even in those countries where these problems are not severe, national action plans to integrate gender concerns in population and development programme have not always been allocated sufficient resources to implement them fully.

Changing the Environment

The Legal Context

107. The achievement of the ICPD Programme of Action goals demands the creation of an enabling environment as the basis for the promotion of gender equality and empowerment of women. The ICPD

Programme of Action reiterated the 1993 World Conference on Human Rights in Vienna, which enshrined women's rights within the context of the human rights doctrine, making clear that culture and history can no longer justify limitations on women's rights. This is because the treatment of women in criminal or family law codes reflects the way in which their role is conceptualized in many societies. In most instances, women embody a series of physiological, social or psychological conditions that make them "victims" to be protected. Throughout, the concept of women as subordinate is based on biological, social and economic definitions of women's experiences. Laws then formalize this perception. International mandates provide the necessary criteria by which norms can be transformed. As a result of these conferences, all countries now have an obligation to revise their legal systems in accordance with international mandates.

108. For the majority of countries, this has meant dismantling old laws that discriminate against women and girls and instituting large-scale legal reform. In this regard, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has been a useful reference instrument to broaden the notion of fundamental rights and to adapt national norms to international standards.

109. With 162 State parties and 97 signatories, CEDAW has been ratified by all but a few countries. Among those that have ratified it, several have still to implement it, and CEDAW remains one of the international conventions with the highest number of reservations. Some countries that have not ratified the Convention have cited religious grounds. Non-implementation is often hindered by reservations on certain clauses of the Convention as well as by traditional norms and values.

110. Many Latin American countries have made major progress in changing discriminatory laws or in enacting laws that protect women. The Inter-American Convention to Prevent, Sanction and Eradicate Violence Against Women, enacted in 1994 in the course of preparations for the ICPD, is an example of the application of gender analysis to the formulation of regional legislation to protect and respond to the needs of the female population. Its existence created additional impetus for individual countries to adopt similar legislation. Thus, Bolivia, Cuba, the Dominican Republic, Ecuador, Honduras, Mexico, Nicaragua and Panama all enacted laws that make violence against women a serious crime. Violations of such laws are classified as torture. Honduras and other countries even created a Special Public Defender position for women and unprotected minors. Additional law reforms in Latin America include new labour laws eliminating discrimination in the labour market; reform of agricultural laws to improve women's access to land; and new educational laws to eliminate sexist language in pedagogical materials and to promote gender equality in access to educational opportunities.

111. In Asia, China, the Philippines and Viet Nam adopted specific legislative changes to protect women from sexual harassment and violence.

112. In Africa, the 14 countries that constitute the South African Development Community (SADC), namely Angola, Botswana, the Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, the United Republic of Tanzania, Zambia and Zimbabwe, have all pledged to enact laws against violence against women. Mauritius has already done so and followed the enactment with a mass information campaign. In Gabon, the Government is approving a law on the social protection of women, mothers and children. Zimbabwe put into effect an inheritance law that protects widows.

113. Despite the measures that have been taken, the legal environment for women is still far from satisfactory. Women in many countries continue to suffer from the lack of legal protection for exercising, in particular, their sexual rights. Patriarchal perceptions of women's good behaviour, proper manners, honour, chastity and virtue are still evident in many laws. Where these have been successfully removed from legal texts they, nonetheless, often pervade the judicial mentality used to interpret them. One such example is the widespread failure by the judicial system to enforce the minimum age at marriage for girls, where it has been enacted, because cultural and social imperatives and, increasingly, economic factors, still favour early marriage for girls. Similarly, many countries have not recognized the concept of rape within marriage, despite the new dimension introduced by HIV/AIDS. This makes it very difficult for married women to negotiate the practice of safe sex with their partners and currently HIV transmission rates for married women are among the highest. Other legal impediments restrict women's access to essential health services on the basis of age, marital status, spousal consent requirements or other factors.

Women in Policy Positions and at Decision-making Levels

114. The underrepresentation of women in positions of power and decision-making means that their perspectives and visions are often excluded from population and development policies and strategies. A significant increase in the numbers of women taking an active role in decision-making, including participation in electoral politics, is, therefore, essential if they are to influence policies.

115. To address this problem, many countries have created or strengthened institutional mechanisms, such as women's ministries or women's bureaus, for women's equal participation in policy processes. Brazil, for instance, established the Women's Intersectoral Health Commission in the National Health Council at the Ministry of Health. It is a high-level organ whose aim is to involve women in planning, managing and monitoring reproductive health-care services. Among its functions is the monitoring of public health policies from a gender perspective.

116. In Asia, some countries have promoted women's participation in the planning, managing and monitoring of reproductive health programmes. In Azerbaijan, the Islamic Republic of Iran, the Philippines and Thailand, Governments enhanced the participation of women by nominating them to high-level policy bodies, including review and oversight bodies at both the central government and regional levels. Some Caribbean countries have adopted similar strategies.

117. In the political arena, achievements have been mixed, with gains made in several countries, but ground lost in others. In general, the environment for political activities is still not conducive to women's participation. Women who want to enter politics find that the political, public, cultural and social environment is often unfriendly or even hostile to them. In many countries, traditions continue to emphasize, and often dictate, women's primary roles as mothers and housewives. This type of gender ideology serves to discourage women who wish to break out of their traditional sex-segregated motherhood roles and, often, to penalize those who do.

118. However, many countries have responded positively by taking strong measures to increase the number of women in electoral politics (Table 3.1). In Morocco, four women were appointed as Secretaries of State in 1997. In Ghana, the numbers of women in Parliament as well as those holding cabinet posts has increased. In Ecuador, the Government approved a law to promote the political participation of women

by establishing an obligatory 20 per cent of representatives to be women in the popular election ballots for all legally recognized parties. In Costa Rica, reform of the electoral code established a quota for women, set at 40 per cent for all official election lists.

**Table 3.1 Parliamentary seats held by women, 1 January 1997
(as percentage of total)**

Africa, sub-Saharan	12
Arab States	4
Asia	
East Asia	20
South Asia	7
Southeast Asia and the Pacific	12
Europe	
Eastern Europe and CIS	8
Western and Southern Europe	18
Nordic Countries	37
Latin America and the Caribbean	10
North America	12

Source: United Nations Development Programme, Human Development Report 1997.

119. Women's low socio-economic status also stands in the way of their entry into the higher levels of decision-making. Socio-economic obstacles include poverty and unemployment, inadequate financial resources, illiteracy, limited access to education, and the dual burden of domestic tasks and professional obligations. So in spite of the obvious advantages evident in broadening the scope of participation in politics and in public life through the adoption of democratic practices in many countries, women, by virtue of their reproductive roles, are still unable to reap the just rewards of democratization. Therefore, women still need to be empowered at family and community levels to have self-esteem and confidence to enter the political arena outside the home, while the society at large also needs to recognize that women's perspectives in politics are essential to sustainable development.

Strengthening Institutions

120. One of the major challenges emphasized in the ICPD Programme of Action is how to institutionalize and sustain change related to gender equality, equity and the empowerment of women. The process of institutionalization requires broad-based alliances that support the adoption of procedural and technical processes which ensure that social practices that promote gender equality become continual and fully sanctioned by prevailing norms. It also entails the creation of capacity among staff to undertake policy analysis from a gender perspective so as to clarify policy objectives, establish measurable goals and timetables and design appropriate operational tools.

121. For many countries, this has meant taking steps to assist organizations and institutions, both governmental and non-governmental, in using instruments and measures that are compatible with the goals of gender equality and the empowerment of women. The presence of such instruments, permeating all structures, pre-empts the tendency to treat issues pertaining to gender equality as peripheral to the organization's or institution's mandates.

122. Estonia, for example, took steps to establish a strong national machinery for promoting gender equality at all levels of government by creating an inter-ministerial committee and a Bureau of Equality. Indonesia and other countries developed gender-sensitization training materials to build capacity in gender analysis for cadres in various institutions.

Advocating a Rights-based Approach

123. The integration of a human rights approach is one of the fundamental goals of the ICPD Programme of Action and is necessary for the achievement of gender equality and empowerment of women. The basis for a rights-based approach is the affirmation that human well-being and health are influenced by the way a person is valued, respected and given the choice to decide on the direction of her or his life without discrimination, coercion or neglect. Many countries have used CEDAW as a strategy to that effect. A number of countries have also begun to propose and to implement affirmative action programmes as interim measures to enable women to exercise rights that, hitherto, had been out of their reach.

124. Dialogue has also been established with the six human rights treaty bodies to find ways in which the treaty bodies can interpret and apply human rights standards to issues relating to women's health. Another purpose would be to encourage collaboration in the development of methodologies and indicators for use both by the treaty bodies and by United Nations agencies and other bodies to promote, implement and monitor women's rights, in particular, their reproductive and sexual rights.

Protecting the Girl Child

125. Considerable progress has been made in many countries in advocating for the protection of the girl child as a major step towards challenging practices that perpetuate the low status of women. Ghana, for instance, took steps to eliminate traditional and religious practices that jeopardize the reproductive and sexual health of the girl child. It enacted a law against FGM, which also criminalizes, *inter alia*, discriminatory widowhood rites and punitive actions, including their seclusion from society, against women suspected of practising witchcraft. In Burkina Faso, a law banning FGM went into effect in 1997, while in 1998 the President of Senegal banned the practice. In Eastern Uganda community based efforts to eradicate FGM have resulted in a decline of the practice of thirty six percent.

126. With regard to education, a variety of interventions are being implemented to narrow gender gaps in educational attainment and to remove gender-based discrimination in educational systems. Cambodia created a Working Group in the Ministry of Education to address the issues of girls' enrolment and retention levels in school. In the United Republic of Tanzania, the Government established additional day classes

for girls in secondary schools in communities where girls' secondary education was adversely affected. Many countries have also used curriculum reform processes to ensure that curricula became more gender-sensitive in both their content and in the images they presented.

Emphasizing Male Responsibility and Partnership

127. Although progress towards ensuring that men take equal responsibility for their own as well as their partners' reproductive and sexual health was slow initially, the gains since 1994 have been impressive. There is now clearly a more open dialogue about the manner in which various cultural practices perpetuate gender stereotyping and gender inequalities.

128. Some countries have tried to guarantee accountability among men by enacting laws that make it illegal not to acknowledge their responsibility regarding their offspring. Brazil, for instance, enacted a civil code reform that facilitates the identification of fatherhood through DNA tests. At the same time, changes to the Penal Code were proposed to increase penalties for men who have sex with girls under the age of 14.

129. The changing perspectives of men on a wide range of population and related issues are being documented, thus creating a basis for the development of appropriate interventions. Research on masculinity in different sociocultural settings is demonstrating that men's roles as custodians of ideology, knowledge and financial resources make them critical and potentially strong agents for change towards the goal of gender equality. Such research is also attempting to decipher why the social construction of male gender identities seems to predispose many of them towards violence against women, and how this can be deflected. Costa Rica, for example, has undertaken a national study on masculinity, sexuality and responsible fatherhood to investigate the attitudes of men, their sexual practices and their fatherhood roles.

Constraints

130. Despite the achievements so far, much more remains to be done to address continuing gender inequalities that constrain the ability of women and girls to experience high standards of reproductive and sexual health. The persistence of traditional, religious and cultural attitudes and practices that subjugate women, such as FGM, also impacts negatively on the reproductive and sexual health of women and girls.

131. Some of the mechanisms for promoting gender equality within government structures have suffered from underfinancing in relation to their often huge tasks. Structurally, some bureaus have no access to high-level policy processes, which may hinder their efforts in gender mainstreaming. Although many government ministries or departments suffer generally from the lack of technically qualified staff, those tasked with the promotion of gender equality may be relatively more deprived because of the scarcity of personnel trained in the relevant techniques: gender and development is a fairly recent field of specialization in most academic institutions.

132. In addition, many new government structures have been given challenging terms of reference, with multiple tasks of policy and strategy development; technical support to operational departments; monitoring and functioning as watchdogs vis-à-vis gender equality and women's empowerment issues; and networking with women's organizations and the civil society. To perform their tasks adequately, many of the

machineries established for women's participation still require strengthening in resource mobilization and technical capacity for monitoring and policy analysis. Their organizational structures and number of staff should also reflect their large mandates. Most important, measures should be established to ensure that these mechanisms are able to hold sectoral ministries accountable with regard to the promotion of gender equality, equity and empowerment of women.

133. Efforts to improve the education of the girl child are constrained at two levels. At the macrolevel, there is an overall scarcity of resources earmarked for the educational sector. This is sometimes compounded by weak political will to invest in the education of girls. At the microlevel, cultural attitudes still result in greater family investment in the education of boys as opposed to girls.

134. Finally, it is essential to note the increasing privatization of many social services in different countries of the world has often had a greater impact on women than on men. With regard to health, the declining role of the state is introducing inequities in access to health because of the increasing cost of private sector health provision. This means that it is the poor, a large proportion of whom are women, who are often shut off from access to health services. In this context, women are also shouldering more of the health burden accruing to families who can no longer afford hospitals, forcing the ill to be looked after at home, often by women. Another factor with gender implications is the globalization of the world economy, which has sometimes led to the incorporation of women into industrial work characterized by lower wages; poor working conditions, often marked by occupational hazards; and absence of workers' rights, including maternity leave and collective bargaining.

Further Action Required

135. Governments should develop multi-sectoral coordination and inter-disciplinary technical teams to systematically address gender, population and development issues at community and national levels.

136. Governments should promote zero-tolerance of gender-based violence through the enactment and enforcement of appropriate laws, the implementation of CEDAW and the undertaking of studies that demonstrate the multiple consequences of gender violence on the health of women and girls and its impact on public health expenditures.

137. Civil society, especially NGOs, should strengthen their advocacy efforts to increase and sustain broad-based political will for the promotion of gender equality. This can be accomplished through the creation of NGO coalitions and consortiums which pool their different expertise together.

138. Parliamentary groups should establish strong linkages with the civil society, especially the NGOs, to strengthen advocacy for the utilization of international instruments and conventions, such as CEDAW, to gauge progress towards gender equality at the national level.

139. Civil society, especially NGOs, should reinforce their IEC campaigns to create awareness in communities and among religious and other public opinion leaders about the negative impact of some prevailing traditional attitudes and practices on women's self-determination and their capacity to make decisions that affect their own lives and/or to participate in national decision-making. Equally, programmes

that aim at eradicating harmful traditional practices, such as FGM, must be expanded and reinforced, building on the lessons learned from earlier successes and failures.

140. Governments should ensure that population and development programmes support and reinforce the positive roles that men play in reproductive and sexual health while safeguarding an enhanced position for women in society. Operational programmes should, therefore, incorporate strategies that enlist the support of men for the promotion of reproductive and sexual health and rights of their partners, while also enabling men themselves to take responsibility for their own reproductive and sexual behaviour.

141. Governments should reinforce their support for the protection of the health of the girl child, including increased investment in her education, life-skills development, and promotion of equal conditions of employment for both young women and men. These efforts should also include strategies and activities that encourage and enhance gender-sensitive socialization processes for boys at home as well as at all levels of both formal and informal education.

142. NGOs should reinforce advocacy for strengthening legal frameworks and policies to promote and protect the human rights of women and girls and to enforce them effectively. Mechanisms to monitor, document and redress human rights violations, especially with regard to vulnerable groups such as refugees, should be put in place.

143. Governments and civil society, especially NGOs, should strengthen collaboration and cooperation for the promotion of gender equality and the empowerment of women. This can be achieved through the establishment of national mechanisms such as Commissions for Gender Equality with a mandate of comprehensive monitoring of progress towards the achievement of ICPD goals.

