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Report of the 1998 UNFPA Field Inquiry

Progress in the Implementation of the ICPD Programme of Action

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United Nations Population Fund (UNFPA)
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FOREWORD

From June through August 1998, UNFPA conducted a global Field Inquiry of developing and developed countries as part of a five-year review of the implementation of the ICPD Programme of Action (PoA) adopted at the International Conference on Population and Development (ICPD) held in 1994. The Inquiry focused on the operational dimensions of population and reproductive health programmes and was designed to assess what progress countries had made since the ICPD and what obstacles they are facing. One hundred and fourteen responses were received from developing countries and those with economies in transition, and 18 developed countries reported their experiences.

The Inquiry undertaken in developing countries covered four subjects: (i) policies and programmes in population and development; (ii) gender equality, equity and women's empowerment; (iii) reproductive rights and reproductive health care; and (iv) government partnerships and collaboration with civil society. Within each of these four areas the Inquiry sought to determine whether progress had been made in key operational areas of interest to the Fund.

In the area of population and development policies, the Inquiry sought to learn the degree to which governments have adopted policy measures emerging from the ICPD PoA. The criteria in this regard centre on an official population policy, strategy and action plan; or a wider plan on integrating population concerns into an overall national development strategy; and whether and how governments have developed mechanisms for monitoring the progress made in achieving the quantitative goals of ICPD.

In the area of gender equality and equity, the Inquiry intended to discover whether governments had taken measures to protect the rights of women and to promote their empowerment, as stipulated in the ICPD PoA. Specific measures raised in the questions included themes such as the elimination of discrimination and violence against women, the promotion of primary education of the girl child, and women's participation in reproductive health-care services.

A central objective of the Inquiry was to assess post-ICPD progress made by countries in the areas of reproductive rights (RR) and reproductive health (RH). The major attention directed to country-level initiatives on RH and RR reflected the importance ICPD placed on them. The Inquiry attempted to learn the progress made in improving access to and quality of RH-care services, including any measures to add new components of RH service, to integrate RH into primary health care, and to decentralise the health-care system. Furthermore, the Inquiry raised the specific issue of addressing the RH needs of adolescents.

The Inquiry also sought to elicit information on the extent of government-civil society collaboration and partnerships in countries. The Inquiry focused on governments' efforts in promoting involvement of civil society at the national level, including new legislative changes and other steps to strengthen the capacity of civil society; initiatives by part of civil society to be a more effective partner and new measures to promote the involvement of the private sector.

The Inquiry conducted in developed countries encompassed the views and perceptions of developed countries regarding the achievements and constraints they faced in the implementation of the ICPD PoA. It also treated partnerships and collaboration between donor countries and non-governmental and other civil society organisations, both in their own countries and in developing countries they are assisting. Also critical to the Inquiry was the need for developed countries' views concerning international assistance, including problems and constraints faced by donor countries in mobilising resources to help implement the PoA

The success of the Inquiry was the result of the good collaboration between UNFPA, governments, partner agencies and civil society. I would like to thank all those officials and members of governments and civil society who generously gave their time to assist UNFPA Field Offices in completing the questionnaires. I would like to acknowledge the excellent support of UNFPA Field Office Representatives and their staff, as well as representatives of partner agencies. Further, many Units and Divisions at UNFPA headquarters provided encouragement and advice, and I would like in particular to thank the four Geographical Divisions for their support. Finally, I would also like to thank members of the Field Inquiry team (listed on page iii) for their good efforts and dedication in carrying out the survey and compiling this report.

I am hopeful that the results of the Inquiry will provide guidance for recommendations to further the implementation of the ICPD PoA, so that all countries may realise its goals and objectives.

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January 1999

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INTRODUCTION AND BACKGROUND

The Programme of Action (PoA) of the International Conference on Population and Development (ICPD), approved by a consensus of 179 countries in September 1994, articulates a vision of population as a fundamental development issue. This has led to a progressive strengthening of commitment to population and development issues as countries have striven to try to make that vision a reality. The ICPD PoA recommends a set of population and development objectives, as well as mutually supportive qualitative and quantitative goals, to be attained by 2015. These include sustained economic growth in the context of sustainable development; universal access to comprehensive reproductive health services, including family planning; reduction of infant, child and maternal mortality; and universal access to primary education, especially for girls.

From June through August 1998, UNFPA conducted a global Field Inquiry of developing countries and developed countries designed primarily to review what progress had been made in the implementation of operational aspects of the ICPD PoA. The aim was to gain some insight into the stages that different countries had reached in implementing specific objectives of the ICPD PoA, together with the constraints they now face and new opportunities that have emerged as a result of actions that have been taken.

The Inquiry undertaken in developing countries was conducted through UNFPA Field Offices, and it collected information in four areas: (i) policies and programmes in population and development; (ii) gender equality, equity and women's empowerment; (iii) reproductive rights and reproductive health care; and (iv) government partnerships and collaboration with civil society. The Inquiry conducted among the developed countries focused on (i) their experiences in implementing the ICPD PoA; (ii) their views on progress achieved and constraints faced by developing countries; and (iii) issues relating to resource mobilisation to further implement the ICPD PoA. The questionnaires are given in Appendix 1.

OBJECTIVES

The objectives of this report are to (i) describe the progress made by countries in implementing specific actions of the ICPD PoA, to analyse patterns of constraints, and to identify emerging opportunities; and (ii) to compare and contrast the progress made across different regions. The results are designed to provide background for a report being prepared by UNFPA for the International Forum, to be held in the Hague between 8-12 February 1999, and for a Report of the Secretary General being prepared for the United Nations General Assembly, to be held in New York between 30 June and 2 July 1999.

RESPONSE TO THE DEVELOPING COUNTRY INQUIRY

In June 1998 questionnaires were sent out to 139 developing countries and those with economies in transition through 66 UNFPA Field Offices. Except for countries engaged in conflict and other emergencies, and some very small island countries, most responded to the Inquiry (see Appendix 2). Of the 66 Field Offices, 62 replied, for a response rate of 94 per cent. In all, 114 developing countries and those with economies in transition responded, for an overall response rate of 82 per cent. Asian countries were most responsive, at 91 per cent. Eastern Europe provided the fewest responses, at 57 per cent (Table 1.1).

Table 1.1 Field Inquiry Response Rates by Region

Area	Total countries	Responding countries	Distribution of responding countries %	Response rate %
World	**139**	**114**	**100**	**82**
Africa	51	43	38	84
Asia	32	29	25	91
LAC*	26	23	20	89
E. Europe	14	8	7	57
Oceania	16	11	10	69

* In this and subsequent tables, LAC denotes Latin America and the Carribean.

CODING OF RESPONSES

Much of the information collected through the Inquiry was obtained through open-ended questions. To analyse the data systematically, the information on the questionnaires was coded using a numeric coding scheme. The approach adopted was as follows. Each multiple-choice question was coded with a two-digit number. The first digit was given to represent the multiple-choice answer to the question. For example, for simple yes/no questions, a code of 1 representing 'no' and 2 representing 'yes' was assigned. The second digit was assigned to represent the intensity, or degree, of implementation or progress. It is based on the simple Likert scale of 4 to 1, where 4 is 'very good', 3 is 'good', 2 is poor , and 1 is very poor. The basic principle is that the more progress made, the higher the value of the code that is assigned. For example, a code of 2.2 for a simple yes/no question means that the country has taken some measures in the given area but the intensity of implementation is 'poor.' Similarly, a code of 2.4 means that the country has taken some measures in the given area with 'very good' implementation.

The coding scheme described above was useful in helping to filter replies where significant measures had been taken. In chapters II to IV, much of the analysis is based on a classification of countries according to the significance of the measures taken with respect to particular area. The term 'significant measures' refers to countries that were assigned a 3 or 4 second digit code.

Some questions did not contain multiple choice answers, but instead asked for open-ended responses (for example, those in the civil society collaboration section). For these questions, only the Likert scale from 1 to 4, reflecting the degree or intensity of progress described in the response, was applied. The coding of constraints, emerging opportunities and future actions was based on a prepared list of observed responses.

In order to ensure consistent interpretation in assignment of codes, each questionnaire was independently coded by two persons. Where there were discrepancies in the codes assigned by the two persons, these were reconciled through discussions and sometimes by reference back to the relevant UNFPA Field Office. The coded information was then input into a database using the statistical software package, SPSS, which was also subsequently used to develop the cross-classified tables used in this report.

STRENGTHS AND LIMITATIONS

The Inquiry achieved several substantive goals. First, it provides a rich database of information for a representative group of countries, allowing for a comparison of changes in policies and programmes since the ICPD. Second, by emphasising the operational aspects of the PoA, the results can be in general terms used as a barometer to measure the effect of ICPD PoA. Third, the information on constraints and emerging opportunities provides valuable guidance to further the implementation of the ICPD PoA.

Although the findings of the Inquiry are based on a large sample of countries, there are some important limitations that should be kept in mind. First, the information sought in the Inquiry required that the person completing it had to have a wide knowledge of the country's population and reproductive health programmes. In some cases the replies to particular questions were rather vague and general, suggesting a lack of information about a particular topic. This limitation may have introduced some biases into the results.

Second, the Inquiry was primarily limited to governments' policies and programmes in each substantive area. Although such data are important as a starting point for assessing progress in the implementation of the PoA, they do not provide full information on the consistency of specific policies and programmes. Nor do they provide information on the status of the translation of policies into actions, and their effects on the clients of programmes. Therefore the quality of services and actual impact of the measures taken cannot be established from the results—that is, without information from individuals using the services.

Finally, the Inquiry was based largely on open-ended questions. There was a good deal of variation in the style and richness of the responses. While many responses contained considerable detail, several suffered from a scarcity of information. Further, the perspectives of respondents on the topics canvassed in the Inquiry may not accurately and completely reflect the actual situation. Discrepancies are likely to be substantial

when governments undertake only cosmetic changes in policies and operational programmes without considering their impact at the local level. An attempt was made to overcome this potential bias by cross-referencing other sources of information.

DEVELOPED COUNTRY INQUIRY

There were 18 replies to the Inquiry conducted among 21 developed countries giving a response rate of 86 per cent. For the developed countries, the questionnaires were sent through official government channels. Given the different structure of the questionnaire canvassed among developed countries, and that many of the questions were open-ended and elicited very different types of responses, it was decided to analyse the results based simply on a detailed review of the qualitative replies without coding the information.

ORGANISATION OF THE REPORT

The next four chapters of this report analyse the results relating to each substantive area covered in the Inquiry to the developing countries: population and development; gender; reproductive health and reproductive rights; and civil society. Chapter VI analyses the results of the responses from developed countries, and the final chapter considers the main conclusions arising from Inquiry results from both developing and developed countries.

NATIONAL POPULATION POLICIES AND PROGRAMMES

The ICPD Programme of Action recommends full integration of population concerns into development strategies, planning, decision-making and resource allocation, at all levels and in all regions of the world. This chapter discusses the population and development aspects of the ICPD PoA, focusing mainly on: (i) the degree to which governments have adopted policy measures, such as an official population policy, strategy, and action plan or a wider development strategy or plan that focuses on the key issues of integrating population concerns into development strategies at the national level; and (ii) whether governments have developed a mechanism for monitoring and measuring the progress made in achieving the quantitative goals of ICPD. The chapter concludes with a consideration of the operational constraints and emerging opportunities for a more comprehensive implementation of the population and development agenda.

POPULATION AND DEVELOPMENT POLICIES

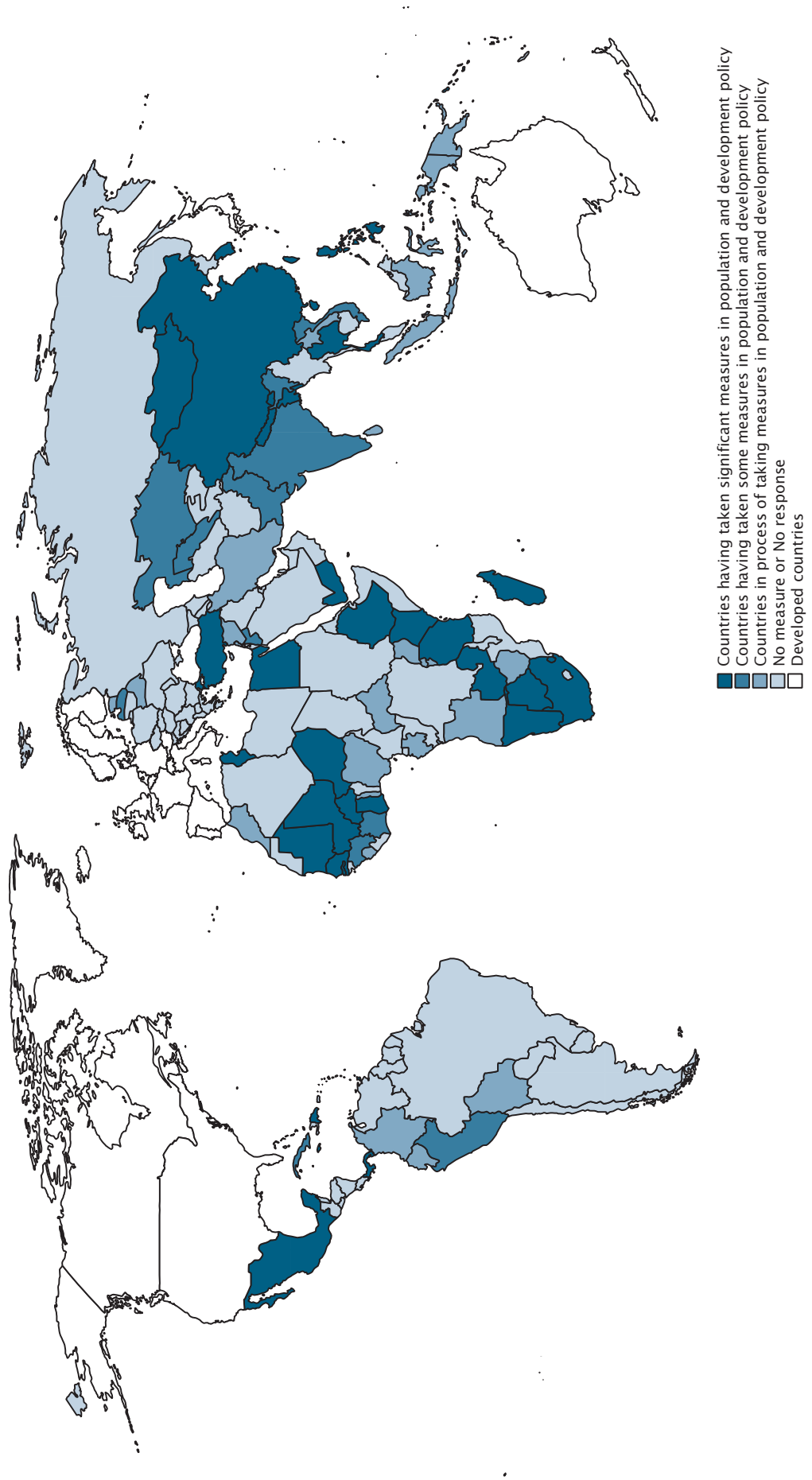
The main aim of the information requested on population and development in the Field Inquiry was to measure the progress made by countries in formulating and implementing policies and plans related to the goals and objectives of the ICPD PoA. Among the 114 countries responded, 35 countries were reported to be in the process of taking major policy measures, while 54 countries were reported to have taken some action in the form of national population and development policies, programmes or legislative changes (Map 2.1).

Among the 54 countries that took some action, 40 countries took significant measures (see Chapter 1, p. 3, for an explanation of how 'significant measures' is determined) in population and development policies (Table 2.1). Many of these countries have updated their population policies to be in line with the ICPD objectives or have integrated population factors, such as the quality of health care, gender equality, and demographic data and information systems improvement, into their long-term development plans. However, countries have different development priorities for implementation that have led to diverse strategies in achieving the PoA objectives. There are sharp

Table 2.1 Countries Having Taken Significant Measures in Population and Development Policies, by Region

Area	Total responses	Number	%
World	**114**	**40**	**35**
Africa	43	19	46
Asia	29	11	38
LAC	23	5	21
E. Europe	8	0	0
Oceania	11	5	46

Map 2.1 Progress among Developing Countries in Population and Development Policy since ICPD



regional variations in actions taken towards implementing the ICPD PoA on population and development.

According to the Inquiry results, several countries in Africa have made progress in their population plans or policies, and integrated population into social and economic development programmes since ICPD. Some countries have highlighted their efforts to incorporate demographic data in the development process. In other countries, decentralisation in policy-making and implementation, and community participation in the formulation and implementation of programmes, plans and strategies on population and development are underway.

The scope of the programmes and policies, and the areas in which the governments have focused within population and development vary. For example, Burkina Faso

Box 2.1 Progress in Population Policy and Programme Formulation

The ICPD PoA adopted by the international community at Cairo is broad and multi-faceted. The challenge to developing countries is to initiate and to find the right mix of policies and programmes to achieve the ICPD goals. Since 1994, many developing counties have undertaken a broad range of actions in the area of population policy. Some examples are:

- In Tanzania, the National Programme for the Implementation of the National Population Policy was approved in 1995. The National Population Policy is being reviewed to accommodate recommendations of the ICPD and other major UN conferences in the 1990s. The integration of population into development is currently being carried out through the incorporation of population variables into sectoral planning and through district development plans. Policy-makers and opinion leaders at all levels are participating in this process.

