ASIA AND THE PACIFIC

A REGION IN TRANSITION

UNFPA
United Nations Population Fund

UNFPA/Johnette Stubbs

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1) Only those countries that are *currently* under the *Asia and Pacific Division of UNFPA* have been included in this publication.
2) We appreciate the cooperation extended to us by all our country offices in sending us programme details and country pictures. Several of the population statistics used in the country articles reflect national estimates, and these may or may not correspond with the United Nations Population Division statistics.

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FOREWORD

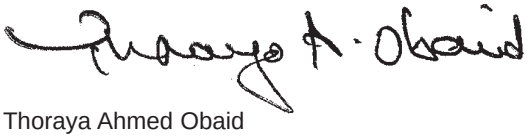
Asia and the Pacific is home to 3.7 billion people — 60 per cent of all people on earth. The region is also home to six of the world's 10 most populous countries: China, India, Indonesia, Pakistan, Bangladesh and Japan. An overall improvement in education, health and nutrition over the past few decades has resulted in a rapid transition from high to relatively low mortality and fertility that has made the eventual stabilization of the region's population a real possibility. But for this possibility to become reality, continued strong efforts are required for women's empowerment, gender equality and reproductive health.

Today Asia and the Pacific region continues to face serious challenges that require greater political commitment and financial support. These include widespread poverty and illiteracy, gender discrimination, growing demands in urban areas, environmental degradation, and the spread of HIV/AIDS. The large youth population and the growing numbers of older persons also present challenges. Unless these issues are tackled with leadership and vision, there is danger of the gains achieved so far being reversed.

The Bali Declaration issued at the conclusion of the Fourth Asian and Pacific Population Conference in August 1992 strengthened the resolve to confront regional population challenges — from the need to improve accessibility and utilization of family planning and maternal and child health services to issues of urbanization, poverty alleviation and sustainable development. Also included were recommendations for governments to adopt national policies and long-term strategies and programmes on mainstreaming gender, and promoting gender equality and women's empowerment in all areas of social and economic development.

The Fund remains steadfast in its commitment to the Millennium Development Goals of halving extreme poverty and hunger, achieving universal primary education and gender equity, reducing infant and maternal mortality, reversing the spread of HIV/AIDS and ensuring environmental sustainability. Guided by the principles of the Programme of Action of the 1994 International Conference on Population and Development (ICPD), UNFPA-funded programmes in Asia and the Pacific, supported by our large network of alliances with governments, NGOs, individuals and foundations, have helped the countries of the region to implement population programmes, improve their demographic monitoring capabilities, and operationalize an integrated reproductive health (RH) approach that emphasizes national capacity building. Reproductive health programmes aim overall to improve the health of individuals and reduce maternal, infant and child mortality. UNFPA advocates for gender equality, with a special focus on adolescents and education for the girl-child. A priority area is the development of strategies and programmes for preventing the further spread of HIV/AIDS. The UN Population Fund is also working to provide emergency reproductive health services to people fleeing armed conflict and natural disasters. By improving health, literacy and awareness, the objective is to improve the well-being of the people of Asia, reduce poverty levels and ensure sustainable development.

As we review the progress made since the Bali Declaration in 1992 and ICPD in 1994, this publication highlights UNFPA's activities, the issues confronting Asia and the Pacific region and the challenges ahead. I would like to thank all partner UN agencies, our country offices, APD and CST staff members, recipient governments and our NGO partners in the region for their continued support, strong commitment, and dedication in making the programmes a success.



Thoraya Ahmed Obaid
Executive Director
United Nations Population Fund
August 2002

United Nations Population Fund

Since its inception in 1969, the United Nations Population Fund (UNFPA) has been helping developing countries and countries with economies in transition, at their request, to find solutions to their population problems, in order to strike an equitable and sustainable balance between population and development. A subsidiary organ of the United Nations General Assembly, the Governing Council of the United Nations Development Programme (UNDP) is the governing body of UNFPA. A quarter of all population assistance from donor nations to developing countries is channelled through UNFPA, which makes it the world's largest internationally funded source of population assistance to developing countries. Till date, the Fund has provided over US$5 billion in assistance worldwide.

In all, UNFPA provides assistance to 142 developing nations, with special emphasis on increasing the quality of reproductive health (RH) services, including family planning (FP); ending gender-discrimination and violence; formulating effective population policies; and reducing the spread of HIV/AIDS. The Asia and the Pacific Division is one of four geographic divisions within UNFPA and covers a total of 36 countries.

The Objectives of UNFPA are:

- Assisting developing countries in providing quality reproductive health, including family planning services, on the basis of individual choice, and in formulating population policies that support sustainable development.
- Advancing the strategy endorsed by the 1994 International Conference on Population and Development (ICPD) and reviewed by a special session of the United Nations General Assembly in 1999 (ICPD+5). The strategy focuses on meeting the needs of individual men and women rather than achieving demographic targets. Key to this approach is empowering women and providing them with more choices through expanded access to education, health services and employment opportunities.
- Promoting coordination and cooperation among United Nations organizations, bilateral agencies, governments, non-governmental organizations (NGOs) and the private sector in addressing issues of population and development, reproductive health, gender equality and women empowerment.

Core Programme Areas

Reproductive Health including Family Planning and Sexual Health – UNFPA helps developing countries, at their request, to improve RH care, all on the basis of individual choice. RH care includes, inter alia, family planning, safe motherhood, counseling and prevention of infertility, prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) including HIV/AIDS, and dealing with the health consequences of unsafe abortions.

Population and Development Strategy – UNFPA helps countries formulate, implement and evaluate comprehensive population policies as part of sustainable development strategies. This includes support for data collection, analysis and research, as well as integration of population variables in planning.

Advocacy – UNFPA is an advocate of ICPD and ICPD+5 goals which include reproductive health and rights; improving the status of women; lowering infant, child and maternal mortality; closing the gender gap in education; strengthening national capacity to formulate and implement population and development strategies; and increasing awareness and resources for population and development.

Funding

The funds mainly come from the following sources: governments and inter-governmental organizations, private sector groups and individuals. The Fund's top ten donors include the Netherlands, Japan, United Kingdom, Norway, Denmark, the United States, Sweden, Finland, Germany and Canada.

It is noteworthy that over the past decade UNFPA has been able to substantially expand its donor base, reaching a target of 100 donors in 2000 and surpassing a target of 110 donors in 2001. Within the context of its multi-year funding framework (MYFF), with clearly defined organizational goals, indicators to track progress, key strategies for achieving results and resource requirements, UNFPA has been striving to obtain multi-year pledges in order to ensure greater stability and predictability in the Fund's resources.

Countries in Asia and the Pacific received about a third of all UNFPA assistance for country programmes, with more than two thirds of the resources being channelled towards the priority area of reproductive health, including family planning and maternal and child health care.

Resource Allocation on the Basis of Priority

In 2000, the Executive Board approved an updated system of resource allocation based on a country's level of achievement in reaching the goals and priorities set by ICPD and ICPD+5. A set of 8 demographic and socio-economic indicators and threshold levels are used to determine a country's need for UNFPA assistance, to be considered along with population size and economic growth. These are:

- Births with skilled attendants (60 per cent)
- Contraceptive prevalence rate (55 per cent)
- Proportion of population aged 15-24 living with HIV/AIDS (10 per cent)
- Adolescent fertility rate (65 per 1,000 women aged15-19).
- Infant mortality rate (50 per 1,000 live births)
- Maternal mortality ratio (100 per 100,000 live births)
- Adult female literacy rate (50 per cent)
- Secondary net enrolment ratio (100 per cent)

Countries fall into five categories. Group A countries include all least developed nations that have met the threshold levels of only 0-4 indicators; have an annual per capita GNP of less than US$900 and thus have the highest need for assistance. Group B countries, which have the second highest need, have met the threshold levels for 5-6 indicators or have a per capita GNP of US$900 or more. Group C countries have made the maximum progress– they meet threshold levels for 6-7indicators and thus require the least funding. In addition, there are two more categories: Group T countries comprise those with economies in transition which have specific needs for external assistance on a temporary basis and Group O (other or non-classified) countries are small developing nations with less than 150,000 people which do not fall in any of the above categories.