144. The private sector should establish mechanisms that monitor the institutionalization of gender equality norms and values, including elimination of sexual harassment and the active promotion of the empowerment of women, in accordance with international conventions and practices.

145. Governments, the United Nations and the donor community should support the development and wide availability and application of gender-disaggregated data and the development of appropriate indicators for monitoring progress towards gender equality. In particular, the gender-differentiated effects of globalization need to be well researched and understood so that appropriate measures can be put in place to safeguard *inter alia* women's health.

146. The United Nations, donors and the international community should support the provision and development of technical capacity at the national level to develop and institutionalize effective strategies for gender mainstreaming, through both North-South and South-South strategies.

147. Governments and the international community should allocate more resources for the implementation of comprehensive strategies which ensure that women's needs and concerns are well reflected in population and development policy and programming processes.

Chapter IV. REPRODUCTIVE HEALTH, INCLUDING FAMILY PLANNING AND SEXUAL HEALTH, AND REPRODUCTIVE RIGHTS

148. The ICPD Programme of Action endorses the right of all individuals to have their reproductive health needs met over their life-spans through a sexual and reproductive health approach to information and service delivery. Reproductive rights are understood as human rights. The right to voluntary choice in reproductive decisions involves ensuring equality and equity between women and men and the provision of universal and equal access to comprehensive quality sexual and reproductive health services that protect privacy, informed and free consent, and confidentiality.

149. In the years before 1994, some developing countries had witnessed significant changes in their population programmes, having shifted from using family planning programmes for controlling population growth to employing the rights-based approach later adopted by the ICPD. The ICPD provided all countries a major impetus for accelerating this shift away from vertical service provision, targets and quotas, and towards covering all the reproductive health needs of clients and promoting gender equality, equity and the empowerment of women, and adolescent reproductive health.

150. The Programme of Action describes the basic principles for implementing quality sexual and reproductive health services. These include the need to:

- C Develop a dynamic policy and implementation process that is participatory and representative of all stakeholders;
- C Develop a strategic implementation plan that is based on phased prioritization and on resource availability to ensure effective progress and accountability;
- C Conduct a structural and strategic reorientation of health systems and finance in the context of health-sector reform and consider shifting from vertical maternal and child health and family planning (MCH/FP) to rights-based sexual and reproductive health programmes, recognizing that reproductive health is not simply a matter of adding services and information to existing family planning services; and
- C Involve and coordinate various sectors to deal with the social, economic and political dimensions of sexual and reproductive health, acknowledging that reproductive health is best addressed through broad, multisectoral approaches and not just by health-sector organizations.

151. This chapter reviews the extent of the change that has taken place in meeting the reproductive rights and sexual and reproductive health goals and objectives of the ICPD. It builds on information gathered through a review of the literature on the subject, interviews, UNFPA field inquiries and Expert Round Table Meetings organized by UNFPA on these issues.⁴

152. There has been considerable progress in implementing key areas of the ICPD Programme of Action through policy reformulation, programme redesign, increased partnership and collaboration, and increased resource allocation. In particular, there has been increasing progress since 1994 in ensuring reproductive

rights and implementing reproductive health as defined by the ICPD Programme of Action. By 1998, many countries had made policy, legislative and/or institutional changes in the area of reproductive health and/or rights since the ICPD. Several countries were testing ways to integrate reproductive health services and were exploring other means to ensure rights-based approaches.

153. Effective and empowered women's movements, other mass movements and NGOs were proving to be important in ensuring progress in policy development and implementation in many parts of the world and in many areas of concern, including generating political will for population and health policies that are rights-based. NGOs, which had been genuine partners in framing the Programme of Action agreements, have become partners in its implementation.

154. Reproductive health is more often being addressed as a component of broad health programmes in countries undertaking health-sector reforms. This broader approach is expected generally to be more cost-effective and to yield greater consumer satisfaction, which, in turn, is likely to lead to more effective use of information and services by consumers.

Developing Reproductive Health Policies after Cairo

Policy Formulation

155. Sector-wide progress in policy formulation has occurred in several countries, while work on improving specific aspects of policies has begun in others. Critical measures undertaken by countries that are more advanced in the implementation of the ICPD agenda have included efforts to provide free and accessible reproductive health services as an overall health component throughout the life cycle (including the voluntary choice of family planning methods). There have also been efforts to broaden issues of reproductive decision-making so that the rights to consensual sexuality, voluntary choice in marriage, family formation and the determination of the number, spacing and timing of children are more widely available.

156. Some policies recognize the equal rights of women and men and the need to enhance women's status so as to allow them to exercise their rights. Most countries give highest priority to those aspects of rights dealing with provision of services, whereas a few specifically address the context in which reproductive decisions are made, i.e., gender and power relations.

157. The success of some countries in formulating reproductive health policies appears to result from the identification by Government of priority needs and the involvement of stakeholders in a multisectoral approach, making the public aware and placing reproductive health at the centre of health-sector reform. In this sense, donors and international agencies have played a facilitating role in Government-NGO collaboration. However, their support for policy and programme development has often been fragmented, which has tended to inhibit the development of national leadership and comprehensive policy and programme development for reproductive health, rights and equality.

158. Various models for policy development have been identified. Some countries embarked on the development of national reproductive health policies; others included reproductive health in policies that address women's health; and some dealt only with specific aspects of reproductive health.

159. Building consensus regarding the reproductive health concept and investing time and resources in the development of policies itself appear to be an auspicious strategy used in some Asian countries. Bangladesh offers a unique example of NGOs engaged in a consortium and of donors working together to support a national goal. The 1997 "Health and Population Sector Strategy", formulated with the involvement of NGOs, professional groups and consultants, affirms the principles of the ICPD and recognizes the need for a client-centred, life-cycle approach in which four areas have priority: safe motherhood, family planning, menstrual regulation and care of post-abortion complications, and the management of RTIs and STDs⁵. The state of Rajasthan in India provides an example of a client-oriented and needs-based policy developed in response to the target-free approach in the country⁶.

160. In Africa, Zambia undertook a multisectoral and decentralized approach involving civil society in formulating a new reproductive health policy which addresses gender issues, including male involvement, as well as the allocation of resources for its implementation. The development of the national reproductive health policy was based on an extensive needs assessment process. Health districts, NGOs, donor agencies, and private and industrial institutions were all involved. In Ghana, the Ministry of Health developed a reproductive health policy as well as reproductive health standards and protocols. The policy was based on the results of a needs assessment process that included consultation with civil-society groups⁷. In South Africa, NGOs provided key support to provincial governments in the development of a women's health policy⁸.

161. The case of Brazil offers an interesting example of what has happened since Cairo. Although a comprehensive women's health policy had been developed in Brazil even before the ICPD, progress accelerated after Cairo with an increased focus on certain aspects, including STDs and HIV/AIDS, safe abortion within the legal provisions, post-abortion care, and adolescents. In 1997, the Congress approved a National Family Planning Law, which covers all temporary contraceptive methods and also recognizes voluntary sterilization as an acceptable procedure for reimbursement by the Unified Health System⁹.

Funding Issues

162. There appear to be no consistent trends in financing reproductive health policies. Funding increased in some countries (Bangladesh, Peru), and plans for the introduction of user fees and cost-recovery mechanisms were being developed in others¹⁰. Even where there was a shift towards increasing private-sector provision of services, some Governments were committed to the provision of a safety net of free services.

163. The other issue involved in funding for reproductive health is the question of decentralization – an important part of health-sector reform in many countries. When health spending priorities are identified at the local level, safeguarding spending for reproductive health will be dependent either on an understanding of reproductive health having trickled down to the regional or local level – or its having "trickled up" from a demand from women, which would be dependent on their empowerment to recognize their needs. In Zimbabwe, a country seriously affected by the HIV epidemic, women's NGOs were instrumental in

organizing the demand for state-subsidized female condoms that allow women to take control over protection against HIV infection.

164. In most countries, however, resources for reproductive health have been limited. Because the capacity to deliver comprehensive services and to make sweeping social change was limited, most countries have defined priority areas for investment, making hard choices about the allocation of scarce human, financial and institutional resources. Often, strategies have continued to focus on the previously high priority areas of family planning and MCH.

165. In countries where the process of health-sector reform has begun, a special effort is being made to include reproductive health as a priority area in the package of basic health services. In Zambia, where the health-sector reform process has been under way since 1992, a broad-based understanding of reproductive health was facilitated by the involvement of all levels of the public health system in the policy-formulation process.

Constraints in the Development of Policies

166. Despite unmistakable progress in the development of policies worldwide, countries reported that there was still an inadequate level of knowledge and understanding of reproductive rights and health as described in the ICPD Programme of Action, partly because it had not yet been sufficiently disseminated.

167. Even where there was general support for and increased understanding of the ICPD Programme of Action, policies did not yet consistently reflect a human-rights approach nor was there sufficient political commitment. Full support was still lacking for legislation to ensure reproductive rights and reproductive health and gender equity and equality. In many countries, existing laws and regulations impeded the implementation of the ICPD Programme of Action in areas such as sexuality education and adolescent access to reproductive health services.

168. Reproductive health policy has tended to be shaped primarily by health-sector organizations and professionals, to the exclusion of other sectors and disciplines. The result has been inadequate attention to the social, economic and political dimensions of sexual health and reproductive rights and little attention to the psycho-social, gender and emotional aspects of individual health and well-being. Political instability and frequent turnover of civil servants have also undermined the continuity of policy development, implementation and monitoring.

Implementing Quality Sexual and Reproductive Health Programmes

Integrating Sexual and Reproductive Health Programmes

169. Many countries reported the availability of various elements of reproductive health care, and many had taken steps to integrate some components of reproductive health into the primary health-care system. Yet, progress in implementing comprehensive, integrated services has been limited. Some countries were more advanced in moving from policy adjustments to actual implementation of the reproductive health approach, while others were just setting out to undertake changes in service delivery. This contrast should

be kept in mind for the following analysis. However, in leading countries in all continents – Brazil, Bangladesh, Ghana, South Africa, Tunisia and Zambia – it is possible to identify prevalent strategies and key issues in implementing the reproductive health approach at the national level. In addition, even where health-care systems had not changed to implementing reproductive health approaches, NGOs were often already doing so. The initial steps taken by countries that were advancing in this area included translating reproductive health policies into operational guidelines by designing an approach to reproductive health services reflective of the ICPD commitment, analysing the human and institutional constraints, and preparing for monitoring progress.

Integrating and Broadening Service Delivery

170. Two key strategic aspects of moving towards a reproductive health approach are the integration of existing services and the broadening the constellation of available services. Managerial concerns in implementing these strategies include institutional set-up, training and supervision.

171. Integrating services. Many countries in all regions – Bangladesh, Brazil, Ghana, Jamaica, Mexico, Peru, South Africa, Tunisia and Zambia, among others – have been testing ways of integrating reproductive health services. Institutional integration seemed to constitute a major hurdle, even in countries which had made integration a priority issue. In many countries, the vertical organizational structure along with compartmentalized budgets and personnel constituted the main institutional barriers to a more integrated approach. When service-delivery activities were divided, for instance, between family planning and health structures, possibly managed by different ministries, countries experienced parallel systems and wasted resources. Thus, in many cases, the institutional change was only a formal one due to bureaucratic inaction and management segmentation including programming, training and evaluation. In less developed countries that depend to a greater extent on outside donors, the lack of coordination among donors also contributed to such segmentation.

172. The most common institutional change was the integration of family planning and MCH under a common institutional umbrella. Although some reproductive health components had been assembled under one institution, it was recognized that only better coordination was achieved in these cases, not full integration¹¹.

173. At the service-delivery level, countries made progress through initiatives – often begun before 1994 – in integrating MCH and family planning services. After the ICPD, the focus was to further integrate these services with STD and HIV/AIDS prevention, screening and treatment. Such integration, however, may have involved only offering services at the same delivery place, while different providers continued to address individual aspects of reproductive health, for instance, screening, counselling and method provision. In some cases, services were offered at the same place and by the same personnel but on different days.

174. Broadening the scope of services. Broadening the scope of services does not necessarily entail the institutional problems of integration, as new services can be placed under the same roof as existing services. Also, a broader approach to service delivery can occur even within vertical structures, which is the case when service providers are trained, for instance, in counselling skills, gender mainstreaming and male involvement. Broadening services involves many of the same considerations regarding training as integrating services. One of the most frequently added services to family planning programmes was the prevention

and management of STDs, including HIV/AIDS, followed in some cases by services for the treatment of the complications of unsafe abortion (as in Burkina Faso, India and Mozambique).

Referral Systems

175. Referral systems relate both to the integration of services and broadening of the scope of programmes. The establishment of horizontal referral systems has been identified as a useful first step in integration where vertical structures still exist. This was the case for many programmes in African countries that were being linked to STDs and HIV/AIDS programmes.

176. Vertical referral systems are also essential with regard to certain aspects of reproductive health, for instance, with regard to maternal care in which referral, including transportation, to emergency obstetric care is an essential intervention to lower maternal mortality and morbidity.

Training

177. A number of countries involved training institutions very early in the process of implementing the reproductive health approach to institutionalize reproductive health training. Also training curricula for both initial and in-service training were adapted to the reproductive health client-centred, needs-based approach, even when full-fledged integration had not taken place. In Romania, the training of staff in family planning to integrate this into primary health care has been a priority as a means of overcoming the service providers' lack of information. In Bangladesh – where a main need was to improve the competence of health-care providers – the training programme is reflecting a broader scope of services to be delivered by the same service providers¹².

178. Training is also key in integrating cross-cutting issues such as counselling, gender mainstreaming and male involvement. The enhancement of gender skills of staff has been identified as a first and crucial step in mainstreaming gender¹³. Progress in this area included the development of techniques for mainstreaming gender in reproductive health training and expanding the availability of such training. For instance, the World Health Organization (WHO), the Women's Health Project, South Africa, and Harvard School of Public Health, USA, developed a core curriculum in gender and reproductive health.

179. Continued supervision that includes problem-solving skills, especially as a follow-up to training activities, has been identified as a key to success.

180. A problem identified in training in the African context – although the problem may apply elsewhere – is that, historically, vertical training curricula had been developed for what now constitute the components of reproductive health. In many places, in-service training continued to be provided component by component. In a typical situation, training in family planning, post-abortion care, STDs, HIV/AIDS and safe motherhood was given, each component in separate training sessions. This situation may well reflect the segregation of budgets and lack of coordination within programmes, which are identified as important constraints to integration.

181. Although more integrated training curricula were developed in Latin America and the Caribbean (as in Colombia, Jamaica, Mexico and Peru), issues related to sexuality, critical to sexual and reproductive

health, were often absent or diluted in the reproductive health part of the whole concept. Reproductive rights and gender perspectives were also often missing, with a resulting effect on client-provider interactions.

182. The shortage of appropriately trained staff was an obstacle to developing and implementing training programmes. This was the case at the national level, where human resources were needed to redesign training curricula and carry out the training of trainers. The decentralization of programme activities also highlighted the limited human resources available at the local level¹⁴.

Quality of Care -- Implementing Reproductive Rights

183. A main objective of the ICPD Programme of Action is to improve the quality of services, defined as the way clients are treated by the service-delivery system. The definition focuses on the process of service delivery, including communication and information sharing; criteria for minimal standards for procedures and examinations; and whether clients receive the service appropriate to their needs. Since the ICPD, much of the debate has centred on the feasibility of improving the standard of quality of care, because it is seen as too costly. However, many studies reveal that improvements in the quality of service provision can be made at a reasonable cost and that without such improvements, initial and continuing utilization of services may suffer.

