

**European Population Forum 2004:
Population Challenges and Policy Responses**
Geneva, 12-14 January 2004

**A Decade of Experience with Implementing the Cairo Program of Action:
The UNFPA Field Inquiry in the UNECE Region**

Tomas Frejka

Background paper for session
Global Population and Development Trends: the European View.

Table of contents

1. Introduction
2. Background
3. Countries in transition
 - 3.1 Population and development
 - 3.2 Gender Equality, Equity and women's empowerment
 - 3.3 Reproductive rights and reproductive health
 - 3.4 Adolescents and youth
 - 3.5 HIV/AIDS
 - 3.6 Behavioral change and advocacy
 - 3.7 Data and research
 - 3.8 Partnerships and resources
 - 3.9 Best practices and emerging issues
4. Western countries
 - 4.1 Population concerns
 - 4.2 Gender issues
 - 4.3 Reproductive health, including HIV/AIDS
 - 4.4 Partnership with civil society
 - 4.5 International assistance to population and reproductive health
5. Summary and conclusions
 - 5.1 Countries in transition
 - 5.1.1 Adopted policies and measures
 - 5.1.2 Main issues requiring constant attention
 - 5.1.3 Principal constraints
 - 5.2 Western countries
 - 5.2.1 Adopted policies and measures
 - 5.2.2 Main issues requiring constant attention
 - 5.2.3 Principal constraints
6. Concluding thoughts
7. References
8. Appendix tables

1. Introduction

The International Conference on Population and Development (ICPD) which took place in Cairo in 1994 was the fifth in the series of world conferences of the second half of the 20th century. It distinguished itself in three ways. The agenda embraced by this conference was broader, the involvement of non-governmental organizations was far greater, and, while difficult to measure some would argue, its impact on national and international policies and programs was more powerful than ever before.

The conferences in 1954 and 1965 convened by the United Nations in collaboration with the International Union for the Scientific Study of Population (IUSSP) brought together experts from UN member countries to discuss scientific ideas and population issues. Starting with the Bucharest 1974 conference the focus shifted from scientific inquiry to that of population policy (Finkle, Crane 1975; Demeny 1985). The conferences became intergovernmental; their purpose was to make governments more aware of their population problems and to assist in dealing with the issues. The preparations for the 1994 Cairo conference, the event itself and its aftermath were in addition marked by a prominent and effective involvement of a wide variety of non-governmental organizations, most notably women's NGOs (Finkle, McIntosh 2002).

The Program of Action adopted by the ICPD “endorses a new strategy that emphasizes the integral linkages between population and development and focuses on meeting the needs of individual women and men, rather than achieving demographic targets” (United Nations 1995). The guiding principles of the Program of Action are full respect for human rights, particularly the rights of women, the empowerment of women and genuine gender equity. A wide range of population issues are covered, such as ageing, care for the elderly, family-sensitive policies, international migration, attention to the status of indigenous populations, as well as international cooperation. These are inextricably linked to broader issues, such as the elimination of poverty, provision of education (especially for women), securing employment and supporting a viable environment. Family planning programs are to be fully geared towards clients' needs and to encompass sexual and reproductive health, which includes not only the provision of and access to contraceptives, but also protection against and treatment of sexually transmitted diseases and HIV/AIDS infections, and attention to the needs of adolescents (United Nations 1995).

The experience with implementing the broad spectrum of policies and programs of the ICPD Program of Action over the past ten years is now being evaluated. On the most general level, not only has the ICPD had a profound impact on population policies and programs, but arguably its impact has been greater than any of the previous conferences. The 1954 and 1965 conferences were to a large extent scientific gatherings that evaluated and discussed the state of affairs, *inter alia*, that family planning programs started to be organized in a few countries reflecting at first the wisdom, foresight and intentions of private policy making entities, such as foundations, and increasingly the interests of developed and developing countries as expressed in the 1967 founding of the United Nations Fund for Population Activities (UNFPA). The clashes of ideologies and

opinions marked by the need for economic and social development in the developing countries (“new international economic order”; “development is the best contraceptive”) at the Bucharest 1974 conference turned out to have little effect on changing the basic nature of the principal policy instrument, family planning programs, which continued to spread throughout the developing world. Similarly, following the controversies at the 1984 Mexico conference (population growth was a “neutral phenomenon” with little or no effect on economic growth), family planning programs continued to spread and provide valuable services throughout the developing countries (Finkle, Crane 1985). Over the years many deficiencies and flaws were criticized and widespread innovations introduced, such as community-based distribution of contraceptives, social marketing and operations research. It was not until the 1990s, particularly as a consequence of the ICPD, that population related activities and programs encompassed a much wider range of issues than ever before, and with an altered focus, namely the individual (McIntosh, Finkle 1995; Finkle, McIntosh 2002).

This paper begins with a section of background information, including a brief description of the UNFPA Field Inquiry designed as an instrument to evaluate progress in implementing the ICPD Program of Action. Sections 3 and 4 are detailed evaluations of the implementation of the ICPD Program of Action in countries in transition and in the Western countries, respectively, as gleaned from the responses to the Field Inquiry questionnaires. Therefore these sections are structured in the same way as the respective questionnaires (see below). Section 5 provides a summary and conclusions.

2. Background

During 2003 UNFPA carried out a global Field Inquiry in collaboration with governments to review the implementation of the ICPD Program of Action in developing and developed countries. The ten-year review focuses on the operational dimensions of population and reproductive health policies and programs, assesses what progress countries have made in achieving the ICPD goals and the obstacles they face.

Two Field Inquiry questionnaires (FIQ) were prepared, one for developing countries, a second one for developed countries. -- The former covers: (i) policies and programs in population and development; (ii) gender equality, equity and women’s empowerment; (iii) reproductive rights and reproductive health; (iv) HIV/AIDS; (v) adolescents/youth (vi) behavioral change and advocacy; (vii) partnerships and resources; (viii) data and research; and (ix) best practices and emerging issues. – The FIQ for the developed countries focuses on (i) priority population concerns; (ii) gender issues; (iii) reproductive health, including HIV/AIDS; (iv) partnerships with civil society; and (v) international assistance to population and reproductive health programs.

This paper reports about information gathered from countries belonging to the United Nations Economic Commission for Europe (UNECE) with over one million inhabitants (Luxembourg was the exception). Countries with economies in transition were invited to complete the FIQ for the developing countries, and Western countries the

developed country FIQ (Slovenia was included in this group). Twenty-three of the 27 countries in transition completed the FIQ, and 14 of the 21 Western countries, i.e. an 85 and a 67 percent completion rate, respectively.

The Western countries fit the demographic characterization of a “developed” country adequately, whereas the case of the transition countries is complicated. Most Central and East European formerly socialist countries had reached low fertility by the middle of the 20th century and were labeled as demographically developed countries at that time. On the other hand, there were a number of countries that had not experienced the demographic transition by the mid-20th century and still had high fertility; these were the central Asian and the Caucasian republics, as well as Albania and Macedonia.¹ Political, social and economic developments in the formerly Soviet bloc differed from the developed and the developing countries. They were considered to be part of the “Second” World (Sauvy 1952). Demographic developments were influenced by the politically authoritarian and the centrally planned economic system. During the 1990s following the implosion of the USSR, population developments had peculiar characteristics, primarily unprecedented rapid fertility declines (Frejka and Sardon 2004; Macura and MacDonald 2003; Sobotka 2003 a, b). This provides part of the explanation why some countries might have had difficulties completing certain parts of the FIQs.

Understandably, the Field Inquiry is not without limitations resulting in differences in the quality of responses. The potential complexity of situations and events might not always be captured and the narratives could be distorted due to misunderstandings or possibly due to vested interests of the respondents. In some countries they erred on the side of describing enacted legislation and established institutions, but covered implementation and activities casually, superficially or only in a limited fashion. The causes of the limitations are several.

Countries used a broad spectrum of approaches to answer questions in the survey:

- (i) an inter-institutional/multi-sectoral response committee/group (including non-governmental organizations and international agencies working in the country);
- (ii) several government institutions;
- (iii) a committee/group from one institution; and
- (iv) a response from one focal individual.

Some degree of subjective judgment was likely to be reflected in the responses. Depending on the individuals or institutions, the answers in the questionnaire could be unintentionally or intentionally distorted. The individual or institutional respondent might have had incomplete knowledge regarding particular issues, events or processes. Alternatively, the individual or institutional respondent might have felt that it is in the interest of the country to present a relatively positive description of a particular issue, event or process, because a realistic description might be undesirable or harmful to the interests of the country.

¹ With the exception of Albania these countries gained independence in the 1990s.

The inquiry was conducted in English and at times that could have been a problem. In several countries the respondents had language difficulties. They might have understood the questions, however, they had difficulties formulating the answers. In other countries, the respondents might have even misunderstood questions and had major problems expressing themselves in English.

Certain aspects in the design of the FIQs could be questioned. As indicated above, there were only two types of questionnaires: for the developing countries and for the developed ones. The questionnaire designed for developing countries was applied in the countries in transition. While this might have been reasonably appropriate say in the Central Asian countries, potential respondents in Central European countries might have found these questionnaires ill fitted for their respective conditions.

Some respondents might have found it difficult to formulate answers to a number of questions in a concise summary form. There were, for instance, questions requesting a description of how the cultural context contributed to, or constrained desired progress on a certain issue. The respondents may have believed that the questions were too broad and that adequate answers would require a long and detailed elaboration. They would have wanted to describe attitudes as they developed during the history of the country, which were possibly different among various strata of the population. The contemporary situation might vary in different parts of the country or among different groups of the population, etc. Even with the best of intentions the actual responses might not have captured the most important features of the present complex situation.

3. Countries in transition

Early in the 21st century countries in transition were relatively poor, but their populations had two important characteristics: they were well educated and reasonably healthy. In a few transition countries the 2001 gross domestic product (GDP) per capita in purchasing power parity was between \$10,000-17,000, but in the majority it was below \$8,000 and not infrequently around \$4,000 or less (Appendix Table 1). In most Western countries GDP/cap was around \$25,000 or more, with the exception of Southern Europe where it was between \$17-25,000.

In contrast to the economic deprivation, the level of general education was almost comparable to Western countries; rates of secondary school enrollment ratios were not much lower in the transition countries. Overall health conditions in the transition countries were inferior, but reasonably favorable in the global context. This state of affairs was the result of secular political, social and economic developments, especially those of the second half of the 20th century, as well as the unprecedented transitions experienced by these countries since the collapse of the authoritarian political systems around 1990. They have to be taken into account when reviewing the implementation of the ICPD Program of Action.

There were major differences among the individual transition countries. The countries of Central Europe and the Baltic Republics had relatively better overall conditions than most of the other countries, especially those of the Caucasus region and Central Asia. The latter were among the poorest in the world, yet even their educational levels were relatively high.

Many countries had adopted comprehensive approaches to issues of population and development, gender equality, reproductive rights and reproductive health, as well as the involvement of non-governmental organizations and civil society. Romania provides a good example. There “strategies, programmes and national plans of action have been elaborated, specific institutional capacities have been created and substantial public funds have been allocated aiming at achieving the goals of the Program of Action adopted by ICPD.” More specifically, this concerns the following areas: reduction of poverty; unemployment and social exclusion; improving the social assistance system; reform of the public pension system and other social insurance rights; health system reform; educational system reform; central and local public administration and regional development reform; a national action program aimed at the protection of the environment and setting up strategies for various population categories, such as child protection, social protection and promotion of youth, women’s rights promotion and equity between sexes, elderly social protection, and upholding multicultural development and cultural and social integration of ethnical communities, with special emphasis on improving the condition of the Roma population.

Efforts to deal with population issues are taking place in the context of the transition of the political, social and economic systems. Any judgments and evaluations of the progress made in transforming the political systems are extremely complex to summarize. Democratic and market economy systems are apparently functioning reasonably well in the Central European and Baltic countries, as well as possibly in other ones. Evidence is provided by the decision of the European Union to incorporate eight of these in 2004 and considering the inclusion of other countries later.

On the other end of the spectrum are countries where the political system still has many deficiencies and/or where ethnic and other tensions were of such magnitudes that they lead to riots and armed conflicts. In Azerbaijan, for instance, there are large numbers of refugees and internally displaced persons comprising around 10 per cent of the population. Most of them live in unsuitable dwellings and have limited income generating opportunities.

The economic transition has been difficult, often painful. Gross domestic products contracted substantially in all transition countries during most of the 1990s (UNECE 2003 a, b; Appendix Table 1). By the late 1990s recoveries were under way, however, the GDP in 2002 had surpassed the 1989 level only in the Central European countries. In a number of countries, such as Georgia, Moldova, Tajikistan and Ukraine, GDP in 2002 had not even reached one half of its 1989 size.

Demographic trends were rather tumultuous marked especially by an extraordinarily rapid fertility decline. At the outset of the 21st century total fertility rates in almost all the countries in transition were below replacement, often substantially. Health conditions were inferior to Western countries (Appendix Table 1). For instance, infant mortality rates in the Central Asian countries in the late 1990s were between 40 and 60 deaths per 1,000 births, however in most other South-Central Asian countries these rates were even higher (UNDP 2003). The state of maternal mortality was similar.

The measure reflecting gender equality in the Appendix Tables is far from perfect, but it does provide an indication of real relationships. In over one third of the countries in transition less than 10 percent of seats in parliaments are held by women and only in 4 of the 27 countries women held more than 20 percent of the seats. On average this is considerably less than in the Western countries.

The low number of telephone lines, in particular in the central Asian and Caucasian countries, indicates the degree of difficulty the majority of the population has with obtaining relevant information.

A crude overall measure of wellbeing of populations is provided by the Human Development Index (HDI)². Practically all countries in transition are above the global average of 0.722 and about half of these countries are among the top one-third (Appendix Table 1). As a rule it tends to be the relatively high level of education that counteracts the relatively low economic status of individual countries in transition, which elevates their HDI.

We now turn to a more detailed evaluation of progress made in implementing the ICPD Program of Action.

3.1 Population and development

Poverty reduction

The prevalence of poverty and strategies for poverty reduction are among the central issues that almost all countries in transition are concerned about. Frequently governments consider efforts to improve the health status of the population, the promotion of reproductive rights and reproductive health, the prevention and treatment of HIV/AIDS as avenues to reduce poverty and these activities are included in Poverty Reduction Strategy Papers (e.g., Albania and Caucasian countries). The main goals of Uzbekistan's poverty reduction strategy are: improvement in the mechanisms of social protection; and reduction of social disparity through strong measures addressing various

² The HDI – human development index – is a summary composite index that measures a country's average achievements in three basic aspects of human development: longevity, knowledge, and a decent standard of living. Longevity is measured by life expectancy at birth; knowledge is measured by a combination of the adult literacy rate and the combined primary, secondary, and tertiary gross enrolment ratio; and standard of living by GDP per capita in purchasing power parity US\$ (UNDP 2003).

levels and groups of population which include government interventions to redress disparities in income.