UNFPA's priority "A" countries in the Asia and the Pacific region are:

Afghanistan
Bangladesh
Bhutan
Cambodia
East Timor
India
Kiribati
Lao PDR
Maldives
Myanmar
Nepal
Pakistan
Papua New Guinea
Samoa
Solomon Islands
Tuvalu
Vanuatu

Agenda for Action

ICPD and ICPD+5

At the International Conference on Population and Development held in Cairo in September 1994 and its subsequent review in 1999 (ICPD+5), 179 countries agreed that population and development are inextricably linked, and that empowering women and meeting people's needs for education and health, including reproductive health, are necessary for both individual advancement and balanced development. Advancing gender equality, promoting male responsibility, eliminating violence against women and ensuring women's ability to control their own fertility were acknowledged as cornerstones of population and development policies. UNFPA, as the lead UN organization for the follow-up and implementation of the ICPD and ICPD+5 Programme of Action, is committed to achieving its goals, which include:

- *Universal access to reproductive health care, including family planning and sexual health by 2015;*
- *Halving the 1990 illiteracy rate for women and girls by 2005;*
- *Enrolling 90 per cent of boys and girls in primary schools by 2010 and ensuring universal access to primary education by 2015;*
- *Reducing infant mortality to below 35 deaths per 1,000 live births and under-5 mortality to below 45 per 1,000 by 2015;*
- *Reducing maternal mortality rates to half the 1990 levels by the year 2000, and by half again by 2015;*
- *Increasing life expectancy at birth to 75 years or more by 2015;*
- *Reducing the unmet need for contraceptives by half by 2005 and eliminating it altogether by 2015;*
- *Ensuring that 60 per cent of primary health care and family planning facilities offer a wide range of services by 2005, including family planning, obstetric care, and prevention and treatment of RTIs, including STDs; and that 80 per cent do so by 2010;*
- *Ensuring that 90 per cent of all births are assisted by skilled attendants by 2015;*
- *Reducing HIV infection in youth by one quarter by 2010; guaranteeing that 90 per cent of 15-24 year-olds have access to information and services by 2005 to help them avoid HIV infection - including condoms, voluntary testing, counselling and follow-up.*

Technical Advisory Programme

The Technical Advisory Programme (TAP) is a partnership among UNFPA, specialized United Nations (UNESCO, ILO, FAO, UNIFEM, WHO, UNAIDS) and other agencies, including several NGOs, through which technical assistance is channelled to developing countries in priority population and RH areas. Since its inception in 1992, TAP has adopted an integrated and coordinated multi-disciplinary approach to population and development issues to enhance partner countries' technical knowledge, analysis and research capacity and to achieve national self-reliance through use and development of national, regional, international, and institutional expertise. Reflecting the ICPD and ICPD+5 goals, the TAP has been structured as a three-tier arrangement: At the national level, there is greater reliance on local and regional institutional expertise; at the regional and sub-regional level, multidisciplinary Country Technical Services Teams (CSTs) composed of technical specialists and experts on population disciplines and recruited by UNFPA and other UN partner agencies, provide the necessary support in collaboration with national counterparts and NGOs; and at the headquarters and regional offices, the Technical Advisory Services (TAS) specialists supply the necessary expertise.

In Asia and the Pacific, the CSTs operate from three countries: Thailand (Bangkok), Nepal (Kathmandu) and Fiji (Suva). Their contribution and technical expertise has been invaluable in: developing coherent and integrated country programmes and subprogrammes and ensuring that key phases of these programmes are undertaken in timely and substantive manner; carrying out country population assessments and developing population strategies; and promoting national self-reliance on population related issues through technical backstopping and use and development of national, regional and institutional expertise, inter alia. As a result, the majority of UNFPA programmes have been able to translate ICPD concepts into concrete operational terms.

Asia And The Pacific: An Overview

Extending from the Islamic Republic of Iran from the fringes of West Asia to the myriad islands of the South Pacific, the region of Asia and the Pacific is home to the majority of the world's people – over 3.7 billion or roughly 60 per cent of the total. The present world population of 6.1 billion is projected to surpass 9.3 billion by 2050. Of the ten most populous countries, six are in Asia – China, India, Indonesia, Pakistan, Bangladesh and Japan. Five of these countries (excluding Japan) will account for 45 per cent of this growth: India (21 per cent), China (12 per cent), Pakistan (5 per cent), Bangladesh (4 per cent) and Indonesia (3 per cent). In the past two decades, the Asian economies have shown a rapid decline in average population growth rates, which at 1.3 per cent today is the lowest among developing nations and closely approximates the world average of 1.2 per cent. Yet, Asia still accounts for almost half the world's annual population increase because of the already existing huge population base.

Though wide regional variations persist in the demography of the region, significant progress has been achieved in the social sector, particularly reproductive health (RH), over the last decade. Better medical facilities and improvements in health and nutrition have resulted in declines in fertility and mortality rates. Life expectancy has improved markedly in the region, averaging over 65 years in most parts. Fertility levels have dropped throughout the region, with notable reductions in China, Democratic People's Republic of Korea, Thailand, Sri Lanka and Republic of Korea, where due to effective population policies, total fertility levels are now below the world average of 2.68. Consequently, population is growing at one per cent or even lower in these countries. The reverse scenario is evident in some other countries of the region. Women in Afghanistan, Bhutan, Pakistan, Cambodia, Lao PDR and Nepal continue to bear more than 4 children on an average. In all these countries population is increasing at a rate exceeding 2 per cent.

Even though significant progress has been achieved in reducing infant, child and maternal mortality, many countries like Afghanistan, India, Bhutan, East Timor, Nepal, Cambodia, Lao PDR continue to have maternal mortality ratios exceeding 400 per 100,000 live births and likewise infant and under five mortality rates are very high. Persisting inequities in gender and wealth distribution are serious deterrents to social and economic development. A vast majority of the people in the region continue to face serious deprivation and live in extreme poverty on $2 a day or less, lacking basic sanitation, clean water, and adequate housing. There are well over 600 million illiterate adults in Asia alone, with many countries having illiteracy rates of 40 per cent or more, women being clearly the more disadvantaged. The continuing high population growth rates in some countries are further neutralizing economic gains.

Most of the countries of East and Southeast Asia are still on their recovery path from the financial crisis of 1997, albeit at a slow pace. As a result, many countries have concentrated on the management of the macro-economic and financial sectors; with the result the social crisis still remains a matter of concern. In the Pacific region, the young age-structure of the Pacific Island countries underscores the importance of responding to the RH needs of adolescents. However, the delivery of development assistance in the Pacific is made more difficult by the diseconomies of scale, with small populations scattered over a necklace of volcanic islands and coral atolls.

Since population growth is seen as a serious threat to sustained economic development, many Asian economies developed population strategies and adopted government supported family planning (FP) programmes decades ago. Countries like India, Malaysia, the Philippines, Singapore and Thailand were among the first to provide integrated health services, including FP. To increase widespread availability of modern contraceptives, community-based distribution projects run by local volunteers were started, particularly in rural areas and urban squatter settlements. The contraceptives were distributed free or at greatly subsidized prices. The results were impressive. Contraceptive use soared in Asia. Several countries succeeded in bringing total fertility levels down significantly. Notable among them were China, DPRK, Iran, Republic of Korea, Thailand, Viet Nam, Indonesia, Malaysia, India, Sri Lanka and Bangladesh. The success

of the FP programme can be attributed to: early recognition of population-related problems; political commitment; lack of strong imbedded religious obstacles to FP; existence of an appropriate health care infrastructure; and the influx of substantial international technical and financial assistance.

Asian governments are struggling to come to terms with rapid urbanization, which is posing a serious threat to the surrounding environment leading to high levels of water and air pollution, land degradation and increasingly stressing the already weak social, health, housing and sanitation services in urban areas. The region has majority of the world's most populous cities, where huge numbers live on the edge of survival in overcrowded slums, squatter settlements or on the streets. Apart from high volumes of rural-urban migration, there is substantial intra-regional migration as well that is causing concern to governments.

Most economies of the region continue to grapple with high levels of poverty, low levels of literacy, gender inequalities and gender-based violence. However, the next biggest threat to the Asian and Pacific region is the rising incidence of HIV/AIDS. Even with HIV prevalence rates as low as 1-2 per cent across the region, an estimated 7.1 million people are currently living with the disease in the region.

Adolescents (those aged 10-19 years) comprise a sizeable and growing proportion of the total population (more than one fifth), most at risk of unwanted pregnancies, STDs and AIDS. The reproductive health of adolescents is increasingly being recognized as a key area for UNFPA support. Likewise, Asia is home to the majority of the world's older people (roughly 54 per cent) defined as those aged 60 years and above, majority being women. This new emerging issue has major ramifications for developing countries of Asia and the Pacific, which still do not have systems of social protection in place, particularly old age security and health insurance.

The Fund's presence in the Asia and the Pacific has been overall catalytic, not only in helping countries plan and expand their population and FP activities, but also in operationalizing their RH services, with an emphasis on national capacity building. Complimenting the efforts of the countries, the Fund has helped them increase their demographic monitoring capability and establish vital registration systems. As a result, the region now has considerable institutional capacity and expertise available to undertake policy research on important population and policy linkages. UNFPA has been extensively supporting projects that improve the status of women, by promoting programmes that improve their education, income and employment opportunities, and by providing access to quality RH services. In addition, UNFPA has supported emergency RH projects in several Asian countries torn apart by crisis, war, armed conflicts and natural disasters.

UNFPA/Photo

The programmes that UNFPA supports in the region are tailored to each country's specific needs and priorities. Though most Asian governments have long experience in planning and implementing population programmes, there is a need to enhance national capacity to respond to the new challenges. This means sensitising and providing relevant training to service providers, policy makers, programme managers and government officials.

The region as a whole has made important strides in implementing the ICPD PoA, especially in operationalizing the RH approach. However, there is still a large unmet need for FP in most countries of the region that needs serious attention, if population growth rates are to be contained and sustainable levels of development are to be achieved. From 1969 till the present, UNFPA has invested more than $1.4 billion in the region, majority being devoted to reproductive health, including family planning and sexual health.

