# From Mexico to Cairo and Beyond: Twenty Years of Population Challenges and Development Goals

*In the two decades since the Mexico Conference, the world, particularly the Asian and Pacific Region, has moved on, in terms of both its economic and demographic situations. The demographic transition in Asia and the Pacific has progressed significantly.*

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According to the United Nations, world population numbered 6.5 billion in 2005 and is currently growing at about 1.2 per cent annually (United Nations, 2005). The 7 billion mark is projected to be reached in 2012, just six years from

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today. Long-range population projections reveal that the world's population could ultimately stabilize at about 9 billion people.

World population is continuing to grow due to the large size of the current population and the youthfulness of populations in developing regions and in least-developed countries. However, considerable dissimilarity exists in the expected population growth of countries. The populations of many African and Asian countries are estimated to expand greatly in the coming decades. By contrast, due to below-replacement fertility levels, some developed countries are anticipated to undergo notable population decline.

The world's urban population is increasing rapidly and is predicted to grow from today's 3.2 billion persons to about 5 billion in 2030. It is predicted that half of the world's population will live in towns and cities by 2007, a year from now.

The number of massive urban agglomerations is also rising. Tokyo, Mexico City, New York-Newark, Mumbai, Sao Paulo and Delhi all contain more than 15 million persons. However, about one in two urban dwellers live in small settlements with fewer than half a million inhabitants.

The proportion of older persons is estimated to increase well into the twenty-first century. As the pace of population ageing is faster in the developing countries than in the developed ones, the former will have less time to adjust to the consequences of the changing age structure. Moreover, population ageing in the developing countries is taking place at much lower levels of socio-economic development.

Most developed countries have fertility levels at or below the replacement level. Although many developing countries have advanced in the transition from high to low fertility, some African countries still have high fertility levels.

Contraceptive use had intensified notably during the 1990s, from 54 per cent in 1990 to 63 per cent in 2000. Short-acting and reversible methods are favoured in the developed countries, while longer-acting methods are more in demand in developing countries.

During the last century, mortality underwent the most rapid reduction in the history of humankind, due to better hygiene, improved nutrition and scientifically-based medical practices. Until recently, mortality was thought likely to continue falling in all countries. However, HIV/AIDS has already increased mortality in Africa, the region most affected by the disease.

About 175 million persons reside in a country other than their country of birth. Between 1960 and 2000, the number of migrants more than doubled with three fifths residing in the more developed regions of the world. International migration policies are currently being re-examined, as these policies affect countries of origin, transit and destination.

Developed and developing countries have wide variation in their population concerns. For developing countries, the most significant population concern is high mortality, particularly infant and child mortality, maternal mortality and mortality related to HIV/AIDS. Developed countries are concerned with low fertility and its consequences, including population ageing and the shrinking of their workforce.

The current population picture is one of dynamic population change, reflected in new and diverse patterns of childbearing, mortality, migration, urbanization and ageing. The continuation and consequences of these population trends present opportunities as well as challenges for all societies in the twenty-first century.

Since the convening of the World Population Conference in 1974, Governments have become increasingly concerned with the consequences of population trends. Moreover, Governments are more inclined to view population as a legitimate area of action and to act upon those concerns by formulating and implementing policies addressing these issues.

This paper will discuss the gradual changes in emphases in population and development programmes over the past two decades, beginning with the International Conference on Population (ICP) held in Mexico in 1984 and continuing with the United Nations conferences during the 1990s, including the 1994 International Conference on Population and Development (ICPD) held in Cairo. This paper will also describe the impact the action plans of those conferences has for the attainment of universally agreed development goals, specifically the Millennium Development Goals (MDGs) contained in the United Nations Millennium Declaration of September 2000. Key population trends relevant for development, and the human rights basis that underpins key conference objectives and recommendations for action, will be summarized. This paper will rely heavily on the findings of the 2003 Global Survey conducted by the United Nations Population Fund (UNFPA), as contained in the report entitled *Investing in People - National Progress in Implementing the ICPD Programme of Action 1994-2004* (UNFPA, 2004), as well as *World Population Prospects, The 2004 Revision* (United Nations, 2005) and the monitoring of population policies at

the international level undertaken by the United Nations Population Division summed up in *World Population Policies 2005* (United Nations, 2006).

## The 1984 International Conference on Population

The International Conference on Population held in Mexico in 1984 reaffirmed the principles and objectives as well as the validity of the World Population Plan of Action (WPPA) adopted at Bucharest in 1974. The Mexico Conference specified a series of activities which needed to be undertaken at national, regional and global levels to improve the standards of living and quality of life of the world's people. The ICP laid out a population strategy in its 88 recommendations spanning such diverse matters as socio-economic development and the environment, the role and status of women, development of population policies, population growth, morbidity and mortality, reproduction and the family, population distribution and migration, international migration, population structure, data collection and analysis, research, management, training, information, education and communication as well as the role of national Governments and international cooperation in the implementation of the recommendations.

The major substantive shifts of emphasis in the Mexico document from the recommendations contained in the Bucharest WPPA are in the areas of integration of population and development, formulation and implementation of policies, the role and status of women, the importance of changes in socio-economic and demographic structures and the focus on urbanization and population distribution.

The dissimilar experiences of countries in policy formulation and implementation during the period 1974-1984, the varied facets of demographic transition that were observed in developing countries, and the thrust on integration of population and development that was strongly endorsed at the Mexico Conference involved some modifications of existing population policies and programmes. It is necessary for population policies to be increasingly based on sound scientific research and effective strategies; more focused on the effects of such variables as mortality, nuptiality, fertility, family planning, migration, urbanization, ageing and other compositional influences; and more effective in their harmonization with development policies.

The resolution of these policy changes involved, among other requirements, stronger national commitment to policy formulation and implementation; more competent research and analysis of population issues; and committed financial, institutional and humanpower support for policies and programmes.