Implementation of poverty reduction efforts are often restricted by a lack of resources. Tajikistan's government states that its concerns in the area of population and development are overwhelmed by the daunting difficulties caused by "the consequences of the collapse of the USSR, and the civil war in the country" ... consequently ... "there is a lack of resources for corresponding program implementation" and "the institutional capacity for implementation is still at a low level."

Population ageing and care for the elderly

Many countries perceive population ageing as an issue and practically all governments have developed programs to improve care for the elderly. The programs tend to include the development of health and social services, providing employment opportunities and leisure activities, but again, implementation is restricted due to lack of funding and whatever measures are implemented tend to be inadequate. In Armenia the major initiatives of the government have been aiming at provision of minimum living standards through targeted social assistance and social benefits. Taking into account the severe budgetary constraints, the initiatives have had little impact. Pensions and benefits of the pensioners and handicapped are 2-2.5 times below the poverty line. The special needs of older people remain largely unmet and are mostly taken care of through informal social support networks (families, charity groups, etc.).

The environment

Environmental concerns have attracted significant attention. Numerous activities are, for instance, under way in Slovakia, namely to improve the quality of the air and water, to deal with waste management and to protect nature. A documentation center for environmental impact assessments was established at the Slovak Environmental Agency.

The Aral Sea area is of special concern for at least two countries. The government of Turkmenistan supports and contributes to the implementation of international and regional programs related to the elimination of consequences of ecological catastrophes, such as the program on the Aral Sea. The international NGO Médecins Sans Frontières collaborates with the governments of Turkmenistan and Uzbekistan to counter the environmental impact resulting from the desiccation of the Aral Sea. Coupled with worsening poverty and a general deterioration of health services, this has exposed the population living in and around the Aral Sea area to an unprecedented humanitarian and health crisis. The Aral Sea area program, covering Khorezm and Karakalpakstan in Uzbekistan, and Dashoguz in Turkmenistan, is a humanitarian attempt to improve the health of a population that suffers from high rates of tuberculosis. The aim is to provide 4 million people in the Aral Sea area with access to a World Health Organization recommended tuberculosis treatment program known as DOTS (Directly Observed Treatment, Short-Course).

Migration

A number of internal and international migration issues are being addressed. One example is the Southeastern Anatolia Project with the objective to diminish the potential for internal migration. This has continued to be implemented as a multidimensional, integrated development project, which is anticipated to gradually narrow the gap between the eastern and western regions of Turkey.

As a consequence of wars some countries had to deal with large numbers of refugees and internally displaced persons, most notably the West Balkan, Caucasian and Central Asian countries. At the same time, illegal international migration, in particular transit migration, is a matter of continuous concern in practically all countries of the region.

3.2 Gender equality, equity and women's empowerment

Legislation and institutions

Relevant legislation has been enacted and various types of institutions have been established to promote and ensure gender equality and support the empowerment of women. In Poland, for instance, the Government established the Office of the Plenipotentiary for Gender Equal Status. In Turkey the General Directorate on the Status and Problems of Women, which was established in 1990 as the national mechanism to empower women and ensure gender equality, continues to function under the Prime Ministry.

Education

Education is the area in which there is almost no discrimination against girls and women in practically all the countries of the ECE region, and moreover there are high rates of enrolment, including secondary and tertiary level education. This provides a solid base for gender equity and empowerment of women. Nevertheless, it was observed that "the mere fact of being educated does not create equal opportunities for women." Other peculiar problems regarding education are emerging. In some countries attendance rates are declining, especially among boys, because they have to start working early in life to support inadequate family income. A related problem is the deterioration in the quality of education due to lack of textbooks, poor physical infrastructure, outdated curricula, low pay and shortage of teachers (Azerbaijan document).

Cultural context and religion

The cultural and societal context surrounding issues of gender equality and empowerment of women is complex and uneven.

The Kyrgyz document, for instance, evokes historical experience: "The domestic life style has been ensuring gender balance of the nomadic Kyrgyz people." Legends such as 'Manas', 'Janyl-myrza' and others are noted. Because of the demands of the nomadic economy, women worked as virtual equals with men, having responsibility for chores such as milking as well as child-rearing and the preparation and storage of food. In the

ordinary family, women enjoyed approximately equal status with their husbands. Kyrgyz oral literature includes the story of Janyl-myrza, a young woman who led her tribe to liberation from the enemy when no man in the tribe could do so. Similar roots for gender equality are found in Azeri history and folklore. On the other hand, the contemporary situation in Moldova is characterized as follows: “In reality ... the situation of the woman ... is less favorable than that of the man.

- Women are more often subject to violence, including sexual violence
- Young women are drawn into prostitution inside and outside the country
- It is completely up to the woman to take responsibility for sexual behavior, pregnancy, the decision whether to have or not an abortion
- It is women mostly who rear and educate the children
- Gender inequality is also supported by traditions ...”

The cultural context enveloping gender issues has been changing in all the countries concerned, but many people seem reluctant to transform their patriarchal worldview on the roles of men and women and to accept the principle of gender equality. The Albanian document emphasizes that its society is male dominated, the status of the woman remains low and the wife is under the dictate of her husband.

The influence of religion -- Catholic, Christian orthodox and Islam -- can be beneficial and harmful at the same time. Religious leaders may be involved in appropriate moral edification, including reproductive health education. Frequently, however, the impact of the church is perceived to be in conflict with the interests of most women. NGOs and many other institutions see the restrictive 1993 abortion law as one of the most serious gender, reproductive rights and reproductive health issues in Poland. These NGOs claim that there is practically no access to legal abortion and only limited access to family planning as well as a limited choice of contraceptive means and questionable sexual education in Poland.

Attitudes to providing a choice of contraceptives, access to safe legal induced abortion, offering reproductive health or sexual education tend to be liberal in most countries in transition. In some countries, for instance in Slovakia and Lithuania, forces opposing the above options are becoming vocal.

Gender-related violence and trafficking

Gender related violence appears to be a common problem. Infrastructure to combat violence and to assist victims is being developed. In Lithuania, for example, women’s organizations run centers which provide support for victims of domestic violence and these work on issues of violence against women, including awareness raising, information campaigns, training, publications etc.

In other countries the institutions and legislation to prevent violence against women are thus far only in the formative stage. In Romania a national committee comprising government institutions and NGOs active in the field was created aiming at designing a national strategy to address domestic violence. Crisis centers providing support for victims of domestic violence, including shelters, counseling, juridical and

social support were organized on a pilot basis by NGOs and by the government following the Beijing Conference. According to the Armenian document “the issue of domestic violence is not being properly addressed. Though the legislature provides for some mechanisms, however, case reporting and law enforcement is very weak. There are few NGOs who are dealing with the issue of domestic violence.” The Uzbek document states that “many cases of infanticide, especially of baby girls, sexual violence and illicit trade of girls have been reported.” In Uzbekistan the Women’s Committee undertakes active work on prevention of violence against women jointly with women’s NGOs and international organizations. The Women’s Committee is developing a draft Law “On Violence” jointly with the Soros Foundation. Also under this activity, a manual for training on gender issues for higher and secondary educational institutions had been prepared. Country-wide, workshops are held on the rights of women and girls. In 2001, the Women’s Committee and UNIFEM launched a project on the prevention of all types of violence against women which is being implemented. Despite these efforts, there are critical problems. There are no organized refuge centers in Uzbekistan where victims of domestic violence and trafficking can receive adequate help and care.

In all countries trafficking of women is a matter of concern. Poverty is a breeding ground for prostitution and many young women are easily recruited by criminal elements engaged in human trafficking. Programs to prevent and control trafficking in human beings have been instituted. They are engaged “in critical areas, such as analysis, assessment and monitoring of the situation, education and awareness raising, support to victims and protection of victims, improvement of legal regulations, etc.” (Lithuania document).

3.3 Reproductive rights and reproductive health

Legislation and institutions

In all countries appropriate legislation has been adopted and relevant administrative bodies have been established. Existing reproductive health service networks have either been strengthened, overhauled, or new ones have been developed. This will tend to include the training of medical, pedagogical and social workers; expansion of prenatal, perinatal and postnatal care; increasing accessibility of family planning services; meeting the population's needs in contraceptives; prevention of unwanted pregnancies; developing an infrastructure for infertility treatment; and intensified attention to STDs, including HIV/AIDS. In some countries the coverage is not yet universal. Most countries have experienced a decline in induced abortions and maternal mortality during the past 10-15 years, but both phenomena are still considerably more prevalent than in the West (Appendix tables).

To provide a glimpse regarding the complexity of dealing with reproductive rights and reproductive health within countries, take the example of Slovakia. The legislative framework for protecting sexual and reproductive health and rights is well developed. Recent political developments may, however, jeopardize some of the reproductive rights and the trends towards improvements in the field of reproductive health that have been

achieved in the most recent decade. A strong anti-abortion movement has recently emerged which is fighting the liberal abortion law as well as the right to family planning services, sex education, contraception and sterilization. The anti-abortion movement receives strong support from the Roman Catholic Church and the Christian Democratic Party. Apparently the conflict between 'pro-life' and 'pro-choice' initiatives is deepening.

Reproductive health services and their quality

The infrastructure to deliver reproductive health services has been strengthened. In the Russian Federation, for instance, the government created about 500 centers of family planning and human reproduction and the Russian Association of Family Planning is operating more than 50 branches. In Armenia the Ministry of Health jointly with UNFPA has set up a network of FP cabinets across the country which provides access to modern contraceptives, and FP counseling. Successful "traveling doctor" schemes operate in several regions of the country, which provide RH services, including antenatal services and FP, to hard-to-reach and remote rural areas.

Efforts to improve the quality of RH services are being pursued throughout the region. In Bulgaria this involves putting in place adequate controls, informed consent, upgrading the facilities of medical practices, training general practitioners in reproductive health matters, creating incentives and setting required levels of qualification. The dilemma is that increasingly payments are required for quality reproductive services and most women cannot afford the costs.

Various measures to reduce maternal mortality were implemented. In Romania the maternal mortality rate dropped significantly in the last 13 years, especially after legalizing abortion and due to the implementation of the family planning program: from 179 in 1989 to 27 maternal deaths/100 000 births in 2002. This rate was still high in the European context. In Uzbekistan the Ministry of Health focuses on a number of issues, namely birth spacing, prevention of early marriages and marriages between close relatives, prevention of unwanted pregnancies, retraining of health care providers, strengthening of logistics of medical facilities, rendering of services to children and mothers. In Kazakhstan, in view of the fact that 63.6 percent of pregnant women suffer from anemia 15 enterprises have started to fortify wheat with iron supplements. The fortification of wheat is planned nation-wide which will help to prevent anemia. Further, information campaigns on the usage of iodized salt for prevention of iodine deficient anemia were initiated.

All governments are making efforts to expand contraceptive choice, but the means to do so are in short supply. In a number of countries a significant proportion of modern contraceptives are provided by international donors. In the Kyrgyz Republic due to the lack of funds the Government relies totally on the support from international organizations and humanitarian aid in order to expand contraceptive choice. In Tajikistan in the majority of towns and regions even the UNFPA supported projects are not sufficient to cover the need for contraceptives. In Uzbekistan the Government provides 10 percent of the total funds for procurement of contraceptives with provision for annual

increase. The rest comes from donors and UNFPA is the main donor for the procurement and supply of all types of contraceptives.

Traditionally the majority of induced abortions were performed under relatively safe conditions and the efforts to prevent and manage unsafe abortions intensified in recent years. In Moldova “12 safe pregnancy-termination centers were equipped. The medical staffs working in these centers were trained in pre- and post-abortion counseling, prevention and management of complications associated with abortion.”

Constraints to improving reproductive health

The constraints to improving reproductive health in individual countries differ from one country to another. The principal constraints are lack of resources: qualified human, material, or financial.

Another constraint is the rejection of hormonal contraceptives. For decades under the previous regimes these were considered unsafe, their use was severely restricted and an atmosphere of mistrust in their use prevailed. The lack of trust in hormonal contraception persists in a number of countries, for instance, in Bulgaria. Also in Bulgaria there is a lack of funding needed for the reimbursement of contraception by the National Health Insurance Fund combined with a lack of understanding from the education authorities. In the Kyrgyz Republic “the major constraint is a lack of population awareness in RH care issues, which is caused by some national and cultural traditions. Lessons on hygiene and sexual education are not enough in secondary and high schools. There are not enough specialists in the above spheres. There is a lack of Government funds.” The Tajik document summarizes the constraints as problems related to the lack of financing of the health sector, still persisting the lack of qualification of the health personnel in the regions, poor telephone communication, low equipment of the health sector with modern medical equipment, lack of contraceptive means and an inadequate program on teaching in secondary schools in RH issues and RH rights. In Kazakhstan the majority of difficulties arise due to limitation of financing of the programs and strategies; for example, the programs dealing with HIV/AIDS. The problem is solved through attracting donor organizations or donor countries. Unfortunately, in the international community there is so called ‘donor tiredness’, which complicates the financing of the programs from outside.

The cultural context

Most countries consider the cultural context for the promotion of reproductive rights and reproductive health as favorable, which is not to say that there are no problems.

In Georgia the lack of information on RH issues inherited from the Soviet era was the main problem and reason for a high abortion rate. Ongoing IEC activities, supported by UNFPA are extremely successful due to the comprehensive approach and relevance within the cultural context. In Azerbaijan over the past few years the importance of collaboration in the promotion of reproductive rights and reproductive health began to be recognized by different groups of civil society. Several activities were conducted among youth in schools, as well as with religious communities in mosques, women’s NGOs,

mass media representatives, writers and artists; discussions on popular radio and TV channels on the subject of reproductive rights and reproductive health were also held. At the same time, the idea of open discussions of certain topics, such as sexual relations, multiple sexual partners, information on safe sexual behavior, etc. have not yet been accepted by the majority of population living in rural regions of the country. The cultural constraints are also the barrier to the use of some terms, such as sex, sexual behavior and the like in textbooks and IEC materials for adolescents.

In Kazakhstan there is a high level of education; family values and tolerance help to promote reproductive rights and reproductive health in urban areas. At the same time, a different situation exists in rural areas where traditionally such problems are not discussed openly and people do not pay attention to reproductive health, contraception and family planning. The Tajik document lists the “encouragement by the religious leaders of the pursued policy” as a positive circumstance and adds that “there exist very many problems, including the existing orientation of families to have many children, not knowing the real approach of Islam to RH services and RH rights, insufficient knowledge of women of their rights, the leading role of a man or a mother-in-law in making decisions on timely reference to medical aid to get aid in RH services, and a high rate of poor families, as impacting negatively on the efficient realization of the public policy of the Government in this field.”

3.4 Adolescents and youth

Reproductive health education

All countries are involved in efforts to provide appropriate information and education as well as youth friendly RH services for adolescents and young people. Many of the activities are still in the design and preparation stage. Often there is a lack of experience and qualified personnel/teachers. In a number of countries opposition to such activities has emerged from conservative institutions, possibly parents are skeptical and the influence of the religious institutions is felt.