Addressing Reproductive Health Needs of Adolescents

Adolescence is a crucial stage in a person's life: a transition from childhood to adulthood. It is a time of social, biological and psychological transformation, which impacts a young person's entire life and societies as a whole. It is a time of boundless energy, curiosity, experimentation, relationships, peer pressure, risk-taking and establishing ones identity. In Asia and the Pacific region, adolescents, aged 10 – 19 years, comprise a sizeable and growing proportion (more than one fifth) of the total population. If one takes into account all people under the age of 25 years, the percentage touches almost fifty in several countries of the region. A more humane and enlightened view of adolescents and young people, understanding their health and educational needs with sensitivity, respecting their rights, and empowering them to make informed decisions is, therefore, of urgent necessity and imperative value.

Demographic Bonus

Many developing countries, in fact, stand to reap a one time "demographic bonus" if societies invest in health and education and job creation. The resulting economic gains will improve the overall quality of life and reduce the burden of supporting older populations in the future. But failure to create new jobs for growing populations, and to reduce existing unemployment, may lead to social unrest and instability. Enabling young women, in particular, to exercise greater control over their sexual and reproductive lives is an essential part of ensuring their contribution to development.

UNFPA, THE STATE OF WORLD POPULATION 1998

Situation of Adolescents in Asia and the Pacific

In the past decade, levels of literacy and educational opportunities in the region have improved. Yet, gender disparities in school enrolment continue to persist in several countries and quality education geared to address the emotional and psychological needs of the adolescents is lacking. The problem gets compounded by lack of trained teachers, unsuitable and outdated school curricula, lack of parental and community participation and paucity of resources. Secondary enrolment ratios in majority of the countries are below 50 per cent, girls being clearly the more disadvantaged. Stereotypical gender notions continue to promote early age of marriage, early childbearing and high rates of adolescent fertility in several countries.

"Education is important for everyone, but it is especially significant for girls. Girls who are educated are likely to marry later, for example, to have smaller healthier families."

Thoraya A. Obaid
Executive Director, UNFPA

In recent years, the rapid pace of globalisation, urbanisation, high rates of migration, widespread availability of communication and information technology and decline in the prevalence of the extended family system, have brought about changes in cultural values. These are now tending to erode traditional customs and affect the sexual behaviour of adolescents. Many countries have reported high levels of unprotected sexual activity both within and outside the marriage, leaving adolescents at high risk of unwanted pregnancies and STDs/AIDS. Many of the unwanted pregnancies end up as induced abortions, often performed under unsafe conditions, resulting in serious health complications and at times maternal death. Although knowledge of at least some traditional form of contraception is almost

- One in ten births worldwide are to teenage mothers. In least-developed countries 1 in every 6 births is to young women aged 15 to 19 years. Girls aged 10 – 14 are five times more likely to die in pregnancy or childbirth than women aged 20 – 24.
- At least 1 in 10 abortions worldwide occur among women aged 15 to 19 years. More than 4.4 million young women in this age group have an abortion every year, 40 per cent of which are performed under unsafe conditions.
- Everyday, 500,000 young people are infected with STDs – most are in the 20 –24 age group, followed by those in the 15-19 age group.

UNFPA. Population Issues Briefing Kit 2001

universal in the region, contraceptive use among adolescents is low and there is a large unmet demand for contraception.

Thousands of adolescents (especially girls) each year are being subjected to sexual abuse, violence and trafficking (both inter and intra-regional) and their economic exploitation (using children as domestic and industrial labour, including coerced child labour in organised begging and prostitution) is widely prevalent in several countries of the region.

The fear caused by the rapid spread of HIV/AIDS in the region has exposed and highlighted the dangers of lack of youth-friendly RH information and services for young people. In many countries, the topic of adolescent sexuality is politically and culturally sensitive; health-care providers have negative attitudes towards unmarried adolescents, particularly females seeking FP services and diagnosis and treatment of STDs; and adolescents themselves are reluctant to use the services out of fear, ignorance or social stigma. Besides, the quality of ARH services is poor. In other words, there is serious lack of a supportive environment addressing the whole issue of adolescent sexuality. While private clinics do provide better services, the cost acts as major deterrent discouraging adolescents seeking such services.

UNFPA: Meeting the Challenge

UNFPA, as part of its life-cycle approach to RH, is committed to providing greater access to youth-friendly information and services on promoting safe sexual behaviour including abstinence, delayed age of onset of sexual intercourse, preventing early and unwanted pregnancies and preventing STDs, including HIV/AIDS through formal and non-formal education and other IEC efforts. With programmes that are responsive to the needs of adolescents, UNFPA has been advocating for policies that recognize the rights of young people and promote their RH. UNFPA seeks the participation of adolescents themselves in the planning, implementation and evaluation of policies and programmes involving them. It also works to address gender issues and is increasingly involving young men in its efforts to promote responsible sexual behaviour and reproductive health. The joint EC/UNFPA Initiative for RH in Asia has been a major innovative step in tackling ARH issues in some of the Asian countries.[1] In an effort to create wider awareness on ARH issues among policy makers, advocacy efforts have been intensified at the country and regional levels and assistance of NGOs sought. Since 1998, a series of technical workshops and regional and international conferences have been organized with UNFPA assistance to assist in the formulation of specific policy and programme strategies.

Taking advantage of multiple communication channels, UNFPA uses innovative means for ensuring behavioural change among young people:

In **Bangladesh,** early marriage and childbearing are common: almost half of women between 15-19 years old are married. Yet, young couples seldom seek RH services. This is partly because the birth of a child proves a woman's fertility to her in-laws. To address this gap, a UNFPA-supported programme identifies and registers newlywed and young couples with one or two children, and offers them orientation sessions and one-to-one basic counselling. The newly married women are often accompanied to orientation sessions by their mothers-in-law and husbands. The sessions serve to break the social and psychological barriers against contraceptive methods. The programme also educates young couples about the risks of early childbearing and lack of birth spacing and provides information on MCH issues and services. Contraceptive use among newlyweds in this programme jumped from 19 percent in 1993 to 39 percent in 1997. What is more significant is that nearly one-third of men have started attending these sessions on their own – suggesting greater motivation, social mobility, and family acceptance than in the past. Unmarried young men and women also attend sessions, suggesting growing demand for information among adolescents. An increasing number of sessions are being hosted in private homes, a sign of wider community acceptance.

In the **Philippines,** a Counselling-on-the-Air project has enabled youth counsellors to reach out to other youth, as well as parents and teachers, through a radio programme that gave young people the opportunity to share their views with other youth and adults.

Conditions are difficult in Jabalpur city in Madhya Pradesh, **India,** but a programme supported by UNFPA that empowers girls to reach other girls living in city's slums with information on RH services, is making a difference. A study found that adolescent girls knew little about their bodies and that young people suffered from a lack of health services and the dangers of sexual exploitation, unwanted pregnancy and unsafe abortion. Today, young community health workers assist in counselling, education and awareness raising among in-school and out-of-school adolescents. They also provide referrals to the expanding network of youth-friendly services, distribute contraceptives and talk with teachers and parents.

[1] See: The *EC/UNFPA Initiative for Reproductive Health (RHI) in Asia* on pages 73-74

Population Ageing

New Generations

With the rate of population growth having slowed and still slowing due to concerted efforts over the last 30 years, the demographic landscape of Asia and the Pacific is undergoing a transformation – More young people than ever are entering their childbearing and working years and at the same time, the number and proportion of people aged 60 years and over are increasing at an unprecedented rate. Our future will be shaped by how well families and societies can meet the needs of these growing "new generations": education and health (including reproductive health) for the young; social, medical and financial support for the elderly. These investments will have an enormous beneficial impact in terms of health, human rights and enabling individual men and women to contribute fully to development.

Urgency of the Problem

A sustained decline in fertility, in conjunction with a sharp decline in mortality rates following medical advances and subsequent increases in life expectancy by 20 years or so since 1950, has transformed the age structure of the population. Though worldwide older persons, defined as those aged 60 and above, constitute an increasingly large proportion of the total population, developing countries and economies in transition are facing unprecedented increases, with the pace of transformation being most rapid in Asia and Latin America. Asia will contain 80 per cent of the estimated 701 million older persons in the developing world by 2020. Projections by the United Nations indicate that many Asian countries will have 10 per cent or more of their populations above 60 in the year 2025, and 20 per cent or more in the year 2050.

Today (2002), the number of persons aged 60 years or older is estimated to be 629 million. That number is projected to grow to almost 2 billion by 2050, when the population of older persons will be larger than the population of children (0-14 years) for the first time in human history. Fifty-four per cent, the largest share of the world's older persons, live in Asia.

Second World Assembly on Ageing Madrid, Spain 8 -12 April 2002

Population ageing is thus becoming a critical public policy issue in the developing world, Asia in particular, because not only are the numbers of aged high in absolute terms, the rate of increase of the older population is happening fastest here. In some of the East and Southeast Asian economies like Malaysia, Thailand, Singapore and Republic of Korea, there is still some form of support system for the elderly because of economic progress. But in the other Asian and Pacific economies, so far there has been a lack of policy and programmatic focus on older people, especially the poor old, the majority of whom are women. Most developed countries underwent the demographic transition quite slowly: in France and Sweden it took 82 and 114 years respectively, for the population aged 65 and over to double from 7 to 14 per cent. The same transition took only 18, 20 and 25 years for Singapore, Republic of Korea and Japan respectively. Countries such as China, India, Sri Lanka, among others, are projected to make this transition in a time span of 25-28 years. This poses a major resource challenge to countries facing the simultaneous challenge of development.