184. The Population Council developed a situation analysis methodology that assesses the quality of services by observing, among other things, the effectiveness of the use of resources in the clinical setting. Situation analysis studies in some countries of sub-Saharan Africa¹⁵ have looked at key aspects of quality of services, such as contraceptive method choice, client load, use of clinical equipment and water, the social context and clients' sexual relationships. This information has begun to shed light on the underutilization of existing resources. These findings also reveal that, with the training of health providers to enhance their interpersonal communication and technical skills, supervisory support, protocols and appropriate rewards, staff can provide better services within the existing narrow scope of services (family planning), and such training may also allow the expansion of services to respond to other reproductive and sexual health needs.

185. One of the critical questions in improving the quality of care is how to define minimum standards in poor resource settings and, at the same time, improve the quality of care continually as more resources become available. Minimum standards should also apply to the private sector, just as special attention should be given to setting minimum standards for unfamiliar or new services and for services provided in emergencies.

186. Among the tools developed for improving the quality of care is Client-Oriented, Provider-Efficient services (COPE), which was designed by AVSC. Now used worldwide in more than 30 countries, COPE facilitates self-assessment and problem-solving by all clinic staff. Family planning providers and supervisors are being trained to solve problems as they arise.

187. Counselling and interpersonal communication between service providers and clients are key aspects of ensuring informed and voluntary reproductive choices and thus, reproductive rights. If clients are not provided with sufficient information to make fully informed choices, their human rights are not being respected. Quality of care also includes issues of confidentiality, privacy, counselling and interpersonal

relations. Since the ICPD, some countries have made progress in involving clients in decisions regarding their reproductive health.

188. To ensure high-quality care in the public and private sectors, some countries reported having improved or developed regulatory frameworks. For example, in India, institutional quality assurance in the health system, including the private sector, will be pursued according to the guidelines disseminated by the central government. In Nepal, the Government recently established the Quality of Care Management Centre within the Family Health Division to provide support to district health-care centres for improving the quality of reproductive health services¹⁶.

189. Strengthening national information systems, including the development of indicators along with operational and policy-relevant research, is considered a key to allowing more effective planning, implementation and monitoring progress to achieve the reproductive health goals and objectives of the ICPD Programme of Action. The Islamic Republic of Iran and the state of Rajasthan in India offer examples of efficient information system designs that are simple and clear to use at the service-delivery level. In these systems, only the most essential data are collected; appropriate technology is applied; and the findings are of immediate use both at the service-delivery level and at higher levels of the health-care system.

190. However, the essential issue regarding the quality of national information systems is the question of indicators. Identifying indicators should entail a consideration of whether they measure process or output and whether they are qualitative or quantitative. A number of international agencies, including UNFPA, WHO, World Bank and the Evaluation Group supported by the United States Agency for International Development (USAID), have developed groups of global indicators to assist in the further adoption of indicators. These indicators are now being tested in the field.

191. At the national level, it has been found to be an advantage if all stakeholders – i.e., all parties that can make use of the information, such as community representatives, service providers, programme managers and researchers – come together in designing information systems. They have to identify what information they need, how should it be analysed and how the results should be presented to different users. For example, the Latin American and Caribbean Health Network – in collaboration with some Governments in the region – identified six thematic issues to monitor in each country they work in, including sexuality and the reproductive health of adolescents, quality of care, management of unsafe abortion, male involvement and the participation of women in decision-making. Qualitative and quantitative indicators elaborated for each of these issues will be used to assess the reproductive health situation in each country¹⁷.

Increasing Access to Reproductive Health Services

Communication and Education

192. Information and the confidence to take action in personal and institutional relationships are preconditions for sexual and reproductive health. NGOs have been successful in building the knowledge base and confidence of women, men and adolescents to claim their sexual and reproductive rights and promote their sexual and reproductive health, including the effective use of health services.

193. Many diverse and innovative communication methodologies and materials have been developed to empower people to act on their sexual and reproductive rights. These include drama, mass media and peer education. However, the effectiveness of methodologies and materials has not always been evaluated and the content has not always addressed the common human experience, such as sexuality and gender power relations, including violence.

194. Only a few communication programmes, carried out mainly by NGOs, have helped men understand how preventing women's access to sexual and reproductive health care endangers women's health and lives and helped them change their behaviour so as not to put women's health at risk and to protect their own health.

Diversification of Service Provision

195. The diversification of service provision for selected reproductive health services through the participation of the private sector and NGOs has improved access in some countries. For example, in Colombia, PROFAMILIA, an International Planned Parenthood Federation (IPPF) affiliate providing more than 60 per cent of the national family planning services, broadened the provision of reproductive health services after 1994. Through a cost-recovery programme, PROFAMILIA subsidized services in poor and remote communities and for teenagers. Cost recovery helped to ensure voluntary and informed choice as well as to maintain a high quality of care¹⁸.

Constraints of Access

196. Notwithstanding improvements, economic conditions and the resulting poor health-care infrastructure in many countries continue to obstruct access to services. Barriers to services include distance, cost, ignorance and the poor attitude of providers. The separation of basic primary health-care services places an exceptional burden on women to meet their diverse needs and those of their children. It also leads to duplication of infrastructural, management, information and other systems.

Increasing Access to Health Services for Adolescents

197. The world today has the largest group of adolescents in history, with 1.1 billion persons aged 10-19. Investing in these young people and providing them with real opportunities in life are vital steps in promoting individual and societal development. However, far too many adolescents lack homes, formal education, work and beneficial recreation, and many live in extreme poverty. Opportunities for girls, as compared with boys, are especially limited.

198. Programme experience indicates that adolescents need support to build self-esteem and to develop life skills and skills to manage intimate relationships and to practice gender equality. Unprotected sexual relations place adolescent girls at risk for both unwanted pregnancy and STDs, including HIV/AIDS, and boys at risk for STDs including HIV/AIDS. Therefore, they need access not only to preventive services, such as information and contraception, but also to youth-friendly health services, including diagnosis, treatment, information and counselling.

199. In the 1998 UNFPA Field Inquiry, it is reported that 55 countries had taken some measures to address the health needs of adolescents, including reproductive health. Among such measures were the inclusion of adolescent reproductive health in youth and national health plans, the development of policies and guidelines for adolescent reproductive health, and the establishment of ministries of sports and youth. In some countries, NGOs were especially active in testing new approaches to programme development for adolescents such as peer education, skills-building and counselling. Actions to foster understanding and support among adults in the family and in the community were being recognized as key investments.

200. In Colombia, PROFAMILIA supported activities in youth centres in 20 of the country's cities, where the youth population have at their disposal medical services, diagnostic support and information, and sexual and reproductive health education. In Kenya, the song "I Need to Know", performed by young Nairobi musicians, was a hit. The song helped adolescents ask for a reproductive health component to be added to school health services. In the Marshall Islands, a youth-to-youth programme trained peer educators and counsellors so that they could provide health education on issues such as teenage pregnancy, STDs and HIV/AIDS, substance abuse and nutrition to youth, their families and the community. The project also catered for the contraceptive needs of adolescents.

201. Young girls are at particular risk of reproductive ill-health. More than 14 million adolescent girls give birth each year. A large proportion of these pregnancies are unwanted. WHO estimates that as many as 4.4 million abortions are sought by adolescent girls each year. Harmful practices, such as FGM and child marriage followed by expectations of early child-bearing, further increase the risk of reproductive ill-health in adolescent girls.

202. Early child-bearing also narrows the life opportunities of girls. In many countries, girls who become pregnant are not allowed to continue to attend school. In others, the education of boys is simply valued higher than that of girls. The result is that girls constitute two thirds of the more than 130 million children not attending school. Some countries have, however, begun to take measures to promote girls' education, including direct incentives, such as waiving fees or providing a small payment or food allocation for girls' attendance, and adapting the school system to facilitate girls' participation. For instance, over the past decade, the Bangladesh Rural Advancement Committee created more than 30,000 schools offering non-formal primary education, in which 70 per cent of the pupils were girls.¹⁹

203. Many studies show that sex education promotes responsible attitudes and behaviour. These studies also show that providing adolescents with information and services on reproductive and sexual health enables them to postpone the onset of sexual activity and that, when they do engage in sex, they are more able to protect themselves from pregnancy and STIs, including HIV/AIDS.

204. Ensuring adolescent sexual and reproductive health and rights as well as improved life opportunities equally for girls and boys will require much greater investment. As yet, few Governments have developed comprehensive strategies for investing in adolescent reproductive health.

Increasing Male Responsibility

205. The ICPD Programme of Action recognizes that human sexuality and gender relations significantly affect sexual and reproductive health and that men need to take responsibility for their own sexual behaviour as well as to respect and support the rights and health of their partners. Many countries have undertaken advocacy campaigns to broaden or promote male involvement in sexual and reproductive health. Since the ICPD, there has appeared to be some increase in men's use of condoms and vasectomy and some expansion of male STD services. In a few countries, NGOs, especially, developed innovative approaches to support the involvement of males in pregnancy and child care and to encourage them to develop relationships based on equality and mutual respect. For example, in Mexico, a group of midwives organized a programme to train Community Health Workers to encourage male participation in reproductive health care, teaching men that pregnancy and birth are a family affair and not just "women's business".

206. It is increasingly recognized that work with boys and youth is essential. Some countries strengthened legislation that supports men's roles in the family, especially concerning child support. There has been little improvement, however, in implementing laws concerning violence against women, and overall progress on male involvement in this area has been limited.

Ensuring reproductive health for refugees

207. Until recently, reproductive health was not considered a priority in the provision of health services in emergency situations. However, the ICPD Programme of Action recognizes the need to ensure reproductive rights and to provide reproductive health care, since reproductive health needs continue to exist. This is especially true for adolescents and women. Women are also at greater risk of sexual violence and rape in emergency situations.

208. Since the ICPD, reproductive health care has been increasingly guaranteed in all emergencies due to the improved capacity and mechanisms of response by the international community. An initiative by United Nations agencies and international NGOs was instrumental in developing a coordinated and collaborative approach to reproductive health. This included the development of a reproductive health manual detailing a basic package of services for emergency situations that includes maternal care; family planning, including emergency contraception; and the prevention and management of STDs and HIV/AIDS. Emergency reproductive health kits have also been developed and stockpiled for immediate distribution when needed.

209. In 1995, an Inter-Agency Working Group was established under the coordination of the United Nations High Commissioner for Refugees (UNHCR), with the representation of 30 NGOs, United Nations agencies, governmental agencies and donor institutions, to organize and facilitate reproductive health in all emergency situations. As a result, the Minimum Initial Service Package (MISP) was developed, consisting of material resources necessary to implement services, including essential drugs, supplies and basic surgical equipment²⁰.

210. Also in 1995, the Reproductive Health for Refugees (RHR) Consortium was funded by organizations representing a mix of field service organizations, public health organizations and policy/advocacy groups. Needs assessment manuals and materials were developed.

211. Although the capacity and mechanisms of the international community to respond to emergency situations have improved, and comprehensive reproductive health services are now being implemented earlier in emergencies, the availability of emergency health personnel skilled in reproductive health information and services remains limited.

Addressing Components of Reproductive Health

212. Whether countries in their overall programme design have pursued the integration of services, improved quality of care or increased access to services, a more comprehensive reproductive health approach can be distinguished by looking at achievements in its key components. Within the concept of integrated and comprehensive reproductive health, three central issues have emerged as global concerns:

- C Meeting the need for family planning;
- C Ensuring maternal health, and preventing and management of unsafe abortion; and
- C Preventing and treating STDs (including HIV/AIDS).

Some countries, however, are increasingly addressing other reproductive health issues – namely, the prevention of cervical and breast cancer and infertility.

Meeting the Need for Quality Family Planning

213. Ensuring the ability of people to choose whether to become parents and, if so, to choose when and how often, is not only a key intervention for improving the health of everyone but is also a human right. For couples and individuals to decide freely and responsibly the number and spacing of their children, a full range of safe and effective methods of family planning, which meet the expressed preferences of people, needs to be accessible and affordable.

214. As of 1998, almost all countries had affirmed the right of couples and individuals to choose the number and timing of children and to have access to information and the means to do so. Only two Member States continued to severely limit access to family planning²¹.

215. In many countries, policies limiting access to family planning services are being lifted. Also, in many countries, regulations and policies are being reviewed concerning such issues as spousal authorization, marital status and age limits or those that deny services to adolescents, to unmarried, divorced or widowed women, and to women who want to delay or space pregnancies but are not able to negotiate this with their husbands. By 1997, however, 14 countries still required spousal authorization for women to receive contraceptive services, and 60 additional countries required spousal authorization for permanent methods²².

216. Family planning remained the central focus of most programmes. However, a reproductive health approach to family planning was the first step taken in the majority of countries where ICPD implementation had begun. This means that efforts now need to be more focused on meeting the needs of clients. This includes reconsidering the range of contraceptive methods made available; information and counselling services to enable contraceptive choice in the context of assessing the individual's sexuality, partner's relations, gender issues and the social context; and information and counselling on side-effects and their management. NGOs, such as IPPF family planning associations (FPAs) and women's NGOs, are leading in this domain. However, national programmes are also making progress. For example, the "target-free approach" was introduced in India in 1995. It discarded demographic and contraceptive goals, replacing them with a "community needs assessment" approach. China, similarly, was endeavouring to change from

pregnancy quotas to a client-centred approach based on reproductive choice in a programme being introduced with UNFPA support in 32 countries throughout the country.

217. Some countries have adopted quality-of-care approaches, which have included appropriate service facilities; appropriate technology; and training of personnel in counselling and communication skills and the availability of a variety of contraceptive methods. Of the clinics studied in five Sub-Saharan African countries, 81 per cent had at least four contraceptive methods in stock.²³

218. Despite the encouraging emphasis on improving the determinants for quality of care, this has not automatically led to clients' actually receiving quality care. A review of five situation analysis studies found that at clinics with four or more contraceptive methods in stock, only 34 per cent of new clients interested in spacing births were informed about at least three methods. In addition, in clinics which had informational materials available, these materials were actually used in less than one fifth of client-provider interactions. Moreover, between 23 per cent and 88 per cent of providers with water readily available did not wash their hands before a pelvic examination.²⁴

219. Some countries have made progress in ensuring informed consent in family planning settings. In Bangladesh, Mexico and Peru and in some states of India, for example, providers were better trained in providing information and in obtaining full voluntary consent from clients.

220. Most developing countries with available trend data showed a substantial increase in contraceptive use. The overall yearly increase in contraceptive prevalence for the developing countries was 1.2 percentage points per annum, when weighted by the number of married women of reproductive age.²⁵

221. Although there appears to have been a substantial increase in contraceptive use in many developing countries, various indicators suggest that the level of unmet need remained high, at about 20-25 per cent of couples. For regional groups, the level of unmet need was highest in sub-Saharan Africa (29 per cent) and lowest in Latin American and the Caribbean (18 and 20 per cent)²⁶.

222. Two new contraceptive methods became available after 1994: once-a-month injectables and the female condom. Approximately 22 countries in sub-Saharan Africa were beginning to provide the female condom, clearly recognizing that women need a method that they can control. In addition, research shows that IUD CUT380A is now effective for 10 years. Research organizations continued their work on contraceptive safety and post-marketing surveillance.

223. Emergency contraception has become better known and accessible since 1994. It covers specific needs of women who are exposed to unprotected intercourse and can act early to prevent unwanted pregnancy. Emergency contraception has been introduced in a number of countries, and training efforts are also being undertaken²⁷.