In Slovakia the concept of education towards marriage and parenthood is designed to contribute to the development of the personality of the boy or girl and to help them to understand moral, social, psychological and physiological differences between the sexes, and thus create optimal human relationships. It is a detailed and adequately tailored system at all levels of primary and secondary education. The content of this education consists of: 1. Education in the family; 2. Basic principles of a healthy life; 3. Negative impact of smoking, drinking alcohol and other drugs on health and behavior of human beings; 4. Gender equality; 5. Birth and evolution of the human being; and 6. Changes in the child’s organism during puberty.

Projects in family planning, sexual education and reproductive health are being implemented in Bulgaria, but so far they are fragmentary and not in effect across the entire school system. The “Health Education in Romanian Schools” national program, including reproductive health education, is to be implemented in the education system

starting 2003/04. Constraints: insufficient information materials, not enough trained teachers and insufficient funds.

In the Kyrgyz Republic the main constraint is lack of training for teachers on RH care issues. The NGOs are working in all regions of the republic. Lectures and seminars are conducted for youth. Video-audio spots on RH issues are developed by trained specialists. Unfortunately, however, such work is undertaken mainly in big towns, whereas access to information of country youth is limited.

Youth friendly services

The effort to establish youth friendly services in sexual-reproductive health is a common goal throughout the region. In Belarus in many policlinics special receptions (cabinets) are set up by child and teenager gynecologists, who undergo special training to work with teenagers. Doctors, gynecologists-obstetricians carry out educational work with senior schoolchildren and students of higher educational institutions. The Moldova document alerts to a common problem, namely that the number and capacity of these centers is insufficient to provide access to reproductive health services for all adolescents.

Unwanted pregnancies and abortions

The Kazakh government is concerned with a complex set of problems, such as undesirable pregnancy, abortions and the high prevalence of sexually transmitted infections among teenagers. At the same time, an even more serious concern is expressed regarding low numbers of desired children and actual depressed fertility of young people presumably caused by untoward social and economic conditions.

Bulgaria has a high incidence of childbearing and abortions before the age of 15 because no special approaches are used to address the needs of girls and boys in this age group, particularly those from the communities at risk: the poor and the Romas. In Romania health education program, including RH and sexuality education, are implemented on a pilot basis by NGOs for young recruits in some military units. The Ministry of Education and Research is also implementing a national program called "The Second Chance" addressed to the Roma population aiming at providing access to education, including health education, for Roma youth that abandoned school.

The cultural context

In general the cultural context in countries of the former Yugoslavia has contributed to the promotion of adolescent reproductive health. However "many people still consider sex taboo so youth should somehow learn, but not in the system or home or at school" (B & H document).

The Azerbaijani document considers the cultural context and the Islam religion as supportive for the promotion of adolescent reproductive health: "Reproductive health of human beings has its detached and individual place in the holy book of Moslems, namely the Koran. The need for promotion of reproductive health and ability to reproduction for both males and females has been described in the corresponding surahs of the book. Being well read on the fundamental essentials of the Koran, Azerbaijani population

promotes the cultural context of Islam with its contribution to the subject of protection of reproductive health for all population strata, and for adolescents as well.”

A number of features regarding the cultural context influencing the promotion of adolescent reproductive health in Central Asia were raised. In the Kyrgyz Republic traditions of minor girls’ match-making, abduction of minor brides, and the practice of illegal polygamy are frequently encountered. Patriarchal stereotypes still run deep in Uzbek society preventing the effective promotion of responsibility for reproductive health, especially among young men. In Tajikistan concern is expressed that the multi-children family, a high level of poverty, a low level of knowledge, particularly among parents, on RH issues of the adolescents and a lack of instruction on the issues of the basics of family life and healthy life style in secondary schools are all constraining the promotion of RH among adolescents.

Employment opportunities

Governments throughout the region realize that one of the priority challenges is to provide appropriate education and employment for their young people. They constitute a large proportion of the potential work force and are faced with considerable difficulties in finding employment. The official youth unemployment rate in Kazakhstan was 24.3 percent, which is more than double the total unemployment rate, 10.8 percent. The alarming fact is that about 75 percent of unemployed are made up by youth. Innovative programs are being implemented. For instance, pilot projects on training and providing credit to young people wishing to open their own businesses were succeeding (on the basis of programs for small business support and regional programs). The Kyrgyz document states that despite of the efforts of the Government, no progress is observed in providing appropriate education and employment for young people.

Participation in public life

The participation of adolescents in policy and program development is taking on various forms. In Ukraine, for instance, youth organizations of political parties are actively involved in political life. A Ukrainian National Committee of Youth Organizations has been established. This Committee represents the interests of young people's movement in relationships with the supreme authorities of Ukraine. In Moldova youth participate in decision making on sexual and reproductive health through NGOs. Youth NGO leaders participate at meetings of the National Council for Family Planning and Reproductive Health, which is under the Ministry of Health. A positive example is also a UNFPA page on RH/FP/IEC in *The Week* newspaper, UNICEF-sponsored column in the weekly *Saptamaina*, called ‘Children’s Parliament.’ This is a very original and effective way for youth to participate in discussions on very important topics for the young generation.

Legislative and administrative steps have been taken in Central Asia for adolescents and youth to participate in policy and program development. Actual involvement tends to be formalized on the national level and some specific activities have been successful. In Kazakhstan two youth television programs were established: ‘City of the future’ (1998) and ‘Azamat’ (1999). During these programs young people discuss

actual questions of the modern world and Kazakhstan, and they offer decisions for solving current problems. These programs provide the possibility for young people to express and defend their own civil position. However, “it should be noted that currently the social and political activity of public youth associations in Tajikistan is at a rather low level.”

3.5 HIV/AIDS

The epidemic and its funding

Comprehensive legal frameworks to combat the HIV/AIDS epidemic have been adopted throughout the region and numerous measures have been applied. Despite that the prevalence of HIV/AIDS is among the highest in the world. UNAIDS has concluded: “The AIDS epidemic in Eastern Europe and Central Asia shows no sign of abating. Worst-affected are the Russian Federation, Ukraine, and the Baltic States, but HIV continues to spread in Belarus, Moldova and Kazakhstan, while more recent epidemics are now evident in Kyrgyzstan and Uzbekistan” (UNAIDS 2003).

Financing of the programs to prevent the spread of HIV/AIDS and to combat the epidemic tends to be a problem. Practically all the countries of the former Soviet Union are heavily dependent on international assistance, however the amounts provided are apparently not sufficient to support needed activities. For instance, the Kazakhstan government received \$ 22 million from The Global Foundation on Counteracting the HIV/AIDS epidemic, tuberculosis and malaria, but states that “for successful realisation of the program this amount is not enough.”

Lack of political commitment and misperceptions of the population

In many of these countries, the severity of the HIV/AIDS epidemic is not sufficiently realized by the authorities. The document for Bosnia & Herzegovina states that “probably half of the government officials claim that HIV/AIDS has nothing to do with BiH.” Further, in addition to widespread misconceptions of the issues in most countries, the cultural environment constrains the implementation of programs. In Lithuania, for instance, there is a “(S)tigma against HIV positive people and vulnerable groups (IDU’s, sex workers, MSM), (and) opposition of catholic religious leaders against condoms and abortion.” This is confirmed in the UNDP comment in the Polish document: “Catholic Church restrictive attitude towards free sexual contacts – does not admit its existence, (and there is a) relatively low public awareness of HIV/AIDS, low tolerance, lack of adequate education and information especially in public schooling.” At the same time the UNDP points to the “(P)revailing culture of care of the sick and vulnerable – (in the) catholic faith background.”

In Romania a big share of the population have a misperception regarding infection transmission. Only 63 percent of men and 50 percent of women consider the condom as a means of prevention. Population with low education and socio-economic status, rural population and Roma are less aware of prevention measures. The self-perceived risk of HIV/AIDS is also low among these categories of the population. The cultural context is

still very judgmental in Romania – an HIV positive person is immediately labeled as a prostitute or drug user. Confidentiality is not considered a value either by professionals or by the general population; that could lead to abuse and social exclusion of HIV positive people.

The cultural context

In Azerbaijan much of the cultural context is considered favorable for combating HIV/AIDS. The government, including the representatives of power ministries and religious communities, has recognized the importance of collaboration with different groups of society in prevention of HIV/AIDS spread in the country. Awareness seminars were conducted for religious communities (male) in mosques and for cadets of the Police Academy. Education campaigns on HIV/AIDS prevention were conducted through radio broadcasts and music programs by popular DJs. Yet difficulties remain. There are several constraints identified during implementation of the activities on HIV/AIDS, such as conducting of open discussions of some aspects of HIV/AIDS, especially those related to sexual behavior, such as preventing HIV infection among the population that is at particularly high risk of infection, including sex workers and men having sex with men, sexual behavior of adolescents, due to the cultural context of a country with the Islamic religion being dominant.

In Uzbekistan, and this is similar in the other countries of Central Asia, the country's cultural values strongly favor the promotion of people's responsibility for health, for a healthy lifestyle, and the raising of a healthy generation. The high respect for the elderly and the strong *makhallya* (local government) system provide ready support for social programs in the community. *Makhallya* leaders are trusted by the people as agents for the dissemination of useful information, new methods and approaches for family and community life improvement. On the other hand, the country's cultural traditions do not allow people to discuss openly intimate sexual life, especially among young people. This factor hampers prevention programs and advocacy for condom use. The Kazakh document adds: "The majority of young people know what measures should be undertaken, however, they do not apply them." An extensive description of the issues involved is included in the Tajik document: "The difficult social-economic situation, insufficient financing for prophylactic programs, poor content of some legislative articles (injection drug users), lack of condoms and needles for vulnerable groups, lack of anonymous free dermo-venerological and narcological services, unemployment, intensive external and internal migration, non-organized treatment of HIV infected by ARV therapy, prevention of the transmission of HIV from mother to child."

3.6 Behavioral change and advocacy

Many different means and methods are applied to bring about behavioral change and conduct advocacy. Usually the focus is on using the media, including modern ones, such as internet web-sites and telephone hot-lines.

The Slovak government is taking a broad and comprehensive approach which includes: improving the legal environment; promoting RH education; coordination and cooperation with the NGO sector; using the modern media (internet, TV, radio broadcast, etc.) for awareness campaigns; and the establishment of centers of counseling and psychological services.

Innovative ideas were introduced and used, for instance, in Romania and Bosnia & Herzegovina. To expand coverage in the mass media of issues relating to reproductive rights and reproductive health in Romania public interest information is broadcasted free of charge by the national public TV and radio stations. Furthermore, the Youth for Youth Foundation with UNFPA support is implementing the VENERIX campaign consisting of an educational computer game on HIV/AIDS/STIs themes, a website (www.venerix.ro) with the game and other information to be easily accessed and downloaded. An intensive game promotion campaign was launched in high schools and internet cafes. In 2002 the site was improved to be really dynamic and attractive: on-line flash games were added, as well as trivia, chat, forum and a newsletter. More than 130.000 visitors accessed the site in 2002. In B & H a UNFPA/IRC project developed very effective mass media projects dealing with STIs, including HIV/AIDS, contraceptives, informed choice, and gender-based violence. Film festivals, sports events, different fairs and mass gatherings are becoming places to promote responsible RH behavior and to recruit volunteers. Also the film Sexicon has been very popular.

Topics covered in public educational campaigns in Russia include such important issues, as safe motherhood; family planning; cruelty to children; violence to women; the responsibility of men; equality of men and women; sexually transmitted diseases and HIV/AIDS; and responsible sexual behavior.

A variety of mass media campaigns devised by government agencies and NGOs have taken place in Albania. Private TV channels have been broadcasting for free programs on RH/RR with the participation of specialists from different fields. NGOs have organized telephone hot lines for gender based violence. Youth centers and internet cafes have been involved in promoting responsible public educational campaigns reproductive health behaviors.

The promotion of behavioral change and advocacy has encountered difficulties. The extent of political commitment can be an issue. In Kazakhstan the problem with sexually transmitted diseases is not emphasized as one of the priorities by the Ministry of Healthcare meaning that it is not under proper attention of ministry. Throughout Central Asia, as described in the Kyrgyz document, the functioning of hotlines, conducting of TV and radio talk shows, the production of documentary films are instituted. Unfortunately, communication technologies, such as the internet, are available for only three percent of the population. Similarly in Uzbekistan there are hot lines through which one can get confidential information and counseling on HIV/AIDS/STI issues. However, due to the limitations of the telecommunication system, access to these is restricted.

3.7 Data and research

Statistical systems and surveys

Almost all countries have relatively advanced and adequate systems of data registration, collection, processing and publication. As a rule these are being modernized, often in collaboration with Eurostat or other Western institutions. The basis for population data were censuses taken in recent years.

Various types of demographic and reproductive health surveys have been taken in practically all the countries of the region. In Central Asia these were conducted in Kazakhstan, the Kyrgyz Republic, Turkmenistan and Uzbekistan; in all three Caucasian countries; and in Eastern Europe in Moldova, Romania, Russia (three urban areas) and Ukraine. Analyses utilizing these surveys provide solid policy relevant research findings. In Turkey Demographic and Health Surveys (DHS) have been conducted every 5 years by the Ministry of Health and Hacettepe University Institute of Population Studies since 1963.

Research activities

A number of the countries in transition have well functioning population/demographic research institutions at universities, at Academies of Sciences or at national statistical offices, and their products are being utilized by the respective governments. This is the case, for instance, in Russia, Ukraine, Romania, Poland, Lithuania and Latvia. Information regarding data analysis and research in the Field Inquiry questionnaires is uneven and incomplete. Extensive activities in Estonia and Slovakia are covered reasonably well. Some of the research activities taking place in Poland are described, but on the whole the wide-ranging research conducted in Poland is underreported. Furthermore, according to the responses in the questionnaires for Latvia and Lithuania there is no on-going research in population and reproductive health, which is not the case. As a matter of fact, a variety of projects were conducted in both countries during the 1990s, for instance, at the Demographic Research Centre of the Lithuanian Institute of Philosophy and Sociology, not the least of which were the Family and Fertility Surveys (FFS) under the sponsorship of the UNECE. Several explanations are possible. Either the research results of the respective institutions in Poland, Latvia and Lithuania are not disseminated effectively or the people/institutions completing the FI questionnaires do not have a complete picture of the activities in population and reproductive health.

In general, the consolidation of data collection as well as the volume and quality of research activities in the countries in transition was not closely related to the ICPD PoA. To a large extent research activities and institutions preceded the ICPD and the overhaul of the statistical systems is due to the change of the political systems and the accession of these countries into the European Union.

Monitoring of the Millennium Development Goals and the ICPD Program of Action objectives

Monitoring of the Millennium Development Goals and the ICPD Program of Action objectives differs from country to country. The Bulgarian document states that experts from Bulgaria's national statistical institute participated in the formulation of the Millennium Development Goals.

In 2002 Turkey established a Population and Development Indicators Data Bank in order to provide timely, reliable and comparable information and to evaluate and monitor the implications of the programs in the field of population and development. Under the leadership and coordination of the Turkish State Planning Organization, an ICPD Follow-up Committee was established. The committee is composed of members from different ministries, universities and NGOs working in the field of population, and aims to coordinate the follow-up activities of ICPD by establishing a monitoring and evaluation mechanism for the implementation of the ICPD Program of Action.