Socio-Economic Implications of Ageing

A growing ageing population implies a shrinking labour force and an expanding number of older dependent persons which could result in declining productivity, public revenues, rates of savings and investments, as well as an increase in public expenditure on social security. Besides the fiscal ramifications, there are complex social implications of this demographic transition that need to be addressed by policy makers. Most developing countries do not have comprehensive systems in place for broader social protection, particularly old-age security. The needs of the older persons often remain unmet, their rights and dignity compromised. Ageing workers of the informal sector are often left without a pension and may not

even receive any kind of financial support from employees and family. Lack of income through employment, pension payments, or discontinuity of remittances from family members, compounded by inadequate or no health care or any other form of economic or social security, puts many older persons in a precarious economic situation and makes them vulnerable to severe poverty.

A striking characteristic of an ageing society, particularly those over 80 years, is that it is female dominated. Many are widows, often poor and illiterate. Fragile in health, restricted in mobility, lacking access to financial and legal resources and subject to discrimination, older women are more vulnerable to exploitation and violence. Women's low status, weaker property rights and limited access to inheritance, strongly influences their social security in old age. In many poor households, women receive less than their share of food. Many long-term female health problems originate in reproductive years and are exacerbated by lifelong discrimination.

UNFPA/Johnette Stubbs

In most developing countries, the family continues to be the main care provider in old age. However, changing family patterns, rapid urbanisation, migration of young people, smaller family sizes, employment of women outside the household, changing family values and ideals, can leave older persons abandoned by those on whose care they were counting.

Rationale for Public Policy: UNFPA Response

Most governments are now becoming increasingly aware of the profound consequences on individuals and societies of the transformation in age structure of the global population and are realising the need for integrating the process of ageing into the larger development processes. This calls for comprehensive public policy for better health, social and financial support services for ageing populations. Policy choices that support intergenerational equity will enable older persons to remain healthy, productive and independent for longer.

The United Nations has already taken measures to address the issue. Following the First World Assembly on Ageing in Vienna in 1982 and the Year of Ageing in 1999, the Second World Assembly on Ageing was held in Madrid in April 2002 in which the focus went beyond the health aspects to the broader development dimensions of population ageing. In collaboration with the UN Department of Economic and Social Affairs (DESA) and the Columbia University Mailman School of Public Health, UNFPA with its network of Country Offices and Country Support Teams is now developing a programme on ageing. The programme will adopt a interdisciplinary, multisectoral approach; use broad-based participation by actively involving governments, policy makers, NGOs and civil society at large to ensure sustainability; and will have four distinct components of capacity building of national governments/organisations: research, training, advocacy and policy development. The goal of the programme is to enable developing countries to improve the quality of life for the growing older populations and influence public policy to effectively respond to the challenges and meet the needs of older persons, with an emphasis on the poor and the vulnerable.

> "The issues of ageing must be at the centre of the global development agenda. Today, the elderly are the world's fastest growing population group, and among the poorest. One person in ten is 60 years or older, but by 2050, the rate will be one person in five. We must meet the needs of the older persons who are alive today and plan ahead to meet the needs of the elderly tomorrow. In the developing world, there are almost 400 million people over age 60, the majority of whom are women, and this figure is expected to rise dramatically in the coming decades."
>
> Ms Thoraya Obaid
> Executive Director UNFPA
> Second World Assembly on Ageing,
> Madrid, April 8-12, 2002

Rising Spread of HIV/AIDS

The devastation and suffering caused by HIV/AIDS[1] has left no scope for complacency. At the end of 2001, an estimated 40 million people were living with HIV/AIDS – 7.1 million in Asia and the Pacific region. The UN estimates that by 2021 at least 150 million people will have died or been infected by HIV/AIDS. AIDS killed 3 million people globally in 2001 of which 435,000 were from Asia and the Pacific region. The far-reaching impacts of the epidemic are decimating the productive sector, robbing people in their prime, leaving children orphaned, eroding incomes, exacerbating poverty, and straining the budgets of many developing countries. Worldwide, AIDS has become the fourth largest killer. The majority of HIV victims worldwide are young people aged 15-24, young women being especially vulnerable. Most are unaware they carry the virus; several million know nothing or too little about HIV to protect themselves against it. In the absence of vigorous prevention efforts, there is considerable scope for further HIV spread. Even HIV prevalence rates as low as 1 to 2 per cent across Asia and the Pacific would cause the number of people living with HIV/AIDS to soar.

The future course of the AIDS pandemic will depend upon not only what happens in Africa but in Asia and the Pacific, that is home to nearly 60 per cent of the world's people.

HIV/AIDS in Asia and the Pacific

Though HIV/AIDS came later to Asia (mid 1980s), its spread has been swift. By the early 1990s, in several Asian countries (Thailand, parts of India, Myanmar and Cambodia) significant heterosexual transmission of HIV was reported, primarily from female sex workers (FSW) to their male clients and then from these males to their regular sex partners. Explosive spread of HIV within injecting drug users (IDU) in addition to FSW was reported soon thereafter in Thailand, northeast India, several provinces of China, Malaysia, Pakistan, Myanmar, Viet Nam and later in Nepal and Indonesia. In 2001,1.07 million adults and children were newly infected with the HIV virus in the region. In fact, the epicenter of the AIDS pandemic has shifted now to Asia and is spreading to the Pacific. And the full impact will not be felt for another decade because of HIV's long incubation period. Although HIV rates have not grown to Africa levels, Asia's infection rates are growing faster than anywhere else in the world. In 1999, only Cambodia, Myanmar and Thailand had documented significant nationwide epidemics with prevalence rates exceeding 1 per cent among people aged 15-49 years. Elsewhere in the region, prevalence rates are below one per cent. However, in vast, populous countries such as China, India and Indonesia, low prevalence rates lose all meaning because the population base of these countries is so large that even low rates imply that huge numbers live with the virus. In India, for example, the national adult HIV prevalence rate was under 1 per cent at the end of 2000, yet this meant that an estimated 3.86 million Indians were living with HIV/AIDS – second only to Africa. The national average also masks huge regional disparities. The Indian states of Maharashtra, Andhra Pradesh and Tamil Nadu have registered HIV prevalence rates of over 2 per cent

UNFPA/Photo

Youth Centres in Pattani Province, Thailand, organise vocational training for out-of-school youth and training on ARH issues, including HIV/AIDS prevention and drug abuse.

AIDS has arrived in the two most populous countries of the world: China and India, home to over a third of the world's population and nearly 70 per cent of Asia's people. Unless serious measures are taken to stem the epidemic in its nascence, the consequences would be ravaging.

[1] The statistical data on HIV/AIDS used in this article is based on UNAIDS/WHO *AIDS Epidemic Update*, December 2001

among pregnant women at one or two sentinel sites and over 10 per cent among STD patients – rates far higher than the national average of less than 1 per cent. In China, the numbers infected may well have exceeded 1 million by late 2001, though estimates vary widely. In Indonesia – the world's fourth-most populous country – after more than a decade of negligible HIV rates, the epidemic is emerging rapidly among IDU and FSW, and in some places also among blood donors. Similarly in Myanmar, nationwide prevalence has been put at 2 per cent. Yet, HIV rates exceeding 50 per cent are being registered among IDU and roughly 40 per cent among female sex workers.

In Asia and the Pacific region, even in countries where the epidemic is localized or prevalent among specific population groups, there is a serious threat of it spilling over into the wider mainstream population leading to major, generalized epidemics.

Factors Aggravating the AIDS Situation:

High risk behaviours, such as unprotected sex between clients and sex workers, needle sharing and unprotected sex between men are the major causes of spread of the disease. Cross border migration in search of employment, proliferating sex trade, rising urbanization, trafficking of women and displacement of refugees are worsening the situation. Movement of populations from low prevalence areas or countries to areas of high prevalence and back again causes HIV to move with these populations. In Bangladesh, Indonesia, Nepal and the Philippines, fewer than half the sex workers have reported using condoms with every client. More than 50 per cent IDU have acquired the virus in Myanmar, Nepal, Thailand, China's Yunnan Province and Manipur in India. Thailand has succeeded in curbing a rampant heterosexual epidemic, but HIV continues to spread through the sharing of drug injecting needles and through unprotected sex between men. In Cambodia, a norm of premarital and extramarital sex for men (usually paid sex) is driving the epidemic. Situations of conflict, violence and instability in some countries have increased the risk of HIV/AIDS in these countries.

Prompt, large-scale, targeted prevention programmes can hold the epidemic at bay as the case of Thailand and Cambodia have revealed.