- In Trinidad and Tobago, the ICPD PoA was presented to the Cabinet. After a series of Inter-Ministerial Workshops on Population and Development for senior planners and NGOs, a new National Population Policy was accepted by the Government in October 1996, and its messages have been subsequently widely disseminated.

- In the Philippines, the Government's improved population and development framework includes planning and policy formulation at the national and regional levels through extensive training, workshops, research and analyses. Its population policy, using a sustainable development framework, seeks to balance population, resources and environment. The Government is currently implementing policies to ameliorate environmental degradation, widespread poverty, gender inequality, population growth, and sustainable population distribution.

adopted a broad development strategy wherein major population concerns are gender equality, reproductive health and overall human resource development. Gambia, in collaboration with NGOs, has developed a programme for sustainable development and a strategy for poverty alleviation. Kenya and Tanzania have emphasised issues related to HIV/AIDS, women's empowerment, and adolescents and youth. Tanzania has emphasised the importance of human resource development in the labour force, education and health.

Eleven countries in Asia have taken significant measures in either the adoption of population policies and/or integration of population concerns into their development plans. Several countries, such as Nepal, the Republic of Korea, Thailand and Turkey, have developed long-term development plans, and their population policies and strategies are closely related to these plans. While African countries are focusing on broad development issues, including poverty and human resource development, Asian countries responded that they are focusing more on issues of reproductive health and mortality. A few countries also mentioned ageing as an emerging concern.

The adoption of population policies has been less frequent in Latin America and the Caribbean region. Countries in that region that have made progress in adopting population policies include: Dominican Republic, Jamaica, Mexico, Panama, and Trinidad and Tobago. The main issues emphasised in the population policies or national development plans differ from other regions. For example, Mexico focuses on poverty and population growth and territorial distribution of population. Jamaica revised its national population policy in 1994 with a new focus on family life education, children and youth, senior citizens and disabled citizens.

MONITORING MECHANISMS FOR ACHIEVING ICPD GOALS

The PoA recommends a set of population and development objectives as well as mutually supportive quantitative goals to be attained over a 20-year period. The objectives include: universal access to comprehensive reproductive health services, including family planning; reduction of infant, child and maternal mortality; and universal access to primary education.

The Inquiry sought to establish if governments have developed mechanisms for monitoring and measuring progress in achieving the ICPD quantitative goals. Some 60 countries reported having taken some action to both integrate the ICPD goals into national strategies and establish monitoring mechanisms. Forty-three of these 60 countries reportedly took significant measures to establish monitoring mechanisms, including the utilization of specific population and reproductive health indicators, adopting national goals, assigning an institution for monitoring responsibility, and conducting surveys (Table 2.2).

Table 2.2 Countries Having Taken Significant Measures in Establishing Monitoring Mechanisms, by Region

Area	Total response	Number	%
World	**114**	**43**	**37**
Africa	43	13	30
Asia	29	16	55
LAC	23	73	0
E. Europe	8	3	38
Oceania	11	5	46

Many governments specified the ICPD goals that they have prioritised and incorporated into their national strategies. However, very often they did not provide information on specific monitoring mechanisms. Most countries now conduct regular housing and population censuses and some have civil registration systems from which information can be obtained on a wide range of population and socio-economic issues. However, reliable monitoring information on infant, child and maternal mortality, as well as access to reproductive health services is not widely available.

Building capacity to collect data and establish monitoring mechanisms is crucial for the successful implementation of the ICPD goals. However, the results of the Inquiry show that African countries are lagging behind in establishing monitoring mechanisms needed to address the ICPD goals. Just 13 African countries were reported to have taken substantial steps in establishing monitoring mechanisms.

Asian countries have been monitoring demographic trends far longer than countries in other regions, and hence it is not surprising that, in general, the overall availability and analysis of data are more advanced in Asia as compared with other regions. More than half of the Asian countries covered by responding FOs were reported to have taken major measures in establishing monitoring mechanisms needed to assess progress in the achievement of ICPD goals.

CONSTRAINTS IN POLICY IMPLEMENTATION

The most frequently mentioned constraints affecting policy implementation in population and development were, in order of frequency, (i) lack of financial resources, (ii) lack of trained/qualified staff, (iii) insufficient institutional capacity, (iv) lack of awareness and understanding of the issues, (v) lack of data, and (vi) insufficient coordination among institutions and ministries (Table 2.3).

Table 2.3 Principal Constraints in Implementing Population and Development Policies

Constraints	Number	%
Lack of financial resources	34	30
Lack of trained/ qualified staff	34	30
Insufficient institutional capacity	34	30
Lack of awareness and understanding of the issues	33	29
Lack of data	28	25
Insufficient coordination among institutions and ministries	24	21

The constraints faced by the countries that have undertaken significant measures in policies and programmes in population and development are different from those mentioned by countries that have not taken any action in the area. The 25 countries that have not taken any action on population policy reported that weak institutional capacity and lack of national planning were the main constraints. The countries that have taken notable action reported that the lack of financial resources, understanding of the issues, and skilled personnel are limiting factors.

While the constraints that countries face change over different stages of implementation of the PoA, their opportunities also continue to change. Emerging opportunities that were most frequently mentioned were legislative/plan/policy actions that were undertaken recently, changes or improvements in institutions or institutional coordination, and renewed political commitments. However, these emerging opportunities were mentioned mainly by countries that have already made important progress in population policy.

GENDER EQUALITY, EQUITY AND WOMEN'S EMPOWERMENT

Women are generally the poorest of the poor and at the same time essential to development. The ICPD Programme of Action (PoA) states that the elimination of all forms of discrimination against women is a prerequisite to (i) eradicating poverty, (ii) promoting sustained economic growth, (iii) ensuring quality reproductive health services, including family planning, and (iv) achieving a balance between population and available resources. The role of women is integral to population and development strategies. The goal of the ICPD PoA is the achievement of equality and equity between men and women, and the realisation of women's full potential. This chapter summarises progress made in meeting this goal by countries as reported in the Field Inquiry.

PROTECTING RIGHTS AND PROMOTING EMPOWERMENT

The ICPD PoA recommends several actions to promote the empowerment and status of women, including the elimination of all practices that discriminate against women, particularly those in the workplace and those affecting access to credit, control over property and social security. The PoA also states that all countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and girls.

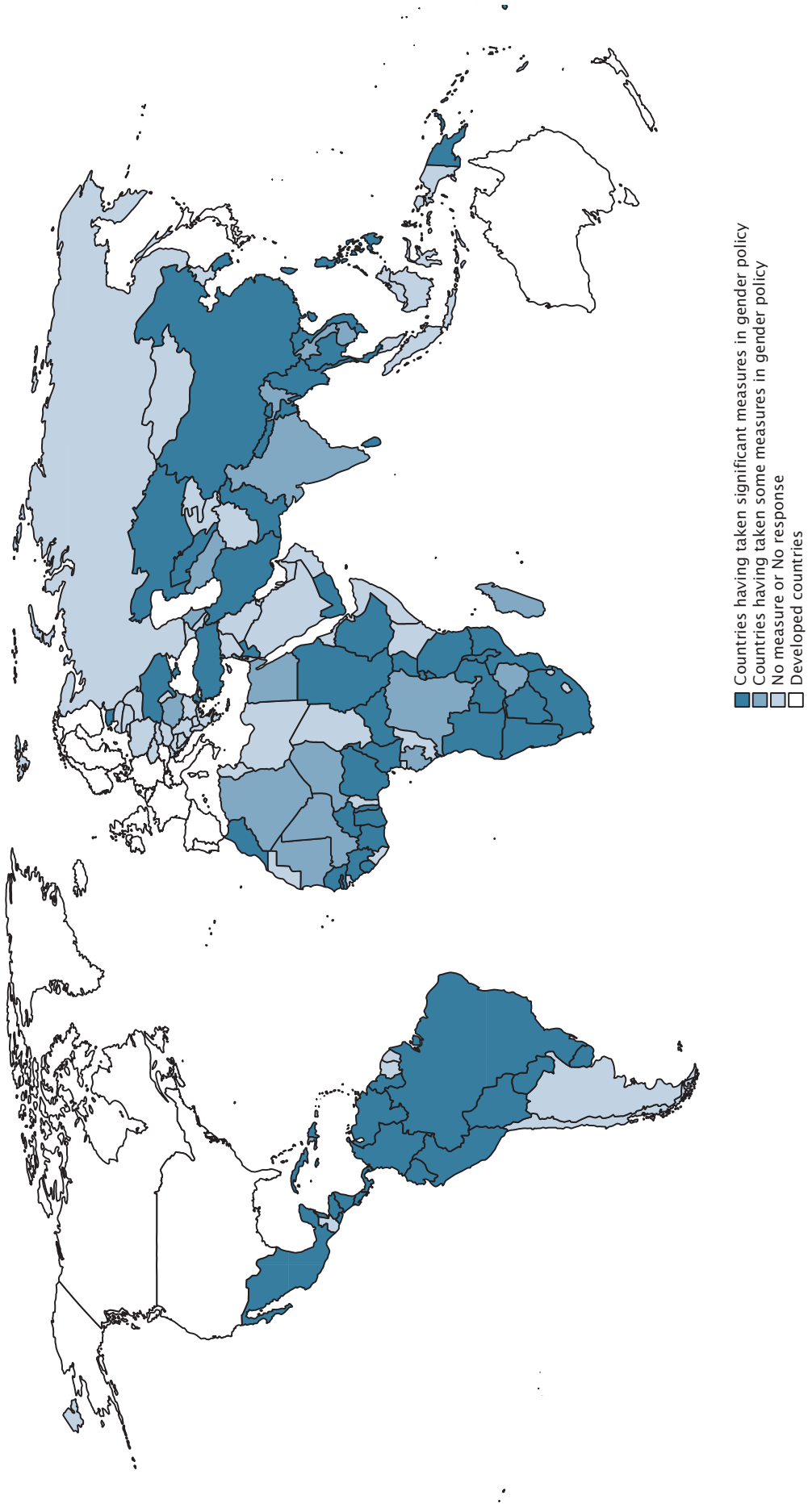
The Inquiry asked if the government had taken any policy measures, legislative changes, institutional changes, or other new measures at the national level to protect the rights of women and to promote the empowerment of women, by, *inter alia*, eliminating discrimination and violence against women, and promoting the fulfilment of women's potential through education, skill development and employment.

Of the 114 responses, 76 countries reported having taken significant measures (see Chapter 1, p.3, for an explanation of how 'significant measures' is defined) to promote gender equality, equity and the empowerment of women (Table 3.1 and Map 3.1). Progress was most prominent in Latin America and the Caribbean (LAC) where all but one, or 22 countries, were reported to have taken significant policy measures, legislative changes, or institutional changes to protect women's rights.

Table 3.1 Countries Having Taken Significant Measures on Gender Policy and Legislation, by Region

Area	Total response	Number	%
World	**114**	**76**	**67**
Africa	43	29	67
Asia	29	16	55
LAC	23	22	96
E. Europe	8	2	25
Oceania	11	7	64

Map 3.1 Progress among Developing Countries in Gender Policy since ICPD



Efforts to promote gender equality through policy and/or institutional changes included: legislation to protect women's rights in employment and inheritance; legislation to prohibit harmful traditional practices; tougher legislation on violence against women; and the establishment or strengthening of women's affairs offices in the government (Table 3.2). In Asia, some countries made extra efforts to protect women's rights and to promote women's empowerment. Nepal expanded its credit programmes to poor women and Thailand continues to closely monitor the implementation of the Convention on the Elimination of Discrimination against Women. The Solomon Islands took some innovative measures in establishing a family support centre, designing programmes to train police to deal with domestic crime, and instituting a development financial scheme for rural women. Barbados took a different approach by producing a National Programme of Action to mainstream gender in the health sector.

Table 3.2 Significant Measures Taken by Countries on Gender Policy and Legislation

Measures taken	Country
Institutional changes, including establishment or strengthening of a ministry or a government office of women's affairs	Angola, Bangladesh, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, CAR, China, Costa Rica, Ecuador, El Salvador, Estonia, Ethiopia, Fiji, Guinea, Guyana, Honduras, Iran, Jamaica, Malawi, Mauritius, Myanmar, Namibia, Nicaragua, Nigeria, Pakistan, Panama, Papua New Guinea, Paraguay, Peru, Rwanda, Samoa, Seychelles, Sierra Leone, Solomon Islands, South Africa, Sri Lanka, St. Lucia, Togo, Tonga, Uruguay, Uzbekistan, Zambia
Adoption of national policy or national plan	Angola, Barbados, Bolivia, Botswana, Burundi, Cape Verde, China, Comoros, Costa Rica, Dominican Republic, Ecuador, Gambia, Jamaica, Marshall Islands, Mexico, Micronesia, Mozambique, Namibia, Nigeria, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Republic of Korea, Senegal, South Africa, Uganda, Ukraine, Viet Nam, Zambia
Legislative changes to protect the rights of women, such as inheritance, property and employment rights; family law modifications; and measures to combat violence against women	Belize, Bhutan, Bolivia, Botswana, Brazil, Burkina Faso, Burundi, Côte d'Ivoire, Cape Verde, China, Comoros, Cuba, Dominican Republic, Ecuador, El Salvador, Ethiopia, Ghana, Guinea, Guyana, Honduras, Jamaica, Jordan, Mauritius, Mexico, Morocco, Nicaragua, Panama, Peru, Philippines, South Africa, St. Lucia, Sudan, Tanzania, Trinidad and Tobago, Venezuela, Viet Nam, Yemen
Legislative action to prohibit harmful traditional practices	Burkina Faso, Côte d'Ivoire, Ghana

Box 3.1 Protecting the Rights of Women

The ICPD recognizes that empowering women is an important basic human right. Moreover, experiences have shown that population and development programmes are most effective when steps have been taken to improve the status of women and to protect their rights. Since the ICPD and the 1995 Fourth World Conference on Women, some notable advances have been made in protecting women's rights as shown in the following examples:

- In Botswana, an expansion of the Women's Affairs Unit has made women's issues more prominent and visible. In addition, Parliament adopted a policy on Women and Development in 1996 and ratified the Convention on the Elimination of Discrimination Against Women (CEDAW).

- The Philippine Plan for Gender-Responsive Development (PPGD) of 1995-2025 guides all Government agencies in addressing long-term Gender and Development issues. The PPGD translates the Philippine Government's commitments to the Beijing Platform of Action and the UN CEDAW and advances national policies such as the Women in Nation-Building Law. In addition, on 30 September 1997, the Anti-Rape Law reclassified rape as a crime against persons.

- The Government of Fiji has established a full-fledged Ministry of Women entrusted to promote women's participation in all spheres of nation-building. Fiji ratified CEDAW in August 1995 and has defined policy encouraging equal representation of women in statutory boards, government offices, etc.

- In Costa Rica, the Ministry and Sectoral Offices for Women were created in 1994 to implement at the institutional level public policies for gender equality opportunities. In 1995, the Programme of Promotion of Active Citizenship of Women was designed as the first initiative of its kind in Latin America to promote women's leadership and access to decision-making jobs.

- In Estonia, the Bureau of Equality was established in the Ministry of Social Affairs in December 1996 and has started offering courses on gender planning (mainstreaming) and gender-policy appraisal. The Parliamentary Group of Women was created in 1998 to serve as a watchdog and supporter of gender-related legislation.

PRIMARY EDUCATION OF THE GIRL CHILD

Crucial to the attainment of gender equality and the empowerment of women is an emphasis on the rights of the girl child. The ICPD objectives are to eliminate all forms of discrimination against the girl child, to eliminate the root causes of son preference, to increase public awareness of the value of the girl child and to strengthen her self-esteem. As a means to securing the rights of the girl child, the ICPD PoA aims to keep girls and adolescents in school with a view to closing the gender gap in primary and

secondary school education by 2005. The Inquiry asked if the government had taken any new measures to improve access to primary education of the girl child.

The Inquiry results show that 47 countries (41 per cent) considered their level of access to primary education of the girl child already adequate. Meanwhile, 31 countries (27 per cent) reported having taken significant measures to improve the girl child's access to primary education (Table 3.3). Every responding Asian country reported either having taken some action to improve access to primary education for the girl child, or already having adequate levels of access. Seventeen Asian countries (59 per cent) reported adequate access levels, and 7 countries (24 per cent) reported significant measures to improve access. Ten African countries (23 per cent) reported adequate levels of girl's education. They are Algeria, Botswana, Cape Verde, Gabon, Lesotho, Madagascar, Mauritius, Rwanda, Seychelles and Tunisia. Of the 26 African countries (60 per cent) reporting some measures to improve access to primary education, particularly of the girl child, 19 countries reported significant achievements. Seven Latin American countries (Belize, Columbia, Costa Rica, El Salvador, Guyana, Paraguay, Venezuela) and three Caribbean countries (Cuba, Jamaica, Trinidad and Tobago) reported that the level of access to the primary education of the girl child was already adequate. Of the 9 countries that took some action to improve girls' access to education, 5 countries responded that these measures have been significant.

Table 3.3 Countries Having Taken Significant Measures to Promote Primary Education of the Girl Child, by Region

Area	Total response	Measures taken to improve access		Access to girls' education already adequate	
		Number	%	Number	%
World	**114**	**31**	**27**	**47**	**41**
Africa	43	19	44	10	23
Asia	29	7	24	17	59
LAC	23	5	22	10	44
E. Europe	8	0	0	4	50
Oceania	11	0	0	6	55

The measures to improve girls' access to primary education include: the adoption of national action plans or strategies; the provision of free education or scholarships; increases in the number and location of schools; initiation of penalties for those who interfere with girls' education; aggressive advocacy campaigns; and revised gender-sensitive curricula (Table 3.4).