In Azerbaijan monitoring of the implementation of MDGs is done in the context of the State Program on Poverty Reduction and Economic Development for 2003-2005 (SPPRED).

The monitoring of MDG and ICPD goals in combination with research has revealed problems in reaching desired goals. In Kazakhstan, for instance, "50 percent of infant deaths could be avoided if there were quality perinatal services, including professional midwives and neonatologists. Another problem is the limited access to primary health care in rural areas. The maternal mortality rate in 2000 constituted 61.6 cases for 100 thousand live-born. Diminishing of this rate has been slowed down due to young women's poor health, low quality of medical services at delivering points and a high abortion rate. Life expectancy at birth is negatively affected by hard socio-economic conditions in the country, worsening of ecology, easy access to alcohol, tobacco and drugs."

3.8 Partnerships and resources

Collaboration between governments, non-governmental organizations and others

Parliamentarians, NGOs, CSOs, religious leaders and other influential personalities would not have been involved in population and reproductive health programs as profoundly and frequently as they actually were during the past decade if the ICPD had not been convened and had not enacted the Program of Action.

In many countries the collaboration between governmental and non-governmental institutions is very fruitful. In Russia population issues are annually presented for parliamentary hearings at the State Duma and at the Council of Federation. So, for example, in April 2001 the draft of 'The Conception of demographic development of Russian Federation till 2015' was discussed and was approved by both parliamentary bodies. This document was also examined at a seminar 'Problem of 2003: demographic

crisis and ways of overcoming it' at the Center of strategic development with participation of scientists and public officials. Also, the Governmental Commission on the Status of Women in the Russian Federation comprises members of the Russian Federation State Duma, heads of federal and regional executive bodies, representatives of NGOs and the Moscow Patriarchate.

In all three Caucasian countries committees involving various institutions are functioning. In Georgia an ICPD Committee is operational; a number of commissions have been formed with the state and NGO sectors participating. Dialogue between the Church and NGOs on population and reproductive health issues is ongoing; seminars and meetings are held. In Azerbaijan the State Committee for Women's Issues as a national machinery responsible for the implementation of gender policy organized an international seminar on 'The Process of democratization: Empowerment of Women' with the participation of experts from the Council of Europe, which involved the relevant ministries, parliamentarians, NGOs and the media. In Armenia the government has established a RH Coordination Committee chaired by the Director of the National RH Program, MOH. However, the Committee does not work on a regular basis, and its coordination work is not satisfactory. There are several other committees which apparently function better: a Country Coordination Mechanism on HIV/AIDS issues, a Coordination Committee on trafficking and a Gender Commission.

Frequently laws dealing with issues of reproductive health and reproductive rights are the result of NGO involvement. In Bulgaria drafting of the law on protection against domestic violence was a joint project with leading non-governmental organizations active in the area. The initial version of the draft law was prepared by the Bulgarian Gender Research Association. Analogously in Romania a national committee comprising government institutions and NGOs was created to design a national strategy to address domestic violence. Similar coalitions were established in support of RH in 1998 and to fight HIV/AIDS in 2002. In Albania interested parties, such as ministries, NGOs, a parliamentarian group and UNFPA, collaborated in the preparation of the RH Law.

NGOs have taken the lead in developing various activities, such as organizing shelters for victims of gender related violence. In Lithuania, for instance, 28 women's organizations centers provide support for victims of domestic violence and work on issues of violence against women, including awareness raising, information campaigns, trainings, publications etc. Of them 15 crisis centers are mostly run by non-governmental organizations. Recently the first Men's Crisis centre was established to work with perpetrators.

The private sector

Throughout the countries in transition there is relatively sparse collaboration with the private sector. Whatever there is tends to be with the pharmaceutical companies. These supply contraceptives, for instance in Moldova Schering, Gedeon Richter, Organon, etc.. Further, some private medical organizations have provided support to the reproductive health system, such as training of pharmacists and medical personnel,

brochures for the public, and social marketing. The Albanian MoH is also working with private pharmaceutical companies to ensure provision of modern contraceptives.

Funding of population, gender equality and reproductive health activities

Prior to the ICPD only limited financial and human resources were devoted to population and reproductive health activities in the countries in transition. In many countries there was a turnaround in the mid-1990s. Domestic and international resources allocated to the field of reproductive health were reported to have increased. Before 1994 Moldova did not enjoy reproductive health and family planning assistance. Starting with the Cairo conference, a number of international organizations and foundations (UNFPA, UNICEF, UNAIDS, USAID, IPPF, SOROS, WHO) have given substantial support to governmental and nongovernmental bodies for the restructuring of the reproductive health care system (opening reproductive health clinics), training medical professionals and school teachers and volunteers, multiplying information materials for the population, implementing information-education-communication projects, and meeting the need for modern contraception.

Striking changes occurred in Albania. The MoH has implemented various programs to improve RH of Albanian people, but the donor community, such as UNFPA, UNICEF, WHO, and USAID, remains the major resource for RH activities. Contributions of international NGOs were also important. Nevertheless, available financial and human resources are in short supply.

In Central Asia governments have increased expenditures on general and reproductive health care and made successful efforts in securing international funding from many different agencies. This includes not only the usual sources of population and health funding, such as UNFPA, WHO, the World Bank, Soros Foundation, but, for instance, in Uzbekistan the European Union, the German KfW (bank and credit institution), GTZ/EPOS (German Technical Cooperation) and others. Frequently governments consider the available resources inadequate. In Kazakhstan current expenditures are enough only for supporting the health care system, however, for its development it would be necessary to double financing. Assistance by international organizations does not cover the budget deficit significantly. In Tajikistan “the Republic is at the stage of overcoming the consequences of the collapse of the USSR, and the civil war in the country. It suffers severe constraints in searching for financial resources for the rehabilitation of the old infrastructure and construction of the new one. The Republic has a big foreign debt. There is a lack of resources for program implementation. The level of the available resources is insufficient in comparison with the needs.”

Countries have increased domestic resources for the implementation of population and reproductive health programs. In Armenia the government has been incrementally increasing domestic resources. However, overall allocations to the social sector (health, education) remain very low in terms of percentage of GDP: in 1999 1.9 percent for the health sector and 2.3 percent for education. The Government of Azerbaijan is extending extensive support to victims of the military conflict with Armenia, refugees and internally displaced persons (R/IDP), and the main bulk of the regular funds of the Ministry of

Health is currently directed towards these purposes. In light of the fact that all medical services and assistance provided to the R/IDP are rendered free of charge, the activities aimed at establishing and providing services to these populations require sizeable investment funds, resulting in the lack of funds at the Ministry of Health for procurement of contraceptives and full and effective maintenance of the national system of distribution of contraceptives. In Georgia allocations for RH programs increased, but the state budget meets only 10 percent of the population's needs in RH services. Thus, as stated in the Armenia document, "the need for external assistance and funding will remain in the foreseeable future."

In Turkey increasingly costs of population and reproductive health programs are covered from national resources. As of 2003, the government purchases and distributes contraceptive commodities to cover approximately 50 percent of the need. The rest of the commodities are purchased individually by the clients.

Efforts at cost recovery are not being neglected, however, the Georgia document states that growing poverty is the main obstacle. Nevertheless, in Armenia the application of cost recovery schemes is in an initial stage. In particular, the Condom social marketing project supported by UNFPA will implement such a scheme for sustainable supply of SM condoms. There are some cost-recovery schemes that are under discussion (publication of books which are of high demand among the population, publication of SRH text books under the WB-supported textbook revolving fund). In Azerbaijan one of the first RH centers established in 1994-1995 has since developed a package of services offered to population on a cost-recovery basis.

3.9 Best practices and emerging issues

Best practices

In each country specific measures, projects or activities are considered as best practices. On a general level, governments have been active in developing networks of reproductive health facilities and institutions in collaboration with NGOs, and these have also been active forces in advocating gender equality and sound reproductive health practices. Collaboration of governments, NGOs, parliamentarians, youth organizations and other institutions is another common positive experience.

In Poland the campaign conducted by women's NGOs and informal groups brought about the establishing of the governmental Plenipotentiary for Gender Equal Status and this office promotes reproductive health and reproductive rights issues.

In Bosnia & Herzegovina a UNFPA/IRC project of Youth Friendly Services has been very well received by young people and local communities, and the extent of response considerably exceeded expectations.

In Azerbaijan a cost recovery scheme in a reproductive health center provided the means to expand services for adolescents and services for women in menopause.

Collaboration of governmental institutions with NGOs, national and international donors and organizations is considered of prime importance in Albania. In Turkey panels and conferences with parliamentarians proved useful in increasing support among policy makers for policies and strategies that promote reproductive health and reproductive rights.

In Latvia, the most successful advocacy strategy was to adopt the Law on Sexual and Reproductive Health led by the NGO sector. There was strong opposition from religious organizations, however broad discussions in society, among parliamentarians and health professionals on women rights to have access to safe abortions helped to adopt the Law.

The drafting of a law on equality between the sexes, free access to contraceptives and the family planning program as such, are considered best practices in Bulgaria. Likewise in Romania the national family planning and reproductive health program can be considered a best practice because of the coherence of coordinated activities and because of the results documented through specific trends.

Emerging issues

Numerous issues were cited as very important: gender equality, domestic violence, trafficking in human beings, employment opportunities, development of health care facilities, various forms of concern for young people (adolescent health, youth friendly services, reproductive health and sex education), responsible parenthood, ageing, balanced population growth, excess male mortality, high child mortality and morbidity, declining fertility, access to legal abortions, access to modern contraceptives, breast and genital cancer as well as sexually transmitted diseases, including HIV/AIDS.

In Tajikistan, concern for the continued prevalence of a patriarchic mindset is expressed. The stereotype of the mentality that ‘a man is bread winner, and a woman is the keeper of the household’ continues to be a problem, and that it is difficult to change this orientation within a short period of time.

4. Western countries

At the beginning of the 21st century Western countries were the wealthiest, best educated, and healthiest in the World. With the exception of a few countries in Southern Europe, their per capita gross domestic product in purchasing power parity was around \$25,000 or more; almost all children acquired a secondary school education; the average life expectancy at birth was between 75 and 80 years; only about 4 to 7 out of a 1000 babies died during their first year of life and maternal mortality was almost non-existent (Appendix Table 2). The relatively high numbers of telephone mainlines indicate easy access to relevant information. The comparatively high representation of women in parliaments is one indication of a higher degree of gender equity than elsewhere. Finally,

the superior values of the human development index in the Western countries, which rank them all on the top of the global list, confirm the overall high standards of life.

Such a generally favorable situation does not imply that these societies did not suffer from numerous social, economic and political problems, but in comparison to the countries in transition or the developing countries, the majority of the population in Western countries enjoyed comfortable lives with reasonable material conditions, and with satisfactory health care in a culturally agreeable environment. Despite a recession around the year 2000, all of the Western countries experienced economic growth during the 1990 – 2001 decade (Appendix Table 2).

In the sections that follow results of the Field Inquiry in Western countries are presented.

4.1 Population concerns

Ageing and migration are among the central population issues of concern to governments of western countries. The approach as described in the Canadian document is representative. Similarly as other countries, the government of Canada takes a broad and comprehensive view of population related concerns and states that it has not adopted explicit population policies. Instead, Canada has articulated separate groups of policies, programs and legislation concerning employment, immigration, health, income security and social welfare which constitute the main elements of its implicit population policies. These policies are in line with the ICPD Program of Action, in particular with chapter 6 with its focus on population growth and structure and the concern for children and youth, elderly people and indigenous people. Canada is also concerned about sexual and reproductive health, in particular about the increase in sexually transmitted diseases, including HIV/AIDS.

Ageing, the elderly and low fertility

Governments realize the need to adapt to a changing age structure of the population and to cope with the evolving challenges. Throughout the western countries a wide range of policies dealing with the elderly are being implemented, some of which are rather innovative. The broad goal is to ensure that all older citizens - today and in the future - can enjoy secure, active, independent and fulfilling lives.

A number of governments are also adopting measures to bring about an increase in childbearing, even though frequently stating they do “not pursue demographic policies characterized by a pronatalist family policy.” These policies tend to be perceived as family friendly with the intention to “make it easier to combine a family and a career and to make it easier for young parents to decide to have children.” If such policies were to succeed in raising levels of childbearing, the process of population ageing would be slowed down.

The Swedish government considers it important that the policy for the elderly focuses on giving them scope for living an independent life and providing those in need with high-quality services, health care and social care. In 1999 a reformed pension system was designed to guarantee a basic measure of economic security for the elderly. Other measures include grants for housing adaptation so that the elderly can stay in their own homes, special transport services, and making municipalities comprehensively responsible for long-term service and care for the elderly. A Parliamentary Commission of Inquiry on Elderly Policy is concentrating mainly on three areas: the elderly in the employment sector, healthy retirement, and the needs of the elderly in health care and social care.

In Finland local decision makers work out a general Old Age Policy Strategy in wide collaboration with the relevant local and regional actors to improve the wellbeing and health of older citizens. Older people themselves are encouraged to participate in the strategy and action plan making process, as well as in setting goals and evaluating results. Independent living, rehabilitation, community-care services, good quality long-term care, (informal) family caregivers, assistance in activities of daily living, security in daily living, and appropriate new technologies, are some of the issues presently debated and discussed in Finland regarding the future oriented planning of long-term care of older persons. A decreasing number of old people are in institutional care. Long-term institutional care has been replaced by service housing and continuous and regular service provision at home (home helping and home nursing).

Austria has devised a policy for all ages based on the principle of strengthening intergenerational solidarity. The government has created a model of involving older people in many aspects of societal activities. The elderly should be contributors and considered as human resources by being (re-)integrated into the work force and acting as volunteers. Austria and Germany actively sponsor a number of new housing forms for older people. While these include projects such as house-sharing schemes for senior citizens, the most noteworthy is the concept of multi-generation housing. This promotes cohabitation among several generations not only within the family, but also among people who are not related. One example is the "Housing for Help" scheme organized by students in Darmstadt and Munich in Germany and in Graz, Austria. Older people who live in large flats but who require a little help with everyday tasks provide students with rooms in exchange for their practical assistance. Further, in Austria eligible persons requiring care receive an allowance and can then choose whether they wish to pay for the services of a care institution or give the money to family members who look after them.

In some countries schemes are being introduced to enable people to save to supplement their state pensions. Efforts are made to change people's attitudes to working in retirement and tax incentives to work beyond the retirement age. Age discrimination is being outlawed. The elderly are encouraged to offer their skills and experience to benefit others in their local communities. Volunteering, sports and physical exercise and lifelong learning are promoted.

The United States government is continuously concerned about the Medicare and Social Security programs. President Bush intends to modernize these programs, using a combination of market-based reforms that will presumably result in better coverage options for seniors.