- Thailand's well-funded, politically-supported and comprehensive prevention programmes, including the FSW targeted "100% Condom Programme" implemented in 1991, have substantially reduced the levels of sexual risk behaviour in Thailand and trimmed annual new HIV infections to about 30,000, from a high of 140,000 a decade ago.
- In Cambodia, concerted efforts, driven by strong political leadership and public commitment and supplemented by education and communication campaigns through a variety of channels and vigorous promotion of condom use ("100% Condom Use") implemented since 1998 in entertainment establishments, have lowered HIV prevalence among pregnant women to 2.3% at the end of 2000 – down by almost a third from 1997.

Apart from being very populous, the Asia Pacific region is also dominated by high levels of poverty in several countries. High-risk behaviour patterns get aggravated by poverty, lack of education and awareness and economic inability to access RH services by marginalized groups. Interventions targeting the poor should go beyond mere awareness-raising to increasing access to condoms and testing facilities. HIV/AIDS is also driven by attitudes related to gender roles. Millions of women and girls because of their subordinate position in societies and economic dependence cannot insist on fidelity, demand condom use, or refuse sex to their partner, even when they suspect he is already infected. Cultural beliefs and expectations about "manhood" often encourages risky sexual and drug-taking behaviour in men. This puts them – and their partners – at heightened risk. Engaging men as partners in fighting AIDS can help change the course of the pandemic.

UNFPA Interventions

Since its inception in 1969, preventing STDs has been a significant component of all RH programmes supported by UNFPA. In the early 1990s, the Fund joined forces with UN agencies, governments and NGOs to fight the escalating HIV/AIDS pandemic. In 2000, UNFPA identified three crucial strategic directions for future interventions:

Stigma Attached to AIDS

Stigma and discrimination are the major obstacles to effective HIV/AIDS prevention and care. Fear of discrimination and shame prevent people from seeking treatment for AIDS or from acknowledging their HIV status publicly. People with, or suspected of having, HIV may be turned away from health care services, denied housing and employment, shunned by their friends and colleagues, turned down for insurance coverage or refused entry into foreign countries. In some cases, they may be evicted from home by their families, divorced by their spouses, and suffer physical violence or even murder. The stigma attached to HIV/AIDS may extend into the next generation, placing an emotional burden on children who may also be trying to cope with the death of their parents from AIDS.

1. Promoting safe sexual behaviour among young people, including abstinence and delaying the age of sexual activity;
2. Condom programming to improve access to and use of condoms (male and female), taking into account user needs and perspectives;
3. Preventing HIV infection among pregnant women and its transmission to children and to HIV-negative partners.

Using its vast wealth of experience in addressing gender relations, sexuality and RH and its extensive network of field offices and multi-disciplinary Country Technical Support Teams, UNFPA along with a strong network of international partners and NGOs, has been following a focused agenda in the global fight against HIV/AIDS. As one of the seven co-sponsors of UNAIDS (Joint United Nations Programme on HIV/AIDS), UNFPA, in partnership with other cosponsors has been integrating HIV-prevention efforts into a wide variety of activities. At the global level, an Inter-Divisional Working Group on HIV/AIDS has been established to maximize UNFPA's response to HIV/AIDS.

Power of Prevention

Since HIV prevention has been given institutional priority, it has been integrated into RH/FP programmes around the world. Prevention also encompasses a range of culturally-sensitive communications and RH services aimed at promoting safer sexual behaviour among young people; making sure condoms are readily available and correctly used; strong advocacy at every level of government and messages in every medium; empowering women to protect themselves and their children by refusing unsafe sex; and encouraging men to make a difference, take fewer risks and assume responsibility.

UNFPA has been mobilizing political commitment and reform through advocacy; increasing resources to fight AIDS; training health care providers and counsellors; and promoting access to testing, counselling and treatment. Programmes have been expanded to prevent HIV infection, especially among young people and pregnant women, and campaigns promoting condom use among sexually active individuals are being widely used. Gender equality is being promoted in all programmes and discriminatory practices that spread HIV infection being

No one initiative holds all the answers, but together they are helping develop positive attitudes and life-saving behaviours.

- In Cambodia, where HIV infection is high, UNFPA, in collaboration with UNESCO and the Ministry of Health, developed the first HIV/AIDS manual for the nation's schools. In 2000, the manual was distributed to all secondary schools, and 1,385 teachers were trained to teach the new material.
- A radio information programme on adolescent reproductive health (ARH) and sexuality is carried out by the Voice of Viet Nam, with technical assistance from the BBC and financial support from UNFPA. Broadcast every Sunday morning, the call-in programme involves a panel of experts who answer questions on ARH, sexuality, gender discrimination and related topics.
- In Maldives, Friday sermons broadcast live on the radio, are powerful channels for reproductive health and advocacy. Radio and television spots dealing with family planning, adolescent health, HIV/AIDS prevention, under-age brides, and early pregnancy have also become common in Maldives, Bangladesh, Mongolia, Cambodia, Philippines, Thailand and other countries.

challenged. In conjunction with other United Nations agencies, UNFPA has urged pharmaceutical companies to provide essential medicines at preferential prices to developing countries. In 2000, UNFPA developed the Global Strategy for RH Commodity Security for integration into all of its country programmes to ensure a supply that is adequate, dependable and diverse.

Funding and Shortfalls

While demand in developing countries has been increasing, donor support for contraceptives has declined since 1994, reaching its lowest level in five years in 1999. UNFPA is urging programme countries, donors and other partners to meet the need and avoid shortfalls. Responding to the shortfall in supply, the Netherlands contributed over $40 million and the UK nearly $37 million in 2001 to UNFPA to avert a crisis in contraceptive and other RH supplies. The Canadian International Development Agency (CIDA) granted UNFPA $0.8 million for 2001 to procure contraceptives, including condoms, for developing countries with the greatest needs.

Partnership and cooperation are central to ensuring that the people who are fighting HIV/AIDS have the means to do so. A pilot project that began in 1997 is developing models for private sector and NGO involvement in making affordable commercial contraceptives and RH services more accessible. Social marketing of condoms employs advertising and marketing techniques to create demand. Through a wide range of channels, from posters to soap operas, social marketing campaigns take the stigma out of condom use and, at the same time, demystify sexuality, increase consumer confidence and make it possible to discuss HIV/AIDS.

PPAT Photo

AIDS prevention campaign in the ethnic communities in Mae Chan District, north of Thailand.

Gender Discrimination and Gender-Based Violence: A Sad Reality

"Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility are cornerstones of population and development programmes."

— ICPD Programme of Action, Principle 4

Pivotal Role of Women

Women are a vital resource. It is unfortunate that many developing countries do not perceive as such and acknowledge women's tremendous contribution towards development. Women in large parts of the developing world are primarily responsible for finding water, collecting fuel wood, preparing food, caring for livestock and tending crops. Many augment the family income while simultaneously assuming responsibility for childcare, household chores, nutrition and hygiene. Yet, much of their work goes unrecognised and underpaid and they are widely discriminated against with regard to income, employment and educational opportunities, both globally and in Asia and the Pacific region. Today, there is growing awareness that no society can progress without treating women as equal and fully empowered partners in development and any society that is a mute spectator to the injustices meted out to women is condemning itself.

Pervasive Phenomena

Gender discrimination and gender-based violence (GBV) persist in all societies in varying degrees. But since GBV relates to private behaviour, attitudes and sometimes culturally accepted norms, there is silence surrounding it, especially where male dominance forms the basis of family life. Elsewhere, unequal treatment of women may be publicly outlawed and condemned, but it continues to exist in forms rendered more socially acceptable.

The fact that a large number of young girls and women are subjected to some form of physical, psychological or sexual abuse worldwide is reflective of their low social status in society. It is roughly estimated that at least one in three women has been beaten, coerced into sex or abused in some way – often by a member of her own family. Violence could be rape, genital mutilation and sexual assault; domestic violence; forced pregnancy, sterilization or sex-selective abortions; battering during pregnancy; female infanticide; forced use or non-use of contraceptives; "honour" crimes; child prostitution; sexual trafficking; or dowry-related violence. Either by law or custom, women in many countries are still discriminated against when it comes to ownership of land and property inheritance, access to credit, attending school, taking up a job of their choice, and accessing RH services. Certain socio-cultural

Gender-based violence exists in a culture of silence. Many UNFPA-supported programmes are designed to break this silence and ensure that the voices of women – and their suffering – are heard.

In **India,** the Family Violence Prevention Fund is working to make sure that women who come to a partner hospital in Bombay will be asked about experiences of childhood sexual abuse and domestic violence. If a woman answers "yes" to any of these questions, she is sent to a trained staff member, who then assesses the client and refers her to appropriate services. If a client is afraid to return home, she is offered the option of staying at the hospital in a special area created for victims of violence.

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Ending violence against women has been the focus of a number of advocacy activities and policy initiatives in **Nepal,** including a march against poverty and violence to women and a signature campaign demanding national actions on these issues. A bill was drafted to protect women against domestic violence and to establish a family court to deal with such violence.

norms, beliefs and attitudes related with perceived gender roles, son preference, early marriage, restrict the choices of women even further. Education offers women the most scope for improved life, yet two thirds of the world's 960 million illiterate adults are women and of the 130 million children not enrolled in primary school, two thirds are girls. Denying women reproductive and sexual rights leads every year to millions of unwanted pregnancies, pregnancy-related complications, unsafe abortions and STIs, including HIV/AIDS. In fact, domestic violence, rape and sexual abuse are also closely linked to the spread of HIV/AIDS, which adds urgency to addressing the issue of discrimination and GBV. Women, due to their subordinate position in society are unable to insist on fidelity, demand condom use or refuse sex to a partner, even when they know he is infected. The lack of economic power and fear of being beaten up and getting ostracised by society prevents them from distancing themselves from abusive relationships. Thus, without eliciting support and cooperation from men, the world will never rid itself from violence against women.