224. In 1998, the use of Quinacrine for female medical sterilization, never considered safe by WHO, was finally banned by the U.S. Federal Drug Administration, which also requested the U.S. promoter to cease distribution of the drug in the United States and yield up all its stocks²⁸.

225. Donor support for contraceptives increased 15 per cent between 1994 and 1996.²⁹ By region, donor contraceptive support for the Asia and the Pacific region doubled in 1996 from the year before. The main reason for this was an expanded social marketing operation in the area. Donor support for the Africa region over the period 1995-1996 was 52 per cent higher than the previous biennium. Initiatives are under way at global and national levels among the public, donor and commercial sectors to expand the role of the commercial sector to market lower priced hormonal contraceptives in developing countries to those who can afford them.

226. The diversification of service providers has improved access to family planning services in many parts of the world. For example, social marketing increased by 13 per cent in 1997. More than 16 million couples in 55 countries benefited from social marketing in 1997, versus 14.4 million in 1996. The large increases were mostly the result of the Indian and Indonesian programmes. A total of 937 million condoms were sold by social marketing programmes in 1997, an increase of 20 per cent over the previous year. The sale of more than 900 million condoms indicates the importance of social marketing, especially in view of the AIDS epidemic³⁰.

227. Access to family planning increased dramatically in the Central Asian countries of Kazakhstan, Uzbekistan and Kyrgyzstan. In these three countries, 59 per cent of married couples were practicing contraception, including modern and traditional methods, compared with less than 20 per cent who did so in 1990³¹.

228. Despite advances in contraceptive technologies and the delivery of family planning services, there remain many people whose access to information and services is severely restricted by logistical, social and behavioural obstacles. These obstacles can be overcome with sensitivity to the changing needs of users and their constraints and with greater attention to logistic systems, management capacity and public information. Providing family planning in the context of comprehensive reproductive health services and encouraging men to accept and support their partners' contraceptive choices will help remove these barriers.

229. Methods for male fertility regulation remain severely inadequate. In this regard, donors and the private sector should increase investments in research and the development of new methods for men as well as female-controlled barrier methods to prevent STD transmission as well as pregnancy.

Promoting Women's Health and Safe Motherhood

230. Greater awareness of the risks of maternal mortality and morbidity exists than 10 years ago due to the momentum generated by the Safe Motherhood Initiative, reinforced by the ICPD and other United Nations conferences. The international health and development community has recognized that maternal mortality is both a development and a human rights issue. WHO and UNICEF estimated that there were 585,000 maternal deaths in 1990. For every woman who dies, many more suffer severe injury or ill-health. The ICPD target is to reduce the 1990 levels of maternal mortality by one half by the year 2000. Although accurate measurement is difficult, it is clear that maternal mortality levels remain highest in sub-Saharan Africa and South-East Asia³² and, more generally, that women in developing countries face an unacceptable and far greater risk of death in pregnancy and childbirth (1 in 48) than do women living in developed countries (1 in 1,800).

231. In 1997, a major technical consultation in Colombo, Sri Lanka, organized by the Inter-Agency Group in Safe Motherhood (which includes UNICEF, UNFPA, the World Bank, WHO, IPPF and The Population Council), reviewed strategies and approaches to reducing maternal mortality. The meeting concluded that training traditional birth attendants (TBAs), providing antenatal screening for high-risk pregnant women and providing simple birth kits was not enough. Women must have access to skilled personnel at delivery, including assisted delivery and life-saving treatments backed up by transport in case emergency referral is required; and to post-partum care. To realize this goal, sufficient numbers of skilled attendants – primarily midwives – need to be trained and deployed, especially in rural areas. They need to be supported with adequate supplies and equipment, regulations that permit them to carry out necessary procedures, and supportive supervision and monitoring. TBAs, trained or untrained, are not defined as skilled attendants³³.

232. At the meeting, it was also recognized that women need to have more autonomy and choices. Increasing education for girls and women and expanding their access to income-earning opportunities and to opportunities for learning life skills can help them improve their status and their access to resources. In this way, they could better avoid poor reproductive health and unsafe motherhood, even before pregnancy occurs.

233. Despite the limited progress overall, some Governments invested resources and developed innovative approaches, some begun before the ICPD. In Tunisia, for example, the Safe Motherhood Programme was initiated in 1990 to improve the quality and coverage of maternal and neonatal health. After the ICPD, the Ministry of Health developed a comprehensive reproductive health strategy with other components, such as reproductive cancers and the prevention and management of STDs. In Indonesia, the coverage of antenatal care and supervised delivery significantly improved after the Government developed a programme to train more than 54,000 community midwives. In Ghana, Nigeria, Uganda and Viet Nam, projects were developed to train midwives in life-saving skills, a training package developed by the American College of Nurse-Midwives. The skills covered in the training were those needed to save the lives of women during obstetric emergencies, including risk assessment, problem-solving and clinical management. In Uganda, the Ministry of Health launched a pilot project in one district to establish a sustainable referral system, which included strengthened referral facilities, communication and transportation. As a result, obstetric referrals and Caesarean sections increased threefold between 1995 and 1996³⁴.

234. Interventions in maternal health are among the most cost-effective in the health sector. A key challenge to their improvement is to alter existing health facilities, logistic systems and training to ensure appropriate and effective care. Another challenge is to overcome social barriers to access.

Prevention and Management of Unsafe Abortion

235. WHO estimates that some 20 million unsafe abortions take place in developing countries each year and that as many as 70,000 women die, accounting for 13 per cent of maternal deaths.³⁵ Most countries are strengthening efforts to prevent unwanted pregnancies, and some are working more systematically to reduce the health impact of unsafe abortion, which remains a major public health concern. A study by the Alan Guttmacher Institute of abortion laws of 152 nations and territories with a population of 1 million or more found that, since 1985, 19 countries (among them, 3 since 1994) enacted new or modified existing abortion laws to expand women's access and choice.

236. The prevention of unwanted pregnancies is the primary objective of any family planning programme or family planning component of reproductive health programmes. The correlation of such efforts to decreasing abortion rates is illustrated in the three Central Asian Republics of Kazakhstan, Uzbekistan and Kyrgyzstan. Data from the Ministries of Health show that the use of modern contraception increased in these countries from 30 per cent to 50 per cent since the beginning of this decade³⁶. At the same time, reported abortion rates declined by as much as 50 per cent.

237. High rates of abortion are also characteristic of a number of eastern European countries. Here, too, efforts are under way to reverse this by increasing contraceptive use. An interesting example is Romania, where family planning was illegal under the previous regime. Consequently, maternal mortality levels caused by unsafe abortions were very high. A dramatic fall in the maternal mortality ratio was evident after December 1989, when an abortion law was enacted. However, to further decrease maternal mortality levels caused by abortion complications, the promotion of modern family planning methods within the scope of the law, were made priorities³⁷.

238. A number of countries – including, in Africa, Ghana, Ethiopia, Kenya, Malawi, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe, and, in Latin America, Brazil, Chile, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay and Peru – have focused on reducing the health impact of unsafe abortion through post-abortion care. As of 1997, more than 114 hospitals and health centres in Mexico were using manual vacuum aspiration (MVA) for the treatment of incomplete abortion. In Ghana, a study was undertaken on the training of midwives working at primary and secondary levels to offer post-abortion care, including the treatment of incomplete abortion. The study demonstrated the feasibility and acceptability of authorizing mid-level providers to offer post-abortion care and had far-reaching repercussions in areas such as improved referral with area hospitals, better community education about unsafe abortion and improved standing of these midwives within their communities³⁸.

HIV/AIDS and STDs

239. The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that 33.4 million people currently live with HIV/AIDS, of whom 5.8 million were newly infected in 1998, the majority due to unprotected sexual intercourse. An estimated 13.9 million AIDS deaths have occurred since the beginning of the epidemic, 2.5 million of them in 1998³⁹. It is further estimated that half of all new infections are to young people between the ages of 15 and 24. The HIV/AIDS epidemic draws its largest toll in Sub-Saharan Africa, where 20.8 million or close to 70 per cent of HIV-infected people live. In 29 countries of this region, life expectancy at birth is already 7 years less than it would have been in the absence of AIDS. Moreover, a total of 7.8 million, equaling 95 per cent, of children who are orphans because of the disease live in Sub-Saharan Africa. Nevertheless, several countries still do not recognize HIV as a major threat to public health⁴⁰.

240. UNAIDS, which became operational after the ICPD, is co-sponsored by UNICEF, the United Nations Development Programme (UNDP), UNFPA, UNESCO, WHO and the World Bank. The mission of UNAIDS is to lead, strengthen and support an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to

HIV/AIDS, in full partnership with its United Nations co-sponsors. Since January 1996, UNAIDS theme groups consisting of representatives of the co-sponsoring organizations and, in some places, of other interested parties, have been established in most countries to increase the efficiency and effectiveness of the response of United Nations system and to coordinate HIV/AIDS activities among the co-sponsoring agencies and with national AIDS programmes. NGOs are also members of the theme group or technical working group in a number of countries, including Brazil, Chile, Democratic Republic of the Congo, Jordan, Rwanda and Swaziland.

241. There is widespread agreement that RTIs and STDs, including HIV/AIDS prevention and treatment, should be an integral component of reproductive health programmes. Since the ICPD, much effort has gone into developing operational strategies and apparatus. Studies have demonstrated the feasibility of integration. Specifically, reproductive health programmes can reduce levels of STDs, including HIV/AIDS, by:

- C Providing information and counselling that addresses critical issues such as human relationships, including sexuality, gender roles and power imbalances between women and men, and mother-to-child transmission of HIV;
- C Distributing female and male condoms; and
- C Diagnosing and treating STDs, developing strategies for contact tracing and referring people infected with HIV for further services.

242. Some case-studies indicate that the training and support for service providers is insufficient, especially in such activities as information and communication, and counselling. For instance, four case-studies conducted in East and Southern Africa underline the need for providers to have sufficient training, available equipment and implementation aids. These studies also identify as important factors for the success of integration the providers' willingness to discuss sexuality and STDs with clients and their ability to correctly identify risk cases for screening.

243. The education of young people is clearly critical to promoting behavioural change in human relationships, values and norms regarding gender roles and gender power imbalances. In 64 countries, support had been provided for the integration of HIV/AIDS-prevention modules into in-school and out-of-school education programmes. According to a 1997 UNAIDS review of the impact of preventive education on the sexual behaviour of young people, quality sex education helps adolescents delay sexual intercourse and increase safe sexual practices.⁴¹ The value of focused efforts can be seen in Uganda, where a direct and comprehensive approach was taken to address the problem among young people, in particular, and where HIV/AIDS prevalence rates are now stabilizing among youth.

244. The technology for HIV/AIDS prevention and control is still inadequate. A vaccine is not yet available, but an important accomplishment has been the development of the female condom, the only female-controlled barrier method that can protect against HIV transmission. Countries have already introduced this new method as a result of the organized demand of women's groups and in recognition of the importance of supporting women's control in this area. Indications are that the public-sector price will

fall in response to increasing demand. With regard to microbicides, 40 new leads have been identified and 15 are now in the clinical trial stage.

245. UNAIDS, UNFPA, UNICEF and WHO, in 1998, embarked on a new initiative to reduce HIV transmission from mother to child in low-income countries. The initiative aims at offering voluntary and confidential HIV counselling and testing to pregnant women, and at providing those who learn they are infected with antiretroviral drugs, better birth care, safe infant-feeding methods and postnatal counselling and family planning. The initiative seeks, initially in approximately 11 pilot countries, to translate into action the findings of research into the efficacy of short-term drug regimens, as in one study in Thailand, which found that a one-month course of an antiretroviral drug had effectively halved the risk of HIV infection in non-breast-fed infants born to HIV-positive women.

Further Action Required

246. To fully realize the goals and objectives of the ICPD Programme of Action in reproductive health and rights, a number of key areas require increased attention. Future actions must be based on the principles, goals and objectives adopted by the ICPD, which emphasize the universality of human rights, including the sexual and reproductive rights of women, men and adolescents, and the need for partnerships of all kinds to enable Governments to meet the ICPD Programme of Action objectives.

Developing Reproductive Health Policies

247. Governments should ensure that national health plans, including health-sector reform processes, fully take into account the sexual and reproductive health needs of their population.

248. Government and donors should both facilitate and finance participatory policy development processes to include representatives of all stakeholders. To ensure effective progress and accountability, policies must include a strategic implementation plan that takes into account human resources, institutional capacity and resource availability.

249. Governments should enact and implement legislation and policies required to meet the commitments made in Cairo, using all necessary and appropriate means, such as removing restrictive laws. They should continue to promote reorientation of the health system to ensure that policies, strategic plans, and all aspects of implementation are rights-based, cover the life cycle and serve everyone.

250. Governments should invest in training parliamentarians, legislators and the media in the importance of the Programme of Action.

251. Governments should engage not only the health sector but all relevant sectors in policy development and implementation.

252. Governments should develop reproductive health programmes based on an assessment of sexual and reproductive health needs which fully involves all stakeholders.

253. Governments should ensure that NGOs and the private sector are enabled to make their fullest possible contribution to national reproductive health programmes.

254. Governments and the international community should ensure that the continuing reproductive health needs of individuals, especially women and adolescents, in emergency situations are met.

Implementing Quality Sexual and Reproductive Health Programmes

255. To move vertical services and management systems towards integrated comprehensive care, Governments, supported by donors and NGOs, will need to undertake several actions, as follows:

- C Bring about the structural integration of reproductive health services or, at least, functional integration, including effective referral systems, training and supervision;
- C Increase investments in standards of service provision, maximizing the use of existing resources to provide quality services and conducting continuing evaluation;
- C Increase investments in training not only to provide technical skills but also to prepare providers to communicate clearly with empathy and with respect for human rights, gender equality (including a recognition of violence against women) and dignity, and to provide dignified care; and,
- C Improve regulatory frameworks and their application to ensure high-quality care.

256. All reproductive health service providers should have integrated reproductive health training, which would increasingly enable them to provide additional reproductive health services at the primary health level.

Strengthening Communication and Education

257. Governments, as well as NGOs, should increase their efforts to evaluate the effectiveness of communication techniques and materials and share them widely. The content must address all appropriate aspects of sexual and reproductive health, including sexuality, power relations between men and women, and violence.

258. The mass media should be encouraged to convey images and messages that are respectful of both women and men, foster positive adolescent health and promote gender equality.

Increasing Access to Health Services for Adolescents

259. Governments should develop and implement a national plan for investing in young people. The plan should include education, vocational training, income-generating opportunities, and sexual and reproductive health information services. Special attention should be given to gender equality and equity and to youth who are disadvantaged due to poverty, residence or disability.

260. Governments should ensure that sexual and reproductive health programmes encompass more than "sex education" and the provision of contraceptives. They should include basic health care and STD screening and treatment, effective referral services, and counselling that addresses sexuality, builds self-esteem and promotes gender equality; skill training to develop broad-based life skills, including assertiveness and decision-making training to resist peer pressure or abusive situations and to manage sexual feelings and overtures, both wanted and unwanted.

Increasing Male Responsibility

261. Governments, together with NGOs and international organizations, should enhance their support for the promotion of male responsibility in reproductive and sexual health, including respect for human rights, support for a partner's access to reproductive health care, and increased responsibility in child care. Information on and access to contraceptive methods that provide protection against STDs, including HIV/AIDS, need to be extended as a way of helping men to take responsibility for their own reproductive and sexual behaviour.