At the time of the Mexico Conference, the world population numbered approximately 4.8 billion, growing at an estimated 1.72 per cent annually with a yearly increment of 80 million people. During the decade between 1980-1985 and 1990-1995, the world's average total fertility rate (TFR) dropped by 17 per cent, from 3.6 to 3.0 births per woman (United Nations, 1998). Undoubtedly, government views and policies concerning fertility contributed to the fertility decline in developing countries. In 1986, 41 per cent of Governments viewed fertility in their countries as too high (United Nations, 2006). Unlike in the past, when perceptions of high fertility were usually not accompanied by policy intervention, after the Mexico Conference 54 per cent of the countries intervened to modify their fertility levels. This figure represented more than half (53 per cent) of the African countries and 71 per cent of the countries in Asia.

Government policies on providing access to contraceptive methods are an important determinant of reproductive behaviour, as well as of maternal and child health. In 1986, 98 countries in the less developed regions provided direct support for contraceptive methods, as compared to 74 countries a decade earlier. Among the least developed countries, the corresponding figures were 35 and 18, respectively (United Nations, 2006).

## The International Conference on Population and Development

The International Conference on Population and Development held in Cairo in September 1994 was the largest intergovernmental conference on population and development ever held. The Conference moved population policy and programmes away from a focus on human numbers to a focus on human lives. It emphasized improvement in the lives of individuals and increasing respect for their human rights. The 20-year forward-looking Programme of Action adopted by 179 Governments built on the success of the previous decades while addressing the needs of the twenty-first century. The ICPD Programme of Action recommended a set of interdependent goals and objectives to be attained by 2015. Those included: universal access to comprehensive reproductive health services, including family planning and sexual health; reductions in infant, child and maternal mortality; universal access to basic education, especially for girls; and gender equality, equity and women's empowerment. The Programme of Action underscored the integral and mutually reinforcing linkages between population and development. It urged the empowerment of women both as a highly important end in itself and as a key to improving the quality of life for everyone.

In 1999, the United Nations General Assembly convened a Special Session (known as the ICPD+5) to examine the progress made in meeting the ICPD goals.

The review reaffirmed the ICPD Programme of Action, adopted *Key Actions* for its further implementation, sought to improve monitoring, facilitated the setting of priorities, and underscored the importance of tackling such emerging issues as HIV/AIDS, population ageing and adolescent reproductive health. The ICPD+5 adopted a new set of benchmarks in four areas: (a) education and literacy; (b) reproductive health-care and unmet need for contraception; (c) maternal mortality; and (d) HIV/AIDS.

Many of the ICPD goals were incorporated into the Millennium Development Goals (MDGs), which were adopted during the Millennium Summit in September 2000. Many of the ICPD goals are essential for meeting the MDGs to reduce widespread poverty, hunger, disease, and gender inequality by the year 2015.

The ICPD Programme of Action reached its midpoint in 2004. This was a good opportunity for countries to take stock of the progress that had been made in achieving its goals. A comprehensive review and appraisal of the implementation status of the ICPD Programme of Action was undertaken by the UNFPA in 2003.

The following paragraphs will describe the progress made and the constraints encountered by countries in their efforts to implement specific actions of the Programme of Action based on the report of the 2003 Global Survey (UNFPA, 2004). Illustrative examples of specific actions taken by selected Asian and Pacific countries will be presented. The Survey aimed to document the actions, measures or initiatives taken by countries to address particular issues or concerns as well as obstacles encountered. One questionnaire was sent to 165 developing countries and countries in transition consisting of nine topics: population and development; gender equality, equity and women's empowerment; reproductive rights and reproductive health; adolescent youth; HIV/AIDS; behaviour change and advocacy; data and research; partnerships and resources; and best practices and emerging issues. A shorter one intended for 22 developed countries belonging to the Organisation for Economic Co-operation and Development (OECD) Development Assistance Committee comprised five topics: population concerns, gender issues, reproductive health (including HIV/AIDS), partnerships with civil society, and international assistance to population and reproductive health programmes. The questions were designed to elicit information on the challenges faced by donor countries in mobilizing resources to support the implementation of the ICPD Programme of Action and on how countries link ICPD goals with international development frameworks and processes.

## 1. Population and development

The Global Survey revealed that 115 out of 149 reporting countries (77 per cent) had adopted multiple measures to integrate population concerns into their development strategies. Only 52 per cent of developing countries had reported doing so a decade earlier.

Almost four out of five countries (79 per cent) reported integrating population factors into local development plans and local structures. This represents significant progress from a decade earlier, when decentralization was a relatively new and still-evolving process. More than half (52 per cent) established local governance structures while half of the countries had integrated population factors into local social plans, and to a lesser extent, into economic and environmental plans.

Nearly three in five countries (57 per cent) reported taking multiple measures in integrating population factors in poverty reduction strategies as compared to 13 per cent in 1994. For example, Bangladesh's poverty reduction strategy visualizes that by the year 2015, the nation will reduce its poverty level by eradicating hunger, chronic food insecurity and extreme destitution. Close to two thirds (65 per cent) of countries with both a high poverty level ( 40 per cent) and higher population growth rate ( 1.47 per cent) had a higher action rate compared to only 40 per cent for countries with the lowest levels of poverty ( 20 per cent) and lower population growth rate ( 1.47 per cent).

Half of the countries had acted strongly to address issues of population and environment with most of them developing programmes, policies and/or laws on the issue. In Indonesia, sectoral development plans aim to empower local communities to manage natural resources and the environment through religion, customs and cultural approaches. When the level of poverty and the population growth rate (PGR) are factored in, countries with a higher level of poverty or a higher PGR are more likely to have adopted multiple measures. Almost twice the number of countries (60 per cent) with high poverty and high population growth had adopted multiple measures compared to those countries with lower poverty levels and PGR (33 per cent).

About two out of five responding countries (39 per cent) addressed the special needs of the elderly as compared to 21 per cent in 1994. India formulated a comprehensive National Policy on Older Persons (NPCP) in 1999. A national scheme of monthly old-age pensions for widows over 60 years of age and for all persons 75 years and over was introduced in Nepal. Countries with higher levels

of population ageing ( 7per cent) were almost twice as likely to have adopted major initiatives (58 per cent) than those with lower levels of ageing (30 per cent).