Trafficking: A Saga of Human Misery

Primarily, the demand for cheap labour and a proliferating and highly profitable commercial sex industry have made trafficking in persons (though illegal) a very lucrative business globally, functioning as organized crime and generating huge profits for traffickers. Its connection with the sex industry, which is a driving force of the HIV epidemics, has added urgency to global anti-trafficking efforts, particularly in Asia. Vulnerability emanating from poverty, illiteracy, gender inequality and lack of adequate economic opportunities have made women, young girls and children in Asia more susceptible to sexual trafficking and exploitation. Though the number of persons trafficked each year is impossible to determine, it is clearly a large-scale problem, with estimates ranging from hundreds of thousands to millions of victims worldwide. The problem is especially serious in the Asia and Pacific region where it has been spreading rapidly in the Mekong sub-region – in Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam – though it is also widely prevalent in India, Bangladesh, Nepal and Sri Lanka. It has become a cross-border issue of regional and global dimensions and is not merely a matter of domestic concern anymore. Trafficking is also occurring within countries, often spurred by commercial demand for young women in the sex trade. People are being trafficked, particularly women and children, and being sold into marriage, domestic servitude or as sex workers and factory labourers. They are often coerced to work in brothels, construction sites, homes, fields, rug factories under horrific working conditions and threats to their families and do other types of exploitative work like begging and drug trafficking. Trafficked migrants face the constant threat of deportation or imprisonment on account of their irregular legal status and lack channels of redress, legal assistance or medical care – remaining dependent and bound to their agents and employers. Traffickers use coercive tactics, including deception, fraud, intimidation, isolation, threats and use of physical force and at times debt bondage to control their victims. New trafficking routes are being regularly established and the market for fraudulent travel documents, clandestine transportation and border crossing has become very well organized. Prevention efforts by countries have been few and ineffective since trafficking is often done in connivance with corrupt state officials (e.g. customs, police, immigration, border patrol) and there is collusion between families and agents.

As part of its commitment to the human and reproductive rights of women, UNFPA is one of the many UN agencies working to bring public attention to trafficking of women and children. Core action is needed, however, and potential UNFPA entry points include (a) technical assistance and training to governmental and other agencies to increase their capacity to develop policies and other anti-trafficking measures; (b) counselling for victims of trafficking; (c) medical supplies and services, including reproductive health services, to victims of trafficking; and (d) awareness and advocacy campaigns.

In 1996, UNFPA participated in the International Congress Against Commercial Sexual Exploitation of Children, held in Stockholm. The Fund also participated in the Second World Congress Against Commercial Exploitation of Children, which took place in Japan in December 2001.

Poverty and inequity are the root causes of trafficking. Tolerance of violence against women also plays a role. Lack of appropriate legislation and political will to address the issue, restrictive immigration policies, globalisation of the sex industry, and the involvement of transnational organized criminal networks are some of the other causal factors perpetuating this heinous crime.

UNFPA – Building Equality


UNFPA/Photo

Around the world, UNFPA has been working with a wide variety of partners in supporting activities and programmes that improve the status of women and girls. It has been striving to raise awareness about GBV and discrimination as a violation of human right and threat to public health; improve laws and policies; change harmful attitudes and behaviours; and empower women by improving their access to health services, education and employment opportunities. Highlighting gender concerns in all its programmes, UNFPA has been working to bring about better legal protection for women and stricter enforcement of existing laws. To promote positive behavioural change, men are being involved in many of the projects.

When women are educated and have the opportunity, they are able to make informed choices about marriage, childbearing, employment, household and environmental management. They adopt healthy lifestyles, and tend to be more assertive and confident. They are able to stand up to injustice and protect themselves from diseases like STIs and AIDS. Realizing the vital importance of women's education in reducing fertility levels, infant and maternal mortality, and the overall health and well-being of families, most UNFPA programmes seek to empower women by stressing the need for educating women and advocating for the elimination of the gender gap in primary and secondary education by 2005 and ensuring universal primary education by 2015.

Empowering Women: Iran, Papua New Guinea, Philippines, Viet Nam

Iran:
A project carried out jointly with the Centre for Women's Participation in Iran aims to mobilize religious figures and decision makers to support the reproductive rights of women. It also aims to strengthen institutional capacity for mainstreaming gender concerns among planners and women's NGOs to improve the socio-economic conditions of women.

Papua New Guinea:
UNFPA is supporting a project initiated by a group *Papua New Guinea Women in Politics,* which seeks to draw attention to women's issues while advocating women empowerment. The goal is to enhance women's political participation and their representation in government at all levels. The project has helped educate women political candidates and voters about the government systems, and has generated awareness on women's issues in public services and the legislative system.

Philippines:
In the Philippines, UNFPA provides funding to local NGOs in 18 provinces that provide gender-sensitive information and services to hard-to-reach groups like sex workers, unmarried women and adolescents. These organizations promote women's empowerment, encourage male participation, and address adolescent reproductive health concerns.

Viet Nam:
A savings and micro-credit project linked with RH/FP has helped improve the status of poor women in 12 selected provinces in Viet Nam. Through regular group meetings, women members were given RH/FP information and provided with loans that helped them carry out a variety of income generation activities. The resulting improvement in their status has given them more power not only within their families but in the community as well.

Responding to Crisis Situations

When calamities strike, be it natural disasters like floods, drought or earthquakes, or violent armed conflicts, persecution, war or acts of terrorism, life takes a spin, as people are forced to flee their countries as refugees or get internally displaced within national boundaries. The overwhelming majority of those uprooted and adrift, often with nothing more than just bare belongings, are women and children. Food, water, shelter and health care, including reproductive health (RH) care, become priorities. Displaced pregnant women face hazardous conditions and are at a heightened risk of malnourishment, violence and infectious diseases. They need pre and post-natal delivery care for which skilled help and basic equipment are prerequisites. The risks due to HIV/AIDS are heightened in situations of emergency with the disintegration of community and family life, disruption of social norms, mixing of populations with higher rates of HIV infection and coercion of women and adolescents into sex in exchange for food, shelter, income or protection.

Youth traumatised by violence, loss of family members, breakdown of social and cultural systems, disruption of school and friendships and lacking constructive occupation and guidance is prone to taking high-risk behaviour and is more susceptible to STIs including HIV/AIDS, drug abuse, sexual abuse and violence. Neglecting reproductive health in emergency situations can thus lead to dire consequences of unwanted pregnancies, preventable maternal and infant deaths and the spread of HIV/AIDS.

UNFPA: Making a Difference

Pledged to implement the ICPD Programme of Action, UNFPA has been supporting emergency RH projects in more than 50 countries torn apart by crisis since 1994. Working in partnership with governments, other UN agencies and local NGOs, UNFPA provides funding, technical assistance and direct support including: emergency RH supplies and equipment; male and female condoms and contraceptives; rapid assessments and data analysis; training of health workers and capacity building; inter-agency coordination and programme planning; and advocating for the RH and rights of refugees and displaced persons. Priority areas for emergency response include:

- Safe motherhood through clean delivery, family planning and emergency obstetric care;
- STD and HIV/AIDS prevention, including information on universal precautions;
- Adolescent reproductive health;
- Prevention of sexual and gender-based violence, including training for counsellors.

UNFPA is a founding member of the Inter-Agency Working Group on Reproductive Health for Refugees, which has developed standards for a minimal initial service package (MISP) for meeting basic needs in emergency situations and has created pre-packaged emergency RH kits. There are separate kits containing equipment and supplies needed to prevent and manage the consequences of sexual violence, reduce HIV transmission, provide safe deliveries, treat miscarriages and unsafe abortions, provide safe blood transfusions and support family planning. Some kits have enough supplies to serve 10,000 people for three months while others can support clinical services for up to 150,000 people for six months.

UNFPA/ Johnette Stubbs

Uprooted and adrift: Afghan refugees arriving in Pakistan in large numbers.

UNFPA is an active member of the Safe Motherhood Initiative and works with United Nations Children's Fund (UNICEF), the World Health Organisation (WHO), the World Bank and several prominent NGOs to promote safe motherhood worldwide. In 2000, UNFPA collaborated with the United Nations High Commissioner for Refugees (UNHCR) and the Reproductive Health for Refugees Consortium – a group of six prominent international NGOs – to strengthen emergency RH services worldwide.