WOMEN'S PARTICIPATION IN DECISION-MAKING AND RH SERVICE DELIVERY

The ICPD PoA recommends the establishment of mechanisms for women's equal participation and equitable representation at all levels of the political process and public life. It stresses the importance of involving women fully in policy and decision-mak-

Table 3.4 Significant Measures Taken by Countries to Improve Access to the Primary Education of the Girl Child

Measures taken	Country
Adoption of a national action plan or strategy	Bangladesh, Burkina Faso, Cameroon, Ghana, Guinea, India, Mexico, Morocco, Mozambique, Namibia, Nigeria, Peru, Senegal, Thailand, Zambia
Provision of free education or establishment of financial support schemes for the education of girls	Bangladesh, Barbados, Ghana, India, Indonesia, Malawi, Mexico, Nepal, St. Lucia, Tanzania, Thailand, Viet Nam
Increase in the number of schools, especially in rural areas, for the girl child	Bhutan, Egypt, Ethiopia, Nepal, Nigeria, Zambia
Measures to penalise those who interfere with the schooling of girls	CAR, Peru, Viet Nam
Aggressive advocacy/sensitisation campaigns	Brazil, Gambia, Ghana, Malawi, Morocco, Nepal
Revision of curricula, textbooks and classroom practices for gender-sensitivity	Côte d'Ivoire, Gambia, Malawi, Nepal, South Africa, Tanzania, Viet Nam

ing processes and in all aspects of economic, political and cultural life as active decision-makers, participants and beneficiaries. The Inquiry asked if the governments had taken any new measures to involve women in planning, managing and monitoring of reproductive health-care services.

According to the Inquiry results, 39 countries (34 per cent) have taken significant measures to involve women (Table 3.5).

Table 3.5 Countries Having Taken Significant Measures to Promote Women's Participation in Decision-making and RH Service Delivery, by Region

Area	Total response	Number	%
World	**114**	**39**	**34**
Africa	43	11	26
Asia	29	14	48
LAC	23	8	35
E. Europe	8	0	0
Oceania	11	6	55

The most common measure was to promote the participation of women at all levels of Government and within oversight and review bodies (Table 3.6). Some countries initiated quotas for the election of women to public office. For example, in Costa Rica, the System of Minimum Quotas of Women's Participation was introduced in 1996 as a reform of the electoral code, in which a minimum of 40 per cent of public-elected posts

Box 3.2 Access to Primary Education of the Girl Child

The ICPD Programme of Action underscores the value of the girl child to her family and society and encourages improvement of her welfare. In many parts of the world, governments have adopted various strategies to improve access to primary education of the girl child and also to protect her rights through the enactment and enforcement of appropriate educational and related policies and laws:

- In Tunisia, general access to primary education of the girl child reached a rate of 100 per cent. This was due to the application of laws that impose mandatory education for girls and boys until the age of 15 years, and punish contravening parents, and the availability of a basic educational framework in the different parts of the country, including the remote areas.

- In Mexico, the Government has put into action diverse strategies, including: (i) the PROGRESA (Program of Education, Health and Assistance/Nutrition) through which children of families living in poverty receive a grant and school supplies so they do not abandon primary studies and have better educational opportunities; and (ii) a network of educational actions created by the Secretary of Public Education to favour women and to determine the zones of greatest inequality in access.

- In Nepal, a programme under the Ministry of Education has substantial female components, including scholarships to various groups of students, training and recruitment of female teachers, advocacy campaigns for girls' education, and monitoring and preparing training materials. There is free primary education in the country, and girls are also provided with free textbooks at the primary level to encourage parents to send their daughters to school. The Ministry of Education runs special classes to encourage non-enrolled girls to formally enter school.

- In Azerbaijan, secondary education is obligatory, with universal access of both boy and girl children to primary and secondary education. In 1996, the literacy rate among women was 96.8 per cent, while girls constituted 46 per cent of the total number of students and 50.8 per cent of pupils in day schools.

should be occupied by women. Other countries involved women-related institutions, primarily NGOs, in policy and oversight groups (Dominican Republic, Peru and Uruguay). Many countries already involve a high number of women health-service providers (particularly nurses), midwives and volunteer health workers, and providing training to these women was another common measure. Other initiatives include support for community-based women's groups that promote and conduct RH activities.

MALE INVOLVEMENT

In terms of male responsibilities and participation, the ICPD PoA objective is to promote gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles. The PoA states that governments should promote equal participation of women and men in all areas

Table 3.6 Significant Measures Taken by Countries to Promote Women's Participation in Decision-making and RH Service Delivery

Measures taken	Country
Participation of women in review/oversight bodies, including women in high-level government positions (ministers, parliamentarians)	Azerbaijan, Bangladesh, Bhutan, Brazil, Comoros, Cuba, Dominican Republic, DPR Korea, El Salvador, Fiji, Ghana, India, Iran, Jordan, Lao DPR, Madagascar, Maldives, Mauritania, Mauritius, Morocco, Mozambique, Pakistan, Panama, Papua New Guinea, Peru, Philippines, Samoa, Seychelles, Solomon Islands, Syria, Thailand, Tonga, Tunisia, Uruguay, Vanuatu, Viet Nam, Zambia
Training in RH delivery services, including midwifery, traditional birth attendance and management	Ethiopia, India, Mauritius, Morocco, Papua New Guinea, Malawi, Mexico, Nepal, St. Lucia, Tanzania, Thailand, Vanuatu

of family and household responsibilities and should consider changes in law and policy to ensure men's support for their children and families.

The Inquiry asked if the government had taken any new measures to encourage and enable men to take responsibility for their sexual and reproductive behaviour and their social and family roles by means of information, education, employment legislation and child-support laws. According to the Inquiry results, 36 countries (32 per cent) have taken significant measures to promote male involvement (Table 3.7).

Table 3.7 Countries Having Taken Significant Measures To Promote Male Involvement, by Region

Area	Total response	Number	%
World	**114**	**36**	**32**
Africa	43	9	21
Asia	29	8	28
LAC	23	15	65
E. Europe	8	1	13
Oceania	11	3	27

IEC and advocacy campaigns targeting men are the most common measures taken in this regard (Table 3.8). Multimedia messages, schools, places of worship, outreach and counselling services serve as vehicles through which men are educated on responsible sexual and reproductive behaviour. In the Caribbean country of Barbados, the Family Planning Association conducted a Public Forum on Gender Issues, entitled "Men Talking To Men about Men's Issues."

In addition, some countries have made policy provisions to underscore the role of men in the family, especially concerning child support. Others are conducting research and

surveys to understand the needs and obstacles to male involvement. Costa Rica conducted research and surveys to find out the needs and obstacles of male participation in reproductive health, including "The National Inquiry of Masculinity, Sexuality and Responsible Parenthood." Other initiatives included: national policies and plans to promote male involvement; activities which involve men in community-based distribution and promotion of condoms; and advocacy workshops conducted at the central and provincial levels.

CONSTRAINTS TO GENDER EQUALITY AND WOMEN'S EMPOWERMENT

Although many countries have taken measures to improve the status of women, there still remain considerable barriers, especially socio-cultural prejudices and discrimination, to the achievement of gender equality and equity. Thus, while countries have taken significant measures to promote women's empowerment, the impact of these measures has not been universally felt. Similarly, the Inquiry reports progress in affirming and implementing policies that ensure equal educational opportunities for boys and girls in basic education; yet it is still the case that many families tend to

Table 3.8 Significant Measures Taken by Countries to Promote Male Involvement

Measures taken	Country
IEC and advocacy activities, including multi-media campaigns	Barbados, Belize, Botswana, Brazil, Burkina Faso, Burundi, Cape Verde, Colombia, Costa Rica, Cuba, El Salvador, Ethiopia, Fiji, Ghana, Jamaica, Marshall Islands, Mexico, Nicaragua, Papua New Guinea, Paraguay, Peru, Seychelles, St. Lucia, Tanzania, Trinidad and Tobago, Venezuela, Zambia
Family law modification, including revised and expanded laws on child support and paternity	Barbados, Belize, Botswana, Brazil, Cape Verde, Costa Rica, Ghana, Jamaica, Nicaragua, St. Lucia and Venezuela
Family Life Education (FLE) in schools aimed to change traditional attitudes about gender roles in the family	Cape Verde, Tanzania
Renewed sensitisation to the promotion of male involvement in the formulation of population strategies and reproductive health programmes	Botswana, Burkina Faso, Burundi, Ethiopia, Ghana, Zambia
Promotion of male contraceptive methods, including condom distribution and male vasectomy	Fiji
New measures to combat violence against women	Ghana, Zambia

Box 3.3 Promoting Male Involvement

The ICPD Programme of Action stresses the importance of increasing the responsibility of men in sexual and reproductive behaviour and family life. This has led to a greater awareness of the need to involve men in reproductive health programmes:

- In Jamaica, reproductive health programmes and systems in government and non-government sectors have been modified to incorporate males more directly. The Ministry of Health has restructured its MCH/FP Programmes to reflect more emphasis on male responsibility. The National Family Planning Board has included modules on males' reproductive behaviour in its recent Reproductive Health Surveys, as well as placing more emphasis on males in its family planning programme.

- In Vietnam, the Law on Family and Marriage has particularly regulated male responsibilities and equality in husband-and-wife relations. Male responsibilities have been widely publicised through mass media; condom use has been promoted through social marketing programmes; and male sterilisation has been encouraged to create favourable conditions for men to share responsibilities in reproductive health-care and family planning. Since 1994, with UNFPA assistance, the Peasant Union implemented a project advocating male heads of households in sharing responsibilities with women in family roles and in the implementation of family planning. From 1995, a series of advocacy workshops were conducted at central and provincial levels to raise the awareness of policy-makers and programme managers about RH concepts, gender equity, the empowerment of women, adolescent RH and the participation of men in RH/family planning activities.

- In Papua New Guinea (PNG), the Department of Education Boards recently passed the Population Education Curriculum Framework. This is the basis for a comprehensive Population Education Package, including male responsibility in RH and social and family roles. Male responsibility in RH is also an integral part of the National Health Plan and programmes have been developed in conjunction with major donors to implement activities related to male responsibility, mainly in IEC. Furthermore, UNFPA set up a programme on PNG role models especially addressing male responsibility in social and family roles. Issues on male responsibility are also addressed in national radio programmes jointly sponsored by Government, YWCA and UNFPA.

favour sons over daughters when choices have to be made. Moreover, while there has been some progress in promoting women's participation in decision-making, in most countries women are still under-represented in senior positions.

The Inquiry asked for a description of the constraints faced by the government in its efforts to achieve the ICPD goals in the area of gender equality and empowerment of women.

The persistence of strong traditional attitudes and values is seen as the main obstacle for the achievement of gender equality and the empowerment of women, as cited by a

total of 62 countries (26 African countries, 17 Asian countries, 11 LAC countries and 8 countries in Oceania). Twenty-nine countries claim that a lack of financial resources/poverty is a major obstacle to the implementation of gender policies. The third most frequently cited constraint was lack of awareness and understanding of the issues, as cited by 16 countries.

Unsurprisingly, the countries that took no action on gender policy designated weak political commitment as their other greatest constraint. Countries that took significant action to integrate gender into their development strategies cited lack of awareness/understanding of gender issues as another major constraint. Table 3.9 lists the major constraints faced by countries at different stages of implementing the PoA.

Table 3.9 Principal Constraints Faced in Efforts to Achieve Gender Equality and Women's Empowerment

Reported levels of measures taken on gender policy	Constraints reported
No measures (16 countries)	Presence of socio-cultural attitudes Weak political commitment
Some measures (98 countries)	Presence of socio-cultural attitudes Lack of financial resources Lack of understanding of issues Lack of skilled personnel
Significant measures (77 countries)	Presence of socio-cultural attitudes Lack of financial resources Lack of understanding of issues

In order to further the implementation of PoA, many countries noted that legislative and policy actions are precisely the measures that need to be taken. Similarly, they emphasised the need for increased advocacy and IEC campaigns to combat the obstacles to gender equality and the practice of traditional harmful practices. Such observation was most notable in Africa, where female genital mutilation (FGM) is most commonly practised. While a large number of countries have passed laws, made institutional changes, and formulated policies that promote gender equality, the biggest challenge is the implementation of these measures and the assurance that they are fully implemented.

4 REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

Sharpened international focus on and attention to reproductive rights (RR) and reproductive health (RH) were key outcomes of the ICPD. A major objective of the Field Inquiry was to assess progress made by countries in these two areas. This chapter presents the findings from the Inquiry on (i) policy measures, legislative changes and institutional changes in RR and/or RH; (ii) newly added components to existing RH programmes; (iii) changes in access to RH-care services; (iv) the extent of integration of RH services into primary health-care (PHC) systems; (v) improvements in quality of existing RH-care services; (vi) promotion of decentralisation of health-care systems and community participation in RH programmes; and (vii) new measures to address the RH needs of adolescents.

In the ICPD PoA, reproductive rights are defined as the rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and the means to do so; the right to be free of discrimination and violence; and the right to attain the highest standard of sexual and reproductive health. Reproductive health rights include the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning (FP) and other legal methods for regulation of their fertility. It also involves the right to have access to appropriate health-care services which will enable women to have safe pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

According to the PoA, RH-care is essential for mental, emotional and physical well-being of all people. It includes preventive information and services that meet the RH needs of women, men and adolescents, including family planning; maternal health including access to obstetric emergency care; prevention services, screening, diagnosis and treatment of STDs and HIV/AIDS; prevention of unsafe abortion and treatment of abortion-related complications; and prevention of infertility.

POLICY MEASURES, LEGISLATIVE AND/OR INSTITUTIONAL CHANGES

The Inquiry results show that since ICPD progress has been made in the affirmation of the recognition of RR and/or RH through policy measures, legislative changes, and/or institutional changes. The Field Inquiry results show progress in 67 countries of which 41 took significant measures (see Chapter 1, p.3, for an explanation of how 'significant measures' is determined). Progress was most evident among countries in Latin America and the Caribbean (LAC) and Asia, although in neither of these regions were significant measures reported by more than half of the countries covered in the Inquiry (Table 4.1).

Table 4.1 Countries Having Taken Significant Measures to Affirm Recognition of RR and/or RH, by Region

Area	Total response	No.	%
World	**114**	**41**	**36**
Africa	43	14	33
Asia	29	12	41
LAC	23	10	44
E. Europe	8	1	13
Oceania	11	4	36

The Field Inquiry results suggest that policy measures were the most common significant measures taken to affirm the recognition of RR and/or RH (Table 4.2). Common significant policy action taken was the development of RH policy and/or the integration of RR/RH into the national population policy or national health policy. Several legislative changes were made relating to the protection of women's reproductive rights, such as the enactment sexual harassment and rape laws and the criminalisation of domestic violence. In Africa, several countries enacted a penal code prohibiting female genital mutilation (FGM) (Burkina Faso, Ghana, and Sudan). In addition, some countries took measures to legalise abortion (South Africa and Cambodia).

Table 4.2 Significant Measures Taken on RR and/or RH

Significant measures	Countries
New policy affecting RR/RH	Cambodia, China, Dominican Republic, Ecuador, El Salvador, Ghana, Kenya, Korea, Marshall Islands, Mexico, Mozambique, Namibia, Nepal, Nicaragua, Panama, Paraguay, Peru, Philippines, Samoa, South Africa, Sri Lanka, Sudan, Thailand, Turkey, Ukraine, Viet Nam, Zambia
Legislation affecting RR/RH	Cambodia, China, Cuba, Dominican Republic, Gabon, Ghana, Peru, Philippines, South Africa, Viet Nam
Institutional changes and training	Burkina Faso, Dominican Republic, El Salvador, Fiji, Gambia, Jamaica, Mexico, Panama, Paraguay, Ukraine, Zambia

IMPROVING AVAILABILITY AND ACCESSIBILITY OF RH SERVICES

Adding New Components

The ICPD Programme of Action calls upon all countries to provide universal access to a full range of high quality RH services throughout the primary health-care system by 2015. Of the 114 countries responding to the Field Inquiry, 36 reported having all RH components before the ICPD. In the period since the ICPD, 54 countries reportedly took some measures to add new components to their existing RH programmes, of which 36 took significant measures (Table 4.3). Progress was most evident in Asia, where 52 per cent of the countries have taken significant measures, but much less so in other regions of the world.

Box 4.1 Affirmation of RR and/or RH

Some of the most important initiatives since the ICPD involve strengthening of national laws, policies and mechanisms promoting human rights, particularly the rights to reproductive and sexual health:

- South Africa's new constitution explicitly prohibits discrimination on grounds of gender, sex, pregnancy, marital status, or sexual orientation, among others. It also recognises that everyone has the right to make reproductive decisions and to have access to reproductive health care.

- In El Salvador, the right to sexual and RH is a general health component within the National Plan on RH. The right to adopt free decisions on the number and spacing of children is considered within the different health programmes, and especially in the development of actions towards creating free, conscious and responsible family planing options for couples and individuals. The right to a secured sexual and reproductive life is foreseen in the development of the Family Law and the New Penal Code.

- In the Philippines, an anti-rape law was enacted. In 1998, the Government created the Philippine Reproductive Health Programme aimed at meeting the RH needs of women, children, adolescents, and under-served groups. The Government enacted the Philippines AIDS Prevention and Control Act, which penalises any discriminatory act against persons with HIV/AIDS, and prohibits compulsory HIV testing.