The Global Survey results showed that 64 per cent of countries took action on internal migration as compared to 41 per cent a decade earlier. Governments had developed plans to promote resettlement schemes, redistributed population by establishing new economic growth centres, decentralized social and economic planning as well as political activities and formulated programmes and strategies to resettle and rehabilitate internally displaced persons.

International migration issues were addressed by nearly three in four countries (73 per cent) reporting in 2003 in contrast to only 18 per cent in 1994. The most common measure adopted was formulating plans, programmes or strategies on international migrants and/or refugees (45 per cent), followed by the enactment of laws or legislation on international migrants and migrant workers (37 per cent), adoption of a migration policy (33 per cent), the undertaking of efforts to enforce international conventions on refugees, asylum-seekers and migrants (11 per cent), and the passing of laws on the trafficking of humans, especially women and children (10 per cent). A growing number of countries have established coordination across agencies within Governments, between and among Governments, NGOs, donors and others.

The ICPD Programme of Action had emphasized that valid, reliable, timely, culturally sensitive, sex-disaggregated and internationally comparable data should form the basis of all policy and programmes. The ICPD+5 *Key Actions* re-emphasized this point by identifying the need to strengthen national information systems to produce reliable statistics on a broad range of population, environment and development indicators in a timely manner. These indicators are relevant to all the international frameworks, including the MDGs and the 2002 World Summit on Sustainable Development. The Global Survey found that 93 countries had strengthened their capacity for collecting, processing, analyzing and utilizing population data; 75 had developed national databases and management information systems; 61 had trained staff on database management and another 61 had created/strengthened national statistical service. China's higher education institutions had trained a large number of professionals in the areas of population and development. In India, the Central Statistical Organisation drew up a national training strategy for skills upgrading and capacity-building in data collection, analysis and utilization.

Monitoring and evaluating the implementation of international development frameworks, including the ICPD Programme of Action (PoA) and the MDGs, are essential for assessing progress in meeting development targets and identifying best practices and constraints. In 1998, only 43 countries had reported taking significant measures to establish monitoring mechanisms for assessing the achievement of the goals contained in the ICPD PoA. Five years later, this figure had increased to 131 out of 151 reporting countries with 82 providing information on the mechanisms used.

The constraints affecting policy development and the implementation of the population and development strategies cited were: (a) financial constraints; (b) lack of trained or qualified staff; (c) insufficient institutional capacity; (d) deficient awareness and understanding of the issues; (e) scarcity of data; (f) inadequate coordination among institutions and ministries; (g) religious opposition; and (h) absence of political will.

The emerging issues in population and development identified by responding countries were: (a) population ageing; (b) poverty alleviation; (c) internal and external migration; (d) improving the situation of refugees/internally displaced persons; and (e) the need to strengthen population data collection, especially censuses, and to improve overall data quality.

**2. Gender equality, equity and empowerment of women**

To remove obstacles to gender equality and to improve the lives of girls and women, the ICPD PoA defined a set of strategic objectives and spelled out corresponding actions to be taken by Governments and other development partners. Five specific areas were covered in the Global Survey responses: (a) protecting the rights of girls and women; (b) women's empowerment; (c) gender-based violence (GBV); (d) gender-based disparities in education; and (e) men's support for women's rights and empowerment.

***Protecting the rights of girls and women*** Almost all responding countries adopted legislation and formulated national laws on the rights of girls and women, ratified related United Nations conventions and implemented the ICPD PoA. More than a third of the countries had formulated policies to remove gender discrimination and less that a third provided constitutional protection to girls and women.

***Women's empowerment*** – All but one of the countries surveyed had taken steps to empower women, the most common of which was promoting increased women's participation in governance. Providing women with economic opportunities and

with education and training, adopting laws and legislation for women's empowerment and promoting women's increased participation in the political process were also mentioned. Indonesia had formed Women in Development management teams at regional and provincial levels to coordinate empowerment activities.

***Gender-based violence (GBV)*** – Two thirds of the countries had adopted laws and legislation on GBV while two in five responding countries had provided support for the victims. Some 37 per cent of the countries surveyed had conducted Information Education and Communication (IEC) and advocacy on GBV and established national commissions while 24 per cent had trained service providers and government officials on handling GBV. Another 24 per cent had set up institutional mechanisms for GBV monitoring and reporting. For example, Iran (Islamic Republic of) had established special centres for female police officers in metropolitan police departments to assist victims of violence against women. The Government supported the setting up of hotlines within police departments.

***Gender-based disparities in education*** – The PoA had set universal primary education as a goal for all countries before 2015. Of the 129 responding countries who reported some progress in addressing the gender gap in education, 22 per cent indicated that the ratio of girls to boys at the primary level was increasing. At the secondary level, 16 per cent of countries reported that the girls-to-boys ratio was rising. Measures initiated by Governments to close the gender gap in education included: (a) providing incentives to poor families to send girls to school; (b) undertaking Information Education and Communication and advocacy campaigns on gender equality in education; (c) promulgating laws and legislation for equal education of girls and boys; (d) incorporating gender issues into school curricula; and (e) setting up an increased number of girls' schools at the secondary level.

Concerning access to primary and secondary education, the most common measure cited was providing free public schooling (40 per cent), followed by declaring compulsory primary education for boys and girls (32 per cent). Other measures taken were furnishing incentives to poor families to send their children to school (20 per cent) and supplying free secondary education (19 per cent).

***Men's support for women's rights and empowerment*** – The majority of responding countries took steps to ensure that boys are instilled with attitudes respectful of women and girls. More than half of the countries developed, reviewed and revised textbooks and curricula to incorporate gender equality concerns; about one third conducted IEC/advocacy campaigns on gender equality; over a fourth advocated gender equality in organizations and one in six developed

reproductive health (RH) education plans and programmes for adolescents and youth.

Government actions taken to enable men to support women's rights and their empowerment consisted of IEC/advocacy campaigns on men supporting women (54 per cent) and the formulation of plans and programmes encouraging male involvement in RH (42 per cent).

### 3. Reproductive rights and reproductive health

Ensuring universal access to a full range of RH care information and services by 2015 is central to the ICPD Programme of Action. Among the 151 countries surveyed, 145 replied to the question on enforcement of reproductive rights, 131 of them having adopted policy measures, laws or institutional changes at the national level to enforce reproductive rights (RR).