The government of Canada also developed a National Framework on Aging which facilitates the application of a “senior lens” to government initiatives at all levels, ensuring that the perspectives and needs of seniors are considered. In its pursuit of the interests of the elderly, health and income security stand out. Canada aims to develop the most effective strategies to expand disability-free years of life, to reduce the occurrence of chronic diseases and disabilities, and to improve the health of seniors. Canada’s system of income provision for its seniors is on solid grounds, apparently sustainable and manageable taking into account prospective ageing trends.

Family-friendly policies

Austria considers itself an international leader with regard to financial transfers to families. The government is committed to mitigating tensions between raising a family and having a career thus making it easier for young parents to decide to have children. Assistance to young parents is based on two key payments to families: a family allowance and a new child care benefit that was introduced on 1 January 2002. Parents are eligible for the family allowance until the child's 27th birthday. In addition, all parents receive a generous child care allowance (436 euros a month), irrespective of whether they were in employment before the birth of a child or not. If mother and father take turns at caring for the child, the child care benefit may be drawn for up to 36 months during parental leave with the possibility of earning up to 14,600 Euros. There is also a nationwide system audited by the government to encourage companies to take greater account of family needs in their own business interests – be it in the form of more flexible working hours, flexible work locations and personnel policies that show sensitivity to the needs of families.

Similarly, in Luxembourg several measures towards lessening tensions between work and family life have been taken: e.g., family allowances have been increased, parental leave for both parents introduced (6 months per parent and child fulltime, or 12 months half time).

Canada has a National Plan of Action for Children and numerous specific programs. Among others, the Centres of Excellence for Children’s Well-Being work to improve the understanding of, and responsiveness to, the physical and mental health needs of children and the critical factors for healthy child development. They focus on the following issues: youth engagement, child-centered communities, early childhood development and child welfare, and special needs of children in rural and remote communities with a focus on Canada’s North.

International migration

All Western countries are preoccupied with issues concerning international migration.

Canada's international migration policy is aimed at managing migration, promoting immigration of those who will benefit the country and restricting the entry of those who pose a threat to the country's security. The policy includes international commitments to refugee protection as well as preferences for family reunification. The growing phenomenon of trafficking is dealt with by making it an offence with severe penalties.

The United States develops and supports policies and programs for orderly legal migration based on protection of human rights and respect for national sovereignty. The US promotes orderly migration worldwide.

The countries of central Europe are attractive immigration destinations for people from the Balkans, Eastern Europe, and Asia. Slovenia is frequently being used as a transit station to countries of the European Union. In principle, admission regulations take national interests into account, but also the consideration of human rights of prospective migrants, be they labor migrants or asylum seekers.

The integration of immigrants is frequently a matter of concern. The Swiss government, for instance, established a Federal Commission on Aliens Affairs, to focus on all aspects of integration, and a Federal Commission on Refugee Affairs. This Commission coordinates the interests of all involved parties and discusses various important issues, such as regulations of the asylum procedure, concepts of integration of recognized refugees, questions of return of rejected asylum seekers.

Most governments wish to manage and restrict immigration flows in the interest of the labor market. Germany had the program of recruitment of foreign IT specialists (known as the Green Card Regulation). Also in Denmark professional fields experiencing a shortage of particular qualified manpower are provided with easier access to work and residence permits. In 2002, special rules formerly applicable to the IT-branch were expanded. The United Kingdom has a Highly Skilled Migrant Programme (HSMP) which was introduced in 2002 and proved successful in enabling highly-skilled individuals to enter the UK to seek and take up work. The UK also has a work permit system which provides a flexible and effective service for employers who are unable to fill positions through domestic recruitment. This is complemented by schemes for lower skilled migration.

Preferences for family reunification are an integral component of migration policies in many countries. In Denmark aliens can obtain a residence permit if they have a spouse, cohabiting companion or registered partner already resident in that country. However, a number of requirements must be met and these requirements have been changed over the last years to combat marriage against the wishes of the parties or pro forma marriage.

Sweden pursues a migration policy with an international focus. Policies must reflect a holistic approach in the areas of migration, security, and trade and development

co-operation. The aim of the Swedish policies is to be fair in processing applications for asylum or for a residence permit for other reasons. It is not the Government's goal to increase immigration or to reduce it.

In the interest of introducing a generally fair system of international migration the Swiss Federal Office for Refugees has initiated the Berne Initiative – a multilateral dialogue on international migration. Its aim is the establishment of a framework for migration management, which consists of common understandings and effective practices. In July 2003, a first international consultation was organized in Berne. Government experts from approximately 35 countries gathered to discuss a first draft of the envisaged framework for migration management.

4.2 Gender issues

Gender equality

True to their modern-day tradition and reputation the countries of Northern Europe continue to be in the avant-garde regarding issues of gender equality and the empowerment of women. Their societies have internalized the relevant principles with a clearly articulated vision, the administrations have implemented appropriate institutional infrastructures, non-governmental institutions work towards mutually compatible goals and the results are apparent at all levels of society.

The first Danish Minister for Gender Equality was named in 1999, and in addition all 18 portfolio ministers hold the responsibility for integrating the gender and gender equality perspective in their own policy areas. In Finland the Council for Equality between Men and Women (established in 2000) monitors and promotes the implementation of gender equality in society; makes proposals and issues statements to reform legislation and take measures affecting gender equality; encourages cooperation among authorities, the social partners, and other organizations; promotes gender equality research and the beneficial use of research results and follows international developments in gender issues. In Sweden gender equality policy affects all sectors of society. Each and every minister in the Government is responsible for analyzing, following up and presenting proposals concerning equality between women and men in their respective sphere of responsibility.

The policy objectives as articulated in the Swedish document are:

- Equal division of power and influence between women and men.
- The same opportunities for women and men to achieve economic independence.
- Equal terms and conditions for women and men to own their own business, work, employment conditions and career development opportunities.
- Equal access for girls and boys, women and men to education and the development of personal ambitions, interest and talents.
- Shared responsibility for work in the home and with the children.
- Freedom from sexual (gender-related) violence.

Moreover, assistance in partner developing countries is based on promoting equality between women and men as an explicit goal for all development co-operation as stipulated by the Swedish Parliament.

In the countries of Western Europe many measures have been taken to protect the rights of girls and women and to promote the empowerment of women. Goals have been set to increase the political representation of women in parliaments and to increase the proportion of women in senior management positions in national administrations and business. Similarly, educational establishments are encouraged to make a conscious effort to achieve proportional representation for women. Various forms of improving economic conditions for women have been adopted. The Netherlands has made provisions for women in higher positions to work part-time. In the UK part-time workers, 80 per cent of whom are women, should receive the same pay, pensions, maternity and parental leave benefits, training, and holidays as equivalent full timers working for the same employer. Also in the UK the national minimum wage is being continuously increased; this is helping to reduce the pay gap between men and women, because around 70 percent of its beneficiaries are female. In Luxembourg pregnant female workers, female workers that have given birth and female workers that are breastfeeding are granted special protection. Women are also protected against sexual harassment at the work place.

Measures to enhance the compatibility of work and the family are being introduced. In the UK a National Childcare Strategy was launched in 1998, to support choice by expanding good quality, affordable childcare. The numbers of children in childcare has been growing steadily since then. Also, employees with children under six have the right to require employers to seriously consider requests for work flexibility.

The principle of equal rights for women and men has been strengthened in all four countries of central Europe. The main objectives are equal chances in the labor-market, reconciliation of family and work, elimination of violence against women in all its forms. In Germany the state as an employer undertakes the function of a role model where the implementation of equality is concerned. Women with the same qualifications are given preference when filling senior positions if they are underrepresented in the respective field, indirect discrimination in any form is banned, improved provisions on the reconciliation of family and work such as a right to part-time employment or leave. Also, the generation change in institutions of higher education is seen as a historical opportunity for increasing the percentage of female professors.

Countries of Southern Europe have also adopted national plans to promoting gender equality and the empowerment of women.

The Agenda for Gender Equality (AGE) is the most recent comprehensive initiative to advance women's equality in 2001-05 under the lead of Status of Women Canada, a cabinet level administrative agency. The AGE includes: engendering current and new policy and program initiatives; accelerating implementation of gender-based analysis commitments; enhancing voluntary sector capacity; engaging Canadians in the

policy process in a sustained and structured manner; and meeting Canada's international commitments and treaty obligations.

The present US administration takes for granted that women have the same legal rights as men. Women have the equal opportunity to train for and work in any career they desire.

Gender-related violence

Gender-based violence is an issue that is being comprehensively addressed in all the countries by governments and NGOs. Stopping gender-based violence in all its forms (including domestic and sexual violence) and bringing perpetrators to justice is a priority. Respective legal instruments have been adopted and modified. The Danish Government launched a National Action Plan to combat domestic violence against women. The Swedish government has prohibited the obtaining of casual sexual services (prostitution) against payment. A National Centre for battered and raped women was established, and women's shelters and other organizations working against violence against women receive annual support.

In the UK the Government recognizes and values the important work of women's refuges. One of the Government's key priorities is increasing safe accommodation choices for women and children.

In Austria there are projects for boys in schools held by Male Counseling Centres, and projects for girls to familiarize them with gender-specific violence prevention.

In Spain the Institute for Women coordinates and implements the program "Plan Against Domestic Violence" which includes an array of preventive measures. The Criminal Law has adopted an innovation, namely it has incorporated psychological damage as part of the crime of domestic violence.

In Canada considerable attention is devoted to reduce gender-based violence. The Family Violence Initiative coordinated and led by Health Canada includes 12 participating departments, agencies and Crown Corporations. Status of Women Canada supports five Research Centers on Violence to develop a national strategy to address violence prevention, in particular against the girl child. Since 1994 a wide range of legislative measures have been adopted which complement violence prevention campaigns, namely community-based supports, such as shelters and rape crisis centers.

In the United States, state and federal laws have been strengthened to prosecute perpetrators of sexual and domestic violence. The government works with the public to limit violence. Federal law mandates that the public be notified when a sexual offender takes up residence in a community.

Combating genital mutilation is another issue of concern. In the Netherlands, female circumcision is considered a violation of the right to physical integrity and is therefore a breach of the law. Various policy measures have been taken to provide information and support to women living in the Netherlands who are from countries

where female circumcision is a traditional practice. Dutch embassies are supporting a number of projects in the context of development co-operation policy to inform, raise awareness of and eradicate female circumcision in countries receiving aid.

Trafficking

To combat trafficking in human beings, especially in women and children, nationally as well as internationally is a priority for all governments. Efforts to reign in prostitution are frequently combined with activities combating trafficking.

Under the Dutch presidency, a conference of EU Ministers of Justice and Emancipation in 1997 adopted the Hague Ministerial Declaration on European guidelines for effective measures to prevent and combat trafficking in women for the purpose of sexual exploitation. The declaration urges signatory states to appoint a national rapporteur to report to their respective governments on the scale, nature and mechanisms of trafficking in women and on the effects of the policies they pursue.

The Danish government elaborated a National Action Plan to Combat Trafficking in Women, which concentrates on support for the victims and prevention of trafficking. It contains a range of concrete initiatives such as: shelters for victims of trafficking; open counseling and out-reach work (cultural mediators) among foreign prostitutes; establishment of co-operation agreements for the purpose of preparing and implementing the return of victims; development of international networks and a hotline for victims of trafficking.

In Sweden, prostitution is acknowledged as a form of male violence against women and children, and the purchase of sexual services has been made a criminal offence. The Government has appropriated special funds for measures against commercial sexual exploitation of children. The money has also been used for activities in Baltic regional co-operation, in international development co-operation and for grants to NGOs.

In order to alleviate the root factors of trafficking in women, such as poverty and lack of equal opportunities, the German government is working towards a goal of reducing extreme world wide poverty by 50 percent. The Swiss government is proposing to enlarge the definition of trafficking of persons to include not only sexual exploitation, but also economic exploitation and organ extraction.

Canada and the United States are addressing the “demand” and “supply” side of the issue of trafficking. In addition to severe penalties included in the new Canadian migration legislation, a large number of Criminal Code offences can apply to trafficking in women and children. On the supply-side the Canada International Development Agency (CIDA) funds numerous programs throughout the world intended to prevent or address the problem of human trafficking. In 2000, the US Congress passed a comprehensive law dealing with trafficking in persons. Penalties include up to life imprisonment; appropriate benefits and services are provided to victims. NGOs are

awarded funds to provide services. In 2002, the US government supported anti-trafficking programs in over 50 countries.

4.3 Reproductive health, including HIV/AIDS

Principal reproductive health issues

A number of established reproductive health issues are high on the list of concern in almost all countries: efforts to reduce the spread of sexually transmitted diseases, in particular of HIV/AIDS; the promotion of safe sex; to cut down on the numbers of unwanted pregnancies and abortions; to reduce the occurrence of gender related violence; and broadening the general knowledge of the public about reproductive health issues, including improvements in sexual education. With rising immigration from developing countries new issues have come to the forefront, such as the prevention of female genital mutilation and honor killings. Finally, there are issues that are considered important in particular countries, for example, reducing relatively high infant mortality in the United States.

The Swedish document lists the need to prevent discrimination of gay people, bisexuals, transvestites or transsexuals; and the involvement of men in reproductive health as requiring attention. In Finland RH services for young people are not considered adequate as many municipalities have closed their family planning counseling clinics which previously covered also youngsters. Other issues attracting attention in Finland are postnatal depression, increased consumption of alcohol and drugs during pregnancy, and family violence during pregnancy and following birth.

Slovenia considers the full implementation of a national program of cervical cancer screening and the establishing of a national program of screening for breast cancer as priorities.

The government and civil society in Switzerland are concerned about the absence of a national law to provide maternity leave for all mothers.

The need to improve the quality of health care services, in particular for young persons, and to involve men in reproductive health programs, is considered a priority emerging issue in Portugal. The Spanish government considers many issues in need of attention: genital mutilation, family planning, care for pregnant women, voluntary termination of pregnancies and HIV/AIDS.

The Canadian government is concerned about the high incidence of low birth weight babies and infertility, of which 20 percent is caused by untreated STIs.

The US government is concerned about high rates of infant and maternal mortality as well as the racial and ethnic differentials in these rates. Adolescent pregnancy rates were declining but remained relatively high. The Bush administration is

also promoting healthy families and aims to increase the proportion of children raised in households headed by married parents.

In Luxembourg there has been a broad based effort to familiarize everybody with sexual and reproductive health issues, including abuse and sexual violence. Sexual education has become integrated into curricula of primary and secondary schools. An increasing number of teachers not teaching the traditional sexual education subjects, such as biology as well as religion and ethics, follow pedagogical training sessions dealing with sexuality, contraception, and reproductive health in order to integrate these themes in their syllabus. Conferences and seminars have been organized in municipalities, youth organizations, and in medical and social services. Sensibilization programs have been conducted for parents and legal guardians. Items related to sexual and reproductive health are mentioned more often in the written, visual and audible media, including incidents dealing with sexual violence.

Reproductive health services

Access to reproductive health services in most countries is considered quite good. In many of the European welfare states and in Canada it is basically free of charge. Despite that there are often serious impediments and efforts to further improve the systems in individual countries are needed.