Table 4.3 Countries Having Taken Significant Measures to Add New Components of RH, by Region

Area	Total response	No.	%
World	**114**	**36**	**32**
Africa	43	13	30
Asia	29	15	52
LAC	23	7	30
E. Europe	8	0	0
Oceania	11	1	9

The most common of the significant measures to add new components to RH programmes since ICPD was the provision of services for the prevention and treatment of sexually transmitted diseases (STDs), including HIV/AIDS. Several countries also reported adding services for the prevention and treatment of infertility and the treatment of reproductive tract infections (Table 4.4). Other RH components added focused on target groups, such as provision of RH services, including information, to teenagers (Burkina Faso, Lesotho, Mali, Philippines, Maldives and Iran) and the involvement of men in RH (Burkina Faso, Mali, Madagascar and Philippines). In Africa, significant measures were taken to provide education for young girls and women to prevent harmful traditional practices (Madagascar), and to provide RH services for older per-

sons (Burkina Faso). In LAC, a strong emphasis has been given to measures involving gender issues, such as the incorporation of sexual, gender, and domestic violence into the RH-care system (El Salvador and Honduras).

Table 4.4 Significant Measures Taken to Add New Components of RH

Significant measures	Countries
Prevention and treatment of STDs/HIV/AIDS	Ecuador, El Salvador, Honduras, India, Iran, Jordan, Lebanon, Lesotho, Madagascar, Maldives, Mali, Mexico, Morocco, Nepal, Niger, Nigeria, Syria, Uruguay
Prevention and treatment of infertility	Bhutan, Botswana, Burkina Faso, El Salvador, Honduras, Iran, Mali, Madagascar, Mexico, Niger, Nigeria, Philippines, Uruguay, Yemen
Treatment of reproductive tract infections	Botswana, Burkina Faso, Jordan, Lebanon, Madagascar, Mali, Nepal, Nigeria, Philippines, Syria, Yemen

Increased Access to RH Services

The Field Inquiry results suggest that more progress has been made since the ICPD in improving universal access to RH services than in the expansion of RH services. Some 87 countries (76 per cent) have taken measures to improve universal access, with significant measures having been taken in 51 countries (Table 4.5). More than half of the responding countries in Asia and LAC reported progress in improving universal access. The countries of Eastern Europe and Oceania tended to lag behind.

Table 4.5 Countries Having Taken Significant Measures to Improve Universal Access to RH, by Region

Area	Total response	No.	%
World	**114**	**51**	**45**
Africa	43	19	44
Asia	29	17	59
LAC	23	12	52
E. Europe	8	0	0
Oceania	11	3	27

The most common significant measures taken by countries to improve access to RH services were (i) increased training of service providers; (ii) constructing more health service delivery points; and (iii) allocating more equipment and resources and/or increased provision of equipment (Table 4.6). Other examples included decentralising the health-care system (Burkina Faso, Costa Rica, Dominican Republic, Ecuador), improving management and logistics in RH services (Ghana, Madagascar, Papua New Guinea) and providing RH services in all health centres (Guinea-Bissau, Senegal, El Salvador, St Lucia, Belize, Nicaragua). In Africa, many measures focused on youth's access to RH services through the provision of youth services (Lesotho, Mali, Zambia,

Burundi), finalisation of RH programmes for youth (Burkina Faso, Comoros), and the integration of family life education (FLE) into school curricula (Lesotho, Comoros, Burundi).

Table 4.6 Significant Measures Taken to Improve Universal Access to RH

Significant measures	Countries
Training of service providers	Azerbaijan, Dominican Republic, El Salvador, Fiji, Ghana, Honduras, India, Iran, Kenya, Papua New Guinea, Samoa, Turkey, Zambia
Construction of more health centres	Burundi, Comoros, Dominican Republic, Ecuador, Ethiopia, Guinea-Bissau, Honduras, Iran, Mongolia, Nepal, Philippines, Senegal, Tunisia, Zimbabwe
Allocating more resources and/or increased provision of equipment	Costa Rica, Dominican Republic, Ecuador, El Salvador, Iran, Mongolia, Nepal, Peru, Samoa

Integration of Reproductive Health Services into Primary Health-Care

The ICPD PoA recommends the PHC approach to achieving universal availability and accessibility of RH services. Of the 114 responding countries, 35 were reported to have already integrated RH-care components into the PHC system. Fifty-five countries, almost half of those covered in the Inquiry, have taken steps to integrate RH services, including FP, into the PHC system. Of these, 33 countries took significant measures (Table 4.7).

Table 4.7 Countries Having Taken Significant Measures to Integrate RH Services into Primary Health Care, by Region

Area	Total response	No.	%
World	**114**	**33**	**29**
Africa	43	14	33
Asia	29	10	35
LAC	23	6	26
E Europe	8	0	0
Oceania	11	3	27

Several countries provided training to RH-care providers as they attempted to integrate RH services into the PHC system. Several types of training were reported, including training of outreach specialists (Burundi, Malawi), and PHC workers (Iran) on different components of RH/FP. Some notable institutional changes were also reported, such as the creation of a Family and Community Health Unit within the PHC directorate in Namibia and the integration of the Division of Population and Health Promotion, Maternal and Child Care and STD/HIV/AIDS into the PHC system in the Marshall Islands. In Nicaragua, RH services were integrated into the PHC system

through the National Health Policy and through the Elected Maternity-Paternity Programme.

Decentralisation of Health-Care Systems

The ICPD PoA recommended that governments promote community participation in RH services by decentralising the management of public health programmes, in addition to cooperating with local NGOs and private health-care providers. Since ICPD, there has been an understanding that decentralisation provides both opportunities and challenges for the development and implementation of RH programmes. Some countries have realised that decentralisation also enables communities to develop programmes that respond more to their needs. Thirty-five countries reported that they have decentralised their health-care system before the ICPD and had not taken new action. The Inquiry found that 49 countries took actions to decentralise their health-care systems since ICPD, of which 31 took major measures. LAC showed the most significant progress compared with other regions (Table 4.8).

Table 4.8 Countries Having Taken Significant Measures to Decentralise the Health-Care System, by Region

Area	Total response	No.	%
World	**114**	**31**	**27**
Africa	43	11	26
Asia	29	7	24
LAC	23	11	48
E. Europe	8	2	25
Oceania	11	0	0

The most commonly reported measures taken to ensure decentralisation have been health sector reforms (Ghana, Tanzania, Zambia, Turkey, Honduras, Panama, Mexico, Jamaica, and Trinidad and Tobago). Some countries have ensured decentralisation through legislative measures, such as implementation of the Community Health Law in the Republic of Korea, or the creation of legislation for direct health funding to municipalities in Brazil. In addition, Senegal has passed legislation outlining a process of decentralisation for nine sectors, including health. Madagascar has developed a National Health Policy emphasising decentralisation. Poor access to services in rural areas has led Ghana to increase its service delivery points in rural and under-served areas. Cambodia has created health districts with decentralised authority.

Other measures taken to encourage decentralisation have focused on reinforcing community and NGO participation on RH issues (Burkina Faso, Ghana, Tanzania). Nepal has encouraged community participation through its National Health Policy, a national PHC outreach programme and various health training programmes. Although Nepal and India have not yet fully decentralised RH services, they are working to involve the participation of certain target groups, such as community leaders and women's groups.

Some of the institutional changes reportedly taken were the promotion of community participation in establishing community health committees (South Africa) and an increase in the number of local health administration committees (Peru).

Improving Quality of RH-Care

The ICPD PoA calls for the right to secure conformity to human rights, ethical and professional standards, in the delivery of RH services, including family planning. It urges governments to provide an environment that is favourable to good-quality family planning and RH information and services.

Box 4.2 Decentralisation of Health-Care Services

Since ICPD, several countries have taken measures to decentralise the health-care system. In many, the effort is part of a larger health sector reform and, in some, is a strategy to close the gap between rural and urban areas:

- In Zambia, health sector reforms have been implemented, which brought decentralisation. Furthermore, District Health Management Teams and Health Boards and Neighbourhood Committees make action plans for community health needs.
- In Cambodia, the Government has created operational health districts, which have decentralised authority and execute their own budgets under a local management system. RH is fully integrated in primary health care through this system.
- In Honduras, the Secretary of Health established access to health services under reform policies of the sector. This process of access is based on reform of the public health sector, involving the return of central planning to local participation planning, based on an analysis of conditions of life and health, community inclusion through municipal plans, and local planning strategy.

The UNFPA Field Inquiry found that more progress has been made since the ICPD in improving the quality of existing RH-care to better meet the needs of clients, than has been the case with any other RH area canvassed in the Inquiry. Nearly 100 countries reported having taken some measures since the ICPD, 63 of whom reportedly took significant measures. Progress was particularly marked among the countries of Africa and Asia (Table 4.9 and Map 4.1).

Table 4.9 Countries Having Taken Significant Measures to Improve the Quality of Existing RH Care, by Region

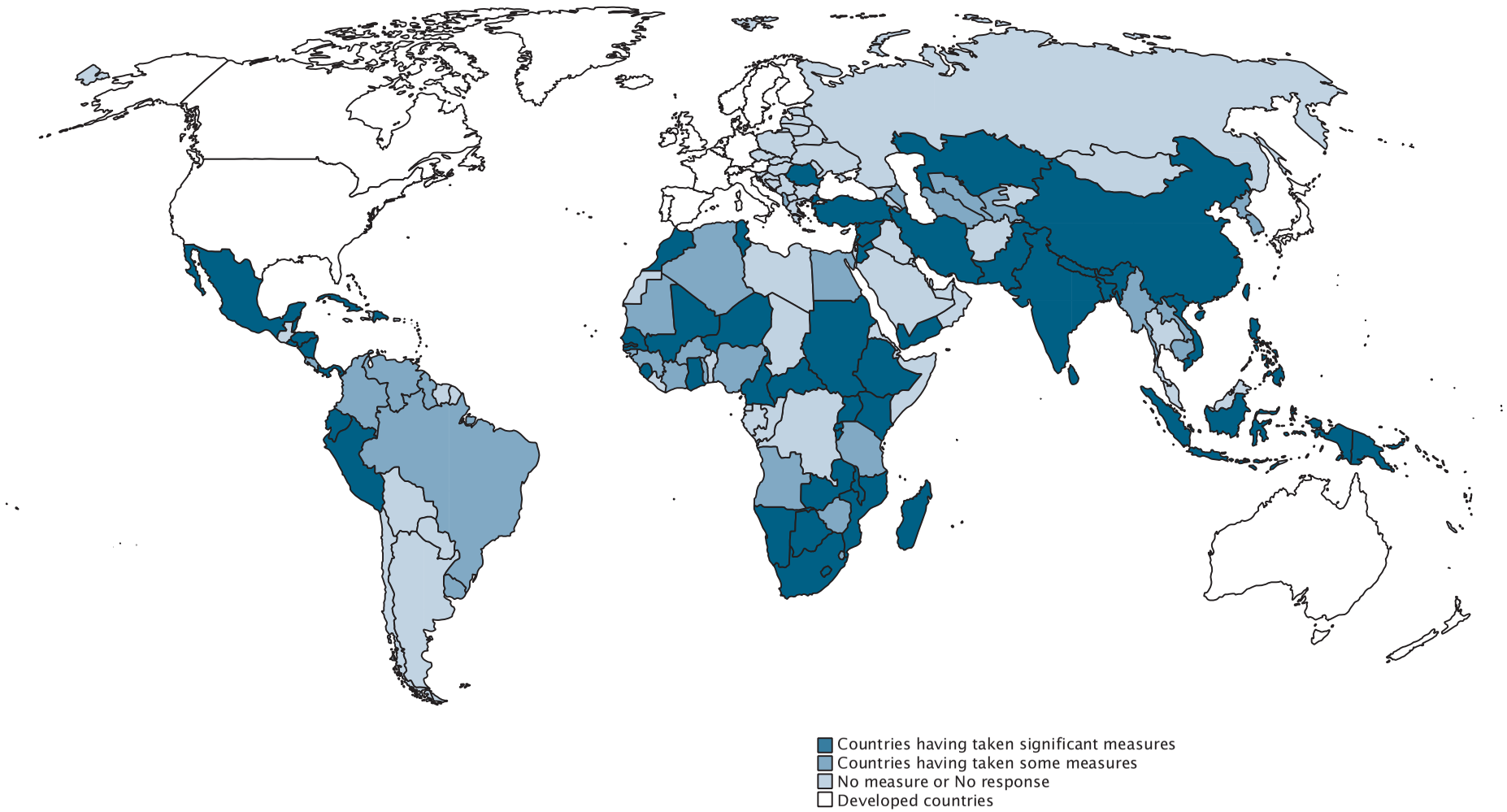
Area	Total response	No.	%
World	**114**	**63**	**55**
Africa	43	27	63
Asia	29	17	59
LAC	23	12	52
E. Europe	8	1	13
Oceania	11	6	55

Of the significant measures taken to improve the quality of care, the most prominent was the training of service providers. Several countries reported improving medical equipment or facilities and monitoring and evaluation/referral of RH services (Table 4.10). Another frequently cited measure was the development of protocols and guidelines in RH policy (Kenya, Ethiopia, Lesotho, Senegal, Zambia, Lebanon, Nepal, Sri Lanka, Turkey, Viet Nam). Several countries reported having emphasised IEC to enhance acceptance of services, such as intensifying health education (Sierra Leone) and developing culturally sensitive IEC materials (Ghana, Romania, Micronesia). Some countries conducted quality assessments of RH services or situational analyses as a means to improve quality of care (Mali, Rwanda, Iran, Lebanon, Pakistan).

Table 4.10 Significant Measures Taken to Improve Quality of Care

Significant measures	Countries
Training service providers	Bangladesh, Bhutan, Botswana, Burundi, Cameroon, Cape Verde, Comoros, Cuba, Ecuador, El Salvador, Ethiopia, Fiji, Gambia, Ghana, India, Indonesia, Jordan, Kazakhstan, Kenya, Kiribati, Lebanon, Lesotho, Malawi, Mali, Marshall Islands, Mauritius, Mexico, Morocco, Mozambique, Namibia, Niger, Pakistan, Papua New Guinea, Philippines, Romania, Rwanda, Senegal, South Africa, St. Lucia, Syria, Trinidad and Tobago, Tunisia, Turkey, Uganda, Yemen
Improving health infrastructure and facilities	Bhutan, Burundi, Cameroon, Cape Verde, CAR, Gambia, India, Kazakhstan, Kenya, Lebanon, Malawi, Mali, Morocco, Papua New Guinea, Romania, Rwanda, Samoa, Senegal, Syria, Tunisia, Uganda
Monitoring and evaluation of and/or referral to RH services	Bangladesh, Botswana, Ecuador, Ethiopia, Indonesia, Lebanon, Madagascar, Mali, Mexico, Pakistan, Papua New Guinea, Philippines, Sudan

Map 4.1 Progress among Developing Countries in Improving the Quality of Reproductive Health Care Services since ICPD



CONSTRAINTS AND OPPORTUNITIES

Several major challenges face countries in their efforts to achieve the ICPD RR and RH goals. The most commonly reported constraint was a lack of financial resources (Table 4.11). Some 48 countries reported that this was a major hindrance to implementing their comprehensive RH programmes. Many of them noted that this problem has led to limited staff capacity and a lack of infrastructure, which ultimately affect the quality of the services that they are able to provide.

Box 4.3 Improvement of Quality of RH Care

After ICPD, many countries instituted changes to reorient and strengthen their policies and programmes in family planning and reproductive health care. Among the various measures taken were improvements in the quality of reproductive health services, including development of protocols and guidelines and the training of health-care providers:

- In Lesotho, there has been development of protocols and guidelines in obstetric care, family planning and syndrome approach guidelines in STD treatment and management, RH policy and training of RH managers and service providers.
- In Indonesia, several initiatives have been taken by the Ministry of Health, including the "demand fulfillment and demand creation" approach as opposed to the "demographic target-oriented" approach; education for clients' rights and responsibilities; development of a training programme and reference materials for quality assurance of FP services, including counselling; and initiatives to improve the referral and supervision system.
- In Mexico, measures taken include training health-care personnel and creating teaching materials, introduction of new contraceptive methods, and improving supervision systems. In 1997, it was agreed to establish a plan of action to improve the quality of services.

Table 4.11 Principal Constraints Affecting RH Programmes, by Region

Area	Total responding countries	Lack of financial resources		Lack of human resources		Socio-cultural attitudes	
		No.	%	No.	%	No.	%
World	**114**	**48**	**42**	**43**	**38**	**42**	**37**
Africa	43	21	49	22	51	20	47
Asia	29	12	41	7	24	12	41
LAC	23	5	22	6	26	6	26
E. Europe	8	3	38	0	0	1	13
Oceania	11	7	64	8	73	3	27

Forty-three countries experienced shortages of human resources that hindered programme implementation. This is a particular problem among countries in Africa and Oceania, where there was a reported lack of training, or refresher training, in RH for service providers. Human resource constraints were also reported as being severe at local levels and as posing a challenge to decentralisation. The FOs emphasised the need for these countries to focus on the development of basic service delivery guidelines and standards that specify minimum skill standards and training requirements. In addition, institutions in these countries need to update their teaching and training curricula to include the ICPD focus on RH.

Forty-two countries reported that socio-cultural and religious traditions hinder the creation of a conducive environment for RH rights and services. Such constraints are most prominent among the countries in Africa. Misunderstandings and misconceptions about religious prescriptions, harmful practices against women, and a lack of women's empowerment affect the ability of women to exercise their RR and provide obstacles to programme implementation.