Some countries have set up national human rights institutions, including national commissions to monitor the implementation of human rights. Others have human rights ombudsmen and many rely on the monitoring procedures of legally binding international human rights treaties ratified by their Governments.

Of the 151 countries, 136 had integrated RH service components into their primary health-care systems. Of these 136, 81 indicated that they introduced these measures after the ICPD. In the last 10 years, many countries embarked on health sector reform to improve efficiency, affordability, quality and client responsiveness. Of the 120 countries implementing health-sector reforms, 106 had included aspects of RH as part of the package. Some countries recognized the needs of a specific clientele, e.g., adolescents and youth (73 countries); women, in particular pregnant women (58 countries); or women, men and youth (44 countries). Twenty countries reported that the package included IEC on RR and RH. Two countries reported that the RH inclusion in the package allowed them to increase budget allocations for RR and RH.

The Global Survey asked about key measures taken by Governments to increase access to high-quality RH services. Malaysia reported that even before the ICPD, core RH service components, including obstetric care, had already been integrated into their primary health-care system. Following ICPD, the treatment of reproductive tract infections and infertility and the screening for cervical cancer were added. The Philippines includes access to high-quality RH service as a key component of its Women's Health Development Programme. All but two of the 151 countries surveyed responded to the question and 143 indicated having taken measures. These countries emphasized the need to correct shortages of trained staff, particularly in midwifery and essential obstetric care. Kiribati opened a

School of Midwifery while Palau provides continuing education for young local physicians. The Fiji School of Medicine conducts regular training programmes for Pacific Islanders. A number of countries (Bangladesh, the Democratic People's Republic of Korea and Mongolia) have introduced protocols for standardizing quality service delivery, while many others have also worked to upgrade their RH facilities.

In terms of expanding contraceptive choice measures, 143 out of 151 countries responded with 126 taking at least one key measure while 88 had taken multiple measures. Progress since 1994 and since ICPD+5 is significant, both in the number of countries taking major measures, and in the variety of measures taken to increase information and access to contraceptives, as well as to increase contraceptive choice.

The ICPD Programme of Action stressed the need to make quality services affordable and accessible to all who need and want them, including a reliable and adequate supply of a range of contraceptive methods and other RH commodities. Responses to the Global Survey revealed that 119 countries had taken one or more measures to improve RH commodity security and 56 reported multiple measures a significant improvement from 1998. The Pacific Plan for Commodity Security was adopted by the Cook Islands, Fiji, Samoa, Solomon Islands, Tonga and Tuvalu in response to a resolution passed by the Commonwealth Health Ministers Meeting in 2002. The Plan calls for establishing regular warehousing with coordinated and effective storage and distribution systems as well as appropriate mechanisms for cost recovery and sustainability. It also provides an independent budget line for commodity security. India has a division dedicated to RH commodity security and has appointed two national agencies for procurement. Indian manufacturers produce, supply and even export the country's own RH commodities.

The ICPD recognized complications related to pregnancy and childbirth as among the leading causes of mortality for women of reproductive age in many developing countries. Among the key measures taken to reduce maternal mortality and morbidity, a large number (113 out of 151 countries) reported training health-care providers, improving prenatal and post-natal services, establishing a network of RH/family planning clinics, providing maternal health services for vulnerable groups or those in remote areas and refining data collection and record keeping.

A great many countries (135) had taken the following measures to prevent and manage sexually transmitted infections (STIs): (a) prevention, treatment and management service provision; (b) IEC/advocacy campaigns on prevention and treatment; (c) government establishment of a national commission/agency/

ministry/desk; (d) monitoring surveillance systems; (e) educational initiatives that target vulnerable populations; and (f) social marketing of condoms and STI medication. As part of its National AIDS and STI Prevention and Control Programme, the Philippines is integrating the syndromic approach in public sector outlets; collaborating with private clinics in STI diagnosis, treatment and surveillance; promoting 100 per cent condom use; providing STI drugs through social marketing; and collaborating with NGOs on peer education for condom promotion and STI prevention. A National Reference Laboratory on STIs and AIDS has been established, with offices in strategic parts of the country.

Of the 151 countries surveyed, 117 reported that they had taken measures to prevent and manage complications of unsafe abortion. Some countries strengthened their family planning services to prevent unsafe abortions. Others prepared guidelines, conducted training, and provided facilities to improve access to post-abortion services, both to manage complications and to prevent the repeat of unsafe abortions.

Of the 137 countries, 124 indicated they had taken measures to involve beneficiaries. Some had assessed the population's needs and opinions by means of public hearings or consumer surveys, or by involving community and civil society in policy and/or programme formulation. Countries also established action groups at the local level, trained community RH workers to involve beneficiaries and meet their needs, and conducted information and advocacy activities aimed at informing and involving beneficiaries.

Although the 2003 Global Survey disclosed that countries were making undiminished progress in RH services and information and in RR issues, the Survey also emphasized the challenges involved in integrating RH in primary health-care systems, especially in the context of health-sector reform. Constraints common to all regions included: (a) insufficient financing and lack of sustainability (64 countries); (b) inadequate number of trained health-care providers (38 countries); (c) absence of equipment and facilities (33 countries); (d) difficulties in accessing services, particularly in remote areas, often due to insufficient decentralization (22 countries); and (e) poor communications (19 countries). Countries also cited gender inequality and problems in providing services for men and adolescents.

**4. Adolescent reproductive health and youth**

Among the reporting countries, 92 per cent had taken at least one measure to address the RH and RR of adolescents, including access to information on these issues. In terms of policy and legislative measures, 34 per cent of countries had

developed and implemented policies sensitive to adolescent RH; 27 per cent had formulated and implemented laws and/or legislation on adolescent RR and RH needs; and 9 per cent had ratified United Nations conventions. With regard to programmatic and strategic measures, 62 per cent had formulated national plans and programmes including the RR and RH needs of adolescents; 33 per cent had utilized IEC and advocacy campaigns on adolescent issues; 26 per cent had integrated RH education into school curricula and 22 per cent had established a national commission on adolescents and youth.