In Sweden sexual and reproductive health services for adolescents are accessible at three settings: *Contraceptive services in public health*, *Integrated services for contraception and STIs*, and *Youth Clinics*. The services are easily accessible, free of charge, and provided by well-trained staff of midwives and obstetricians. These have contributed to significantly lower rates of teenage mothers and the postponement of sexual debut. In Finland, on the other hand, the situation in access to services has worsened because of the decrease in reproductive health services in several municipalities and in schools. The number of abortions of young women has increased. In 1994 health education was abolished from school curricula, but is required by law to be included in curricula again.

In Slovenia access to reproductive health services is universal and covered by the basic health insurance package. In Germany and Austria special attention is focused on RH services for adolescents. A successful consultancy "First Love" was established in Vienna which advises around 1000 girls a year on sexuality, contraception and the first visit to a gynecologist. It has been replicated in 12 other hospitals around the country. In Germany an Internet site www.loveLine.de provides youth-attuned information on all matters related to love, sexuality and partnerships. In Switzerland abortion has been depenalized and is allowed within the first twelve weeks of pregnancy, when there is a strong social or psychological distress of the mother.

Access to RH services is being improved in Portugal, for instance by creating district HIV/AIDS counseling and testing centers. In general, new legislation provides RH health service for migrants free of charge. Mobile units help to make services more

accessible for specific strata. In Spain less than half of the immigrant population is enrolled in the Social Security system and thus has limited access to RH services.

The US government has an Office of Family Planning which supports clinics that provide preventive health services particularly for low-income people, such as patient education and counseling; breast and pelvic examinations; cervical cancer, STI and HIV screening; and pregnancy diagnosis and counseling. Research to develop innovative methods of family planning is being funded in an effort to provide increased access to contraception through a broad range of choices. Since 1994 the proportion of mothers receiving prenatal care in the first semester has steadily increased presumably by reaching more low-income strata through increased access to Medicaid.

A number of activities were undertaken to improve the quality of RH services in recent years. In Finland, for instance, there are more effective measures to alleviate fear and pain, and to support the role of the father, early interaction between the baby and the parents, and breast-feeding. This is however, building on a tradition which was widespread prior to the ICPD.

In Austria hospitals offering services in assisted reproduction have to undergo quality control. In Switzerland HIV/AIDS counseling services have established a national quality assessment. A similar initiative will be developed in the field of counseling in reproductive health since equal access to and equal provision of services is not available in every part of the country. A national study was conducted in 2002 and published in 2003 to identify the quality of the provision of services in the field of sexual and reproductive health in Switzerland.

In Canada Centres of Excellence for Women's Health operate as partnerships among academics, community-based organizations and policy makers. Among others, these have focused on young women's health issues, such as sexual and reproductive health. In 2001 a first US Summit on Safe Motherhood was convened, which brought together a broad coalition of agencies, organizations and professionals dedicated to improving maternal health and coordinating actions to make it a national priority.

HIV/AIDS

The prevention and treatment of HIV/AIDS is arguably the most thoroughly developed area of reproductive health services in Western countries. Comprehensive and intensive activities are in place, including attention to specific groups, attention to stigmatization and integration of reproductive health components. Governmental institutions collaborate effectively with NGOs.

In Denmark AIDS control is based on autonomy, anonymity, open, direct and honest information, and ensures the individual's right to confidentiality in turning to health care authorities, as well as the desire to avoid any kind of discrimination.

Education is the primary tool for HIV/AIDS prevention among the young population in Northern Europe. In Sweden the HIV prevention program has

recommended that all strategies be gender sensitive. Sweden has a long tradition of education in sexuality and personal relations in schools (obligatory in primary and secondary schools since 1957). In addition, special youth centers addressing sexual health care and services for young people are available all over Sweden. Especially young women visit these centers for contraceptives and control of STIs. Further, Sweden has had screening programs for pregnant women since 1987. Nearly all pregnant women attend maternity clinics and are offered HIV testing as a part of the standard health check-up for pregnant women.

In Finland, in addition to health education of the general population, NGOs have developed specific protection services for sex workers and injecting drug users providing 'low-threshold' services such as counseling, social services, free clean needles, hepatitis B vaccination, temporary accommodation, meals and general health services.

In Luxembourg a multidisciplinary Committee for the Surveillance of AIDS was established in 1984. A centralized registration and accurate epidemiological evaluation system permit continuous surveillance of the incidence, prevalence and mortality of HIV/AIDS, the early detection of risk groups or risk circumstances, and the implementation of rapid public health reactions.

In the Netherlands there is a special focus on various segments of young people. The Netherlands Foundation for STI Control developed sex education teaching packs for secondary schools which specifically address the different educational needs and psychosocial factors involved in safer sex and sexuality of various target groups – girls and boys; students of Dutch and non-Dutch origin – to enable them to protect themselves against sexual risks (STIs as well as unwanted pregnancy and coercive sex). Specialized projects deal with safe sex during vacations, migrant youth, poorly educated youth and youth in prisons.

Spain has centrally designed and coordinated HIV/AIDS prevention programs which are implemented by decentralized local authorities. Nonetheless, due to the lack of a unified system to track and collect data, it is difficult to measure the reduction of HIV.

The Canadian Strategy on HIV/AIDS launched in 1998 is an extension of the National AIDS Strategy of 1990. It represents a shift from a disease-oriented approach to one that looks at the root causes, determinants of health and other dimensions of the HIV epidemic. In addition to aiming to prevent the spread of HIV infections, to finding a cure and ensuring care, treatment and support for those living with HIV/AIDS, it aims to minimize the adverse impact of HIV/AIDS on individuals and communities, and to minimize the impact of the social and economic factors that increase individual and collective risk for HIV. Particular attention is devoted to educating young people. Canada has also developed a national Aboriginal Strategy on HIV/AIDS.

In the United States HIV prevention begins with the message to unmarried persons that abstinence is the only guaranteed way to avoid transmission of HIV/AIDS. In addition to support for abstinence-based programs, unprecedented amounts of funding

are devoted to researching and implementing prevention efforts. These consist of efforts to reduce the number of people at high risk, especially among specific target populations (e.g., MSM, adolescents, IDUs, sex workers); increase HIV testing (a rapid HIV test is widely available); link infected individuals with proper care and treatment; and strengthen the ability to monitor the epidemic and respond effectively. School health programs are considered as one of the most efficient means of reaching young people to reduce the behaviors that place them at increased risk for HIV infection. The Centers for Disease Control funds a significant number of state and territorial education agencies, local education agencies and national NGOs to implement HIV prevention education programs in schools. The prevention of perinatal transmission of HIV has been an ongoing concern and since 1992 the incidence of diagnosed perinatal acquired AIDS has been declining.

4.4 Partnership with civil society

The role of non-governmental organizations

Non-governmental organizations play an important role in advancing gender equality and reproductive health within their own countries, in development work in other countries and in international forums. They tend to work primarily with special groups, such as adolescents, migrants and victims of gender violence. NGOs also tend to be major players in the prevention of STIs, particularly HIV/AIDS. Many NGOs and their activities predated ICPD, however often they have been expanded in recent years.

Some activities are internationally coordinated. For instance, the European Observatory on Violence against Women advises national Observatories in a number of countries.

NGOs have conducted a wide variety of activities in protecting the rights of girls and women and empowerment of women. In Sweden a *Women's network* fought for greater political representation of women in the early 1990s and as a result, the parliamentary parties nominated a greater number of female candidates in the course of the 1994 election. At the cabinet level, women then assumed half of the ministerial posts. Women's shelters and other organizations fighting violence against women undertake significant work to protect and help women subject to violence and their children. The Swedish Women's Lobby was established in 1997 and is a non-governmental umbrella organization for the women's rights movement. Main priority issues are: women and economy; health and representation.

Luxembourg reports that its nation-wide family planning NGO is functioning effectively with 30 per cent of the beneficiaries being adolescents. In 1986 another association, "Liewensufank" (Start of life), was created by parents and midwives with the aim to implement through information, counseling, psychological follow-up and social services a healthy and beneficial prenatal, natal and postnatal environment for the baby, the mother and the father. Also in Luxembourg a number of NGOs are active in raising awareness for the still existing injustice against women and girls and to fight against

gender based discrimination. The association “Femmes en détresse” (Women in distress) was created in 1979 by members of the “Movement for the Liberation of the Women” with the objective to set up houses, offering refuge to women and their children, who suffered violence from men.

Ireland has a Social Partnership Program in place which involves the close cooperation of the government with business, farming and trade unions in developing policies, including social policy issues. The National Health Strategy was developed utilizing this mechanism.

In Portugal the principal NGO is the Association for Family Planning (APF), an independent non-profit organization which has been active in promoting and defending reproductive and sexual rights, through information, awareness-raising and counseling services. The APF pays special attention to the needs of adolescents. A number of other NGOs work with the Commission for Equality and Women’s Rights.

In Spain the (federal) Institute of Woman has agreements with the local governments (Comunidades Autonomas) and local NGOs. These agreements channel resources to local NGOs in order to develop programs concerning reproductive health as well as women’s rights. The following issues are dealt with: contraceptive methods, voluntary interruption of pregnancy, sexual transmitted diseases, HIV/AIDS, breast and cervical cancer, violence against women, health in the work environment, mental health and eating disorders (bulimia and anorexia), the role of woman in the family and working environment, equal rights and equal opportunities for men and women, women’s participation in the decision-making process, the role of women in the media, the job-market for women, the woman as entrepreneur, strengthening and promoting women’s organizations.

To meet the health needs of adolescents the Canadian Association for School Health and the Canadian Association of Principals collaborate with the government in joint initiatives focusing on sexual and RH needs of young people. Another collaborative project involving all levels of government, health practitioners and NGOs is the Enhanced Surveillance of Canadian Street Youth which monitors rates of STIs, hepatitis B and C viruses and risk factors among the target population. The Department of Justice has funded numerous community-based projects. Among others, a project entitled “Links Project” by the Canadian Association of Sexual Assault Centres, which enhanced the criminal justice system’s response to family violence and provides improved services to women victims (and their children) of family violence. Canada’s Private Sponsorship of Refugees Program has facilitated the resettlement of over 30,000 refugees since the ICPD. The Canadian Council for Refugees together with others are actively involved in delivering services to refugees in seeing that they are provided with adequate access to medical services, education and social services.

In the United States NGOs and CSOs, including faith-based institutions and advocacy organizations, have been very effective in providing access to education and

other important aspects of reproductive health, including abstinence education and information on healthy choices for young people.

As regards development aid, many Danish NGOs support the follow up on the ICPD Program of Action in their partner countries. Focus is put on strengthening the capacity building of the partner organizations and the civil society in implementing the Program of Action and on providing sexual and reproductive health services, as well as raising awareness of the commitments signed by their governments and of the need to support the Program of Action ICPD.

Collaboration between governments and non-governmental institutions

All governments promote collaboration with NGOs, business and civil society institutions. The Canadian government encourages collaboration with NGOs in many areas of concern. Issues dealing with sexual health and sexuality education in schools across the country are tackled together with the Canadian Association for School Health, the Canadian Association of Principals, Planned Parenthood Federation of Canada and the Society of Obstetricians and Gynecologists. Health Canada works with the Centres of Excellence for Women's Health on issues related to women's rights and health.

In the United States the government collaborates with the National Healthy Mothers, Healthy Babies Coalition and the March of Dimes to improve infant health and lower the infant mortality rate. The Bush Administration is committed to collaboration with the private sector, faith-based and NGO communities in promoting abstinence programs, enabling young people to make healthier choices, including the delay of sexual initiation, and support for families as primary caregivers of children and adolescents, including support for fatherhood initiatives so that fathers remain influential in their children's lives.

In Germany the Federal Centre for Health Education works with the federal Länder, the associations of independent welfare and other independent organizations and initiatives. It generally works together with a large number of partners in the field of topics related to sex education, family planning and contraception. There are many modes of collaboration of the governments with the national family planning organization Profamilia in Germany and the RH umbrella organization PLANE in Switzerland at all administrative levels.

With respect to any emerging opportunities to strengthening partnership with the private sector, NGOs and other CSOs in population and reproductive health, Luxembourg points out the following: A need for the reinforcement and enhancement of sexual education; sexual education should start very early in children's life (kindergarten, first years of primary school); sexual education should become an evolutionary and multidimensional program, covering the entire educational experience of children and adolescents; specific programs for children and adolescents at risk, responding to their specific needs and demands, should be developed; information and sensibilization of parents, professionals and the public in general should be intensified. An expansion of NGO activities in the efforts to reduce the number of undesired pregnancies and to reduce

the number of abortions, as well as a reinforcement of the fight against sexual violence is suggested.

Parliamentarians

Parliamentary groups in population and reproductive health are functioning in every country. The Swiss parliamentary group CAIRO+ was co-founder of the Inter-European Parliamentary Forum on Population and Development, an international non-profit organization created in 2000 and based in Brussels, which is an association of the all-party parliamentary groups around Europe dealing with matters related to population, development, sexual and reproductive health and rights, as well as related gender issues.

In Finland, the Interparliamentarians Group for Population and Development was established in 1995. The group is active, and has organized annual seminars and study tours, and kept ICPD issues on the agenda. In 2001, a network on sexual and reproductive health and rights that cuts across party lines was established in the Swedish Parliament.

Parliamentary groups were established in Austria and Switzerland following the ICPD. In Germany parliamentarians actively pursued reproductive health matters earlier; the Maternity and Family Welfare Act, which introduced and implemented a broad, extensive concept for sex education and family planning, was enacted in 1992.

The Canadian Association of Parliamentarians for Population and Development was formed in 1997. Its most recent high-level activity was the International Parliamentarian's Conference on Progress towards the Implementation of the ICPD Program of Action in Ottawa in 2002.

The US Congress has shown great interest in protecting the maternal rights of pregnant women. In 2002 it passed the Born-Alive Infants Protection Act and a year later legislation to ban the practice referred to as "partial-birth abortion" was enacted. Pro-choice organizations, however, consider these acts as undermining women's rights.

4.5 International assistance to population and reproductive health programs

The role of population and reproductive health programs in development assistance

In the aftermath of the 1994 International Conference on Population and Development international assistance in population and reproductive health has risen to the top of national and international political agendas. It has become an integral component of poverty reduction strategies, it has increasingly included a broader array of substantive areas, and become a more integrated part of development assistance in general. International development agencies utilize poverty reduction strategies and related national processes to promote ICPD goals. The Millennium Development Goals provide the reference framework for multilateral co-operation and in bilateral co-operation agreements, and at the same time it has been increasingly realized that the implementation of the goals of the ICPD Program of Action are effective tools in

reaching the MDGs. The Dutch document, for example, notes that any occasion is utilized to make clear that MDGs can not be reached without the implementation of the Cairo agenda.

There have also been some controversies. The government of Denmark states that “in many parts of the world, strong opposition persists to sexual and reproductive health and rights. Issues such as sexuality education and abortion continue to create controversy. A loose ‘alliance’ of states seeks to reverse the outcomes of ICPD on sexual and reproductive health and rights. The opposition to the outcomes of ICPD is expected to stay strong in the foreseeable future and the ICPD agenda must therefore be promoted in a somewhat difficult environment. Lack of sufficient funding for ICPD related activities remains an issue in many developing countries.” In a number of countries, notably the Nordic ones, the controversies surrounding the ICPD PoA have generated a stronger resolve to support it. For instance the Swedish document states that “support to the ICPD agenda is increasingly solid and due to the unfounded attacks on it, the Swedish support has expanded and has been even further strengthened during the last years.”