Meeting the Need for Quality Family Planning Services

262. Governments should increase their efforts to ensure access to a full range of safe contraceptive methods, including new options such as the female condom and emergency contraception.

Promoting Women's Health and Safe Motherhood

263. Governments and donors should invest in training skilled providers and in ensuring effective access to well-staffed and equipped first-referral-level hospitals, including transport, and much stronger interventions to help the community – particularly males – understand and accept their roles and responsibilities in preventing maternal mortality.

Preventing and Managing Unsafe Abortion

264. Governments should train and equip health personnel to provide post-abortion care and provide reliable information, compassionate counselling and post-abortion family planning.

265. International agencies should develop a system for monitoring the implementation of paragraph 8.25 of the ICPD Programme of Action.

Dealing with HIV/AIDS and STDs

266. Countries should increase access to female condoms. Investments are urgently required for research and development of microbicides, simpler diagnostic tests and single-dose treatments. Service and communication campaigns must include sexuality and gender power issues.

267. Governments and the international community should ensure that prevention and management of STDs, including HIV/AIDS, become an integral part of reproductive health programmes, particularly at the primary health-care level.

268. Governments and the international community should make HIV/AIDS prevention and control a priority at the highest political level and immediately focus their major efforts in the most severely affected countries in Southern Africa.

Chapter V. BUILDING PARTNERSHIPS

Forging Partnerships with the Non-Governmental Sector

269. The ICPD marked a turning point in international policy-making. It has become synonymous with the spirit of inclusion, cooperation and consensus for a new generation of reproductive health and population-related policies based on human rights, gender equality and equity, and partnership. The Programme of Action is an intergovernmental instrument, adopted by 179 Governments; it is also a reflection of unofficial discussions between government delegates and NGO representatives at the ICPD. It recognizes that to implement the conceptual shift to an approach highlighting human-centred development and the life-cycle concept of sexual and reproductive health within the fuller framework of sustainable human development, a broad-based and interactive collaboration among Governments, the international community and civil society,⁴² especially NGOs and the private sector, would be required. Thus, the Programme of Action calls for the promotion of an effective partnership between all levels of Government and the full range of NGOs and local community groups in the design, implementation, coordination, monitoring and evaluation of population policies and programmes. It also calls for strengthening the partnership among Governments, international organizations and the private sector to identify new areas of cooperation; and for the promotion of the role of the private sector in service delivery and in the production and distribution of high-quality reproductive health and family planning commodities and contraceptives, which are accessible and affordable to low-income sectors of the population.

270. Four years after Cairo, changing development paradigms have shifted the roles of Government, civil society and the international community. Partnership has emerged as a basic element to support and advance the Programme of Action implementation process, both vertically and horizontally. Since the ICPD, important changes have taken place in many parts of the world, which have both strained the existing patterns of, and provided new opportunities for, the political, economic and social construct. The changes have contributed to creating a public setting that undergirds the idea of a civil society. Emerging patterns are creating different institutional arrangements which have given a major thrust to the rationale for the increased inclusion of civil society in an holistic development process.

271. It has become increasingly apparent that Governments alone cannot manage to provide the development services to meet the basic human and social needs and aspirations of their citizens. The involvement of civil society in initiating and sustaining social and economic transformation has become essential in the context of economic globalization, privatization, limited resources and the downsizing and decentralization of the government apparatus. At the same time, new information technologies are dramatically transforming the global context of information exchange and the sharing of ideas and experiences from cities to communities. The full participation of civil-society organizations and leaders will become increasingly critical, particularly with respect to the provision of reproductive health information and services as well as the promotion of advocacy and social mobilization efforts, in order to carry forward the goals of the Programme of Action.

272. A review of progress over the last few years on the scope of collaborative efforts with civil society provides a basis for optimism. Major strides have been taken in procedural areas, such as positive changes in the concept of participation and the processes for consultation; recognition of the changing roles of civil society; increasing acceptance of innovative and varied development approaches, including decentralized and community-based modalities; and improved partnership among United Nations organizations and bodies. Similarly, the context for substantive discourse and action by all parties has also changed, with increasing awareness of the societal dimensions of development and economic issues; growing recognition of the necessity for a human rights-based approach; expanding acceptance of reproductive and sexual health concepts and programmes; and deepening awareness and acknowledgment of gender inequities and the need for gender equality and the empowerment of women.

Creating an Enabling Environment for Partnership in Policy Formulation and Programme Implementation and Monitoring

273. After the ICPD, most, if not all, Governments accepted the increasing involvement of a broad range of civil society representation in all aspects of national development, including the promotion of reproductive health and rights. Although NGOs, in particular, have long been active in the population and reproductive health areas, their roles and responsibilities dramatically expanded after the ICPD due to, *inter alia*, economic globalization, reduction in government human and financial resources, the increased demand for reproductive health services, and the need for realization of human rights, including gender equality and equity. As of mid-1998, at least 106 Governments recognized – and, of these, 48 Governments supported -- NGO/civil-society involvement in the implementation of the Programme of Action; 59 Governments included NGOs in all phases of the formulation, implementation, monitoring and/or assessment of population policies, plans and programmes, while 28 Governments included NGOs only in the formulation and implementation of programmes and projects. Many Governments have adopted significant measures since 1994 to promote the involvement of NGOs at various stages of policy and/or programme implementation in areas such as reproductive health and gender equality. The most general new measure adopted was to include representatives of NGOs or other civil society members on the national bodies responsible for formulating policies. In some other countries, Governments made efforts to involve NGOs in policy formulation through policy dialogue or consultation. Regarding programme implementation, numerous Governments established an office to coordinate programmes with NGOs; in other cases, NGOs implemented government-funded programmes. Little or no cooperation between Governments and NGOs seemed to exist in only a few countries, primarily due to mutual mistrust, civil unrest or political instability. Even in many of these situations, however, the international community played a constructive role by ensuring the inclusion of all appropriate parties in the implementation of the Programme of Action.

274. Notwithstanding the new policies, legislation or other measures that have been adopted by many Governments to enable NGOs to play a larger role in population programme implementation, the enabling environment for NGO participation needs to be further strengthened in most countries.

Strengthening the Human Resource and Institutional Capacity of Civil Society for Effective Partnership

275. For the civil society to become an even more effective partner in advancing the Programme of Action agenda, it is crucial that the human resource and institutional capacities of civil-society organizations be significantly strengthened. Since 1994, only limited progress has been made in this respect. In some countries, Governments took strong measures to strengthen the institutional capacity of civil society, including, *inter alia*, the provision of funding and the removal of cumbersome legal restrictions. Government provision of technical and financial support to NGOs, however, was hampered for various reasons, including the limitations of government resources and the difficulty of selecting recipients from among the large number of local NGOs.

276. Almost all Governments allowed NGOs to receive funding, directly or indirectly, from external donors. In at least 57 countries, Governments permitted direct funding of NGOs from all external donors (e.g., international NGOs, bilateral and multilateral donors), with no restrictions; due to the relatively recent difficult economic situation and the reduction or withdrawal of external bilateral assistance in some cases, governmental restrictions on external funding of NGOs seems to have eased. In at least 27 countries, direct funding, with some restrictions (e.g., Government to be informed; limitations on amount of funding), was permitted. In at least 21 countries, indirect funding, through government channels or with their approval, was allowed. External funding, however, also poses several dilemmas: increased competition among NGOs for such funding; lack of strategic planning regarding institutional and programmatic objectives and sustainability by NGOs due to their predominant reliance on external donors, which may have their own agendas; and crises of institutional and programme viability when external funding is withdrawn from NGOs.

277. The contribution of civil society to the advancement of population issues has been enormous. In particular, most of the achievements in reproductive health and rights, especially in the area of family planning, are due to efforts of courageous women leaders, the energy of volunteer workers and the commitment of NGOs. NGOs, at international, regional and country levels, continue to play a vital role in the wide gamut of population and reproductive health activities. The importance of their participation in public policy and decision-making, research, advocacy, education and training, service provision, and monitoring and evaluation cannot be overestimated or overstated. Nevertheless, it is clear that although civil society, and NGOs in particular, have been instrumental in the progress achieved to date, the vast potential of civil society in the population field has only begun to be tapped.

278. For civil-society institutions to play their full role, their organizational capacities and management capabilities must be significantly increased and enhanced. In many countries, the civil society has taken initiatives to strengthen their institutional sustainability, build coalitions and mobilize resources. Overall, however, in most countries, NGOs have achieved only limited progress towards strengthening their institutional and financial sustainability, enhancing networking with other organizations, improving their transparency, accountability and responsiveness to constituencies or in mobilizing additional public and financial support for population activities. The limited achievements in this respect hamper the potential contributions to be made by NGOs. For example, NGOs are appropriately recognized for the innovative

approaches that they undertake. The replicability and broad adoption of their innovative approaches, however, have often been stymied by weak or non-existent networking and coordination among NGOs themselves, particularly at the country level. For example, in only about 21 countries have NGOs established a national coordinating group on advocacy and/or for implementation of the Programme of Action. In several countries where such a coordinating mechanism has been initiated, issues of sustainability have arisen. Similarly, in only an estimated 25 countries, have NGOs tried to coordinate their activities on a thematic basis (e.g., gender equality, HIV/AIDS and advocacy) whereas in about 12 others, NGOs have instituted a forum for networking and information exchange. In contrast, in at least 53 countries, no mechanism for NGO coordination or networking has been established.

Promoting Partnerships with the Private Sector

279. The commercial private sector provides reproductive health-care services in nearly all developing countries. In most of these, the private sector had already been active before the ICPD; for example, in some countries, the private sector had been operating clinics, informing and educating the public or offering affordable commodities. The private sector is most involved in social marketing programmes in which Government-subsidized, low-priced contraceptives are distributed through commercial channels. Multilateral organizations and international NGOs have strengthened country-level activities in the social marketing of contraceptives. Innovative initiatives are now being undertaken by international organizations such as UNFPA to work with Governments and the private sector to minimize barriers and to facilitate cost reductions so that reproductive health services, including contraceptive commodities, may be made more accessible -- both more affordable and more available -- to the majority of the population, while at the same time, better enabling those who can afford to pay to do so. Activities with the private sector to provide reproductive health information, education, counseling or services for employees or for local communities have been additionally undertaken or initiated, for example, by the TATA Foundation in India. While progress has been made, important opportunities for cooperation with the private sector remain to be explored. Proactive initiatives are required to sensitize and more fully involve the private sector, especially corporate leaders, business associations and trade unions, in all appropriate aspects of implementation of the Programme of Action.

Recognizing the Unique Role of Parliamentarians

280. Parliamentarians play a unique role in the partnership between Governments and civil society. They are, in essence, the bridges between the civil society and the government apparatus. Significant progress at the advocacy level has sensitized parliamentarians to the Programme of Action issues. As a result, intra-parliamentary lobbying activities have increased, relevant legislation has been promulgated and regional and international parliamentarian networks are thriving -- for example, the Asian Forum of Parliamentarians on Population and Development, the Forum of African and Arab Parliamentarians on Population and Development, the Inter-American Parliamentary Group, and the Global Committee of Parliamentarians on Population and Development. All-party parliamentary committees and groups, however, need to be established, where they do not exist, and strengthened to ensure that Governments meet their commitments to the ICPD. Parliamentary advocacy has enabled the level of funding to be maintained and sustained in some countries where such funding was to be decreased or eliminated. A number of donor countries,

however, have not met their commitment to the process of meeting the ICPD target, and resources have not significantly increased, which may result in an overall shortfall if current trends continue. In some developing countries, Governments have increased the proportion of their allocations to the social sector, while in countries with economies in transition, health-sector allocations have decreased as a proportion of overall national investment.

Strengthening Collaboration among United Nations and Inter-governmental Organizations

281. In 1994, the General Assembly adopted a resolution on the international follow-up of the ICPD that requested United Nations agencies and organizations to review and adjust their programmes in the context of the Programme of Action objectives and report to the Economic and Social Council (ECOSOC) on the respective policy implications. It urged the organizations and bodies of the United Nations system and the Regional Commissions to actively implement the Programme of Action through the United Nations Resident Coordinator system at the field level. This section highlights partnerships and collaborative efforts among the United Nations specialized agencies and funds, inter-agency units, regional commissions and intergovernmental organizations to achieve the goals of the Programme of Action.

Partnerships and Collaborations among United Nations Agencies and Organizations

282. As a follow-up to the ICPD, various United Nations agencies have collaborated on a range of initiatives relating to key areas of the Programme of Action. UNFPA has often served as a catalyst to promote enhanced coordination as well as joint activities among sister United Nations organizations and other donor community partners in the implementation of the Programme of Action. The examples summarized below are only an indication of the broad spectrum of such collaborative efforts.

283. United Nations agencies have been working closely in tracking progress in reducing child and maternal mortality, particularly in helping countries build a statistical base for monitoring and reporting on such progress. Efforts have been made to bring together both users and producers of data to ensure that policy and decision makers have access to understandable and current information that will help them take informed decisions on the formulation and implementation of policies and programmes. In collaboration with WHO and UNFPA, UNICEF has issued *Guidelines for Monitoring the Availability and Use of Obstetric Services*, which details measurement issues, proposes a set of process indicators and provides options for collecting needed data. In addition, a core set of reproductive health indicators and methodologies for generating and analysing reproductive health information has been developed through a joint undertaking of UNFPA, WHO and other United Nations system agencies and organizations.

284. WHO, UNICEF and UNFPA recently established a Coordinating Committee on Health (CCH) to enhance partnership and concerted action in achieving health and related social goals as well as in promoting the more efficient use of resources. The CCH is a transformation of the UNICEF/WHO Joint

Committee on Health Policy, which was established 50 years ago. The first CCH meeting took place in Geneva in July 1998.

285. WHO, UNICEF, UNFPA, the World Bank and two NGOs - IPPF and the Population Council - have co-sponsored the Safe Motherhood Initiative, which focuses on five key areas of action: advocacy; epidemiological, social and operational research; information dissemination; human resource development; and health-service improvement measures (e.g., renovation of facilities, provision of equipment and supplies and support for training for essential obstetrical care) in numerous countries. In October 1997, a technical consultation on Safe Motherhood was held in Sri Lanka to review progress on this aspect of reproductive health.

286. Regarding adolescent reproductive health, UNFPA, UNICEF and WHO have developed a common agenda for action and support through the WHO Adolescents Health and Development (AHD) Programme. The AHD Programme aims at using and expanding the available knowledge base to achieve effective and sustainable programmes; facilitating action in countries; expanding human, institutional and material resources to promote adolescent health and development; and providing technical cooperation to countries and key partners.

287. Harmful traditional practices concern both the health and the rights of women and children. UNFPA, UNICEF and WHO are undertaking concerted action to support policies and programmes that can bring an end to the harmful traditional practice of FGM. Within this collaboration, WHO focuses on increasing knowledge through a research and development programme and promoting technically sound policies and approaches. UNICEF emphasizes the elimination of FGM through the work of its field offices and country programmes. UNFPA continues to advocate for the elimination of FGM and supports the review and revision of national policies, laws, regulations and traditional practices which serve to perpetuate the practice. UNFPA sponsored a technical consultation in Ethiopia in 1996, with representatives from 25 countries, to discuss, *inter alia*, the types of training, research and services needed to eradicate the practice. The potential impact of such advocacy is highlighted by the tremendous success of the UNFPA-funded Reproductive Education and Community Health (REACH) Programme in Kapchorwa district, Uganda, where community-based agents involved community leaders and other persons from all sectors of society in sensitization seminars about the harmful aspects of FGM. The REACH Programme resulted in a 39 per cent drop in FGM in less than one year.