The 2003 Survey results showed that 140 out of 151 countries had taken at least one measure to introduce health education into school curricula and out-of-school youth programmes. The most common measures undertaken were the provision of: (a) school curricula that included RH and life skills (89 per cent); (b) out-of-school programmes and clinics (39 per cent); (c) training on RH for teachers and other school staff (26 per cent); and (d) peer education programmes (19 per cent).

Of the 151 country respondents, 133 had provided access to information on RH to adolescents. Among the measures taken were: (a) IEC/advocacy (54 per cent); (b) formulation and implementation of national education plans, programmes and strategies (35 per cent); (c) provision of peer education programmes (29 per cent); and (d) use of media such as TV and radio to convey RH information (28 per cent).

Ensuring adolescent access to affordable, confidential, gender-sensitive and youth-friendly RH services was one clear recommendation of the ICPD Programme of Action. Close to three in five countries (57 per cent) established youth-friendly services; formulated plans and programmes for the provision of RH services to adolescents (34 per cent); counseled adolescents on RH (27 per cent); and undertook IEC/advocacy on RH services for adolescents (27 per cent).

Life-skills training for adolescents and youth were also supplied by Governments. The measures reported in support of the comprehensive development of young people included the provision of: (a) relevant education system and education in vocational and entrepreneurial skills (61 per cent of the countries); (b) vocational and entrepreneurial education to out-of-school youth (55 per cent); (c) government jobs for youth (33 per cent); and (d) entrepreneurial training for youth by NGOs (18 per cent). The Government of Pakistan is addressing small and medium enterprises (SMEs) development and information technology (IT) with soft loans extended to young people to promote self-employment, as well as greater access for women to microcredit through the Women's Bank and Agricultural Development Board.

Since the Cairo Conference, the participation of young people in policy and programme development has been encouraged. Of the 151 countries surveyed, 64 per cent had engaged adolescents and youth in project formulation and implementation; 47 per cent had included adolescents in policy development; 28 per cent had established fora for youth to elicit information; and 19 per cent had promoted youth organizations or associations as a channel for their participation.

Religion as a factor promoting Adolescent Reproductive Health (ARH) was reported by some countries. Some religions include RH information as part of their religious teaching. When asked how the cultural context constrained the promotion of ARH within the country, 43 per cent of the countries underscored the lack of information available to the youth and reported that open discussion on sexual behaviour and RH issues with adolescents and youth is considered inappropriate or simply not done. Moreover, 23 per cent reported that religious opposition can sometimes prevent youth from seeking RH services.

**5. HIV/AIDS**

The number of people living with HIV and AIDS continues to grow, most markedly in sub-Saharan Africa. However, with the epidemics expanding in Asia, the Pacific, Eastern Europe and Central Asia, more than five million people became newly infected half of them young people between the age of 15 and 24 and are now part of today's 40 million people across the globe living with HIV/AIDS. As HIV/AIDS is a key component of RH and a critical factor influencing the achievement of ICPD goals and the MDGs, the 2003 Survey asked countries to describe successful strategies used to address the HIV/AIDS pandemic. The collective findings are categorized into three distinct groupings: (a) plan, policy or strategy formulation; (b) adoption of prevention approaches; and (c) support activities. Three fourths of the countries reported adopting a national strategy on HIV/AIDS, over a third stated they had specific strategies aimed at vulnerable and high-risk groups, two in nine had adopted a specific policy on HIV/AIDS and one in six passed laws or legislation in support of HIV/AIDS efforts.

Based on the survey responses, a large proportion of countries are addressing prevention as part of their response to HIV/AIDS. Among those measures are: (a) IEC; (b) blood safety; (c) voluntary counselling and testing; (d) prevention and treatment for HIV/AIDS and other STIs; (e) promotion of condom use; (f) surveillance (both epidemiological and behavioural); (g) harm reduction; (h) care, treatment and support of those infected and affected; (i) capacity-building combined with strengthening the health infrastructure; (j) elimination of stigma and discrimination; (k) increased involvement of people

living with HIV/AIDS; (l) advocacy and other supportive measures; and (m) monitoring and evaluation.

A total of 131 countries targeted interventions to high-risk groups such as sex workers (73 per cent); injecting drug users (31 per cent) and long-distance truck drivers (24 per cent). Vanuatu is gathering baseline data and information on services for sex workers and their clients. Popular artists in Bhutan have recorded IEC messages in the form of songs for distribution to truck and taxi drivers. Among the vulnerable groups, the highest percentage of action targeted adolescents and youth (62 per cent), followed by pregnant women and their spouses (28 per cent), women (14 per cent) and street children (5 per cent). Soldiers and uniformed service personnel and migrant workers were targeted by 18 and 12 per cent of countries, respectively. Since January 2000, the Bangalore Oniyawara Seva Costa Organization in India has initiated interventions aimed at street and working children with the help of the Karnataka State AIDS Control Society. To date, 1,000 street children have been provided with interpersonal counselling and all STI cases have been referred to local hospitals for treatment.

Cultural practices and other country-specific factors play either a facilitating or constraining role in confronting the HIV/AIDS pandemic. Among facilitating factors, 73 countries cited culture; 35 reported that social and cultural attitudes promoted community involvement; 24 stated that religious beliefs in their countries had the potential to reduce risky behaviours in the population; while 14 felt that culture promoted delay in the onset of sexual activity. Another eight stated that the extended family system of their culture has helped in the care and support of HIV-positive individuals in their population.

Some 121 countries reported that social and cultural factors in their countries had a constraining influence on addressing the HIV/AIDS pandemic. The factors cited were: (a) absence of open discussion and dialogue on HIV issues; (b) difficulty in reaching those affected because of stigma and exclusion of people with HIV/AIDS; (c) lack of perception on the risk of HIV/AIDS in their countries; (d) obstructive traditional social and cultural practices; and (e) the impediment posed by women's low status.