Development agencies note a higher awareness for policies and programs as adopted in the ICPD Program of Action. In many countries programs and policies have shifted from vertical family planning programs to more broad based reproductive health programs and policies. Rights of women are more discussed, but not yet very much improved world-wide in the view of the Dutch government.

The government of the Federal Republic of Germany devised a poverty reduction strategy as the guiding principle of German politics in the scope of its development co-operation. In 2001, the German government issued the "Action Programme 2015" in which access to social services is mentioned as a major milestone on the road to achieving the reduction of poverty. Family planning and the fight against HIV/AIDS are underscored. Gender aspects, particularly with respect to school enrolment, are also dealt with prominently. In all, the poverty reduction program of the German government incorporates all MDGs with a direct or indirect reference to the Cairo PoA.

In Spain’s international cooperation plans reproductive health is considered a priority as a mechanism to fight poverty. The Institute of Woman is implementing these plans and has started to promote reproductive health programs in Latin American countries, primarily in Peru and Colombia.

CIDA is implementing programs in support of the Millennium Development Goals. In 2000 CIDA launched the “Social Development Priorities: A Framework for Action” as a foundation for its international development activities in the fields of health (including HIV/AIDS), nutrition and education. These are consistent with the goals and objectives of the ICPD PoA and the Beijing Platform of Action. They are tied into a broader context of sustainable development strategies and Canada utilizes national poverty strategies, PRSPs, SWAPs and sector reforms as vehicles to promote gender equality and the provision of sexual and reproductive health services.

USAID emphasizes maternal and child health consequences in its population and reproductive health programs, including better birth-spacing and interventions that reduce the incidence of abortion and reduce HIV transmission, including mother-to-child transmission. US international cooperation places increased emphasis on poverty reduction. President Bush established a Millennium Challenge Account (MCA) aimed at stopping the cycle of poverty in the developing world. The MCA defines a new partnership between the US and governments demonstrating a commitment to domestic reforms necessary for sustained growth, including governing justly, investing in their people and promoting economic freedom.

The German and the Swiss governments consider the following developments as positive changes in developing countries induced by the ICPD PoA and ICPD+5 Key Actions on policies and programs in population and reproductive health:

- The overall development from a vertical approach to a more integrated approach when it comes to sexual and reproductive health.
- The development of specific strategies to fight and control communicable diseases, especially HIV/AIDS prevention.
- The importance of dealing with reproductive health including HIV/AIDS issues in an integrated way.
- Increased gender awareness, and development of gender-sensitive policies and strategies.
- Reproductive health and improved maternal health as highest public health priorities within national health policies, including increased resource allocations to the health sector and reproductive health.
- Progress in use of contraceptives.
- Decreasing fertility and infant mortality rates.
- Community participation and empowerment.

The Canadian government has observed that the ICPD PoA has been internalized in developing countries. Policy makers and program directors in Ministries of Health address issues of population and reproductive health in the spirit of the ICPD. The US government views the increased focus on the individual as a human being with needs to be met as the single greatest impact of the ICPD PoA on population and reproductive health policies and programs in developing countries. Increasingly family planning and RH programs are designed to address the needs of women and men while preserving their dignity. Voluntarism and informed choice provide the foundation for US population assistance and are becoming priorities for policy and programs in developing countries.

Constraints

With regard to constraints in implementing the Program of Action, the Swedish document states that issues related to ICPD are still challenged by extreme views, which in turn are related to power structures. Also, harmful traditions, taboos, and cultural contexts are aspects contributing to make it more difficult to implement those parts of the ICPD Program of Action that concern gender equality, young people, and sexual and reproductive health. The funding situation remains a constraint for many developing countries. Human rights continue to be violated in many countries.

In the view of the UK government developing countries are constrained in their implementation of the ICPD PoA by a weak institutional and administrative infrastructure, especially by weak health systems. The Dutch government raises the question of whether the attention paid to HIV/AIDS might not be overly emphasized thus detracting from attention to broad sexual and reproductive health issues. The interconnection of HIV/AIDS with sexual and reproductive health and behavior and with gender inequality tends to be overlooked. Given the discussion regarding “access to drugs,” HIV/AIDS risks becoming more of a logistics and medical problem instead of a behavioral problem. Funding for ICPD is considered insufficient and the reduction in ICPD funding is seen as a constraint. The government of the Netherlands is concerned about the attacks of conservative forces in many countries on the ICPD consensus which reinforces the perception that “S&RH equals abortion.”

In the view of the German and Swiss governments the following are major constraints faced by developing countries in implementing the ICPD PoA and the ICPD+5 Key Actions:

- The lack of infrastructure and access to RH supplies, particularly in remote areas.
- The lack of funds and of qualified personnel at all levels.
- In part a lack of understanding the implementation of the Cairo Program of Action as a socio-political and social rather than a mere medical issue.
- In many countries there are internal forces – sometimes strongly supported by international agents – which render progress in fields like safe abortion, youth-services, women empowerment, etc. rather difficult.
- Increase of poverty and unequal power relations.
- Structural inequalities between women and men, including unequal participation in decision-making.
- Unequal access to education and health services.
- Lack of coherent health policies/health sector reforms and strategies for their implementation.
- Lack of equitable access to and quality of reproductive health services.
- Pressure by fundamentalist and faith-based groups which deny sexual and reproductive rights of women, adolescents and young people.
- Gender discrimination and violation of human/women’s rights linked to cultural factors, traditional values and harmful practices.

According to the Canadian government, key constraints to the implementation of the ICPD PoA include lack of, or ineffective, policies combined with lack of political will to address issues of sexual and reproductive health and rights, and the empowerment of women. Developing countries also face the problem of lack of funds combined with dependency on outside funding. In many countries women’s inability to exercise their reproductive rights for social, political, religious, cultural and economic reasons is a major impediment to the implementation of the ICPD PoA. The US government also considers lack of resources as the principal constraint to implementing the ICPD PoA. Although increasing, resources for implementing the PoA still fall far short of the ICPD

goal. Budget shortfalls are likely to result in shortages of contraceptives and other RH commodities.

Resources for international assistance

The provision of resources for international assistance in the population and reproductive health field in the North European countries is generous. Sweden has allocated over the past years around 4 per cent of overseas development assistance to the population and reproductive health field. Assistance to population and reproductive health in Denmark has remained at a relatively high level since the ICPD. The Finnish document states that new funds are not easily available and there is competition among sectors. However, there is great interest in HIV/AIDS issues.

Luxembourg has not faced any problems in financing the specific field of population and reproductive health, which is one of the key priorities of Luxembourg's development co-operation, and the government has substantially increased its contribution in previous years. In the Netherlands funding for ICPD increased up till 2001. UK overall overseas development assistance has been increasing since 1997 and is anticipated to continue to do so up to 2005/06. Increasingly the Department for International Development provides assistance through PRSPs, SWAPs and budget support mechanisms.

The Swiss Agency for Development and Cooperation increased its contribution to reproductive health from approximately CHF 15 million per year in the nineties to approximately CHF 39 million per year in 2002. Following the ICPD there has been a significant increase of development expenses in Germany for SRH in supporting multilateral institutions like UNFPA, IPPF, WHO and EC, and it became a priority area. German financial cooperation implemented through the Kreditanstalt für Wiederaufbau (KfW) has become one of the major players as far as contraceptive supplies are concerned. Through contraceptive social marketing especially condoms are made available to broad sections of the population and education campaigns reach the public at large. Furthermore this type of program offers the opportunity to strengthening private-sector structures and to involve them in the RH sector systematically.

In Canada and the United States there does not appear to be any major opposition to mobilizing resources for international assistance in the population and reproductive health areas. The US continues to be the largest contributor of funds; US bilateral assistance increased from \$372 million in 2000 to \$425 to \$446 million in successive years.

5. Summary and conclusions

The Program of Action adopted at the 1994 International Conference on Population and Development has had an enormous impact on the way population, gender and reproductive health issues have been dealt with during the past decade in the UNECE

region, in particular in the countries in transition, but also in the Western countries. Arguably the repercussions have been greater than of any previous conference. That is the overriding conclusion of this evaluation.

The numerous issues that were on the agenda of the ICPD have one thing in common. They are directly related to the basic concerns of everyday life of millions of people around the globe, particularly of women and children. Progress achieved in dealing with these issues can make a significant difference in improving human wellbeing. That is presumably the primary reason why the ICPD has had such a profound impact.

If the ICPD had not been convened, some issues would not have been dealt with at all, and considerably less attention would have been devoted to making progress on practically all the main issues that are elaborated in the Program of Action.

We will now summarize the policies and measures that have been adopted to achieve the objectives of the ICPD Program of Action, issues which require continued attention, as well as principal constraints, separately for the countries in transition and the Western countries.

5.1 Countries in transition

5.1.1 Adopted policies and measures

Significant progress has been made in achieving the objectives of the ICPD Program of Action. Often it is necessary to list qualifications together with success.

- A legislative basis was created and appropriate institutions were established to deal with issues of population, gender equality and reproductive health in all countries in transition.
- Population and development issues -- especially the reduction of poverty, environmental degradation, population ageing and care for the elderly, as well as care for refugees and internally displaced persons -- are particularly difficult to deal with because they are closely related to progress in economic growth and availability of resources. These issues are on the political agenda of governments, but the responses in the documents reflect the limited options to achieve measurable results in the short-term, given the lack of resources and the economic difficulties countries in transition were faced with during the past decade. At the same time progress can be anticipated because these populations are well educated, the educational and health systems are functioning reasonably well and economic growth has been for the most part promising in the early years of the 21st century.
- The virtual absence of gender discrimination in education provides a good basis for gender equality and empowerment of women. Various ways of educating

children and young people on gender and reproductive health matters were developed or improved.

- Another favorable circumstance in most countries is a generally liberal attitude towards central issues of reproductive health: contraception, induced abortion and reproductive health education.
- The availability of contraceptives has been greatly improved and contraceptive choice expanded.
- Special attention is being paid to combating socially undesirable phenomena, such as gender and child violence, and trafficking in human beings. In the central Asian republics even infanticide, especially of baby girls, still occurs. Violence against women is widespread and has been dealt with extensively, although more effectively in some countries than in others. Measures include information campaigns, awareness raising and crisis centers for victims are being established often with the help of non-governmental organizations.
- Trafficking in human beings is a matter of serious concern. Governments are being assisted by the International Organization for Migration (IOM) in their efforts to combat trafficking. Activities include prevention, awareness raising, capacity-building and legislation, as well as the protection and assistance needs of individual victims of trafficking, including their voluntary return to and reintegration into their countries of origin.
- Networks of facilities to provide reproductive health services were built or existing facilities were upgraded. The quality of maternal and child health institutions were improved. Consequently there is easier access to these services. Various measures to reduce infant and maternal mortality were introduced and the respective rates are declining.
- Measures were implemented to limit the spread of sexually transmitted diseases, including HIV/AIDS. Nevertheless, in a number of the East European and Central Asian countries these efforts are inadequate and governments are increasingly aware of that. Significant ongoing assistance of international institutions may bring better results in this endeavor.
- Numerous new non-governmental institutions were created. NGOs were influential in promoting the gender and reproductive health agenda and frequently NGOs were also providing services.
- Governmental and non-governmental institutions collaborated effectively in many activities, including the formulation of legislation and provision of services.
- All forms of communication media, including the internet and telephones, were utilized to disseminate knowledge and to educate the population, especially young people. Various activities were carried out to alter misconceptions and to stamp out traditional gender and reproductive health behavior.
- Data collection and analysis systems were significantly improved. Activities of research institutions were expanded and utilized for policy relevant purposes.
- Resources allocated for gender and reproductive health matters increased, especially those from international institutions.

5.1.2 Main issues requiring constant attention

All the issues in which progress was achieved require continued attention. The analysis of the responses in the questionnaires however points to the following issues as being of fundamental importance.

- Reduction of poverty requires particular attention because living standards of large strata of the population in many countries of the region are very low. This is a major obstacle to progress in many of the gender equality and reproductive health issues.
- Living conditions of the elderly are as a rule considerably lower than those of the remainder of the population which justifies special attention to various forms of care for the elderly.
- The status of women and gender equality in many countries and among various strata of the population is incompatible with the standards of modern societies. Among others, it is reflected in a relatively high prevalence of gender violence. Furthermore, a number of the countries in the UNECE region are among those where trafficking in human beings, particularly of women and children, is extensive. These phenomena have complex roots and reasons and require comprehensive and long-term attention.
- In a number of countries sexually transmitted diseases, especially HIV/AIDS, are spreading at a faster rate than elsewhere and could pose a considerable danger not only to health conditions, but also to long-term economic and social development.
- Reproductive health knowledge among the general population and RH education of the young generations lag far behind of what is desirable for healthy life styles. Moreover, personal attitudes and the cultural environment that would support successful improvements in dealing with issues of gender equality and reproductive health are often old fashioned, traditional or ill informed. Continuous education and advocacy is required to gradually remedy this situation.

5.1.3 Principal constraints

The following appear as the principal constraints to fulfilling the objectives of the ICPD Program of Action virtually in every country document:

- Lack of financial, human and material resources.
- Lack of experience in dealing with the issues.
- Vestiges of patriarchal beliefs and behavior regarding gender relationships and reproductive health.
- Some countries in transition were encumbered by armed conflicts and consequently had to take care of large numbers of refugees and internally displaced persons. Resources employed towards these ends could not be used for anything else, including population and reproductive health matters.

5.2 Western countries

5.2.1 Adopted policies and measures

Many Western governments take a broad comprehensive approach to population, gender and reproductive health issues in the spirit of the ICPD agenda. Furthermore, often governments feel obliged to assert that they do not have explicit population policies.

- Ageing is the principal concern in Western countries. Two strategies are proposed to deal with this issue. On the one hand, family friendly policies which are intended to mitigate tensions between raising a family and taking on a career are implemented. Western governments presume that such policies will raise fertility and thus generate a more favorable age structure and retard the population ageing process. On the other hand, numerous measures addressing the wellbeing of the elderly are promoted and implemented.
- Family-friendly policies include family and child financial benefits, tax relief, extended parental leave, expanded child care facilities and flexible work-time arrangements.
- Policies concerning the elderly include adequate pension systems, health care provisions, social services, appropriate housing conditions, transport services, employment opportunities, volunteering, assistance to family caregivers and special forms of multi-generation housing arrangements also of people not related to each other.
- The main principles governing international migration policies are to manage migration flows in an orderly fashion, to promote immigration in the interest of the respective country and to prevent entry of those who pose a threat to security. Family reunification tends to be a priority consideration as is the protection of refugees. Governments are actively involved in preventing the trafficking of human beings.
- Concern for gender equality has been continuously advanced to a considerable extent based on the experience of the Nordic countries. Ideally this involves equal division of power and influence of women and men; the same opportunities and conditions for women and men to achieve economic independence, to own their businesses, to work, and for career development; equal access to education and the development of personal ambitions, interest and talents; shared responsibility for work in the home and with children; and freedom from gender-related violence.
- Continuous progress can be observed throughout the Western countries in dealing with central reproductive health issues, namely curbing the spread of sexually transmitted diseases, in particular of HIV/AIDS; the promotion of safe sex; reductions in the numbers of unwanted pregnancies and abortions; coping with gender related violence; and broadening the general knowledge of the public about reproductive health issues, including improvements in sexual education. With rising immigration from developing countries new issues have emerged, such as the prevention of female genital mutilation.