Other constraints reported that affect RR and RH services include lack of awareness or understanding of the broad scope and multi-sectoral nature of RH among decision-makers and health-care workers (26 countries); lack of health-care infrastructure (16 countries); weak institutional capacity (14 countries); weak coordination between different institutional structures (14 countries); national economic instability (13 countries); inadequate legal environment (13 countries); opposition to government initiatives (11 countries); and lack of data in the field of RH (10 countries).

Several countries reported post-ICPD changes in legislation/policy provided emerging opportunities for improved RR and RH programmes. Other positive developments included institutional changes and sustained IEC and advocacy campaigns that apparently created more favourable environments. The most common action proposed to achieve ICPD RR and RH goals was IEC/advocacy. Many of the proposed IEC/advocacy actions focus on (i) creating awareness in the community, including adolescents, on RR and RH issues through community-based IEC and introduction of population curriculum in and out of schools; and (ii) sensitising decision-makers to the need for supporting RH programmes.

ADOLESCENT REPRODUCTIVE HEALTH

The ICPD PoA specifically states the importance of addressing adolescent sexual and reproductive health issues through the promotion of responsible and healthy reproductive and sexual behaviour and the provision of appropriate services, including counselling.

The Inquiry results suggest that some improvements have been made in addressing the needs of adolescent reproductive health (ARH) since the ICPD. Some 91 countries

took some action, of whom 55 took significant measures (Table 4.12). Latin American and the Caribbean region has shown the greatest progress in meeting ARH needs, followed by Africa.

Table 4.12 Countries Having Taken Significant New Measures to Address the Needs of ARH, by Region

Area	Total response	No.	%
World	**114**	**55**	**48**
Africa	43	23	54
Asia	29	11	38
LAC	23	15	65
E. Europe	8	2	25
Oceania	11	4	36

Of the countries that have taken significant measures to address ARH needs, several have provided outreach efforts/advocacy and school-based programmes; developed youth-related policies; and established new institutions for providing RH services to adolescents (Table 4.13). Some countries have realised the importance of adolescents' participation in the design, implementation and evaluation of their own programmes. This is reflected in Morocco, where youth design RH education programmes that target their peers. Peer education and counselling are now offered in many countries (Seychelles, Zambia, Mauritius, Botswana, Gambia, Russia, Jamaica, St. Lucia, Papua New Guinea).

Table 4.13 Significant Measures Taken to Address the Needs of ARH

Significant measures	Countries
Outreach efforts/advocacy	Bhutan, Bolivia, Cape Verde, Comoros, Costa Rica, Cuba, Ecuador, El Salvador, Ethiopia, Haiti, Kenya, Madagascar, Malawi, Maldives, Marshall Islands, Mauritius, Mexico, Mongolia, Morocco, Mozambique, Papua New Guinea, Seychelles, South Africa, St. Lucia, Syria, Trinidad and Tobago, Tunisia, Uruguay, Uzbekistan, Viet Nam, Zambia
School-based programmes	Bhutan, Cape Verde, Comoros, Ecuador, Fiji, Gambia, Haiti, Lesotho, Madagascar, Mali, Mongolia, Morocco, Papua New Guinea, Peru, Russia, South Africa, Turkmenistan, Uzbekistan, Viet Nam
Youth related policies	Bangladesh, Bolivia, Botswana, Costa Rica, Ecuador, El Salvador, Ghana, Lesotho, Malawi, Mali, Mexico, Morocco, Niger, Peru, South Africa, Uganda, Viet Nam, Zambia
New institutions	Bhutan, Burkina Faso, Cape Verde, Costa Rica, Dominican Republic, Ecuador, Fiji, Ghana, Kazakhstan, Mongolia, Mozambique, Nicaragua, Turkmenistan

Adolescent reproductive health is an area where there has been some progress in collaborative work between NGOs, the private sector and governments, particularly in Africa. In Botswana, where NGOs participate actively in addressing ARH needs, the Government has provided institutional and moral support. In Mali, the Government and NGOs work together on ARH, placing a special focus on IEC activities.

Box 4.4 Addressing the Needs of ARH

The ICPD PoA recognizes the importance of improving adolescent reproductive health and rights. Programmes for adolescents are most effective when they have the full involvement of adolescents in identifying their reproductive and sexual health needs and in designing programmes that respond to those needs. Since the ICPD, many countries have taken measures, albeit often limited in scope, to improve ARH:

- In Morocco, a cross-sectoral National Youth Policy has been formulated. The Ministry of Youth and Sports developed an innovative approach to involve young people in reproductive health services through youth clubs. Other measures are reproductive health-related education for adolescents, integration of reproductive health concepts into secondary school curricula, and awareness through mass media.

- In South Africa, the Government through the National Youth Policy has developed a comprehensive strategy to address major concerns of young people, including RH issues. The Department of Health has also developed the National Youth Health Action Plan for addressing the needs of adolescents. The Government has also introduced a nationwide Family Life and Sexuality Education into secondary schools in 1998. The Government collaborates with the private sector in developing information packages for adolescents, disseminated through multi-media channels.

- In Bangladesh, adolescent health is included and will be rendered in the Health and Population Sector Strategy (HPSS), under the umbrella of Essential Service Packages (ESP). The new Health and Population Sector Programme (HPSP) under the HPSS is envisaged to implement specific activities to deal with adolescent health problems. The Government is also planning to train service providers on adolescent health. In 1997, four workshops were held on adolescent health in the country, during which IEC messages on adolescent health were developed.

- In Costa Rica, the General Law of Protection to Adolescent Mothers, approved in 1997, regulates all policies, actions, and programmes of government institutions addressing this group. The Programme of Adolescent Women (1998), supported by European Economic Commission (EEC), integrated the development of adolescents and elimination of gender inequalities.

CONSTRAINTS FACED IN PROMOTING ARH

While it is apparent from the Inquiry responses that there is increased awareness of ARH issues, and that many countries have taken policy measures and initiatives, it is important to bear in mind that new policies take time to be translated into widespread programmatic action and the generally small or limited scale of many of the new initiatives. The rather limited progress is not surprising given that many governments and communities have traditionally been hesitant to provide services and information to adolescents, particularly to those who are unmarried, on account of a combination of cultural, religious, moral and political sensitivities. In addition, the Inquiry responses suggest that there are other obstacles confronting the provision of ARH services, including lack of institutional mechanisms for supporting ARH services, lack of trained personnel specialising in ARH issues, as well as some opposition to the introduction of population education in the school curriculum.

STRENGTHENING PARTNERSHIP WITH CIVIL SOCIETY

The ICPD Programme of Action asserts that "to address the challenges of population and development effectively, broad and effective partnership is essential between governments and non-governmental organisations [NGOs]." It also calls for the governments and NGOs and international organisations to "intensify their cooperation with the private sector" in the implementation of population and development programmes. Since ICPD, the scope of partnership has expanded beyond NGOs to include other citizens' associations such as parliamentarians, community groups, religious groups, professional groups, women's, men's and youth groups, universities, labour and trade unions. In the Inquiry, the term civil society was chosen to reflect this broader concept of partnership.

Many examples were cited in the Inquiry of collaboration or contribution of civil society in the areas of reproductive health (RH) and gender equality and the empowerment of women. NGO and civil society involvement in the promotion of gender equality and the empowerment of women is underscored by the description of valuable collaborative efforts in 68 countries covered in the Inquiry. Civil society members were probably most active in exerting pressure on governments in adopting gender policy or in enacting women's rights legislation. Women's NGOs in some countries participated in the development of policy and legislation reforms or in monitoring of gender policy implementation. Many NGOs and civil society organisations worked in collaboration with the government in conducting advocacy campaigns to promote gender equality and equity, especially in female literacy and the integration of males in reproductive health. Other initiatives include provision of RH services by women NGOs and dialogue with male groups and religious associations on ways to improve the promotion of male responsibility.

Similarly, the result of the inquiry also shows tremendous progress in broadening collaboration with NGOs and civil society in the area of RH. Sixty-one countries reported significant contributions and/or collaboration with civil society. The most commonly reported initiative is the provision of reproductive health/family planning services, including information, education and communication (IEC) programmes for adolescents. Also common is providing IEC on RH/FP issues to create awareness among the general public. Another strong focus has been on providing RH services to all districts and hard-to-reach areas to promote universal access. In some countries, NGOs and the private sector have also been involved in shaping various RH/RR policy changes.

This chapter focuses mainly on the extent to which government-civil society collaboration and partnership is taking place in countries. Specifically, the focus is on governments' efforts in promoting involvement of civil society at the national level, including new policy measures, legislative changes and other steps to strengthen the capacity of civil society; new major initiatives on the part of civil society to be a more

effective partner; and new measures to promote the involvement of the private sector since ICPD. The various constraints facing both government and civil society in promoting the partnership are considered, and the chapter concludes with a presentation of emerging opportunities identified by countries to implement further the ICPD goal of strengthening partnership with civil society.

STRENGTHENING CIVIL SOCIETY AND PROMOTING PARTNERSHIPS

The ICPD marked a turning point where NGOs received recognition as genuine partners to the government in planning, managing, implementing and/or monitoring population and development policies and programmes. Forty-nine countries were reported to have taken significant measures (see Chapter 1, p. 3, for an explanation of how 'significant measure' is defined) to promote the involvement of NGOs at various stages of policy/programme implementation. Further, 26 countries have taken significant measures to strengthen the institutional capacity of civil society (Table 5.1 and Map 5.1). Given that 19 countries have taken significant measures in both areas, a total of 56 countries took considerably strong steps to strengthen the partnership with civil society. Progress in this area has been most significant in Latin America, where 61 per cent of countries took significant measures. The Asian region follows with 55 per cent of countries. In Africa, 47 per cent of countries took considerable measures.

Table 5.1 Countries Having Taken Significant Measures to Strengthen Partnerships with Civil Society, by Region

Area	Total Response	Measures to involve civil society		Measures to strengthen civil society		Significant measures in both areas	
		Number	%	Number	%	Number	%
World	**114**	**49**	**43**	**26**	**23**	**19**	**17**
Africa	43	18	42	13	30	11	26
Asia	29	13	45	5	17	2	7
LAC	23	13	57	5	22	4	17
E. Europe	8	2	25	0	0	0	0
Oceania	11	3	27	3	27	2	18

The most common measure taken in strengthening partnerships was to have representatives of NGOs or other civil society members at the national bodies responsible for formulating policies or other committees that address the issue of population and development. For example, in Jordan, the National Population Council and other national committees include all major NGOs. In 19 countries, similar arrangements had been established (Table 5.2 and Box 5.1).

In countries where formal representation of civil society is not present, governments made efforts to involve NGOs in policy formulation through policy dialogue or consultation. Nineteen countries across the regions expressed their commitment to involve civil society through measures such as the following. In Gambia, consultations

Table 5.2 Measures to Develop Partnerships with Civil Society

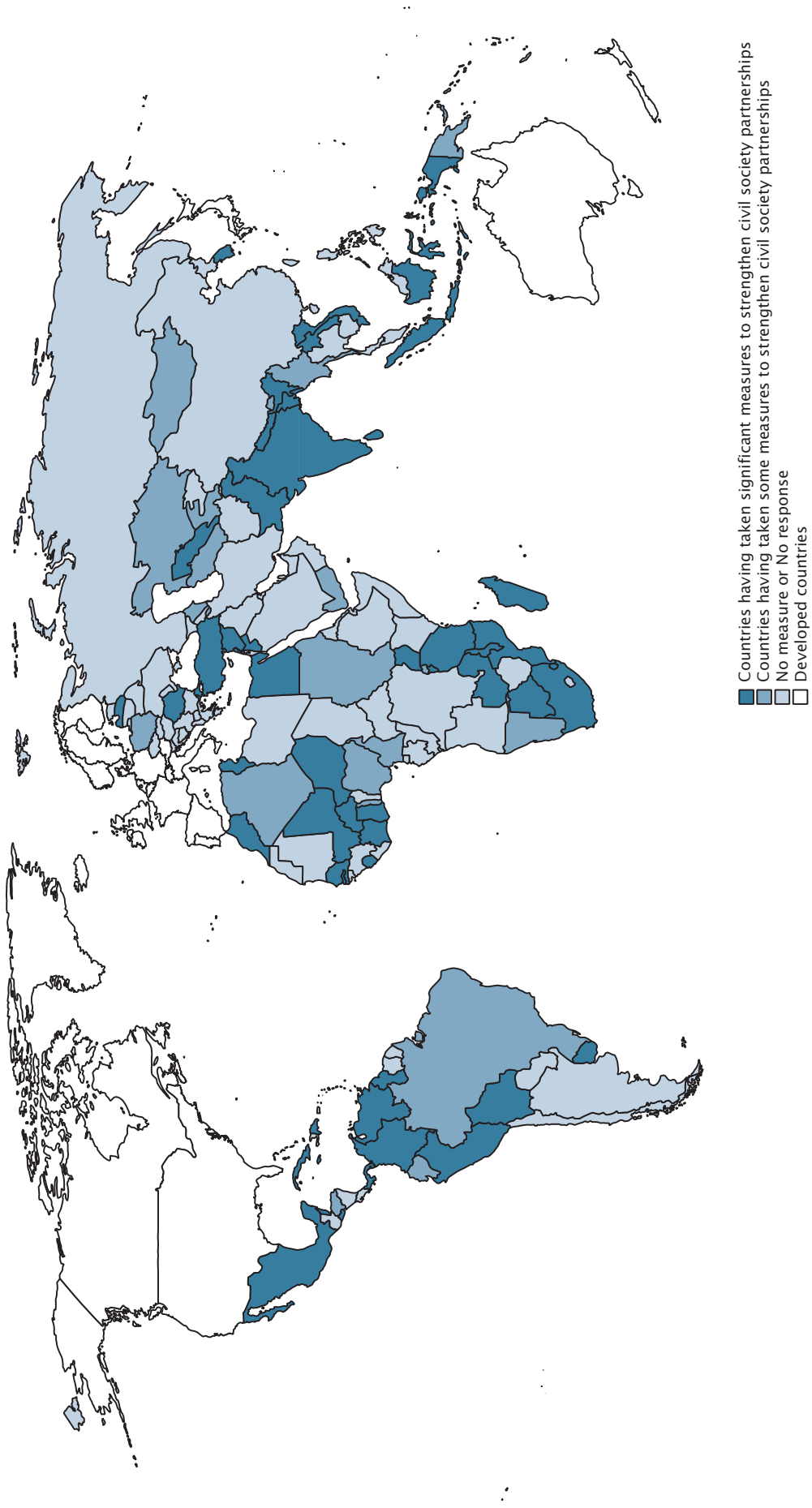
Measures taken	Countries
Representation in government bodies	Belize, Bolivia, Botswana, Côte d'Ivoire, Egypt, Gambia, Ghana, Jamaica, Jordan, Lebanon, Madagascar, Morocco, Nepal, Peru, Senegal, Sri Lanka, Syria, Tunisia, Turkey
Consultation/dialogue	Bangladesh, Botswana, Colombia, Cuba, Dominican Republic, Gambia, Lao DPR, Latvia, Malawi, Maldives, Mali, Mexico, Mozambique, Panama, Swaziland, Tanzania, Trinidad and Tobago, Zambia, Venezuela
Coordination mechanism	Colombia, Côte d'Ivoire, Egypt, Gambia, Jamaica, Mali, Nepal, Romania, Senegal, South Africa, Sri Lanka
Creating enabling environment	Burundi, El Salvador, Guyana, Republic of Korea, Mexico, Nepal, Romania, Senegal, South Africa, Uganda
Recognition in policy/plan	Burkina Faso, Niger, Samoa, South Africa, Uruguay

were carried out before and after ICPD with the members of civil society at three levels: the federal government, the village development level and the grass-roots level. In Mexico, active participation of NGOs was possible through formulation of consultative groups. Creation of local-level councils in Dominican Republic allowed a wide range of civil society members to participate in the planning process of development. In Botswana, civil society was involved in the formulation of policies that include the National Population Policy, the Youth Policy, the Gender Policy, and HIV/AIDS Policy. Similar efforts were observed in the responses from other countries.

To coordinate activities with NGOs and also to assist the NGOs more effectively, many countries established an office or other body responsible for matters related to NGOs. Gambia, Jamaica, Nepal, Romania, South Africa and Sri Lanka established either a full agency, an office within a ministry or a council to facilitate dialogue and coordination with an increasing number of NGOs. Eleven countries have taken similar measures.

Ten countries reportedly took significant measures to create an enabling environment for civil society, including NGOs, by establishing formal procedures for registration, providing tax breaks, or allowing broader funding possibilities. In Senegal, the government established an accreditation procedure for NGOs in which a committee that includes representatives from the civil society oversees the process. Legislation that facilitates legal registration of NGOs was passed in El Salvador, Nepal and South Africa. In Nepal, the Social Welfare Act simplified the procedure and relaxed several restrictions that led to an increase in the number of NGOs from about 300 in 1991 to 15,000 in 1996. In the Republic of Korea and Romania, a law that allows local government to fund NGO activities was promulgated, leading to further cooperation locally

Map 5.1 Progress among Developing Countries in Strengthening Civil Society Partnerships since ICPD



Box 5.1 Progress in Partnerships

One of the keys to effectively operationalise the ICPD Programme of Action is to strengthen partnership and collaboration between governments, non-governmental organisations and the private sector. Since 1994, there is evidence that progress has been achieved in this area, particularly in the field of population and reproductive health:

- In Nepal, the Ministry of Health formed a National Reproductive Health Programme Coordinating Committee, comprised of government officials and NGOs working in the area of reproductive health. They meet quarterly and share their work plans for reaching the goals set in the National Reproductive Health Strategy, which has fully integrated ICPD recommendations.