### 6. Advocacy, education and behaviour change communication

A great many countries (92 per cent) reported having taken one or more successful advocacy strategies and other measures to promote responsible and healthy RH behaviours, especially among high-risk groups. Included among the measures were advocacy, IEC and behaviour change communication (BCC) campaigns (68 per cent), activities targeting vulnerable groups of young people,

women and men (32 per cent) and media campaigns using radio and television (23 per cent). These measures were often complemented by educational efforts such as peer education on RH issues (23 per cent) and the introduction of health education in school curricula. Changes in population policies relating to gender equality and RH (especially for adolescents) were introduced in Viet Nam through education and advocacy activities in the mass media and in schools.

Sixty countries reported lobbying for legislative changes and new laws related to the ICPD PoA while 45 established local advocacy bodies and 37 developed national and regional advocacy strategies. Four out of five countries (81 per cent) reported the use of electronic media (radio, TV and Internet) to address RH issues while 59 per cent used print-media materials such as newspapers, magazines, posters and fact sheets. In the Philippines, population-related IEC and advocacy materials are stored in digital form for easy retrieval and access. Messages were also conveyed through creative communication channels such as concerts, street plays, dramas and local seminars (32 per cent) as well as through the celebration of national awareness days (13 per cent). The Kalyani radio programme in India encourages debate through quizzes, discussions and real-life stories on RH themes. Folk music and drama-based serial programmes are broadcast in 13 languages. About a third of the countries mentioned training national and local media practitioners on RH issues.

Nearly 60 per cent of countries reported setting up hotlines or phone-in-radio and TV talk shows on RH issues. About 47 per cent of countries set up web sites for individuals to access information on RH-related topics. The establishment of village-level computer centres, as reported by 14 per cent of countries, enabled more people to access information on RH matters, including HIV/AIDS. Communication technologies have also helped disseminate information on RH during national awareness days and have been used to establish management information systems to support RH programmes and the empowerment of women and youth.

Policy and funding constraints, programme-related issues and sociocultural factors were mentioned by 45 countries as challenges to overcome in influencing attitude and behaviour change. Other constraints cited were lack of political will, religious opposition, insufficient human resources, absence of monitoring and evaluation mechanisms, deficient coordination between agencies and inadequate equipment and training.

## 7. Partnerships and resources

Building partnerships between Governments and civil society is also a key strategy and target of the MDGs; hence, efforts to achieve the ICPD PoA also contribute to the achievement of the MDGs. Ninety-five per cent of responding countries reported at least one successful effort to strengthen partnerships with civil society organizations in implementing the PoA. Partnership efforts that involved policy and programmatic measures included development of population and RH plans and programmes; capacity-building and training in population and RH issues such as those implemented in Papua New Guinea; establishment of parliamentary caucuses like in India and Indonesia; formulation of laws and legislation on RR and RH and population policy-making. Collaboration on the production of population research and census data was also cited by a few countries. The most common coordinating mechanisms for partnership efforts were partnerships between national population commissions and NGOs (39 per cent); national fora for NGOs (17 per cent); and partnerships between local governments and community-level NGOs (15 per cent).

Nine in ten responding countries in every region reported partnership efforts, more than double the number and proportion of countries that were reviewed in the 1999 ICPD+5 (49 out of 114 countries or 43 per cent).

Government partnerships with civil society organizations cover a wide variety of substantive issues. These include: attending to the special needs of older persons and internal and international migrants; protecting the rights of girls and women (Women's Crisis Centres in the Philippines, for example cater to women and children who are victims of domestic violence); monitoring human rights; expanding access to quality RH information, services and commodities (the Indonesian private sector provides RH services to the poor and to those living in rural and remote areas); reducing maternal morbidity and mortality; preventing HIV/AIDS (social marketing campaigns for male condoms were launched in Mongolia in May 2000 with over 2 million condoms supplied); and monitoring the progress of the ICPD and the MDGs at country-level.

In addition to building partnerships with civil society, Governments have been actively expanding their collaboration with the private sector. Only 8 per cent of countries responding in 1999 had taken significant measures to involve the private sector in population and RH activities. The corresponding figure in 2003 was 75 per cent, underscoring the spectacular development of government partnerships with the private sector.

The private sector played an important role in the provision of contraceptives and RH services (49 per cent); sponsorship of social marketing campaigns and outreach programmes (47 per cent); sponsorship of IEC and advocacy activities on RH issues (42 per cent); and private sector representation in government coordination bodies for population and RH issues (30 per cent). A smaller number of countries also reported private sector provision of financial assistance for RH activities.

The Global Survey asked Governments to report on the level of domestic and international resources available in their countries for population and RH programmes and to assess whether the resources were sufficient to meet their national RH needs. Countries were also asked to report on cost-recovery approaches, absorptive capacity maximization, and other ways to utilize available resources fully. Major constraints to making the most of available resources were also reported by countries.

Over 80 per cent of countries reported that available resources did not meet their countries' RH needs. They also noted that their absorptive capacities were often inadequate to maximize available resources. More than four in five countries attempted to increase domestic resources for population and RH programmes, underscoring their commitment to achieving the ICPD PoA. The Ministry of Health of Cambodia developed a Health Sector Strategic Plan that includes a medium-term expenditures framework to coordinate multi-year public expenditures based on sectoral financing needs and for the protection of the total amount of resources available from both domestic and external resources. Due to difficult economic circumstances, most countries were only able to make incremental funding increases .

In view of these shortfalls, many countries are looking for innovative strategies to maximize and augment available resources, including strengthening partnership efforts and implementing cost recovery and cost sharing strategies. The Government of the Philippines formulated the Philippine Investment Plan to estimate the budgetary requirements for the population programme over multiple years and to determine the budgetary allocation for each programme component as well as strategic action areas, including service delivery, IEC, advocacy and capacity-building.

More than four in five countries (84 per cent) responding to the Global Survey reported mobilizing international assistance for the implementation of population and RH programmes. Most countries tried to make the most of their resources through partnerships with international agencies (including members of

the United Nations), development banks, bilateral government agreements and donor country development organizations.

Over 67 countries reported facing constraining factors in attempting to maximize the impact of available resources for population and RH programmes. The most prevalent constraints were lack of financial resources (44 countries), insufficient human resources and professional training (28 countries) and absence of materials, equipment or facilities (13 countries).