RAPID RESPONSE

UNFPA conducts rapid assessments to identify FP needs in emergency situations. To facilitate a quick and coordinated response, UNFPA has signed partnership agreements with United Nations High Commissioner for Refugees (UNHCR), the Office of the United Nations High Commissioner for Human Rights, the International Organisation for Migration, the International Federation of Red Cross and Red Crescent Societies and other NGOs active in the field, including the International Planned Parenthood Federation and the Japanese Organisation for International Cooperation in Family Planning (JOICFP). In 2000, a rapid-response fund of $1million a year was established to enable a quicker response to emergencies. UNFPA dispatched an unprecedented 35 shipments of emergency RH kits in 2000 to 20 countries and territories. In recognition of the Fund's leading role in emergency RH, UNFPA was accorded full membership in the United Nations Inter-Agency Standing Committee for Humanitarian Affairs in April 2000.

Relief on the Ground

- In **East Timor,** where the nation's health care infrastructure had been virtually destroyed and where an estimated 85 per cent deliveries are done at home, the Fund worked with NGOs in 1999 to provide emergency supplies enough to serve a popultion of 400,000 people for 3 months. Individual kits for safe home delivery were distributed to pregnant women, which included basic supplies such as soap, plastic sheeting and a razor blade for cutting the umbilical cord of a newborn. Equipment and supplies for clinical delivery support were also provided in each province.
- In response to the major earthquake that struck **India's** western state of **Gujarat** in January 2001, killing more than 20,000 people and rendering some 800,000 homeless, UNFPA and UNICEF conducted a rapid assessment in the worst affected areas of Kutch district. A three stage response was drawn up. In the first stage immediate emergency issues relating to temporary settlement, water-borne and other epidemics and restoration of electricity, water supply and sanitation were to be addressed. Second, an in-depth analysis was to be conducted regarding the situation of the homeless and making provisions for restarting health, education and nutrition in temporary settings. The third stage would involve, providing permanent settlements, economic activities and social services for restoring normalcy in life. UNFPA subsequently dispatched emergency resources and personnel following the assessment. Funds were redirected to support 12 mobile health units in Gujarat and counselling was provided to affected women.
- In a rapid response to the post September 11, 2001 crisis, UNFPA has been participating in **Afghanistan's** reconstruction as part of the integrated UN assistance mission. Priorities identified together with the Ministry of Public Health and the Ministry of Women's Affairs include strengthening maternal health services and girls' education, with an initial focus on rebuilding health and education infrastructure. Essential medical equipment and supplies, including life-saving medicines, operation theatre equipment, ambulances and emergency RH kits have been airlifted and delivered. The Fund provided lifesaving equipment to the Malalai Maternity Hospital, and the Rabia Balkhi Women's Hospital and rebuilt a vocational school for women and one for girls. The material was procured and shipped to Afghanistan under a major emergency assistance project funded with contributions from the governments of Luxembourg, US, Italy, the Netherlands and Norway.
- The Fund has been providing support to around 2 million **Afghan refugees** in the Northwestern Frontier Province, Punjab and Balochistan provinces of Pakistan and to roughly 1.5 million refugees in Iran by improving the skills of health professionals in the delivery of RH/FP services; sensitizing adolescents and males to HIV/AIDS; delivering limited RH services through the existing health infrastructure in the refugee camps; providing safe delivery kits and FP supplies to the UN refugee agency, UNHCR.

East and Southeast Asia

East and Southeast Asia (excluding Japan) is home to almost 1.9 billion people, or roughly one third of the world's total population. The region includes some of the world's most populous countries – China, with 1.28 billion people, followed by Indonesia, with over 210 million. The transition to lower fertility has been very rapid in the region, particularly in East Asia, where it is below replacement level (1.76). In Southeast Asia too, women are bearing fewer children. Consequently, the average population growth rate has registered a significant decline and it is estimated that by 2050, the region will contain only one fourth of the world's total population. Young people (those below 25 years of age) comprise a sizeable and growing proportion of the population and their reproductive health concerns have become a major issue, especially in view of the spreading HIV/AIDS pandemic. Population ageing is emerging as an area of concern in the light of declining fertility and increasing longevity. People aged 60 years and above are expected to more than double and they will constitute almost 20-25 per cent of the total population in several countries of the region by 2050.There have been marked improvements in the areas of health, nutrition and education in several countries. However, some countries continue to grapple with low per capita income, rapid rate of urbanization, inadequate access to quality reproductive health services, high rates of infant and maternal mortality and high rates of abortions. Gender inequity, gender based violence and trafficking in women and children continue to remain serious issues.

In East and Southeast Asia, UNFPA has programmes in the following countries:

Cambodia
China
DPR Korea
East Timor
Indonesia
Lao PDR
Malaysia
Mongolia
Myanmar
Philippines
Republic of Korea
Thailand
Vietnam

Cambodia

Two decades of wars and turmoil followed by international isolation have left their mark on the country's economic and social development. However, since December 1998, the political and security climate have improved. The first commune election was held in February 2002 signalling encouraging progress towards economic stabilization and political stability. Cambodia is a category "A" country for UNFPA support.

Facts and Issues

Cambodia has a per capita GNP of less than US$290, with well over a third of the entire population living below the poverty line. Rural households comprise 90 per cent of the country's poor. The current population estimated at over 13 million continues to grow at 2.4 per cent per annum. The age structure is very young, with over half the population being under the age of 20 years. The sex composition is adverse, with 93 men for every 100 females and almost a quarter of the households being headed by a female. According to the Cambodia Demographic and Health Survey of 2000 (CDHS 2000), women continue to have more than 4 children on an average, though the modern contraceptive prevalence rate (CPR) has more than doubled from 6.9 per cent in 1995 (MOH KAP 1995) to 18.5 per cent for married women in 2000 (CDHS 2000); infant mortality rate is 95 per 1,000 live births; roughly one in every eight children born in the country dies before his or her fifth birthday; and maternal mortality ratio (MMR) is still very high at 437 per 100,000 live births, even though this is a marked improvement from 900 in 1994 (UNICEF 1994). The estimated life expectancy at birth is around 58 years (Census 1998).

Small gains in RH are being offset by the AIDS pandemic. Although there is almost universal awareness of the disease, Cambodia has the highest HIV/AIDS infection rate in Southeast Asia. Heterosexual transmission accounts for the majority of the infections, other contributory factors being poverty, poor health status, labour migration and widespread patronage of sex workers.

Gender-based violence is widespread, affecting some 16 per cent of married women. Due to the weak law enforcement system, Cambodia is fast becoming a regional centre for trafficking in women and children. Gender concerns are high on the development agenda, but progress has been slow, as evidenced by the male-female dichotomy in literacy: 29.2 per cent women and 47.6 per cent men (UNDP/UNESCO Functional Literacy Survey 2000) are functionally literate.

Achievements through Collaboration

UNFPA started assistance in May 1994. The country was pro-natalist until 1990 and there was little health care service in the country until 1993/1994. Cambodia adopted the National Birth Spacing Policy in January 1995 that relied heavily on the principles of ICPD. Between 1995 and 1997, UNFPA's assistance covered only 2 provinces and Phnom Penh Municipality, given the difficult security situation in the rest of the country. Between 1997-2000 (First Country Programme), UNFPA's support was extended to all 24 provinces. The Fund collaborated with the government in strengthening and expanding quality RH services through the National Reproductive Health Programme.

In 1997, a nationwide Safe Motherhood/Birth Spacing Project (SM/BS) was launched to encourage the use of modern birth spacing methods, provide more antenatal care visits and use of health facilities for deliveries. A number of pilot outreach projects utilizing volunteers and community-based distributors were also launched to support the SM/BS efforts. With the main SM project having nationwide coverage by end 1999, CPR increased from 6.9 per cent in 1995 to 18.5 per cent in 2000. TFR declined from 5.3 in 1998 to 4.0 in 2000 (CDHS).

In March 1998, UNFPA supported the first national Census in 36 years that not only generated the much-needed high quality national data but also established an invaluable sampling framework that is being used by subsequent sampling surveys in

UNFPA/Photo

Community outreach activities for training in reproductive health. The shade of a tree provides the venue in this rural area.

the country (e.g. poverty survey by UNDP and the World Bank). In addition, Cambodia Demographic and Health Survey (CDHS) was carried out in 2000 with joint funding from UNFPA, UNICEF and USAID. The information gathered has greatly assisted the government in targeting donor funds and providing baseline data against which to measure progress. The Fund has also played a major role in assisting the government in integrating population variables into the Second Socio-Economic Development Plan (2001-2005), which is the first national planning document to integrate population variables into development planning. An Adolescent Reproductive Health Initiative, part of a 7 Asian Country Initiative under EC funding (US$4.5 million), was initiated in 1998 (to be completed in mid 2002). UNFPA also started providing support in social marketing of oral contraceptives. Today, UNFPA is the only external aid agency providing support in RH on a nationwide basis down to the health centre level. By 2000 end, almost 90 per cent of the planned Health Centres (HC) had become functional, although quality of services still remains a major problem.

In the field of advocacy, UNFPA's main activities in the past have been: development of a Gender Resources Library in the Ministry of Women's and Veteran's Affairs; training of gender focal points in ten line ministries; organisation of "gender forums" with high-level decision-makers (Secretaries of State, members of Parliament and senators); support to various NGOs.