- In Jamaica, the national, inter-sectoral body for population policy formulation, management and evaluation all include critical representation from NGOs and the private sector. The National Working Group on International Migration is chaired by a representative of civil society. The Planning Institute of Jamaica has established an NGO Desk to facilitate dialogue and cooperation with NGOs.

- In Ghana, NGOs and civil society actors are also taking lead roles in supporting policy development. The highest government body responsible for coordinating population issues in Ghana, the National Population Council (NPC), has NGO representation. They are involved in various NPC committees, thus strengthening collaboration between these agencies for more effective and sustained programme implementation.

between public health organisations and NGOs. The government of Uganda took steps to encourage donors to directly support NGOs. In some countries, such as Mexico and Romania, the governments took measures to provide tax advantages to NGOs. In Guyana and Burundi, NGOs are now free from custom duties in importing medical supplies and other commodities. Some countries have taken the first but important step in building partnerships with civil society by stating their commitment in an official policy statement or a strategic plan. They include Burkina Faso, Niger, Uruguay, Samoa and South Africa.

Other examples of partnerships are more conventional in nature, such as financial support from the government for innovative programmes of NGOs and contracting NGOs to implement governmental programming.

INITIATIVES BY CIVIL SOCIETY

There has also been progress on the part of civil society, most notably NGOs and parliamentarians, to play a more effective role in promoting the population and develop-

ment agenda. Major initiatives undertaken by NGOs include coalition-building, strengthening their institutional sustainability, and mobilising resources. Parliamentarians formed a special committee in some countries to exert pressure on the government to push the population issues forward. Of 44 countries reporting cases where civil society took major action, NGOs in 28 countries formed a coalition or a network under a common theme of women's rights, youth or reproductive health (Tables 5.3 and 5.4).

Table 5.3 Countries Where Civil Society Has Led Major Initiatives, by Region

Area	Total Responses	Number	%
World	**114**	**44**	**39**
Africa	43	19	44
Asia	29	12	41
LAC	23	8	35
E. Europe	8	1	13
Oceania	11	4	36

Box 5.2 Initiatives by Civil Society

Civil society and non-governmental organisations in many countries are actively working to ensure implementation of the ICPD Programme of Action:

- In Nicaragua, 130 NGOs have gathered since June 1997 to discuss the governmental policies that affect women. The National Coordinating Organisation of NGOs has been formed, linking 120 organisations with the principal objective of setting criteria, and creating consensus and presenting coherent responses to the Government.

- Various NGOs in Bangladesh working in different sectors have recognised the multi-disciplinary nature of development and adopted an integrated approach (e.g., BRAC working with Pathfinder; Grameen Bank working with the Family Planning Association of Bangladesh).

- In Kenya, a major initiative is the establishment of a coalition of youth-serving organisations, under the umbrella of the Kenya Association for the Promotion of Adolescent Health (KAPAH). Its main objectives are: (a) to support the establishment of adolescent health services including counselling, treatment and community centres; (b) to promote adolescent-friendly activities by encouraging public education, primary health care and school education programmes; (c) to encourage positive policies set by the federal and local government; (d) to create networks and to communicate with other bodies with similar interests locally and internationally; (e) to raise funds to sponsor adolescent health-care activities; and (f) to support adolescent research projects.

Table 5.4 Countries Where NGOs Formed Coalition since ICPD

Area	Countries
Africa	Botswana, Burkina Faso, Cape Verde, Egypt, Ghana, Iran, Kenya, Madagascar, Morocco, Mozambique, Nigeria, Senegal, South Africa, Syria, Turkey
Asia	Bangladesh, India, Nepal, Philippines
LAC	Dominican Republic, El Salvador, Nicaragua, Panama, Peru, Venezuela
E. Europe	Latvia, Uzbekistan
Oceania	Cook Islands

Other examples of civil society initiatives include: mobilising resources (Fiji, Gambia, Maldives, Mexico); undertaking major advocacy/IEC activities (Haiti, DPR Korea, Niger, Tanzania, Vanuatu); and strengthening human resource capacity (Fiji, Sudan) and institutional capacity (Côte d'Ivoire, Togo). In Pakistan, NGOs drafted legislation pertaining to reproductive rights, and it is to be approved and adopted by the government.

In some countries parliamentarians have started to play an active role. In Jordan, a parliamentary committee on population and development was established for the first time, and similar steps have been taken in Sierra Leone and Viet Nam. In India, representatives of the local legislative body (Panchayat) now receive training on reproductive health issues, and they, in turn, are active in ensuring provision of quality reproductive health services in their constituencies.

INVOLVEMENT OF PRIVATE SECTOR

The civil society includes a wide range of institutions, including the private sector. The ICPD PoA states that "the private, profit-oriented sector plays an important role in social and economic development, including production and delivery of reproductive health-care service and commodities" and that it "has or is developing the financial, managerial and technological capacity to carry out an array of population and development activities in a cost-efficient and effective manner." Thus, the private sector is considered a crucial partner to government, international organisations, and NGOs in achieving the goals of ICPD.

According to the results of the Inquiry, in 37 countries the private sector is already playing an active role in the implementation of reproductive health-care services. Its activities include operating clinics, undertaking social marketing schemes, and providing information through mass media. Of the remaining countries, 9 countries have taken new significant measures to promote the involvement of the private sector (Table 5.5). The private sector is most involved in a social marketing scheme, in which government-subsidised, low-priced contraceptives are distributed through commercial channels. At least in 5 countries across all regions (Zimbabwe, Mali, Morocco, Mexico, Nepal), a collaboration began between government and the private sector in providing affordable contraceptives through social marketing. Bangladesh offers a more compre-

hensive case of privatisation of services (see Box 5.3). Other examples of private sector involvement are training of private sector personnel by the government (Zimbabwe), provision of incentives to establish private hospitals, which would include reproductive health services (Samoa), and collaboration with bus companies to disseminate information on family planning (Morocco). "Adopt a Community" in Trinidad and Tobago is an unique example of private sector involvement in addressing social issues.

Table 5.5 Countries Having Taken Significant Measures to Involve the Private Sector, by Region

Area	Total response	Number	%
World	**114**	**9**	**8**
Africa	43	3	7
Asia	29	3	10
LAC	23	2	9
E. Europe	8	0	0
Oceania	11	1	9

PRINCIPAL CONSTRAINTS

An attempt was made to explore the constraints facing governments and civil society in promoting closer partnerships. Separate questions were included in the Inquiry to capture the point of view of both parties. Consistently across regions, the most frequently cited constraint of both the government and civil society was lack of coordination or weak coordination between government and NGOs. In the responses for 41

Box 5.3 Involvement of the Private Sector

In a growing number of countries since ICPD, the private sector has played an increasing and important role in the provision of reproductive health-care services. The following examples of private sector involvement are geared towards assisting groups, particularly those most in need:

- "Adopt a Community" in Trinidad and Tobago is a programme whereby corporate sponsorship is sought to finance reproductive health care and other services for communities in need. It seeks to facilitate a direct partnership between the private sector and government in implementation of reproductive health care.

- In Bangladesh, under the Health and Population Sector Program, some of the public sector activities are shifted to the private sector and NGOs. The Government will support and encourage the provision of high-quality care through "franchising" of selected and specially trained private sector providers who will commit to adhere to agreed standards of quality of care and to publicise fee schedules that are affordable to low-income groups.

countries, it was noted that the civil society felt the lack of, or weak, coordinating mechanism was a constraint to building partnerships with the government, and 26 countries said the same for the constraint facing the government. Weak coordination or lack of coordination was cited as a constraint even by those countries which have taken significant action to promote involvement by civil society, reflecting the reality that building partnerships is a continuing process beyond dialogue and consultation.

The other frequently cited constraints for government in promoting partnership with civil society were: lack of financial resources (20 countries); lack of awareness or understanding of the importance of such partnerships (17 countries); and weak institutional capacity of NGOs (15 countries). For the civil society, the list of constraints include: lack of financial resources (39 countries); lack of skilled personnel within NGOs (24 countries); weak institutional capacity of NGOs (22 countries); hostile or confrontational relationship between government and NGOs (14 countries) and weak coordination among NGOs (12 countries) (Table 5.6).

Table 5.6 Principal Constraints in Promoting Partnerships

Constraints	Number of countries out of 114	%
Cited by Governments		
Weak NGO-government coordination	26	23
Lack of financial resources	20	18
Lack of awareness	17	15
Weak institutional capacity of NGOs	15	13
Negative NGO-government relationship	12	11
Weak institutional capacity of government	10	9
Limited number of active NGOs	10	9
Cited by Civil Society		
Weak NGO-government coordination	41	36
Lack of financial resources for NGOs	39	34
Lack of skilled personnel within NGOs	24	21
Weak institutional capacity of NGOs	22	19
Negative NGO-government relationship	14	12
Weak coordination among NGOs	12	11

EMERGING OPPORTUNITIES

For civil society, increased dialogue with governments is seen as a key emerging opportunity to further strengthen partnership, while governments consider new formal legislative or policy action as the most important emerging opportunity. Although the number of responses citing specific opportunities was relatively small (28 for governments; 16 for civil society), the responses given confirm the optimism regarding increased partnership between governments and civil society in many countries.

The most frequently cited challenges, both for governments and civil society, was to continue the dialogue and to increase the involvement of civil society in government planning and implementation of policies and programmes (38 for governments and 43 for civil society). Some responses cited the specific actions needed to increase dialogue, such as taking specific legislative/policy measures (20 responses), or institutional changes to improve coordination with civil society (23 responses) as key measures necessary for strengthening partnerships.

A major challenge for civil society organisations is to further enhance their capacity in order to strengthen partnerships with governments. The responses for 30 countries mentioned that NGOs and other members of the civil society must build their institutional and/or human resource capacity in order to be a more effective partner with the government, and 28 responses cited the need for NGOs to improve coordination amongst themselves and to build stronger coalitions under a common agenda.

PERSPECTIVES OF DEVELOPED COUNTRIES

Responses to the Field Inquiry from 18 developed countries underlined the universal importance placed on population issues. This chapter is divided into four parts. The first part describes population issues and concerns that developed countries have faced in addressing the goals and objectives in the ICPD PoA, as well as measures that they had taken to address them. Part two focuses on the views of developed countries regarding the achievements and constraints faced by developing countries in the implementation of the ICPD PoA. The third part discusses partnerships between donor countries and civil society organisations, both in their own countries and in the developing countries that they are assisting. The final part considers issues related to international assistance, including problems faced by donor countries in mobilising resources to help implement the PoA.

POPULATION ISSUES AND CONCERNS OF DEVELOPED COUNTRIES

Population Ageing

The rising proportion of older persons in the industrialised countries and its implications for economic, social and health policies continues to pose a major concern. Nearly all of the 18 developed countries responding to the Inquiry cited population ageing as an important issue that they have addressed both before and after ICPD. The concern focuses on meeting the needs of older persons, especially the fiscal requirements associated with the financing of pensions and health care. Several countries noted the rising demand for health-care services and some of the measures that they had taken to reorient such services. In addition, steps aimed at securing the public pension schemes for future generations have also been taken by a number of countries. The Netherlands, for example, has created a special fund solely for the payment of pensions. In Switzerland, a policy has been approved wherein one per cent of the Value Added sales tax will be used to support old age insurance.

Developed countries generally recognise the positive economic aspects of the participation of older workers in the labour market. After the ICPD, several countries formulated policies and/or instituted reforms to address issues relating to age of retirement. For example, Italy has raised the effective age of retirement for both men and women. Similarly, extending the standard age of retirement from 62 to 65 years has encouraged working in later life for Swiss women. In other countries, special re-training programmes have been set up for older workers to ensure that their labour skills remain relevant and marketable.

Other recurrent concerns relating to population ageing mentioned by several developed countries include: (i) addressing the special needs of the substantially larger numbers of women in older populations; (ii) support of families and other caregivers to older persons; and (iii) the need for increased recognition of the numerous productive and social cohesion roles older persons play in society.

Inflows of Migrants and Refugees

Several respondents to the Inquiry mentioned that despite the increasingly restrictive admission policies aimed at reducing economically-motivated immigration from other countries, the stream of immigrants has continued unabated. The unstable economic and political situation in many countries has given rise to large flows of refugees and asylum seekers. While most receiving countries recognise the positive contributions of migration, particularly its beneficial effects on the economy, growing levels of illegal immigration are a major concern.

Since the ICPD, a number of countries have revised their immigration policies. For example, in Italy, two new laws have been passed aimed at better regulating the flow of immigrants by quotas and definitions of the immigrants' rights and duties. In Switzerland, Parliament adopted a new legal framework on refugees. Portugal has likewise revised its laws on foreigners and refugees to better align them with the European Union and Schengen framework regulations. France is reinforcing its policy on illegal immigrants, including easing their return to their home countries. In many receiving countries, policies and programmes have aimed at promoting the social integration of immigrants, and specific measures have been adopted to ensure equality of opportunities in the access to jobs, housing, health, education and other social services and amenities.

Other Population Concerns

Several developed countries emphasised the impact of population growth and distribution on the prospects for environmentally sustainable development. The United States, for instance, has taken measures to reduce the greenhouse gas emissions, promote energy efficiency and alternative fuels and develop more sustainable agriculture.

Other population-related concerns include measures in the social sector aimed at supporting families and working mothers. In Norway, additional steps have been taken to reconcile family life better with participation in the labour force and to enable parents to spend more time together with their children. In Finland, as in its neighbouring countries, family policy provides for the provision of day care for each child under school age. In Italy, some of the family support measures include financial assistance for maternity and childcare, while in Austria measures have focused on allowances for children and paternity leave with re-employment guarantee.

REPRODUCTIVE HEALTH

Almost all developed countries responding to the Inquiry described their high level health-care system, including access to family planning and reproductive health services and information, both before and after ICPD. The Swedish health-care and medical services, for example, have been designed to provide equal treatment and care irrespective of the economic, social or health circumstances of the individual.

Contraceptives and counselling services have been offered regularly by maternity care centres, as well as by private centres and youth clinics.

Several countries have reported post-ICPD adjustments to their RH programmes, including the provision of additional resources. Thus, in New Zealand, increased funding has been provided by the Government to improve access to oral contraceptives and counselling services. In the United States, the Food and Drug Administration approved the marketing of emergency oral contraceptive pills aimed at preventing unintended pregnancies. The United Kingdom implemented a national programme of women-centred maternity care in 1994 and in 1996 established a national network of breast-feeding coordinators. In Japan, prefectures and some municipalities in 1996 began implementing lifelong health support projects for women, including health education and counselling. In 1995, the Irish Department of Health issued guidelines to the health boards responsible for the delivery of health care aimed at ensuring equitable, accessible and comprehensive family planning services throughout the country.

In most developed countries, recognition has grown in the academic and scientific fields of the scope and special health needs and problems of women. Many medical practitioners have come to address the needs of women as the primary caretaker in the family by modifying their practices to be more receptive and sensitive to women's needs and requirements. In the United States, for instance, medications are now tested on both women and men. Breast, ovarian and cervical cancers are beginning to receive as much attention as typical male cancers, like prostate or colon cancer. Since ICPD, programmes for the prevention and treatment of, as well as research on, sexually transmitted diseases (STDs), including HIV/AIDS, have continued. Some countries, like Spain and Finland, have also paid special attention to the treatment of infertility and have prepared clinical guidelines on its care.

Most developed countries voiced common concerns about adolescent reproductive health issues. These concerns include (i) early and unwanted pregnancy; (ii) increasing incidence of STDs, including HIV/AIDS; and (iii) substance abuse, smoking and alcoholism. Many developed countries reported having taken measures to expand and improve the RH services available to adolescents. For example, in Portugal, healthcare services for adolescents were available in only 13 per cent of the health centres in 1993, but this figure increased to 24 per cent in 1997. In the Netherlands, services have been designed to ensure that groups with the highest health risks, particularly children and young people up to the age of 19, receive the most attention. In Austria, efforts have been directed toward the introduction of new guidance and counselling institutions that cater especially to the reproductive health and family planning needs of socially disadvantaged youth.

Several countries underscored the importance of providing sound and relevant information about sexuality and reproductive health to young people. Some noted the con-

tinuing efforts of service providers in the health and educational systems to disseminate information to the young people they serve about sexual maturation and sexual behaviour; pregnancy and childbirth; responsible family planning practice; the dangers of STDs, HIV and AIDS; and other issues, such as the dangers from tobacco, alcohol and drugs. The Japanese government is currently revising the school curriculum to improve the quality of sex education taught at school. Efforts are also being made to develop a database of effective methods and programmes of teaching and counselling about HIV/AIDS and reproductive health.

Since ICPD, information campaigns have been intensified to reach a larger number of young people. In Switzerland, for example, under a project entitled "Necessaire", a toiletry case containing an information brochure, "My guide to femininity, love, sexuality and prevention" as well as condoms, are available to adolescent girls in pharmacies all over the country. A similar project has been designed for adolescent boys. An information booklet "Ho les filles" (Hello, Girls) about adolescence, sexuality and pregnancy has been published for the cantons in the French-speaking region.

Special initiatives have been taken by a number of countries to make services available to young men and also to encourage them to become more responsible in sexual and reproductive health. In the United States, in 1996, funding has been provided for demonstration projects employing adolescent males in some clinics while also providing them with reproductive health and family planning education and services.