288. Six co-sponsors – UNDP, UNESCO, UNFPA, UNICEF, WHO and The World Bank – have pooled and focused their efforts through UNAIDS to strengthen the capacity of the United Nations system to, *inter alia*, assist Governments and civil society to effectively respond to the HIV/AIDS epidemic; and to improve the content of, access to and use of the body of knowledge needed to accelerate prevention and control of HIV/AIDS. UNAIDS also gives a high priority to developing, advocating and implementing best practices in combating the epidemic. At the country level, United Nations Theme Groups on HIV/AIDS have been established to support an expanded multisectoral response to the HIV/AIDS epidemic and have become a key mechanism for coordinated and joint United Nations action in data collection and analysis; advocacy and awareness campaigns and prevention programmes; and provision of financial and technical support.

289. Recognizing that the provision of reproductive health services is as important as providing other services in refugee and emergency situations, UNHCR and UNFPA have given a new impetus to meeting reproductive health concerns in refugee and emergency situations. The two agencies have signed a memorandum of understanding establishing a framework for collaboration for the benefit of persons in refugee situations. UNHCR and UNFPA are jointly developing strategies and programmes to provide reproductive health information and services for women, men, youth and adolescents and to combat sexual violence; and organizing joint assessment, monitoring and evaluation missions relating to reproductive health information and services.

290. The BSSA Task Force, established in 1995, expanded the terms of reference of the earlier Inter-Agency Task Force on the Implementation of the Programme of Action of the International Conference on Population and Development. Eighteen United Nations organizations and agencies, including the Bretton Woods institutions, participated in the BSSA Task Force. The mandate of the Task Force encompassed the following key concerns: population, with a special emphasis on reproductive health and family planning services; basic education; primary health care; drinking water and sanitation; shelter; and social services in post-crisis situations. The BSSA Task Force mandate also encompassed the main parameters of the 20/20 Initiative. (The 20/20 Initiative is a mutual commitment between interested developed and developing country partners to strive to allocate on average 20 per cent of their ODA and 20 per cent of their national budgets, respectively, to basic social services.) The Task Force factored into its work the following cross-cutting dimensions: selection and use of indicators; gender perspectives; resource mobilization; policy frameworks; the targeting of specific groups, including those in post-crisis situations; and the involvement of civil society.

291. The Task Force adopted a pragmatic and time-bound programme of work that would clearly respond to key issues and priorities at the country level, using the modality of working groups with lead agencies. These included the Working Group on Primary Health Care (led by WHO and UNICEF); Working Group on Reproductive Health (led by WHO); Working Group on Basic Education (led by UNESCO); Working Group on International Migration (led by ILO); and Working Group on National Capacity-Building in Tracking Child and Maternal Mortality (led by UNICEF). UNFPA served as the Chair of the BSSA Task Force.

292. The Task Force maintained a strategic focus on its primary objective: to provide coordinated support to the United Nations Resident Coordinator system in assisting developing countries to implement policies and programmes for achieving the goals adopted at recent United Nations global conferences. Member organizations of the BSSA Task Force also focused on strengthening and expanding their collaboration with civil-society organizations and the private sector to maintain strategic partnerships among all development partners. One of the principal outputs of the Task Force was a set of Guidelines to enable the Resident Coordinator system to bridge the normative and operational dimensions of social-sector activities. The Task Force also developed indicators to enable countries to better monitor their progress in achieving the goals agreed to at the United Nations global conferences. Other end-products included a wall chart on basic social services; guidelines on key areas of the Programme of Action; a report on lessons learned/best practices in donor collaboration for assistance to the social sector; an information card on advocacy for

basic social services; and a compendium of international commitments relevant to poverty and social integration.

United Nations Regional Commissions

293. Recommendation 16.16 of the Programme of Action calls on regional commissions, organizations of the United Nations system functioning at the regional level, and other relevant subregional and regional organizations to play an active role within their respective mandates to implement the Programme of Action through subregional and regional initiatives on population and development and to coordinate their activities in order to ensure efficient and effective action in addressing population and development issues relevant to their regions.

294. Since the ICPD, the ECA has established a committee of Member States, with the Bureau of the third African Population Conference as core members, to review progress on the implementation of the Dakar/Ngor Declaration and the ICPD Programme of Action. Some of the programmed research studies have focused on the following areas: management of family planning programmes; urban environment and health; infant, child and maternal mortality; population and conflict; impact of environmental policies and programmes relating to population and human settlements, and the convening of a Regional Working Group on the Recommendations for the 2000 Round of Population and Housing Censuses. ECA has held seminars and workshops on the integration of population factors in development planning; patterns, causes and consequences of female migration; and adolescent fertility in Africa. Special emphasis is being given to population policies in the context of their relation to food, environment and sustainable development. Arrangements are under way to create better collaborative relations between ECA and its development partners in assisting Member States.

295. In 1996, ECE, with support from UNFPA, focused its population efforts on the countries with economies in transition. Assistance was provided for data collection and analysis, research and the dissemination of policy-relevant information in the key areas of fertility and reproductive health, population ageing and international migration. The ECE project on population ageing and elderly persons is based on censuses conducted *circa* 1990 in about 15 mostly central and eastern European countries. Comparative research and country-specific analyses are based on national data sets, including information on living arrangements, work and retirement patterns and housing conditions. ECE is collaborating with the United Nations Department of Economic and Social Affairs, the Statistical Office of the European Union (EUROSTAT), the Council of Europe and the Organization for Economic Cooperation and Development (OECD), to streamline the collection and dissemination of population statistics in the region.

296. ECLAC and the Latin American Demographic Centre (CELADE) conducted joint activities with national statistical offices and other institutions to produce new population estimates and projections at the country level. CELADE is implementing a project on international migration in Latin America (IMILA), which comprises a database with information from each national census on persons born abroad. A project funded by the Inter-American Development Bank (IDB) was designed to integrate population variables into specific IDB investment programmes and projects launched by CELADE. IDB/CELADE produced a book on the impact of demographic trends on social sectors and prepared several technical reports on

methodological issues connected with the integration of population factors into social sector policies and programmes. CELADE, which developed a specialized computer software package to analyse geographically disaggregated data, down to the city-block level, has offered several workshops on the utilization of an updated version. This software is now in use for social programming at the municipal and ministerial levels in various countries of the region. In close cooperation with POPIN, information has been put on the Internet by the Bibliographic Information System for Latin America and the Caribbean.

297. ESCAP has focused its efforts on addressing population, environmental, poverty and quality-of-life issues; using population data for local area development planning; strengthening monitoring and evaluation systems for measuring progress in reproductive health/family planning programmes; strengthening policy analysis and research on female migration, employment, family formation and poverty; and studying implications of ageing for Asian families and the elderly and assisting Governments in developing and strengthening policies for involving the elderly in social and economic development.

298. ESCWA organized an Expert Group Meeting in 1995 in Cairo on Demographic Estimates and Projections for the Arab Countries. Its Population Section has developed regular contacts with organizations specializing in applied system analysis, with a view to designing and implementing a population projections project, integrating, for the first time, demographic and related socio-economic variables. The Population Section has undertaken two studies as part of the activities of the ESCWA Task Force on Poverty Alleviation in Western Asia, one on population dynamics and poverty in the region and the other on Palestine. Also in 1995, ESCWA embarked on an UNFPA-supported three-year project on Population Policies in the Arab Countries. The project provides for: training on population policy formulation, implementation and monitoring for the technical staff of national population committees; coordination meetings for the heads of the committees; and the establishment of an ESCWA population policies integrated information system, which will facilitate monitoring the implementation of the recommendations of the Arab Conference on Population and Development, held at Amman, Jordan, in 1993 and of the ICPD Programme of Action.

Partnerships among Inter-governmental Organizations

299. The World Bank has substantially increased loan allocations in the area of health, including reproductive health, gender, education and other social development areas. As a co-sponsor of UNAIDS, the World Bank is one of the leaders in the funding of HIV/AIDS programmes and links its efforts to broader initiatives in reproductive health. Through active partnership with several United Nations specialized agencies, donor countries and NGOs, the World Bank is supporting health-sector reform and capacity-building in the developing countries.

300. The OAU adopted a resolution in 1995 requesting Member States to make policy, institutional and financial arrangements for the implementation of the ICPD Programme of Action. Since then, OAU has organized several seminars, workshops and conferences for different target groups, such as the diplomatic community in Addis Ababa. Study tours to promote population issues will soon be implemented under this programme. The objectives include seeking areas of collaboration and information exchange between Governments and NGOs on population issues.

301. An intergovernmental initiative, Partners in Population and Development (PPD), launched at the ICPD by 10 developing countries – Bangladesh, Colombia, Egypt, Indonesia, Kenya, Mexico, Morocco, Thailand, Tunisia and Zimbabwe – commenced programme activities in 1996 with support from the Rockefeller Foundation, UNFPA and the World Bank. China and Pakistan joined the PPD in 1997, and India and Uganda in 1998. The PPD work plan includes strengthening the capacity of developing countries for South-South cooperation, the promotion of "twinning" modalities and the development of training institutions. PPD has focused on four priority areas to facilitate and coordinate South-South collaboration in research, training and information: i) integration of family planning and reproductive health services and the establishment of reproductive health structures; ii) promotion and integration of STD and HIV/AIDS prevention and care within the reproductive health structure; iii) provision of family planning/reproductive health services aimed at the special needs of both male and female adolescents; and, iv) reduction of maternal mortality and morbidity.

302. Through its country programmes, UNFPA is encouraging countries to make use of South-South activities, both as recipients and/or providers, and to draw upon the technical resources of public institutions, NGOs, private organizations and individuals from developing countries. UNFPA Representatives are required specifically to consider this modality during programme review exercises as well as in the formulation of country programmes and projects. Consequently, UNFPA is supporting South-South exchange activities under several country programmes, including those in the Dominican Republic, Honduras, Indonesia, Kenya, Malawi, Thailand, Tunisia, Uganda and the United Republic of Tanzania.

303. Following the ICPD, the International Organization for Migration (IOM) incorporated into its strategic planning and operational programmes the objectives concerning international migration and development set forth in Chapter X of the Programme of Action. IOM has also become involved in supporting government efforts to improve international dialogue on migration issues at the regional level, especially with respect to the CIS and relevant neighbouring countries, all of the countries of Central and North America and countries in East and South-East Asia. For example, IOM, along with UNHCR, was active in planning the 1996 CIS conference on the problems of refugees and displaced persons and in implementing the Conference's Plan of Action. In Central and North America, IOM has given substantive and logistical support to ongoing regional consultations among the participating States, known as the "Puebla Process." In Asia, IOM continues to assist the "Manila Process," which brings together 17 countries for regular exchanges of information on irregular migration and trafficking as well as a second regional process, the Asia-Pacific Consultations, which meets periodically to discuss a broad range of topics on population movements. Among the other components of IOM's programmes are national migration policy workshops, technical assistance on migration legislation and training workshops for migration officials, including a major new International Migration Policy and Law course, launched in November 1998 in Budapest, as a joint endeavour of the United Nations Institute for Training and Research (UNITAR), UNFPA and IOM.

Constraints

304. Numerous constraints frustrate collaboration and constitute obstacles to the achievement of the partnership envisioned by the Programme of Action. Governments have increasingly included NGOs in the population programme process. However, such inclusion has been primarily of NGOs as part of the government-directed programme. Little coordination exists among the reproductive health programmes directed by the Government, NGOs and the private sector; these programmes operate separately and in parallel. Thus, one major constraint to partnership faced by both Governments and NGOs is the lack of a coordination mechanism; another major constraint is that of insufficient financial resources. Other constraints may include in varying degrees, depending on the respective country: insufficient NGO and Government institutional capacity, human resources and trained staff; insufficient NGO coordination; a hostile or confrontational Government-NGO relationship; a lack of awareness or understanding of the issues by the civil society; and a lack of awareness or understanding of the importance of partnership and weak political commitment.

305. Other bottlenecks include: divergent agendas and priorities among partner groups; volatile political climates; lack of a clear legal framework, regulations and guidelines for the partnership; unresolved stereotypes, including biases, about potential partners; lack of trust among partner agents and agencies; weak commitment to the partnership, often evidenced by rhetoric which is not backed by action; lack of communication among partners; protection of vested interests; cultural, language, class and race as well as religious biases and barriers; hesitancy in collaboration based on historical legacies or former experiences; fear of perceived dominance of the partnership by some players; geographical preferences (the urban-centric bias); lack of human resource capacity, especially given the increased staffing needs due to the decentralization of the government apparatus; insufficient or poorly described information about the Programme of Action; and loss of momentum since the ICPD.

306. Regression has also occurred in some areas. Advocacy with trade unions and employers' associations for implementation of the Programme of Action has subsided. Reduced commitment of bilateral donors, both in financial support and in their partnerships with civil society, and decreased funding from official development assistance (ODA) for reproductive health has affected several countries.

307. Further efforts are required for the building of strong dynamic partnerships at the national level. It is critical for Governments to take a lead role in establishing a positive, supportive enabling environment for partnership – through the promulgation of appropriate policies and legislation; the institution of modalities for interactive discussion and the development of a consensus on common objectives and strategies to integrate the Programme of Action into all economic and social activities; and agreement on respective roles, responsibilities and comparative institutional advantages for programme implementation. For the institutions of civil society to play an effective role as development partners, financial and technical assistance for capacity-building is essential. Human, institutional and managerial strengthening is vital for improved and enhanced accountability, transparency, sustainability, coalition-building and responsiveness to constituencies. For the broad range of private-sector companies, their role may encompass, inter alia, the provision of a work environment safe for reproductive health; the provision of reproductive health information, counselling and services for their employees, on-site or as part of their insurance benefits

package; and the promotion of employment practices which promote gender equality and equity. Private-sector companies engaged in commodity production, insurance coverage or service provision have a special role in ensuring full access to a wide range of affordable, high-quality reproductive health services.

308. Government and civil society institutions have another critical role to play in extending the partnership to all individuals – at every level, in every city, town and village. Leaders, including those in the political, civic, business, media and religious spheres, have a special obligation to translate the Programme of Action for their constituencies and to assist them in adopting the Programme's provisions as their own personal agendas for action. The Programme of Action is meant to be a People's Agenda – only in that way will its vision be transformed into action to open the future for the hopes, dreams, opportunities and choices of women, men and youth everywhere.

Further Action Required

Establish an Enabling Environment for Effective Partnership

309. In order to establish an enabling environment for effective partnership, Governments, working closely with civil society, should:

- C institute common forums for dialogue for building partnerships;
- C adopt policy measures to facilitate the involvement of civil society, particularly of NGOs, in the formulation, implementation and monitoring of strategies and programmes to achieve the Programme of Action objectives;
- C formulate a common framework for working together and establish the underlying principles governing their collaboration and partnership so that roles will be clear, expectations will be realistic, and programme accountability can be promoted;
- C identify key common legislative, policy and programme issues as the basis for further collaboration;
- C identify key players and institutions to involve in addressing population and social issues and encourage the adoption of various approaches to enhance civil society participation, such as the facilitation of community-based initiatives; and,
- C develop transparent systems to become accountable to their respective constituencies.

Strengthen the Human Resources and Institutional Capacities of Civil Society

310. Governments should adopt innovative financial and technical assistance approaches, including direct funding to NGOs to foster effective partnerships.