**8. Donor experiences**

A shorter questionnaire was prepared for developed countries belonging to the OECD DAC, referred to here as *donor countries* as part of the 2003 Survey. The responses obtained from 18 donor countries covered: population issues and concerns they had faced since the ICPD and the measures enacted to address them; actions taken relating to gender equality and women's empowerment; measures carried out to increase access to RH services, including those adopted to reduce the spread of HIV/AIDS; and partnerships between donor countries and civil society organizations, as well as issues related to international assistance, including problems and challenges faced by those countries in mobilizing resources to support the implementation of the ICPD Programme of Action. The following paragraphs will also describe how these countries link ICPD goals with international development frameworks and processes. Several of them reported using the MDGs as a basis for the development of programmes and policies promoting the ICPD agenda.

All but two donor countries cited population ageing as an important issue confronting them. The formulation of effective policies, programmes and strategies to respond to the special needs of older persons poses a continuing challenge. The major initiatives taken on this issue by a number of donor countries since 1994 include framing policies, strengthening institutions, building capacity in the areas of continuing education and training, supporting research, and undertaking innovative projects, including those promoting alternative living arrangements. In 2002, the Danish Parliament adopted legislation introducing free choice in relation to the care of older persons and those with disabilities. Participants have a choice in the type of housing and in the home-based provider of personal and practical help. Austria believes that multigenerational housing promotes cohabitation among several generations not only within the family, but among people not related, and in addition it counters increasing isolation and loneliness among the elderly, especially in rural areas.

Responding countries raised a number of issues and concerns regarding international migration involving the social and economic integration of migrants (as in Switzerland and in Finland), family reunification, and issues relating to human trafficking, illegal immigrants, refugees and asylum-seekers. Steps taken include those aimed at promoting equality of opportunity in access to jobs, housing, health and education, along with other social services and amenities. Since the ICPD, a number of donor countries have introduced changes in their family-reunification policies such as Denmark, which no longer considers reunification with spouse a statutory right, and New Zealand, which has strengthened the legal obligations of sponsors to ensure that they take more responsibility for family members brought into the country. Developed countries have recently been viewing migration as a response to medium-term labour supply shortages. The actions have been directed exclusively towards highly skilled immigrants, reflecting a rising demand for skilled labour due to demographic changes and the increasing globalization process.

The spread in the trafficking of human beings is a major challenge to migration management. Nearly all countries had enacted laws and legislation to oppose trafficking and many had ratified international treaties. Half of the responding countries prepared specific programmes to cope with this issue. Norway undertakes information campaigns in sending countries aimed at curbing human trafficking and at reducing the number of illegal immigrants, as well as asylum-seekers. To address the problem more effectively, many countries examined its root causes. One half of the countries supplied international aid to work against the trafficking of women and children, while nearly all furnished services to victims.

The growing levels of illegal immigration and the unremitting flows of refugees, as well as asylum-seekers, remain major concerns. To manage migration effectively, greater international cooperation will be needed.

Since the ICPD Conference in Cairo, two thirds of the donor countries passed new laws and legislation protecting the rights of girls and women. These laws focused on the trafficking and exploitation of women, ensuring gender equality in society (including in education and in parliamentary representation), enforcing gender equality in the workplace (including parental work leave and equal wages), and restraining sexual harassment. The Netherlands and Luxemburg passed legislation requiring employers to protect their staff from sexual harassment. Some countries have established women's commissions or agencies within government structures.

In reference to national strategies to address GBV reported by donor countries, 12 had enacted laws and legislation on this issue, and many have established institutional mechanisms in their legal and judiciary systems. Australia's Family Violence and Prevention Legal Service Units are funded to work with victims and communities in a holistic manner to prevent domestic violence. Almost half of the responding countries provided services for GBV victims. Seven countries are raising awareness, providing BCC, as well as training service providers and government officials, on GBV. Denmark circulated a tool kit containing rules, legislation and advice related to GBV and provided training for service providers and government officials on GBV.

Since the ICPD, donor countries have addressed a range of RH issues reducing unwanted or unplanned pregnancies, meeting the need for counseling and services for high-risk groups, and preventing HIV/AIDS and other STIs. Norway's goal is to provide education, prevent high-risk behaviour, ensure that HIV-infected persons are properly diagnosed and counseled, combat discrimination against those infected and make sure that health-care and social workers have sufficient expertise. Most donor countries (94 per cent) reported that the quality standards with regard to RH service delivery have improved since the ICPD, especially in the areas of human capacity-building and institutional development. The Government of the United States of America is committed to provide underserved communities with improved quality and access to health care.

Donor countries continue to face adolescent and youth RH concerns, including adolescent fertility, the increasing incidence of STIs and substance abuse. Measures taken to address these issues include making contraceptives available for free or for a subsidized fee, providing counselling and youth-friendly RH information and services to adolescents and young people. The RH needs of migrants and indigenous populations are also being tackled. Sweden provides additional training for midwives serving migrant women.

Donor countries have developed national strategies and policies that consider the need for a multisectoral and comprehensive response to HIV/AIDS. These include availability of funding for research and prevention programmes, access to care and treatment, organized support networks, human rights advances and the use of new information technologies to raise awareness of HIV/AIDS and to disseminate relevant information. Donor countries have developed national strategies and policies that take into account the need for a multisectoral and comprehensive response. Many have partnered with local authorities, NGOs, medical experts, and international organizations to fight the spread of HIV.

High-risk groups were targeted through IEC campaigns and service-provision efforts. Laws and legislation were enacted to protect the rights of people with HIV/AIDS. Sexually transmitted infections (STIs) counselling and testing, family planning counselling, and antenatal care have been integrated into HIV/AIDS programmes aimed at reaching a greater number of people, reducing the stigma associated with HIV/AIDS and intensifying the efficient use of limited health-care resources.

Fifteen donor countries reported active partnerships with NGOs, a significant increase from 1998 when only half of the donor countries indicated measures on partnerships. Moreover, five countries reported that since 1994, NGOs have been playing more active roles in their partnerships with Governments, specifically on RH issues.