GENDER EQUALITY AND EMPOWERMENT OF WOMEN

From the momentum gained at the ICPD and the Fourth World Conference on Women, held in Beijing in 1995, many developed countries have undertaken measures to protect and promote the empowerment and human rights of women. For example, the Japanese government developed its first comprehensive national plan of action called "The Plan for Gender Equality 2000." Additional measures have been taken in many developed countries, particularly in (i) preventing and eliminating violence against women; (ii) increasing the participation of women in the workforce; and (iii) increasing women's capacity to participate in decision-making and leadership.

Following are several specific examples of initiatives and programmes from various countries that have been put in place since the ICPD to prevent and eliminate violence against women. In the United States, the Violence against Women Act of 1994 has combined tough new penalties with programmes to better prosecute offenders and help victims of violence. In 1995, New Zealand introduced its Domestic Violence Act while Portugal adopted a new Penal Code, which increased penalties for domestic violence and rape. In 1996, the United States Congress passed legislation to criminalise the practice of female genital mutilation (FGM). Government officials have held community meetings with immigrants and organisations working with them to learn how best to develop outreach programmes to provide education on the dangers of FGM. Similar

measures have been taken in France by increasing awareness among the migrant population and implementing a new law against such practices.

In many countries, legislation has been passed that outlaws discrimination in employment on the basis of sex and marital status. Examples are the 1995 major amendment of the Act on Equality between Women and Men of Finland, the 1998 Employment Equality Act of Ireland and a new law in Japan that reinforces the existing Equal Employment Opportunity Law. In Finland, treating of women differently for reasons of pregnancy or childbirth was expressly added to the text. In most countries, measures have been taken that encourage the diversification of occupational choices for women and the upgrading of their skills with the aim of increasing their numbers in leading positions in such areas as politics, business, administration and the sciences. In particular, several countries have taken various initiatives aimed at encouraging the increased representation of women in decision-making. In Finland, for example, the participation of women in governmental bodies increased after the provision of a 40 per cent quota. In New Zealand, the number of women appointed to government boards has increased from 25 per cent in 1994 to 31 per cent in 1998.

While gains have been made since ICPD in the area of women's empowerment, most countries recognise that further action will have to be taken to achieve the goals of the ICPD PoA and the Beijing Platform for Action. A number of countries mentioned (i) the need for more gender-specific statistics and studies on women; (ii) an increased awareness of specific health needs of women; (iii) new campaigns against violence towards women and sexual harassment; and (iv) new measures to rectify the disparities in the participation of women and men in economic, political and social life. Several countries emphasised the need to share models, strategies and techniques and best practices that are working in different countries in order to attain gender equity and equality.

IMPLEMENTATION OF THE ICPD POA IN DEVELOPING COUNTRIES

Achievements

> *". . . an important positive change induced by the ICPD Programme of Action is the fact that population issues and reproductive health matters in particular have been placed on the agenda of governments in many developing countries and policies are being developed on the basis of the Programme of Action. In a number of countries, the ICPD had been instrumental in reconciling contradictions and controversies between family planning policies and health-care in general."* (Response to the 1998 UNFPA Field Inquiry by the Netherlands)

Most developed countries indicated that they believed many developing countries were making substantial progress in the implementation of the ICPD PoA, particularly in five key areas: (i) population and development; (ii) reproductive health, including family planning; (iii) youth, particularly on the reproductive health needs of adolescents; (iv) gender equality, equity and the empowerment of women; and (v) collab-

oration and partnerships between governments and civil society in population and reproductive health. This view is consistent with the responses of many developing countries as discussed in the earlier chapters. Some respondents also noted efforts in developing countries to adopt a human rights-centred approach to population that emphasised policies based on meeting the needs of individuals rather than on demographic targets.

Several countries, including Japan, the United Kingdom, Germany and Australia, noted that since ICPD many developing countries have moved away from narrowly defined demographic targets in favour of a new and broader reproductive health approach that was elaborated in the PoA. Family planning has been increasingly integrated with other reproductive health concerns, and improving the quality of services has been a principal goal.

The greater attention on youth, particularly initiatives taken by many governments to meet adolescents' reproductive and sexual health needs in developing countries, was mentioned in several responses to the Inquiry. For example, Portugal has observed that there has been better access to reproductive health services for adolescents since the ICPD in some of the Portuguese-speaking African countries, as well as increased efforts to combat STDs and HIV/AIDS. Finland noted that while reproductive rights of adolescents are gradually being realised in many developing countries, much remains to be done. Several respondents were encouraged by the increased awareness of gender issues at all levels, including by political leaders and by the public at large in most developing countries around the world. Sweden has observed that many developing countries have recognised that the gender dimension and the empowerment of women are vital to the development process.

Constraints Identified by Developed Countries

> *"It may be that reproductive health in practice [in developing countries] has at best represented components of services being added on to previous programmes without the necessary integration . . ."* (Response to the 1998 UNFPA Field Inquiry by Norway)

Developed countries responding to the Inquiry identified three groups of constraints that hinder developing countries from fully implementing the ICPD PoA. First, limited resources combined with competing priorities and demands for those resources. The situation has not been helped by the general declining trend in official development assistance (ODA). Second, donor countries also mentioned the institutional limitations in many developing countries, including lack of trained human resources and the weaknesses of existing vertical organisational structures in the delivery of RH services. Third, several respondents referred to various factors, such as sensitivity of reproductive health issues in many developing countries; religious and cultural opposition; lack of political commitment towards gender equality and environmentally sus-

tainable development; and resistance on the part of some governments to greater NGO and private sector participation in population and RH programmes.

PARTNERSHIPS WITH CIVIL SOCIETY

> *"The ICPD+5 process itself has stimulated the creation of a series of NGO task forces to promote U.S. domestic support for ICPD goals. The 'U.S. NGOs in Support of the Cairo Consensus' is a consortium of NGOs representing the population, family planning, environment, women's rights and development fields. The groups are assessing resource allocation and population research, as well as explaining the successes of ICPD and expanding the grassroots base of support for implementation of the Programme of Action in the United States."* (Response to the 1998 UNFPA Filed Inquiry by the United States)

Most respondents noted that although there had been numerous cases of close cooperation between governments and civil society organisations before ICPD, collaboration and partnerships between them have grown and strengthened considerably during the follow-up to the Conference.

Governments have been providing substantial financial contributions to NGOs in their own countries and to international and local NGOs in developing countries working in the field of population and reproductive health. Reflecting the growing importance attached to their role, the amount of funding to NGOs by the Portuguese government has been steadily increasing since ICPD. In Australia, NGOs are supported through various funding mechanisms, including bilateral programming. In 1998-1999, assistance channelled through Australian and international NGOs is expected to be around 7 percent of the total aid programme. Since ICPD, New Zealand has also greatly increased the amount of official development assistance channelled through NGOs.

Several donor countries mentioned that since ICPD, the number of NGOs involved in population and development has increased. Italy noted the greater commitment of NGOs in projects implementation and the effectiveness and coverage of their advocacy activities. Swiss NGOs have included parliamentary networking within Europe, as well as between Europe and parliamentarians in Asia and Latin America. In the United States, collaboration with civil society organisations has been a prominent feature of its international population assistance. This collaboration has included US-based NGOs and private voluntary organisations as well as many NGOs based in developing countries. Similarly in Japan, NGOs are closely involved in the major initiative (Global Issues Initiative on Population and AIDS) undertaken by the Government. The Japanese Government held 25 consultative meetings with Japanese NGOs in the last four years in order to actively engage them in the initiative.

Collaboration between donor countries and NGOs has covered a wide range of concerns that are addressed in PoA, including school curricula development on relation-

ships and adolescent sexuality education, contraceptive social marketing, the integration of immigrants, and support for victims of violence, particularly women.

Donor countries also mentioned difficulties encountered in partnerships, including: (i) reluctance of some government agencies to tap NGO expertise fully, such as in programme formulation; (ii) concern by some NGOs in developing countries that funds are increasingly being directly channelled by donor countries to civil society organisations in their own countries; (iii) constraints faced by NGOs in dealing with governmental policies and regulations (for example, political opposition to abortion in the United States Congress has resulted in decreased funding for international family planning assistance); (iv) the delicate nature of the partnership in which NGOs resist a "donor-led" relationship, especially by NGOs involved in advocacy and service provision that aspire to be independent from official policy restrictions; and (v) the need for both governments and civil society organisations to engage in frank dialogue.

Donor countries also noted several issues facing NGOs, including: (i) their need for more financial resources to support their programmes, given the larger number of civil society organisations involved in providing RH services; (ii) the need for more NGOs with specialised skills and experience; (iii) the need to identify and involve potential and new clients, such as men's groups in RH; and (iv) the need for more complementarity, not competition, among NGOs when initiating and implementing programmes. The United States provides a good example where NGOs recognise that generally they can achieve more by coordinating their efforts.

While the important role played by the private sector and other civil society organisations in the implementation of the ICPD PoA is recognised by donor countries, they expect more active participation and involvement from them in the future. In the United States, the private sector is already playing an active role as the principal source of medical services, including reproductive health services for the majority of the population. Private health-care professionals, institutions and retail outlets have been important sources of reproductive health counselling, commodities and related services. Additionally, the pharmaceutical industry has contributed greatly to the distribution and marketing of contraceptives and medication for many women's health concerns.

Private foundations have long been leaders in establishing and assisting institutions to address population and reproductive health issues and needs in the United States. Foundations have taken the lead in funding research into areas of reproductive health that are often not covered by the for-profit sector, specifically contraceptive development. They have become trend-setters by funding domestic and international population programmes where Government funding cannot be used for various reasons.

RESOURCE MOBILISATION

> *"The biggest constraint in implementing the [ICPD] Programme of Action is the falling trend in development assistance and in particular in assistance to population issues."*
> *"Increased public awareness of population activities is a prerequisite for a future high level of support to population issues."* (Response to 1998 UNFPA Field Inquiry by Denmark)

The priority accorded by several donor countries to population and development issues and concerns has helped the mobilisation of resources for international assistance in the population field. Japan has disbursed $2.4 billion so far to the Global Issues Initiative on Population and AIDS launched in 1994, which accounts for four-fifths of the target expenditure. Within a year after ICPD, the Parliament of the Netherlands voted for the adoption of a 4 per cent target ODA earmarked for population and reproductive health funding. The Norwegian contribution to international population assistance had already reached this target, while Finland has aimed for the same target by the year 2000.

The United Kingdom's funding for population programmes has increased over the period 1994 to 1997 from 2.2 per cent to 3.6 per cent of ODA. Australia has continued to give priority to family planning as a fundamental component of primary health care. In the United States, support for population activities and programmes by private foundations has increased significantly since ICPD. In 1995, for example, foundations provided approximately $88.3 million for international population activities. This amount will almost double to about $165 million in 1998 and is expected to continue to grow in 1999 and after.

While a number of developed countries have mobilised resources and contributed significantly to the flow of international assistance for population and development programmes, there are constraints which inhibit countries to mobilise additional resources required for the full implementation of the ICPD Programme of Action. Among the constraints encountered by donor countries are: (i) declining ODA; (ii) weakening economies and budget cuts; (iii) lack of interest in supporting international population projects on the part of many foundations and philanthropists; (iv) lack of understanding of the interdependence of population and development and of the importance of integrating population into development planning; and (v) perception that there is no need to mobilise resources for population activities because population concerns are adequately addressed by the health and/or social sector.

Donor countries recognise the need to intensify efforts to mobilise resources for the continued implementation of the ICPD PoA, and suggested the need to (i) explore new modalities, such as increased involvement of the private sector, including private foundations, in financing reproductive health services, including family planning; (ii)

increase donor support for inputs essential to the core ICPD activities where countries are not in a position to provide these inputs themselves, such as commodities, specialised training, or data collection for monitoring and evaluation; (iii) increase international population and reproductive health assistance in the context of health sector reform and decentralisation; and (iv) encourage developing countries to increase domestic allocation for national population programmes and, in particular, in promoting social sector programmes within the 20/20 initiative discussed at ICPD and endorsed by the 1995 World Summit for Social Development held in Copenhagen.

7 CONCLUSIONS

In June 1998 UNFPA conducted a Field Inquiry designed to provide information on the stages that different countries had reached in implementing specific actions of the ICPD PoA, together with the constraints that they face and emerging opportunities. Information was collected from 114 developing countries and those with economies in transition, giving a response rate of 82 per cent. There were 18 replies to a smaller and different inquiry conducted among 21 developed countries, giving a response rate of 86 per cent. The results of the Inquiry provided a rich database of information on country progress in the implementation of the ICPD PoA, allowing comparisons across different regions and providing guidance for recommendations to further its implementation. However, some important limitations need to be kept in mind in interpreting the results, especially on account of the fact that (i) the Inquiry was primarily limited to government policies and programmes in each programme area; (ii) there was a good deal of variation in the style and richness of the responses; and (iii) the Inquiry did not focus on the extent to which the actions taken have affected the lives of individuals, especially those most in need of services and information.

POPULATION AND DEVELOPMENT

Many countries reported having undertaken policy and programme measures reflecting the goals and objectives of the ICPD PoA. The nature of the measures taken has a distinctive regional character. African countries have tended to focus on broad development issues, including poverty and human resource development, while Asian countries have focused more on issues of reproductive health and infant, child and maternal mortality. In terms of the obstacles faced in implementing population and development policies and programmes, African countries mentioned major resource and operational problems, including poor information and institutional capacities. Asian countries frequently mentioned operational aspects and lack of awareness of the importance of the linkages between population and development.

Relatively modest progress is reported on developing and implementing the necessary mechanisms for monitoring and measurement of the quantitative goals of the ICPD PoA. About one-third of the countries covered in the Inquiry reported having taken significant actions to establish monitoring mechanisms; some have established monitoring indicator frameworks or Management Information Systems, adopted national goals, designated responsible institutions for monitoring, and conducted surveys on population and RH issues. Sub-Saharan African countries tend to lag far behind in meeting the quantitative goals on mortality and reproductive health and also in establishing effective and sustainable monitoring mechanisms.

GENDER EQUALITY, EQUITY AND WOMEN'S EMPOWERMENT

It is evident from the Inquiry that a majority of countries have taken at least some measures since ICPD to protect the rights of women and promote women's empowerment. Countries have taken actions in several areas, including gender policy, legislative and institutional changes, girls' education, women's participation in reproductive health services, and some limited measures to promote male responsibility. The areas where countries reported the greatest changes were in gender policy and the provision of access to basic education. Thus 68 per cent of countries covered in the Inquiry made important policy changes to protect women's employment and inheritance rights; to prohibit harmful traditional practices; to protect women from acts of violence; and to establish Women's Affairs Offices. About one-third of countries consider the level of access to education for the girl child adequate and a further 27 per cent have taken significant measures to improve access through incentive programs, policy changes, advocacy campaigns and revised gender-sensitive curricula.

Although many countries have taken measures to improve the status of women, there still remain considerable barriers, especially socio-cultural prejudices and discrimination, to the achievement of gender equality and equity. Fifty-four per cent of respondents cited the prevalence of socio-cultural attitudes as the major constraint faced in achieving gender equity, while a quarter claimed that lack of financial resources and poverty are the major obstacles to the implementation of gender policies. Thus, while countries have taken some measures to promote women's empowerment, the impact of these measures has not been universally felt. Similarly, while there has been progress in affirming and implementing policies that ensure equal educational opportunities for boys and girls in basic education, it is still the case that many families tend to favour sons over daughters when choices have to be made. Moreover, while there has been some progress in promoting women's participation in decision-making, in most countries women are still seriously under-represented in senior positions.

REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

The result of the Inquiry suggests that the ICPD PoA is having an important impact in the areas of reproductive right (RR) and reproductive health (RH). The most significant impact appears to be in stimulating measures to improve the quality of RH services: more than half the countries in the Inquiry reported having taken significant measures towards improving the quality of existing RH-care services. Key measures taken include increased training of service providers, improved health infrastructure and facilities, monitoring and evaluation, and referral to RH services. There has also been increased recognition of RR, with several countries having formulated policies and laws against FGM and sexual and gender violence. Legislative and policy actions are seen as key emerging opportunities for improved RR and RH. Of course, the mere existence of positive policies and legislation is insufficient if not supported by meaningful and widespread implementation measures.

The Inquiry results show that increased attention is being paid to issues of adolescent reproductive health (ARH). Since ICPD, many countries have formulated policies and implemented programmes to address the RH needs of adolescents. In addition, there exists a better understanding among governments of the importance of adolescents' participation in programmes targeted at them. However, it is important to bear in mind that new policies take time to be translated into programmatic actions, and new initiatives generally begin on a small scale. Rather limited progress is not surprising given that many governments and communities have traditionally been hesitant to provide services and information to adolescents, particularly to those who are unmarried, on account of a combination of cultural, religious, moral and political sensitivities. In addition, the Inquiry responses suggest that there are obstacles confronting the provision of ARH services, including lack of institutional mechanisms for supporting ARH services, lack of trained personnel specialising in ARH issues, and some opposition to the introduction of population education in the school curriculum.

The Inquiry does not show much progress in adding new RH components or in the full integration of services. The Inquiry responses also suggest that more efforts need to be devoted to promoting decentralisation of health-care systems. Major challenges include improving financial resources, strengthening human resources and addressing socio-cultural issues.