311. In order to enhance the institutional viability and programme sustainability of civil society, donors should broaden the scope of their financial and technical assistance to include components to build and strengthen the human resource and institutional capacity and sustainability of civil society institutions,

especially NGOs. Governments should consider earmarking core grants to support civil society involvement.

312. Civil society should establish mechanisms to promote and strengthen its human resources and institutional capacities. Such mechanisms might include, for example, the establishment of training and research centres to build the managerial skills and organizational capacities of NGOs and the creation of an independent body to accredit NGOs and to set standards for NGO operations.

313. Civil-society institutions, especially NGOs, should give increased attention to coalition-building and networking at the national and regional levels in order to promote programme replicability, complementarity and synergy, in addition to facilitating information exchanges and concerted action for policy and legislative inputs.

Strengthen and Intensify Social Mobilization Efforts

314. Governments, working closely with civil society, should strengthen and intensify their social mobilization efforts. They should formulate IEC and advocacy strategies which are bolder and more innovative than those used in the past, and which are designed, on the basis of socio-cultural and economic research, to reach specific audiences within a broader spectrum of civil society. For the Programme of Action to be adopted by all segments of the population, it is crucial that the Programme of Action message be translated into the vernacular of the selected audience, explaining it in terms which will have meaning within their realm of experience and hopes. In addition, more time and money should be devoted for the effective use of the media.

315. Governments, assisted by civil society, should open up for public discourse controversial topics and cultural taboos, in a manner which is culturally sensitive and which promotes justice and health.

Promote Access to High-Quality Reproductive Health and Family Planning Services

316. Governments together with NGOs, the private sector and international organizations, should significantly increase their efforts to identify areas, as well as promote innovative modalities, for concerted action to achieve programme complementarity and synergy, particularly with respect to reproductive health.

317. NGOs and professional organizations should take the leadership role in assisting the Governments in determining appropriate standards for quality reproductive health service and in disseminating these standards to providers and clients.

Encourage the International Community to Meet its Commitments

318. The international community needs to be encouraged to increase its technical and financial assistance for the implementation of population and development programmes in developing countries, in fulfilment of the commitment established in the Programme of Action of the ICPD.

319. United Nations agencies and organizations should promote and strengthen inter-agency coordination and collaboration at all levels on selected population and development themes; they should provide their field staff, in particular, with technical and operational guidance on selected themes in order to enhance coordination and collaboration at the country level.

320. The United Nations Resident Coordinator system needs to liaise with and utilize the existing country-level inter-ministry theme groups, a counterpart of the United Nations inter-agency theme groups, to strengthen and expand linkages with NGOs, the private sector and civil society, and to draw upon their comparative advantages to build and strengthen national capacity.

Chapter VI. MOBILIZATION OF REQUIRED RESOURCES FOR IMPLEMENTING THE ICPD PROGRAMME OF ACTION

321. Full implementation of the ICPD Programme of Action envisages mobilization of resources for a variety of development sectors. The Programme of Action, while providing specific estimates in the areas of reproductive health and other population activities, emphasizes the need to mobilize additional resources for other social-sector goals and objectives, such as universal basic education and continued infant, child and maternal mortality declines, improvement of the status of women and poverty eradication. While a large portion of the additional funds required will need to come from domestic resources, the Programme of Action calls for a substantial increase in complementary resource flows from donor countries, development banks, international NGOs and foundations. The costed-out portion of the Programme of Action estimates that, in developing countries and countries with economies in transition, \$17 billion will be needed in 2000, including \$5.7 billion from donor sources, including development banks. These figures increase slightly over the period 2000-2015, reaching \$18.5 billion a year in 2005 and \$21.7 billion by 2015. They reflect the level of resources required to finance activities in basic reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted disease (STDs) and HIV/AIDS, as well as the collection and analysis of basic population data.

322. UNFPA regularly collects data on flows of international financial assistance for population activities and annually publishes the *Global Population Assistance Report*, based on the collected data.⁴³ That report describes the levels, trends and characteristics of international financial flows for population assistance. Since January 1997, UNFPA has worked closely with the Netherlands Interdisciplinary Demographic Institute (NIDI) to collect annual data on both international and domestic financial resource flows for population activities. This chapter draws heavily on data collected through that project.

The Costed ICPD Reproductive Health and Population Package: Donor Response

323. The term "external population assistance" is often used to indicate financial grants from donors (Governments or private foundations) and from multilateral organizations such as UNFPA as well as concessionary and "regular" loans from the World Bank and other development banks.⁴⁴ Over the period 1990-1996, total external assistance to developing countries and countries with economies in transition increased substantially, from \$972 million in 1990 to \$2,044 million in 1996. The increases in 1994 and 1995, around the time of the ICPD, were especially steep, rising 55 per cent over the two years. Incomplete data for 1997 and 1998 indicate that increases have not continued and that there have instead been small decreases in external population assistance to developing countries (Table 6.1).

Table 6.1 Trends in Total External Population Assistance, 1990-1997*
(in millions of \$US)

	1990	1991	1992	1993	1994	1995	1996	1997
Total External Population Assistance	972	1,306	1,033	1,310	1,637	2,034	2,044	1,889

*1997 figures are provisional

Source: UNFPA, *Global Population Assistance Report*, various years (New York, UNFPA).

324. While the increases in assistance during 1993-1995 should be interpreted as reflecting support for the Cairo agenda, the increases are also partly the result of definitional changes in what was meant by "population assistance". As a result of the broader population and reproductive health paradigm agreed to at Cairo, the definition of what constitutes population assistance has been expanded. Additional components of reproductive health have been incorporated into the definition of population programmes, and into the accounting of resource flows.

325. One reason for the slowdown in the growth of external aid for population after 1996 is the fall in the levels of Official Development Assistance (ODA).⁴⁵ As Table 6.2 indicates, ODA peaked in 1992, at almost \$61 billion and has since declined, reaching \$47.6 billion in 1997.⁴⁶ Seen in the light of this sizeable downward trend, population assistance has fared reasonably well. Preliminary estimates suggest that the share of ODA devoted to population assistance increased in 1997 to 2.8 per cent, due to the faster erosion of overall assistance than of population assistance. As discussed below, new forms and sources of assistance have emerged in the past few years that needs also to be taken into account in assessing resource trends.

Table 6.2 Official development assistance (ODA) of donor countries, 1990-1997
(in millions of \$US)

	1990	1991	1992	1993	1994	1995	1996	1997
Total ODA	52,961	56,678	60,850	55,636	59,153	58,643	55,114	47,580
Total ODA for population	669	774	766	777	977	1,372	1,369	1,316
Population assistance as % of ODA	1.26	1.37	1.26	1.40	1.65	2.34	2.46	2.77

Source: UNFPA, *Global Population Assistance Report*, various years (New York, UNFPA).

326. The United States has historically been the largest provider of population assistance, and, until 1996, was increasing its aid in this area as fast as or faster than other countries. Denmark, the Netherlands, the United Kingdom and Australia also notably increased their support for population activities in the 1990-1997 period.

327. The United States is also well ahead of any other country in the share of ODA allocated for population activities. In 1995, approximately 9 per cent of its ODA went for population activities; in 1996, 7 per cent of its ODA was spent for population. These percentages are unprecedented in the history of population assistance and are far above the notional ODA target of 4 per cent for population assistance used in the early 1990s, when the definition of population assistance was narrower. However, the level of ODA as a percentage of the gross national product (GNP) in the United States was, in recent years, under 0.3 per cent, less than half of the long-standing agreed target of 0.7 per cent reaffirmed at the Social Summit in 1995. The shift in the definition of comprehensive reproductive health care to include safe motherhood and HIV/AIDS prevention programmes had a significant impact in increasing the funds counted as ODA in the population sector.

328. It is noteworthy and encouraging that a number of donor countries with exemplary overall ODA performance records in the 1990s led by the Danish, Norwegian and Swedish Governments traditionally allocated a relatively large share of their ODA for population and, in recent years, the Netherlands, the United Kingdom and Australia have begun to devote a relatively large share of ODA for population. The adoption following Cairo of an expanded definition of population and reproductive health programmes, however, also suggests that the prior notional share of development assistance earmarked for population needs to be reassessed upwards, perhaps to 4.5 to 5 per cent.

329. The political will of a country to provide ODA at or near the agreed target level of 0.7 per cent is a complex result of many factors, including the level of available wealth, technical capacity, moral sentiments, commitment to international development and beliefs about the efficacy of different strategies for assisting developing countries. In relation to their relative national wealth, the Nordic countries and the Netherlands have been strong supporters of ODA, including for population and reproductive health concerns.

The Costed ICPD Reproductive Health and Population Package: Developing Countries

330. Total amounts expended by Governments and NGOs for the financing of the costed-out components of the population package vary greatly from region to region and from country to country.⁴⁷ Estimates of global, regional and domestic resource flows have been generated based on information for 61 countries reporting in 1996.⁴⁸ Globally, it is estimated that in 1996 Governments and national NGOs spent almost \$7 billion on population programmes from resources mobilized in developing countries. It is further estimated that private channels in these countries were responsible for another \$1 billion.

331. The data show that countries in Asia and the Pacific mobilized the most domestic resources for population and reproductive health programmes (\$5.21 billion), followed by Latin America and the Caribbean (\$1.02 billion). Smaller amounts were mobilized in Western Asia and North Africa (\$260 million) and sub-Saharan Africa (\$192 million). Additionally, an estimated \$103 million was mobilized in countries in economic transition.

332. Further development of the methodologies for monitoring national resource allocations will be required, particularly in private resource mobilization, where further increases will be particularly important. While some progress has been made, monitoring the allocation of resources to the different functional

components of the population and reproductive health package remains problematic.⁴⁹ Data making such distinctions can only be indicative, and related conclusions tentative.

333. Some of the regional findings are skewed and must be qualified insofar as a small number of large countries accounted for a sizeable proportion of regional totals. For instance, the combined expenditures of China, India, Indonesia, the Islamic Republic of Iran and Mexico amounted to \$5.5 billion, approximately 80 per cent of the entire estimate of \$6.8 billion mobilized from domestic resources in 1996. On a per capita basis, the remaining 56 countries for which data was available expended only \$0.35 per capita, compared with the 61-country spending of \$2.20 per capita. Therefore, although a few large developing countries with high levels of commitment and well-articulated policies were mobilizing large amounts of resources domestically, most other developing countries had limited capacity and/or constrained financial resources to utilize for population and reproductive health programmes as well as underdeveloped systems for monitoring flows. The per capita income levels and the available public resources in the majority of these countries, and particularly the 51 least developed countries (LDC's), were clearly inadequate to meet their populations' needs for reproductive health and family planning services.

334. For example, on average, only 26 per cent of resources were mobilized domestically in sub-Saharan Africa, and some countries in the region were only able to mobilize a smaller proportion of these resources. In contrast, the regions of Asia and the Pacific (at 89 per cent) and Latin America and the Caribbean (at 76 per cent) contributed far more to ICPD implementation from domestic sources. Significant variations existed within all regions, particularly between large countries with established population programmes and countries with less developed programmes largely dependent on external support. Within external assistance, grants accounted for the largest share of inputs (75 per cent in the aggregate, although less than two thirds in Asia and the Pacific and in Latin America) except in the countries in economic transition, where loan support predominated. Overall in 1996 approximately 20 per cent of all population resources expended in developing countries and countries in transition, or about \$2 billion out of a total of \$10 billion came from the international community. These findings indicate that although overall expenditures increased, the expected overall increase in the proportion of external support for population and reproductive health did not materialize.

335. Along with the other functional components of resource requirements, renewed attention needs to be given to mobilizing the \$1.3 billion for STD/HIV/AIDS-prevention programmes in the year 2000 as proposed in the ICPD Programme of Action. The latest United Nations Population Division population estimates and projections, based on UNAIDS data, suggest more dramatic potential impacts of the pandemic on life expectancy and national growth (demographic and economic) than had been anticipated in 1994. The number of people infected with HIV/AIDS rose from 14 million in 1994 to 33.4 million in November 1998, and the number of women and children with HIV infection skyrocketed in the same period. More than 43 per cent of infected people over 15 years of age are female, and half of all new infections are occurring among young people aged 15-24. There is no indication yet that these trends will reverse. Thus, prevention efforts, including those targeted at adolescents, require full funding. Successful models for prevention efforts have been found to be effective where commitment and resources have been appropriately mobilized. A recent United Nations report⁵⁰ indicates that young people were more likely to practice abstinence or safer sex than adults when they had the information enabling them to do so.

336. The prospects for changes in the balance of national and international support are difficult to assess. Initial information suggests that the economic crisis in South-East Asia threatens the ability of affected countries to maintain the high proportions of domestic financial support for their population programmes they had reached in the early and mid-1990s. Impoverished populations and the young are particularly vulnerable to the negative economic conditions and to potential programme erosion. The escalating demand and size of populations requiring services, will continue to challenge both domestic and international support.

The Role of the Private Sector

337. In addition to Government and NGO expenditures, the private sector is an important component of resource flows in developing countries and countries with economies in transition. An increasing amount of attention is being given to expanding the potential of private-sector efforts in both multilateral and bilateral assistance programmes. Methodologies to monitor private-sector inputs require further development. The UNFPA/NIDI resource survey has not yet attempted to measure the role of the private sector, but some information is available through individual country studies. These and other research efforts show that diverse mixtures of public and private financing and provision of services are possible. These include the funding of private clinics by private foundations, private investment in family planning education, the provision or sponsoring of family planning services at for-profit institutions, and public or private insurance schemes covering reproductive health services.

338. Many countries are encouraging the private provision of services, particularly for those with the ability to pay, and assessing fees to recover portions of the cost of public-service provision. Health-sector reform programmes are using these means to increase the efficiency and cost-effectiveness of health-service delivery. Household expenditure surveys consistently indicate that many people make out-of-pocket payments to health service providers (public, private and traditional), including payments for reproductive health care. Regular assessments of the willingness and capacity of different groups in the population to pay fees for quality reproductive health services could improve programme planning.

339. The extension of national health accounts and the inclusion in surveys of information on costs and willingness to pay are positive developments that will facilitate the monitoring of trends in private resources. Interesting national developments include the inclusion of reproductive health services in national insurance schemes (as in Bolivia and Mexico). Notwithstanding the many technical and managerial challenges that remain, especially for ensuring equitable access to services among the poor and other marginalized populations, the prospects for an increased private-sector role in channelling programme resources are positive. UNFPA has co-sponsored meetings to further develop a Private Sector Initiative programme. A November 1998 meeting recommended the expansion of the Initiative at the national level and support for technical studies to provide information to further encourage private-sector interest and partnership.

The Role of Non-Governmental Organizations and Private Foundations

340. Non-governmental organizations have become increasingly important as full partners of Governments and key recipients of both domestic and international resource flows for programme development and the implementation of comprehensive reproductive health activities. As recommended in the Programme of Action, these efforts must continue and must build on past successes particularly in HIV/AIDS-prevention and control, adolescent programmes and the testing of innovative programme approaches. For their part, private foundations contributed a total of \$141 million in 1996 to help finance population programmes in developing countries, an increase of 66 per cent over the 1995 total.

341. Many international foundations and donor agencies support research and programme activities in advocacy, IEC and HIV/AIDS prevention, among other issues emphasized at the ICPD. The funds are frequently channeled through domestic NGOs, furthering the development of the large NGO sector as a cost-effective alternative provider at the grass roots level of reproductive health information and services and of advocacy on population issues.