Since Cairo there appears to be continued momentum for the implementation of the PoA in donor countries. In sum, nearly all 18 donor countries have revitalized their RH programmes through increased attention paid to the RH needs of adolescents, young people, migrants and indigenous populations; availability of high-quality and comprehensive RH services; and training of health-care providers. However, donor countries continue to be concerned with such emerging issues as: (a) meeting the special needs of older persons; (b) the growing levels of illegal immigration; (c) the trafficking of human beings; and (d) the continuing flows of refugees and asylum-seekers.

## The ICPD Programme of Action and the Millennium Development Goals

Many of the goals contained in the ICPD PoA and the ICPD+5 *Key Actions* parallel those of the MDGs. The PoA's focus on population-related efforts, such as increasing access to RH services, promoting gender equality, and nurturing a better understanding of the linkages between population dynamics and poverty, are essential to the achievement of the larger development goals of the MDGs, such as eradicating poverty and hunger. However, the MDGs are silent on the core ICPD goal of universal access to RH services by 2015, even though they contain targets related to RH components like maternal health and HIV/AIDS.

Both the ICPD and the MDGs prescribe targets for providing universal primary education, promoting gender equality and empowering women, reducing child mortality, ameliorating maternal health and hindering the spread of HIV/AIDS and other diseases. The PoA supports the MDGs' focus on ensuring environmental sustainability by recognizing the linkages between and among the

environment and internal and international migration, population growth rates and resource consumption.

Population policies and programmes in many countries have been reoriented towards the ICPD PoA, the *Key Actions* of the ICPD+5 review conducted in 1999 and the ICPD+10 review undertaken in 2004, as well as the series of regional conferences and reviews held in the wake of the ICPD. For example, in the area of family planning, policies focusing on women of reproductive age have given way to a life-cycle oriented RH approach embracing both sexes. Fertility reduction and contraceptive-use targets have given way to ones diminishing the unmet need for contraception. The current priorities are improving method choice and quality of care.

Fulfilling the PoA goals and objectives would ensure the achievement of equivalent MDGs, particularly in lowering child and maternal mortality, providing universal access to primary education, ensuring parity in access to secondary and higher education between girls and boys, minimizing the spread of HIV and achieving gender equality and women's empowerment. Further benefits would be gained due to the synergies between these and other universally agreed development goals.

Carrying out the PoA would lead to empowering women in every sphere of life and to greater men's involvement in the exercise of reproductive rights and responsibilities. Advancements in education, particularly of girls, would contribute to a decrease in poverty, hunger, child and maternal mortality, and the spread of HIV, as well as help bring about gender equality. Furthermore, a better-educated population would likely alter its demographic behaviour with regard to nuptiality, fertility, and health and migration in ways that would enhance its overall well-being.

The PoA offers guidance on ways of addressing the major challenges of the future, including increased urbanization and population ageing, so that its fulfillment would contribute to achieving objectives declared by both the United Nations Millennium Declaration and the Second World Assembly on Ageing. The PoA also focuses special attention on the needs of vulnerable groups, including children and youth, the elderly, the poor, the disabled and indigenous populations, and stresses the need to provide support and protection to families, especially single-parent families, and to vulnerable family members, such as orphans and widows. Implementing the PoA fully would benefit the whole of society, particularly the most vulnerable, and lessen inequality. It would also promote the equal participation and sharing of responsibility between women and men in all areas of family and community life.

Building a partnership for global development depends on the cooperation of all stakeholders Governments, multilateral and donor agencies, civil society and the private sector to realize the goals and objectives of the ICPD Programme of Action. It would validate the importance of the goals included in the United Nations Millennium Declaration and emphasize the paramount importance of international cooperation in carrying out population and development programmes, particularly in the least developed and other low-income developing countries.

## Conclusion

In the two decades since the Mexico Conference, the world, particularly the Asian and Pacific Region, has moved on, in terms of both its economic and demographic situations. The demographic transition in Asia and the Pacific has progressed significantly. During the period 1980-1985, Asia's total fertility rate (TFR) stood at 3.7 children per woman. Two decades later, the TFR was around 2.5. Asia's life expectancy at birth for both sexes stood at 60.5 years during the period 1980-1985; the corresponding figure for 2000-2005 was 67.7 years. Moreover, there are few countries in the region where fertility has not fallen. In fact, there are some countries where fertility in the first half of the 1990s was already below replacement level and is now sinking to even lower levels. The Asian and Pacific region has experienced a clear shift to lower fertility and mortality levels, though within that shift there is considerable diversity among countries.

In terms of economic development, the region has seen impressive growth, again exhibiting wide variations between countries. This follows for poverty as well, although exact trends are debatable. In 2002, the Fifth Asian and Pacific Population Conference was convened under the theme Population and Poverty in Asia and the Pacific. Mrs. Thoraya Ahmed Obaid, (2002) Executive Director of the United Nations Population Fund (UNFPA), in an article featured in a special issue of the *Asia-Pacific Population Journal* (December 2002), wrote:

> *"To confront the challenges of the twenty-first century successfully, we must strive to promote, respect and protect all human rights: economic, social, civil and political. Asia has made excellent progress over the past 30 years and we must maintain the momentum. The Programme of Action of the International Conference on Population and Development and the Key Actions adopted at the review and appraisal of the Conference in 1999, remain feasible, affordable and effective. We must now increase our efforts. By giving greater policy attention and generating greater resources to population and reproductive health issues, we will*

*actually make greater progress in reducing poverty, maternal and child mortality, halting the spread of HIV/AIDS, increasing gender equality and equity and ensuring sustainable development, as world leaders agreed at the Millennium Summit".*

Steven W. Sinding (2005), then Director-General of International Planned Parenthood Federation, in his Viewpoint printed in the August 2005 issue of the same *Asia-Pacific Population Journal,* commented on the decline in funding for population activities. He concluded that in the face of competing demands for funding and ideological threats to reproductive health, he believed that "if the sexual and reproductive community pulls together, if reproductive health and AIDS organizations integrate their work, if we work together to prove the critical link between ICPD goals and fighting poverty, then and only then will we see donors recommitting to funding reproductive health. If not, we risk losing hard-won gains".

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