STRENGTHENING PARTNERSHIPS WITH CIVIL SOCIETY

The results of the Inquiry confirm the perception that elements of civil society, including NGOs, have become important partners to governments in implementing the goals of the ICPD PoA. Almost half of the countries covered in the Inquiry reported significant measures either to involve civil society members at various stages of policy/programme implementation, or to strengthen the capacity of civil society, or both. The most common measure to promote partnerships was to engage civil society members in policy dialogue and consultation, either through formal representation or informal or ad hoc arrangements. On the other hand, there were not many strong examples of involving the private sector. Only 9 countries provided significant and concrete examples of working with the private sector, mostly through social marketing schemes. Although about one-third of countries acknowledged that the private sector was already active, many did not describe the extent of their involvement in working with the governments to implement the ICPD PoA goals.

In spite of the achievements in terms of more active engagement between government and civil society, lack of, or weak, coordination was a frequently cited constraint in further strengthening partnerships. This is an important reminder that building partnerships is an on-going process that does not end with simply initiating dialogue or consultation. In addition to governments' commitment to continuous dialogue and increase involvement of civil society, there is also much need for civil society to enhance its own capacity. More than one quarter of countries acknowledged that

NGOs and other members of civil society must build and strengthen their institutional and/or human resource capacity in order to be a more effective partner with their government.

CONSISTENCY IN MEASURES ADOPTED

Some countries have consistently taken actions in all the major areas of the ICPD PoA. Thus, many countries who have taken significant measures in population policies have also taken actions to implement mechanisms to monitor progress in the achievement of ICPD goals.. Cross-theme analysis of the areas of population policy and RH indicates a fair degree of consistency in the level of actions taken by governments. For example, positive correlation exists between population policy and RH/RR policy, quality of care, and adolescents reproductive health.

Similarly, some consistency was found in the area of RH. Of those countries which took significant measures to improve access to RH services, over 75 per cent also took major action in improving the quality of RH services, and close to 70 per cent of them took significant measures in addressing adolescent reproductive health. A majority of the countries that took significant measures to improve the quality of care also took major steps to strengthen civil society partnerships, reflecting the increasing role NGOs.

Particularly strong correlation was found between initiatives in the areas of gender and civil society partnerships. Over 70 per cent of countries that had taken significant measures in gender policy also took actions to strengthen civil society partnerships. Furthermore, strong examples of NGO initiatives were evident in the responses from those countries, confirming the active involvement of civil society in gender issues.

PERSPECTIVES OF DEVELOPED COUNTRIES

There appears to be continued momentum for the implementation of the ICPD PoA in developed countries. Nearly all the 18 countries that replied to the Inquiry have revitalised their RH programmes, including the provision of additional resources to various services, such as those focused on the sexual and reproductive health needs of adolescents, training of health-care providers and extensive research, including prevention and treatment of sexually transmitted diseases and HIV/AIDS. Significant measures have also been taken to protect and promote women's empowerment and human rights, including increased penalties for domestic violence, rape and trafficking in women and girls. However, most developed countries continue to be concerned about the growing number and increasing proportion of older persons and the long-term implications for economic, social and health policies; the unabating streams of immigrants and refugees; environmental degradation; and social problems relating to the increasing use of harmful substances, especially among young people.

Developed countries perceive that there has been considerable progress in implementing various key areas in the ICPD PoA in developing countries, including a sharper focus on the need and urgency to eradicate poverty and address the basic needs of the poor; institutional changes to strengthen and reorient RH policies and programmes, including family planning; recognition of the gender dimension and the empowerment of women as vital to the development process; and the willingness shown by many governments to work closely with NGOs and other civil society organisations. While developed countries have mobilised resources to assist developing countries in implementing the ICPD PoA, donor countries have noted that the economic and financial constraints facing developing countries, coupled with declining ODA, threaten to derail the further implementation of the PoA. Donor countries recognise that they need to intensify efforts to: explore new modalities in financing population programmes, such as increased involvement of the private sector, including private foundations, and the adoption of a four per cent target ODA earmarked for population programmes; encourage developing countries to increase domestic allocation for national population programmes; and promote social sector programmes in developing countries in the spirit of the 20/20 initiative.

SUMMING-UP

The findings of the Inquiry provide striking evidence of the global impact of the ICPD PoA. The results suggest that some progress has been made in several key areas, especially in gender policy, quality of RH care, the provision of services for the prevention and treatment of STDs and HIV/AIDS, and strengthening of civil society partnerships. In addition, the issue of adolescent reproductive health seems to have emerged as a major concern of many countries, leading to a number of rather limited but explicit initiatives in this area. On the other hand, a serious lack of financial and human resources, together with a host of institutional and socio-cultural factors, pose obstacles to the full implementation of the ICPD PoA. These are frequently cited constraints across all thematic areas. However, in many countries post-ICPD policy and legislative changes provide emerging opportunities for making a real difference to the lives of people through actions leading to the further implementation of the ICPD PoA.

APPENDIX 1 – Questionnaires on Country Level Experiences

A. QUESTIONNAIRE FOR DEVELOPING COUNTRIES

I. NATIONAL POPULATION POLICIES AND PROGRAMMES

1. Has the Government taken any new major policy measures (such as adopting an official population policy, strategy, action plan, white paper; or adopting a wider development strategy or plan that focuses on population as one of the key issues) that *integrate population concerns into an overall development strategy* at the national level?
    a. No development strategy exists
    b. No population concerns integrated/Only superficial integration
    c. In the process of adopting new policy/plan
    d. Yes (Please describe in one paragraph the key feature(s) of integration.)
2. Has the Government set up an *institutional body* (such as an inter-ministerial population council) for the purpose of integrating population concerns into relevant sectors of development efforts at the national level?
    a. No such institution exists
    b. A pre-ICPD institution exists (Please describe in one paragraph how it functions and any post-ICPD changes to its constitution.)
    c. Yes (Please describe in one paragraph the new institution and how it functions.)
3. Has the Government developed a mechanism for monitoring and measuring the progress in achieving quantitative goals of ICPD, such as universal access to reproductive health services, maternal and infant mortality, life expectancy, and others?
    a. ICPD goals have not been integrated into national strategy
    b. ICPD goals have been integrated into national strategy but no mechanism in place for monitoring
    c. Yes (Please describe the key indicators being tracked and how data is collected.)
4. Please describe constraints and challenges in integrating population concerns into development strategy.
5. Please state any *emerging opportunity and key future action* that could be taken by the Government to overcome these constraints to achieving the full integration of population concerns and development strategy as stated in the Programme of Action.
6. Has the Government or non-governmental institutions produced any major studies or reports after the ICPD that deal with key linkages between population dynamics (growth, distribution, age structure, fertility, mortality, migration, etc.) and socio-economic factors (unemployment, environment, production, savings, investment, social-sector spending, education, health, housing, food, security, natural resources, etc.)?
    a. No major reports/studies have been produced
    b. Yes (Please list their titles, author institutions and manner of dissemination.)

II. GENDER EQUALITY AND EMPOWERMENT OF WOMEN

7. Has the Government taken any policy measures, legislative changes, institutional changes, or other new major measures at the national level to protect *the rights of women* and to promote *the empowerment of women,* by *inter alia* eliminating discrimination and violence against women, and promoting the fulfillment of women's potential through education, skill development and employment?
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)
8. Has the Government taken any new major measures to improve *the universal access to primary education of the girl child?*
    a. Level of access already adequate
    b. Level of access not adequate and no new measures have been taken
    c. Yes (Please describe in one paragraph some of the key new measures.)
9. Has the Government taken any new major measures to involve women in planning, managing and *monitoring of reproductive health-care services?*
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)

10. Has the Government taken any new major measures to encourage and enable *men to take responsibility* for their sexual and reproductive behavior and their social and family roles by means of information, education, employment legislation, child-support law and others?
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)
11. Please describe any major *contribution of or collaboration with the civil society*, including non-governmental organizations, in, a) protecting the *rights of women* and promoting the empowerment of women, b) improving universal access to *primary education of the girl child*, c) *involving women* in planning, managing, and monitoring of reproductive health-care services, d) promoting *male responsibility* about their role in ensuring gender equality, and/or any other major initiatives in the area of gender equality and empowerment of women.
12. Please describe *constraints or challenges* faced by the Government in its efforts to achieve the ICPD goals in the area of gender equality and empowerment of women, some of which are described in the questions above.
13. Please state any *emerging opportunity and key future action* that could be taken by the Government to overcome the constraints to achieving the goals of the Programmes of Action in the area of gender equality and empowerment of women.

III. REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH-CARE

14. Has the Government taken any policy measures, legislative changes, and/or institutional changes or other major measures at the national level to affirm the recognition of *reproductive rights*, such as the right to decide freely the number and spacing of children, the right to a full range of reproductive health services, the right to be free of discrimination and violence, and others.
    a. No aspects of reproductive rights are explicitly recognized
    b. Some aspects of reproductive rights already explicitly recognized, and no new measures taken (Please describe in one paragraph which rights are already ensured.)
    c. Yes (Please describe in one paragraph key new measures.)
15. Has the Government taken any new major measures to improve the *universal access to reproductive health-care services*, including family planning?
    a. Level of access already adequate
    b. Level of access not adequate and no new measures have been taken
    c. Yes (Please describe in one paragraph some of the key new measures.)
16. Has the Government taken any measures to add *new components* (such as prenatal care, safe delivery and post-natal care, prevention and treatment of infertility, treatment of reproductive tract infections, sexually transmitted diseases, etc.) to the existing reproductive health programme?
    a. All components already exist
    b. Limited components exist and no new components added (Please list the existing components.)
    c. Yes (Please describe both the existing and new components added.)
17. Has the Government taken any new major measures to *integrate reproductive health-care services, including family planning, into primary health-care system?*
    a. Reproductive health-care components already fully integrated
    b. No or only limited reproductive health-care components integrated and no new measures have been taken
    c. Yes (Please describe in one paragraph which reproductive health services have been integrated into primary health-care system and how.)
18. Has the Government taken any new major measures to improve the *quality of existing reproductive health-care* to better meet the needs of clients?
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)
19. Has the Government taken any new major measures to *decentralize the health care system* and/or to promote *community participation* in reproductive health programmes?
    a. Health-care system already decentralized and no new measures have been taken
    b. Health-care system not decentralized and no new measures have been taken
    c. New measure(s) to decentralize the health care system have been taken (Please describe in one paragraph some of the key new measures.)
    d. New measure(s) to promote community participation have been taken (Please describe in one paragraph some of the key new measures.)

20. Has the Government taken any new major measures to address the needs of *adolescents* in reproductive health-care services, including information?
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)
21. Please describe any major *contribution of or collaboration with the civil society*, including non-governmental organizations, in, a) improving the *universal access* to reproductive health-care services, b) *integrating* reproductive health-care services into primary health-care system, c) improving the *quality* of existing reproductive health-care, d) addressing the needs of *adolescents* in reproductive health-care, and/or any other major initiatives in the area of reproductive rights and reproductive health-care.
22. Please describe *constraints or challenges* faced by the Government in its efforts to achieve the ICPD goals in the area of reproductive rights and reproductive health care, some of which are described in the questions above.
23. Please state any *emerging opportunity and key future action* that could be taken by the Government to overcome the constraints to achieving the goals of the Programmes of Action in the area of reproductive rights and reproductive health care.

IV. STRENGTHENING THE PARTNERSHIP WITH CIVIL SOCIETY

24. Has the Government taken any new major measures to promote the *involvement of civil society*, including non-governmental organizations, in planning, managing, implementing and monitoring population and development and policies and programmes at the national level?
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)
25. Has the Government taken any policy measures, legislative changes or any other major measures to strengthen the *institutional capacity of civil society*, including non-governmental organizations, working in the population field?
    a. No new measures have been taken
    b. Yes (Please describe in one paragraph some of the key new measures.)
26. Please describe any major initiatives by civil society, including non-governmental organizations, in, a) strengthening their *institutional sustainability*, *coalition building* and *responsiveness* to constituencies, and b) mobilizing additional *public and financial support* for population, especially Programme of Action goals and objectives.
27. Has the Government taken any new major measures to promote the *involvement of the private sector* in the implementation of the reproductive health-care services?
    a. Private sector already playing active role
    b. Private sector not active and no new measures have been taken (Please describe constraints in involving the private sector.)
    c. Yes (Please describe in one paragraph some of the key new measures.)
28. Please describe constraints or challenges faced by the Government in its efforts to promote the involvement of civil society, including non-governmental organizations, in population and development policies and programmes.
29. Please state any *emerging opportunity and key future action* that could be taken by the *Government* to overcome the constraints to strengthening the partnership with the civil society.
30. Please describe *constraints or challenges* faced by *civil society*, including non-governmental organizations, in their efforts to participate in policy dialogue and/or programme implementation at the national level.
31. Please state any *emerging opportunity and key future action* that can be taken by *civil society*, including non-governmental organizations, to overcome the constraints to strengthening the partnership with the Government.
32. Please describe any major progress made and/or any future action which might be taken in strengthening the partnership among the Government, non-governmental organizations and international bi- and multi-lateral development agencies.

B. QUESTIONNAIRE FOR DEVELOPED COUNTRIES

I. POPULATION CONCERNS AND ISSUES

1. Please describe current major population issues and concerns within your country, and any measures that have been taken to address these issues since ICPD.
2. Have there been any major developments in your country since ICPD on improving the *access to reproductive health care?*
    a. No major developments
    b. Yes (Please describe some of the key developments.)

3. Have there been any major developments in your country since ICPD addressing the *special needs of adolescents in reproductive health care?*
    a. No major developments
    b. Yes (Please describe some of the key developments.)
4. Have there been any major developments in your country since ICPD on protecting the *rights of women* and promoting the *empowerment of women*.
    a. No major developments
    b. Yes (Please describe some of the key developments.)
5. Please describe any major contribution of or collaboration with non-governmental organizations or other civil society organizations in, a) improving the access to reproductive health care, b) addressing the special needs of adolescents in reproductive health care, c) protecting the rights of women and promoting the empowerment of women, and/or in other initiatives in the area of key population issues.

II. INTERNATIONAL ASSISTANCE TO POPULATION PROGRAMMES

6. In the context of international assistance, what does your country perceive as the positive changes in developing countries induced by the Programme of Action on policies and programmes in population and development field?
7. Please describe what your country sees as major constraints faced by developing countries in implementing the Programme of Action.
8. Please describe constraints and challenges in your country in mobilizing resources for international assistance in the population field.
9. Please describe any emerging opportunity and key future actions to overcome the constraints discussed above.
10. Have there been any major developments in your country since ICPD with respect to the role played by non-governmental organizations as channels of international assistance?
    a. No major developments
    b. Yes (Please describe some of the key developments.)
11. Please describe any major contribution of or collaboration with non-governmental organizations or other civil society organizations in the area of international assistance in the population field.
12. Please state any issues in international assistance that you would suggest to be considered at the International Forum and in the preparatory activities of the Forum.

III. PARTNERSHIP WITH CIVIL SOCIETY

13. Have there been any major changes since ICPD in the role non-governmental organizations play in the policy-making and/or delivery of reproductive health care services in your country?
    a. No major changes
    b. Yes (Please describe some of the key changes.)
14. Have there been any major changes since ICPD in the role private sector plays in the reproductive health care programmes in your country?
    a. Private sector already playing active role
    b. Private sector not active and no changes since ICPD (Please describe constraints in involving the private sector.)
    c. Yes (Please describe some of the key changes.)
15. Please describe constraints or challenges faced in strengthening the partnership with non-governmental organizations and other civil society organizations.
16. Please state any emerging opportunity and key future action that could be taken to overcome the constraints discussed above.
17. Please describe constraints or challenges faced by non-governmental organizations in their effort to strengthen the partnership with Government.
18. Please state any emerging opportunity and key future action that could be taken by non-governmental organizations to overcome the constraints discussed above.

APPENDIX 2 - Developing Countries and Countries with Economies in Transition and Developed Countries Responding to the Field Inquiry

Region/subregion	Number	Countries
Africa	**43**	
East Africa		Burundi, Comoros, Ethiopia, Kenya, Madagascar, Malawi, Mauritius, Mozambique, Rwanda, Seychelles, United Republic of Tanzania, Uganda, Zambia, Zimbabwe
Central Africa		Angola, Cameroon, Central African Republic, Democratic Republic of Congo,
Southern Africa		Botswana, Lesotho, Namibia, South Africa, Swaziland
West Africa		Burkina Faso, Cape Verde, Côte d'Ivoire, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Togo
North Africa		Algeria, Egypt, Sudan, Tunisia, Morocco
Asia	**29**	
East Asia		China, Republic of Korea, DPR Korea, Mongolia,
Southeast Asia		Cambodia, Indonesia, Lao DPR, Myanmar, Philippines, Thailand, Viet Nam
South Asia		Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, Sri Lanka
West Asia		Jordan, Lebanon, Syrian Arab Rep., Turkey, Yemen
Central Asia		Azerbaijan, Kazakhstan, Tajikistan, Turkmenistan, Uzbekistan
E. Europe	**8**	Albania, Belarus, Estonia, Latvia, Poland, Romania, Russian Federation, Ukraine
Latin America and the Caribbean	**23**	Belize, Bolivia, Brazil, Colombia, Costa Rica, Ecuador, El Salvador, Guyana, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Uruguay, Venezuela
Caribbean		Barbados, Cuba, Dominican Republic, Haiti, Jamaica, St. Lucia, Trinidad and Tobago
Oceania	**11**	Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu
Total	**114**	
Developed Countries		Australia, Austria, Denmark, Finland, France, Germany, Ireland, Italy, Japan, Netherlands, New Zealand, Norway, Portugal, Spain, Sweden, Switzerland, United Kingdom, United States of America
Total	**18**	

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