342. In 1996, the top foundation donors were the Ford Foundation, the Rockefeller Foundation, the MacArthur Foundation, the Hewlett Foundation and the Mellon Foundation,⁵¹ all contributing between \$10 and \$30 million for population activities. In a highly encouraging recent development, the Packard Foundation announced in November 1998 that it will be allocating more than \$300 million to international population and reproductive health programmes over the next five years (1999-2003).

343. More recently, foundations such as the newly created United Nations Foundation, a subsidiary of the Turner Foundation, gave specifically targeted grants focusing on population and women, with special emphasis on adolescents. In its first round of grants in May 1998, the Foundation provided UNFPA with \$8 million for six population projects. In its second round of grants, the Foundation will give UNFPA \$4.3 million over a two-year period for the advancement of adolescent reproductive and sexual health. In addition, the William H. Gates Foundation contributed \$1.7 million to the United Nations, for specific use by UNFPA to support collaboration among developing countries. These grants exemplify the targeted private resource flows that will have an impact on the ICPD+5 review, supporting a special youth forum as well as funding advocacy, education and training programmes for adolescent reproductive health in Latin America and the Caribbean.

Sector Investment Programmes and Sector-Wide Approaches

344. New modalities to improve the impact and sustainability of development cooperation are especially relevant to resource flows and programme management. Sector Investment Programmes (SIPs) and Sector-Wide Approaches (SWAs) are two such modalities. Both address constraints or weaknesses in the traditional mechanisms of donor support for projects and programmes, including the fragmentation of resource management, perpetuation of budgetary imbalances due to reliance on long-standing projects without sufficient monitoring and evaluation mechanisms, and differing commitment levels to projects viewed as externally driven.

345. SIPs and SWAps, although not new concepts, are now being implemented in a number of countries targeting a particular sector. SWAps differ from SIPs primarily in that they include all types of resources involved in a sectoral programme, not only investment, as in the case of SIPs. Both include clearly stated sectoral goals and objectives, pooled or parallel resource flows and a coherent and well-developed policy and investment framework. A key element is the recipient country's increased responsibility for developing and articulating the approach, and its resultant ownership. Although only preliminary information is available on the efficacy and efficiency of SIPs and SWAps, they do provide alternative development assistance modalities that engender more communication and collaboration between developing countries and donors with regard to programme objectives and resource allocation. The SWAp mechanism is being increasingly used as an element of overall health-sector reform initiatives.

346. National experiments in broad participatory approaches to the delivery of essential service packages for health systems are under way in a variety of countries (including Nepal and Bangladesh). At the same time, the decentralized management of health-sector reforms provides opportunities for the further generation and more efficient use of local resources. Ensuring adequate representation of all stakeholders, including those endorsing reproductive health programmes, remains a key issue.

Resources for the Broader ICPD Goals

347. The ICPD Programme of Action viewed population issues as a fundamental part of a broader approach required for sustainable development, which, in addition to integrated reproductive health programmes, includes efforts to provide other basic social services, improve the status of women and other development initiatives. Although the ICPD focused on and estimated resource requirements for the major reproductive health and population components of a concerted action agenda, the Programme of Action also made it clear that other important parallel actions had to be undertaken. The resource targets, including the \$17 billion needed annually by the year 2000 for integrated population programmes, would have to be supplemented by resources aimed at meeting the other goals and objectives set forth in the action plan, such as the reduction of infant, child and maternal mortality, basic education for all (and especially girls) and the empowerment of women.

348. It has been estimated that developing countries and countries with economies in transition devote approximately 0.2 per cent of their combined GNP to population activities that are part of the "costed package." Data available for all efforts in the health and education sectors reveal that far larger sums are expended in these sectors generally. Overall, and in approximate terms, these countries spend about 2 per cent of GNP in the health sector and 4 per cent in the education sector. If health and education are taken together as the two main areas of social spending, expenditures for the ICPD costed package amount to only 3 per cent or less of social spending. Only about 10 per cent of total health outlays go to reproductive health and family planning activities, despite the contribution of reproductive health to the overall burden of disease in developing countries and the cost-effectiveness of many relevant interventions.⁵²

Recent Advances in Development Partnerships

349. The 20/20 Initiative which was endorsed at the Social Summit in 1995 is a mutual commitment between interested developed and developing country partners to strive to allocate, on average, 20 per cent of their ODA and 20 per cent of their national budgets, respectively, to basic social services. The five components of basic social services, in a definition agreed on at a 20/20 meeting in Oslo in 1996, are basic health; basic education; reproductive health, including family planning and sexual health; nutrition; and, basic water and sanitation. Government expenditure accounts rarely separate basic social services from other spending, such as on tertiary health systems, e.g., hospitals, or education, including universities.

350. Since 1996, efforts to measure basic social services expenditures have led to a number of special studies in many developing countries. A follow-up meeting, attended by 29 developing countries, 19 donor countries, 11 international NGOs and 13 multilateral development organizations, held in Hanoi in October 1998 led to the 31-paragraph "Hanoi Consensus on the 20/20 Initiative: Universal Access to Basic Social Services". The meeting agreed that the current economic and financial crisis underscores the relevance of the 20/20 Initiative to protect access to basic social services for the most vulnerable people. The meeting also identified the 20/20 Initiative as addressing the input dimension of the Development Assistance Committee (DAC) partnership strategy enunciated in *Shaping the 21st Century: The Contribution of Development Cooperation*, noting that at the country level the shared need will vary, depending on local circumstances. The meeting urged the DAC to prepare a report on donor support for basic social services using both data reported by members and the assessment of efforts in peer aid review and to present it to the preparatory meeting for the World Summit for Social Development (WSSD)+5. The meeting agreed that the Hanoi Consensus and the objective of achieving universal access to basic social services should be presented and promoted in relevant international forums.

351. The World Bank, through its International Bank for Reconstruction and Development (IBRD) facility and International Development Assistance (IDA) lending provided funding for investments in the Social Sector totaling \$8.48 billion in fiscal year 1998. This accounting includes loans earmarked for the social sector, for health, nutrition, and population, for education, and for the social protection components of other sectoral commitments. Bank lending has increasingly supported integrated reproductive health programmes that give priority to population issues, both directly and through sector-wide assistance and health reform efforts. According to the Bank's 1998 Annual Report, an average \$354 million a year since fiscal 1992 supported projects containing these two components.

352. The Bank's 1998 Annual Report notes significant allocations in projects to gender components (\$2.5 billion); to health, nutrition and population sectors (\$2.0 billion); and to education (\$3.1 billion). An additional \$3.76 billion have been loaned for efforts in the area of social protection, which includes projects directed towards helping the poor cope with economic hardships and change, assisting refugees and other displaced persons in emergency situations as well as related policy development and locally generated social development initiatives.

353. It was announced in November 1998 that IDA will have \$20.5 billion to disburse to 80 or more of the world's poorest countries from mid-1999 through mid-2002. The Bank indicated that it aims at providing 50 per cent of IDA's resources during that period to African countries that are committed to poverty reduction, including social-service interventions, economic reform and sustainable broad-based growth.

354. Studies undertaken for the 20/20 Initiative provide rough estimates of the developing countries' current expenditure on basic social services as well as the additional resources required. Adding the basic social services components together, a further \$70-80 billion would be needed beyond what is currently being expended to achieve universal access to the complete basic social services package. The shortfall in resources includes the additional \$7 billion needed to implement the costed-out portions of the ICPD Programme of Action.

355. The European Union (EU) announced in Cairo that it planned to increase its aid in the population sector by more than 10 times by the end of the century, to reach a projected yearly total of \$347 million by the year 2000. Its financial support of population projects and programmes has been increasing; by 1997, the European Union allocated an estimated \$140 million for population activities. With increased political commitment and the strengthening of technical capacity to allocate and monitor these funds, this modality could further supplement existing bilateral and multilateral mechanisms.

356. Technical co-operation between developing countries has been increasing through the expanded activities of the Partners in Population and Development Programme ("the South-South Initiative"), supported by the UNFPA and private foundation funding. Such efforts provide an additional cost-effective mechanism for technical assistance and an additional component of resource flows.

Constraints

Donor Countries

357. Since the ICPD, some positive trends have been observed. First, the 1994-1995 period saw some growth in external assistance for population. Second, several donor countries have responded to the ICPD by reassessing their aid policies and the role that the Programme of Action should play in their overall development assistance strategy. Denmark, Germany, Japan, the Netherlands, the United Kingdom and the United States have all undertaken significant major changes so that the ICPD goals could be better addressed in their aid-giving strategies.

358. Additionally, the proportion of total ODA destined for population has increased since the ICPD and, in 1997, stood at a historic high level of 3.09 per cent (preliminary) of ODA, demonstrating the donor community's greater emphasis on population concerns than in the past. Although this trend is encouraging, total ODA has declined in recent years, and therefore that percentage actually reflects a much slower growth or even negative growth in total resources allocated to population activities.

359. Unfortunately, although funding for population has increased since the ICPD, it has not increased at a rate consistent with meeting the agreed-upon target of \$17 billion by the year 2000. A major obstacle to increasing resource mobilization in line with the ICPD resource goals has been the slow downward trend in ODA. The reasons for this trend are several. Some donor countries have reduced aid as an overall drive to reduce budget deficits. There has been a loss of confidence in some countries as to the efficacy of development aid. The large increases in private-sector investment in 10 or 12 developing countries in the 1993-1996 period, as well as the growing belief in the centrality of market-driven development, may also have worked against ODA that is preponderantly tied to projects in the public sector.

360. The trends in decentralization of both external assistance and national resources, along with overall structural reform, have posed new challenges for programme management, monitoring and evaluation. These restructuring trends, which will make assistance more effective in the long term, have left countries faced with the need to more rapidly expand their technical and financial capacity to implement programmes.

361. Rigid donor aid policies inhibit the flexibility needed for increasing and efficiently using resource flows and donor management information systems that are both demanding and inappropriate for monitoring decentralized population assistance.

362. The level of commitment of some donor countries is another constraint to realizing the resource targets contained in the Programme of Action. A number of donor countries that had devoted a relatively small part of their total ODA to population before the ICPD are continuing at low levels, despite the consensus on the centrality of population to development and the need to implement the 20-year plan contained in the Programme of Action. Thus, a number of countries in Europe commit substantially less than even 1 per cent of their ODA towards the implementation of the Programme of Action.

363. From another perspective, if all donor countries not currently extending assistance at least at the level of 3.5-4 per cent of ODA were to have done so in 1996, an additional \$902 million to \$1.11 billion would have been available to finance international population efforts, in addition to the \$2 billion actually allocated.⁵³ If a higher level (4-5 per cent) of ODA were to be achieved, consistent with the expanded definition of population and reproductive health programmes, further resources could have reached as much as \$1.71 billion.

Developing Countries

364. Besides financial constraints, insufficient technical and human resources are among the most prevalent constraints noted in reports by developing countries regarding obstacles to implementing the ICPD Programme of Action. Other obstacles have militated against increased resource flows, such as financial crises, very low prices for export commodities, constraints necessitated by on-going structural adjustment programmes and political instability. Under such circumstances previous pronouncements do not always translate into domestic resource flows for population programmes, basic social services and programmes aimed at fostering gender equity and equality.

365. Poverty and the necessary responses to economic crises that have eroded already meager public sector resources translate into far too few resources being available for basic social programmes. The answers to questions about what priorities should guide governance and finance decisions remain critical. The estimated \$8 billion raised domestically for population is still \$3.3 billion short of the year-2000 target. While it will be difficult under the current circumstances to totally fill that gap, best effort attempts are called for to build on the gains and resulting progress in the 1994-1997 period.

366. One obstacle that may result in a lack of political commitment is the lack of timely and accurate policy-relevant information generated within developing countries, which would shed light on national population issues, programme progress and linkages to other development concerns, and would help garner support for further efforts. Insufficient and incomplete systematic data on resource flows and programme

requirements impede efforts to assess and prioritize needs and evaluate current programmes as well as to mobilize and allocate resources.

367. While some noteworthy progress has been made since the ICPD, opposition to population programmes on traditional or cultural grounds remains an obstacle to the mobilization of resources in certain domestic contexts. Such opposition can also influence the scope of the population programmes to which the resources would be allocated. At times, misinformation campaigns regarding the real purpose of population programmes have been used to stigmatize population activities and create adverse public opinion. IEC, training and advocacy related to population issues and their relevance to development strategies can help correct such misperceptions.

Further Action Required

368. Efforts should be redoubled – by developing countries, donors, multilateral organizations, including the regional development banks, foundations, the private sector, NGOs and other civil-society representatives – to both advocate for and help provide the level of resources required for the full implementation of the ICPD Programme of Action.

369. Governments of developing countries should increase their investment in broader social sector and attempt to provide an increasing portion of their resource needs domestically.

370. Governments of developing countries should continue their efforts to ensure the efficient and effective use of both national and external resources by strengthening the technical and managerial capacity of reproductive health programmes, especially in light of such developments as sector-wide approaches and decentralization.

371. Governments of developing countries should strengthen mechanisms to coordinate national reproductive health programmes involving all partners – including civil-society organizations, NGOs and the private sector. Moreover, both donor and recipient countries should work to improve the planning and implementation of population programmes and their relationship to development strategies.

372. Governments of developing countries should conduct studies to create a knowledge base that is capable of dramatizing the interrelationships among population, environment, poverty and development. Such studies need to be undertaken on an advanced level and linked to an advocacy strategy so that their messages will reach the public, the media, parliamentarians and opinion leaders.

373. Finally, the implementation of the Programme of Action must be viewed by all countries and all partners as a collaborative effort in which all parties continue to work together to do more to attain the ICPD goals and objectives. All countries, developed and developing, should participate in open, accurate and timely sharing of information on programme progress and constraints and on their resource commitments and expenditures.

374. After two years of encouraging growth in the levels of international population assistance in 1994 and 1995, the levels of ODA in 1996 and 1997 declined. International population assistance in 1996 hovered

at the 1995 level; provisional figures show a slight decrease in 1997. This is a discouraging and disheartening development, especially in light of the significant negative impact on the provision of social services engendered by the economic and financial crisis of the past 18 months in South East Asia, in Russia and in Latin America and the continuing vulnerabilities in other developing countries and regions. These highly disruptive developments greatly heighten the concern of all of the parties and individuals committed to reaching the goals and objectives for improving the quality of life that are set forth in the ICPD Programme of Action. It is to be hoped that 1996-1998 will prove to be only an anomaly and that increased mobilization of international population assistance will resume in 1999 and accelerate in the year 2000 and beyond.

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- ⁴³ The *Global Population Assistance Report* is available on the Internet at <http://www.nidi.nl/resflows>.
- ⁴⁴ Although such loans are usually counted as external assistance, a portion of them must be paid back by the recipient countries, so a large fraction of the total loans could really be counted as domestic allocations.

⁴⁵ ODA is the funding originating from donor countries only, not multilateral or private sources.

⁴⁶ The data provided for 1997 (and below for 1998) are preliminary and incomplete.

⁴⁷ NGO expenditures, from their own income, are a very small proportion of the total compared to Government expenditures.

⁴⁸ Estimates of expenditure per capita were calculated by subregion and then expanded to encompass the regions' entire populations.

⁴⁹ The authors of the NIDI case-studies state that although the functional population categories used for measuring resource flows are based on paragraph 13.14 of the ICPD Programme of Action, reporting of allocations among the elements of reproductive health, family planning, and occasionally HIV/AIDS-prevention activities are not consistent across countries. The difficulty of allocating resource flows of the shared delivery system infrastructure between family planning and other reproductive health services was recognized in paragraph 13.15 of the Programme of Action, where a combined delivery system proportion was indicated.

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