- Access to reproductive health services has been improving and in most countries these services are low cost or free-of-charge for the client.
- Reproductive health services and education for young people have been expanding often utilizing innovative approaches.
- Activities dealing with HIV/AIDS deserve to be singled out. Continuous progress is made in developing medications, improving treatment, educating people, working with particularly vulnerable segments of the population, and attending to the social and psychological aspects and circumstances.
- Non-governmental organizations play an important role in advancing gender equality and reproductive health within their own countries, in development work in other countries and in international forums. Frequently NGOs work with special groups, such as adolescents, migrants and victims of gender violence. NGOs also tend to be major players in the prevention of STIs, particularly HIV/AIDS. Many NGOs and their activities predated the ICPD, but often their activities have expanded in recent years. For the most part there is good collaboration between governmental and non-governmental institutions.
- Parliamentary groups concerned with population, gender and reproductive health are functioning in virtually every country. Many of their activities are coordinated by the Inter-European Parliamentary Forum on Population and Development.
- International assistance in population and reproductive health has risen to the top of national and international political agendas, it has become an integral component of poverty reduction strategies, it has increasingly included a broader array of substantive areas, and become a more integrated part of development assistance in general. International development agencies utilize poverty reduction strategies and related national processes to promote ICPD goals. The Millennium Development Goals provide the reference framework for multilateral co-operation and in bilateral co-operation agreements; at the same time it has been realized that the implementation of the goals of the ICPD Program of Action are effective tools in reaching the MDGs.
- Certain issues, such as sexuality education and abortion, are the subjects of controversy in international assistance, at times hampering the promotion of the ICPD Program of Action. The controversies have however also generated a stronger resolve of some governments to support the ICPD agenda.
- Funding provided for international assistance to further the goals of the ICPD Program of Action is uneven. The contributions of the Nordic countries and some other governments are generally in line with the expectations of the Program of Action. Altogether the objectives formulated in 1994 are not being fulfilled.

5.2.2 Main issues requiring constant attention

Analogously to the countries in transition, all the issues listed above, even when success has been achieved, require continued attention.

- Population ageing is on the top of the agenda in a majority of countries. Governments are concerned about the growing numbers and proportions of the

elderly, and how the necessary resources will be secured to guarantee continued needs in housing, health and social care. This task is complex and of gargantuan proportions but pales in comparison with the task of retarding the process of population ageing, which can be attained primarily by increasing childbearing.

- In most countries in the region fertility is considerably below the replacement level and it appears that it will remain at this low level in the foreseeable future (Frejka, Sardon 2004). Such levels of fertility entail rapid population ageing (United Nations 2003 a). Western countries are seeking and implementing family-friendly policies to lessen the tensions between child raising and work obligations. However, the effects on childbearing to date are marginal at best.

5.2.3 Principal constraints

Western governments and non-governmental organizations do not list any major constraints with regard to fulfilling the objectives of the ICPD Program of Action in their own countries. It is when collaborating with developing country governments in the implementation of the Program of Action that Western governments and NGOs encounter various constraints. These include:

- Traditions, taboos, and unfavorable cultural contexts.
- Weak institutional and administrative infrastructures, especially weak health systems.
- Lack of funds and qualified personnel.
- Prevalent poverty and unequal power relations.
- Inequalities between women and men, especially unequal participation in decision-making.
- Unequal access to education.
- Pressure by fundamentalist and faith-based groups which deny sexual and reproductive rights of women and adolescents.

6. Concluding thoughts

Governments and civil society throughout the UNECE region will continue to face formidable and numerous challenges on the path towards meeting the objectives of the ICPD Program of Action.

A large number of issues, if not all, are of concern in both sets of countries, although the degree of urgency to deal with particular issues in the foreseeable future might differ, or the aspects that require attention could be different.

So far population ageing is more of a concern in Western countries, yet certainly for countries in transition it is also a matter of considerable importance. In contrast, poverty reduction and environmental degradation are issues of utmost urgency in most of the countries in transition, but they are also relevant in many Western countries. Many

aspects of gender equity, the empowerment of women, reproductive health and gender-related violence are not satisfactorily resolved, although in some countries a great deal of success has been achieved. The need to ease tensions of child-rearing and work is likely to persist as a perennial concern for all. In the case of international migration, people will more often be leaving or passing through countries of transition and will be aiming for Western countries. Similarly, the victims of trafficking in human beings tend to be recruited in countries in transition, and are then taken advantage of in the Western countries.

These considerations point to a final conclusion: countries can learn from each other, and there is an obvious need for coordination and collaboration.

7. References

- Demeny, P., 1985, "Bucharest, Mexico City, and beyond," *Population and Development Review* 11(1): 99-106.
- Finkle, J.L. and B.B. Crane, 1975, "The politics of Bucharest: Population, development and the new International economic order," *Population and Development Review* 1(1): 87-111.
- Finkle, J.L. and B.B. Crane, 1985, "Ideology and politics at Mexico City: The United States and the 1984 Conference on Population," *Population and Development Review* 11(1): 1-28.
- Finkle, J.L. and C.A. McIntosh, 2002, "United Nations Population Conferences: Shaping the Policy Agenda for the Twenty-first Century," *Studies in Family Planning* 33 (1): 11-33.
- Frejka T. and J.-P. Sardon, 2004, *Childbearing Trends and Prospects in Low-Fertility countries: A cohort analysis*. Dordrecht, New York and London: Kluwer Academic Publishers.
- Macura, M. and A.L. MacDonald, 2003, "Fertility and fertility regulation in Eastern Europe: from the socialist to the post-socialist era," in I.E. Kotowska and J. Józwiak, eds., *Population of Central and Eastern Europe: Challenges and Opportunities*, Warsaw: European Population Conference, pp. 35-90.
- McIntosh, C.A. and J.L. Finkle, 1995, "The Cairo conference on population and development: A new paradigm?" *Population and Development Review* 21(2): 223-260.
- Sauvy, A., 1952, "Three worlds, one planet," *L'Observateur*, 14 August.
- Sobotka T., 2003 a, "Understanding lower and later fertility in Central and Eastern Europe," in I.E. Kotowska and J. Józwiak, eds., *Population of Central and Eastern Europe: Challenges and Opportunities*, Warsaw: European Population Conference, pp. 691-724.
- Sobotka T., 2003 b, "Re-emerging diversity: Rapid fertility changes in Central and Eastern Europe after the collapse of the communist regimes," *Population* 58 (4-5): 451-485.
- UNAIDS, 2003, *Fact Sheet Eastern Europe and Central Asia*, December 2003, <http://www.unaids.org>.
- United Nations, 1995, *Programme of Action adopted at the International Conference on Population and Development, Cairo, 5-13 September 1994*, New York: United Nations, ST/ESA/SER.A/149
- United Nations, 2003 a, *World Population Prospects: The 2002 Revision*, ST/ESA/SER.A/222, New York: United Nations.
- United Nations, 2003 b, *Economic Survey of Europe 2003, No.1*, United Nations: New York and Geneva.
- United Nations Development Program, 2003, *Human Development Report 2003, Millennium Development Goals: A compact among nations to end human poverty*, New York, Oxford: Oxford University Press.

8. Appendix tables

Appendix Table 1

Selected social, economic and demographic measures, countries in transition, 1995-2003

Country Region	Human Development Index value 2001	GDP per capita		Seats in Parliament held by women (in % of total) 2003	1995 - 2000			Maternal Mortality Ratio (per 100,000 live births) 1995	Secondary School Enrollment Ratio 2000/01	Telephone Mainlines (per 1,000 people) 2001
		US\$ Purchasing Power Parity 2001	Annual Growth Rate 1990- 2001		Total Fertility Rate	Life expectancy at birth	Infant Mortality Rate			
Central Europe and Baltic States										
Czech Rep.	0.861	14,720	1.3	15.7	1.18	74.3	7	14	88	378
Estonia	0.833	10,170	1.6	17.8	1.28	70.1	11	80	83	354
Hungary	0.837	12,340	2.1	9.8	1.38	70.6	10	23	87	375
Latvia	0.811	7,730	-1.0	21.0	1.17	69.3	16	70	74	307
Lithuania	0.824	8,470	-1.6	10.6	1.38	71.4	11	27	89	313
Poland	0.841	9,450	4.4	20.7	1.48	72.8	10	12	91	295
Slovak Rep.	0.836	11,960	1.9	19.3	1.40	72.2	10	14	75	289
Eastern Europe										
Belarus	0.804	7,620	-0.6	18.4	1.27	68.5	12	33	76	288
Moldova	0.700	2,150	-8.2	12.9	1.56	67.3	20	17	62	146
Russian Fed.	0.779	7,100	-3.5	6.4	1.25	66.1	17	75	n.a.	243
Ukraine	0.766	4,350	-7.4	5.3	1.25	68.1	15	45	n.a.	212
West Balkan Countries										
Albania	0.735	3,680	4.3	5.7	2.43	72.8	28	31	74	50
Bosnia & Herz.	0.777	5,970	n.a.	12.3	1.35	73.3	15	15	n.a.	111
Croatia	0.818	9,170	2.1	16.2	1.60	73.3	10	18	79	383
Macedonia	0.784	6,110	-0.9	18.3	1.92	72.7	18	17	81	263
Slovenia	0.881	17,130	3.0	12.2	1.25	75.2	6	17	n.a.	402
Serbia&Mont.	n.a.	n.a.	n.a.	n.a.	1.77	72.2	15	15	n.a.	n.a.

Appendix Table 1 (continued)

Selected social, economic and demographic measures, countries in transition, 1995-2003

Country Region	Human Development Index value 2001	GDP per capita		Seats in Parliament held by women (in % of total) 2003	1995 - 2000			Maternal Mortality Ratio (per 100,000 live births) 1995	Secondary School Enrollment Ratio 2000/01	Telephone Mainlines (per 1,000 people) 2001
		US\$ Purchasing Power Parity 2001	Annual Growth Rate 2001		Total Fertility Rate	Life expectancy at birth	Infant Mortality Rate			
East Balkan Countries & Turkey										
Bulgaria	0.795	6,890	-0.6	26.3	1.14	70.9	15	23	70	359
Romania	0.773	5,830	-0.1	9.9	1.32	70.5	20	60	80	184
Turkey	0.734	5,890	1.7	4.4	2.70	69.0	47	55	n.a.	285
Caucasian Countries										
Armenia	0.729	2,650	-1.3	3.1	1.14	70.9	15	29	64	140
Azerbaijan	0.744	3,090	n.a.	10.5	1.32	70.5	20	37	78	120
Georgia	0.746	2,560	-5.5	7.2	2.70	69.0	47	22	73	174
Central Asian Countries										
Kazakhstan	0.765	6,500	-1.9	8.6	2.10	64.6	58	80	83	121
Kyrgyz Rep.	0.727	2,750	-3.9	6.7	2.89	66.9	43	80	n.a.	78
Tajikistan	0.677	1,170	-9.9	12.4	3.72	67.2	57	120	76	36
Turkmenistan	0.746	4,320	-6.1	26.0	3.03	65.4	55	65	n.a.	80
Uzbekistan	0.729	2,460	-1.5	7.2	2.88	68.3	41	60	n.a.	67

Sources: United Nations Development Program 2003, United Nations 2003 a.

Appendix Table 2

Selected social, economic and demographic measures, Western countries, 1995-2003

Country Region	Human Development Index value 2001	GDP per capita		Seats in Parliament held by women (in % of total) 2003	1995 - 2000			Maternal Mortality Ratio (per 100,000 live births) 1995	Secondary School Enrollment Ratio 2000/01	Telephone Mainlines (per 1,000 people) 2001
		US\$ Purchasing Power Parity 2001	Annual Growth Rate 1990- 2001		Total Fertility Rate	Life expectancy at birth	Infant Mortality Rate			
Northern Europe										
Denmark	0.930	29,000	2.0	38.0	1.50	75.9	6	15	89	722
Finland	0.930	24,430	2.6	36.5	1.74	77.2	4	6	95	548
Norway	0.944	29,620	2.9	36.4	1.85	78.1	5	9	95	732
Sweden	0.941	24,180	1.7	45.3	1.56	79.3	4	8	96	739
Western Europe										
Belgium	0.937	25,520	1.9	24.9	1.36	77.9	4	8	n.a.	498
France	0.925	23,990	1.5	11.7	1.60	78.1	6	20	92	573
Ireland	0.930	32,410	6.8	14.2	1.90	76.1	6	9	n.a.	485
Luxembourg	0.930	53,780	4.2	16.7	1.73	77.4	6	0	78	780
Netherlands	0.938	27,190	2.3	33.3	1.60	77.9	5	10	90	621
United Kingdom	0.930	24,160	2.5	17.1	1.70	77.2	6	10	94	587
West Central Europe										
Austria	0.929	26,730	1.8	30.6	1.36	77.7	5	11	89	468
Germany	0.921	25,350	1.2	31.4	1.34	77.4	5	12	88	634
Switzerland	0.932	28,100	0.3	22.4	1.47	78.6	5	8	88	732

Appendix Table 2 (continued)

Selected social, economic and demographic measures, Western countries, 1995-2003

<i>Country Region</i>	<i>Human Development Index value 2001</i>	<i>GDP per capita</i>		<i>Seats in Parliament held by women (in % of total) 2003</i>	<i>1995 - 2000</i>			<i>Maternal Mortality Ratio (per 100,000 live births) 1995</i>	<i>Secondary School Enrollment Ratio 2000/01</i>	<i>Telephone Mainlines (per 1,000 people) 2001</i>
		<i>US\$ Purchasing Power Parity 2001</i>	<i>Annual Growth Rate 1990- 2001</i>		<i>Total Fertility Rate</i>	<i>Life expectancy at birth</i>	<i>Infant Mortality Rate</i>			
Southern Europe										
Greece	0.892	17,440	2.0	8.7	1.30	77.8	7	2	87	529
Italy	0.916	24,670	1.4	10.3	1.21	78.2	6	11	91	471
Portugal	0.896	18,150	2.6	19.1	1.77	75.2	7	12	85	425
Spain	0.918	20,150	2.2	26.6	1.19	78.4	6	8	94	434
North America										
Canada	0.937	27,130	2.1	23.6	1.56	78.7	5	6	98	676
United States	0.937	34,320	2.1	14.0	2.05	76.2	7	12	88	667

Sources: United Nations Development Program 2003, United Nations 2003 a.