Under the Second Country Programme (CP2) 2001-2005, with a pledge of US$ 26 million, UNFPA has embarked on joint programming initiatives for safe motherhood and birth spacing with WHO and UNICEF. Highlights of CP2 include: *Reproductive Health:* Operationalizing a four-month midwifery training course; Improved birth-spacing service delivery with focus on quality of care and outreach; Expansion of the community based distribution programme for contraceptives; Strengthening interpersonal counselling skills of health service providers; Community mobilisation for RH through village development committees; Adolescent reproductive health activities. *Population and Development Strategies:* Analysis of population data in terms of poverty reduction and Poverty Reduction Strategy Papers (PRSP); Nationwide dissemination of Census and CDHS data; Strengthening the technical capacity of the Centre for Population Studies at the Royal University of Phnom Penh. *Advocacy:* Development and implementation of a broad ministerial Advocacy Strategy for gender equity and equality and assistance to the Ministry of Women's and Veteran's Affairs to play a catalytic role in gender mainstreaming in other sectoral ministries. In all activities, the UNFPA is deeply committed to building the capacity of national counterparts for sustainable development in Cambodia.

Challenges Ahead

Cambodia continues to face the challenge of high fertility and infant and maternal mortality; general poor health; imbalances in age-sex structure; high levels of poverty; low levels of human resource development; gender inequalities; and the HIV epidemic.

In the area of RH, several significant challenges need to be addressed: high MMR, large gap of unmet FP needs, and prevalence and use of ineffective and harmful family planning practices. Operational problems include provision of quality service delivery and improving the interpersonal skills of providers. Low government salaries of healthcare providers are a major obstacle in improving the RH situation in the country.

Adolescents are becoming sexually active at a younger age and Cambodia remains the country with the highest HIV/AIDS prevalence rate in Asia. In light of the epidemic, the Royal Government of Cambodia has adopted a pragmatic approach, modelled after Thailand's success. In 1995, a National Policy promoting 100 per cent condom use in commercial sex was adopted. Subsequently, the HIV/AIDS prevalence rate decreased from 3.9 per cent in 1997 to 2.8 in 2000 (MOH, HSS-HIV Sero-Surveillance Surveys of 1997 and 2000). The statistics may have dropped but expected increases in AIDS cases will further constrain the country's economic development.

China

With an estimated population of roughly 1.28 billion in 2001, China is the most populous country in the world. Yet, it is a country that has succeeded in bringing down the population growth rate from 2.2 in the early 1970s to below 1 per cent in 2001. Although regional and socio-economic disparities persist, China has already met the threshold levels of all the ICPD indicators and now falls under Category "C" for UNFPA assistance.

Facts and Issues

To address the problem of its vast population and ensure sustainable development, the Chinese Government accorded population policies top priority in the late 1970s. Population factors were integrated into socio-economic development planning and since the early 1980s, the tenets of national population policy have been delayed marriage, fewer births and longer spacing between births. The strict population policy succeeded in bringing fertility rates at replacement level (total fertility rate around 2) and resulted in a contraceptive prevalence rate of 83 per cent.

Though economic reforms in China have resulted in rapid economic growth, more than 65 million Chinese, particularly in remote rural areas, continue to live in poverty with very little access to RH services. Improving the role and status of women has made little progress in these areas. In major cities, the maternal mortality ratio is comparable to those of developed countries, whereas in some rural areas it is reportedly as high as 400 to 700 deaths per 100,000 live births. RH services for adolescents are still not readily available. Awareness of STDs and RTIs as a health problem is low, and China is facing the risk of extensive spread of HIV/AIDS, even though HIV infection is not widespread at present.

Levels of literacy are high with over 90 per cent in males and about 80 per cent in females. There has been a recent trend of mass migration from rural to urban areas, which has increased the percentage of urban to over 32 per cent. The government has also been placing emphasis on maternal and child health (MCH) and a three-tier MCH network has been created for the provision of prenatal, perinatal and postnatal care.

Achievements through Collaboration

UNFPA has been supporting China's RH/FP activities since 1979. The Third Country Programme (1990-1994), with resources of US$57 million, aimed at integrating MCH/FP services at the grassroots level with a combined management information system, and improving the quality of client services in collaboration with other UN agencies. The model was then applied to other counties with financial assistance from the World Bank. Also, study tours by Chinese high-level officials to Thailand and Indonesia facilitated in the creation of new Chinese RH/FP models. Between 1995-97, apart from a small assistance to RH/FP, no multi-year programme was formulated.

Under the Fourth Country Programme (1997-2002), approved for US$20 million, a client-centred RH/FP project being implemented in 32 disadvantaged counties is providing a wide range of quality health services including MCH, treatment of RTIs and STIs and extensive FP services, making available a broad range of contraceptive methods. Two pilot projects that deal with ARH and social marketing are being undertaken in urban areas. UNFPA has also assisted the government in developing the Standard Service Delivery Protocol (SSDP), which provides information to RH/FP service workers on client-centred care.

With the emergence of HIV/AIDS, a pilot Condom Social Marketing Project was implemented in one district in Beijing and one in Shanghai, targeting internal migrants, adolescents, unmarried persons, and high income people who can afford commercially available condoms. A project evaluation has highly rated the popularity of the condom by the

brand name “Love Time”, and it is felt that the purchase of condoms from vending machines by current users is very likely to increase.

A women’s empowerment project was implemented in 15 rural counties. Women were provided with income-generation credit and RH/FP information to raise their socio-economic and health status and give them more decision-making power on RH issues within the household. Newly developed IEC materials on RH/FP have integrated the issues of gender equality and male involvement.

China’s achievements in the area of RH have been remarkable in slowing down its population growth in the past two decades. UNFPA’s South-South Collaboration project facilitated the establishment of a network of six Chinese institutions called “Chinese Centres of Excellence”, where the neighbouring countries can benefit from China’s experience.

Since ICPD, there has been a considerable conceptual and attitudinal change on the part of the government from an administrative-oriented FP approach to a more voluntary, client-centered approach. China now follows a more relaxed holistic approach in its population programme to attain sustainable social and economic development. In fact, China has introduced new concepts like Quality of Care and Informed Choice, which are now being applied in over 800 counties all over the country.

There has been a widespread increase in NGO participation in FP programmes and other activities: *China Family Planning Association* on ARH and HIV/AIDS; *All China Women’s Federation* on women’s empowerment and gender issues; *China Preventive Medicine Association* on reproductive health advocacy, inter alia.

Challenges Ahead

The net annual increase of the Chinese population by 12 million is still a heavy burden on development, environmental protection, education, health care, employment and social security.

The rapid decline in both fertility and mortality rates, under circumstances of relatively low socio-economic development, will pronounce the problems of population ageing which is emerging too early and too rapidly. The transformation of society is also placing the traditional old-age support of the family in jeopardy. According to the unofficial figure from the 5th population census completed at the end of 2001, the sex ratio of male to female births is out of balance, which could lead to social problems in the future.

In August 2001, the Chinese Government finally admitted that the country was facing a serious HIV/AIDS crisis. Previously, the extent of the Chinese epidemic had been unknown. Though it is difficult to predict the future course of the epidemic, given the huge size of the population, a serious commitment nevertheless is required. Due to China’s tradition, adolescent reproductive health has also long been ignored and the door for sex education has just barely opened. This is another area of crucial concern in the light of the spreading HIV/AIDS pandemic.

UNFPA/ Photo

Empowering women through improved RH and development of income generating activities.

Democratic People's Republic of Korea

The estimated population of the Democratic People's Republic of Korea (DPRK) is around 23 million, growing at an average annual rate of 0.7 per cent. The recurrent natural disasters in the last several years, combined with economic difficulties, have adversely impacted the country's health services, adding to the acute shortage of essential drugs, contraceptives and medical equipment, and thereby contributing to an increase in the maternal mortality ratio (MMR), premature childbirth and low birth weight.

Facts and Issues

Around 80 per cent of DPRK is mountainous and only 17 per cent of the land is arable. Roughly 61 per cent of the people live in urban areas, with Pyongyang, the capital city, having approximately 12 per cent (2.7 million) of the total population. There is an extensive infrastructure of health care facilities in the country. Hospitals and clinics are well managed with adequate staffing. Yet, economic hardships and natural disasters in recent years have brought misery and affected the health and well-being of the people. According to government data, since 1993, the prevalence of anaemia among pregnant women has risen from 6 per cent to 35 per cent; infant mortality rate has risen from 14 to 23 per 1,000 live births and MMR has almost doubled from 54 to 105 per 100,000 live births. Average life expectancy is estimated at around 67 years.

According to the RH Profile Survey conducted with UNFPA support in 1998 in the three selected provinces of North Phyongan, South Hwanghae and Pyongyang city and its suburbs, induced abortions are estimated at 17.7 per 1,000 live births and unwanted pregnancies account for more than 80 per cent of induced abortions. The government, however, does not have an explicit population policy or programme. The total fertility rate is reported around 2.1; about two thirds of married couples practice family planning (FP); and the contraceptive prevalence rate using modern methods is about 52 per cent. There is very little male participation in matters relating to RH/FP.

Achievements through Collaboration

Cooperation between UNFPA and the Government of DPRK began in 1985. UNFPA was among the first international organizations to work in the area of FP in the country. Having met the threshold levels of RH indicators specified by ICPD, the DPRK has now been classified as a Category "C" country for UNFPA support. The programmes, therefore, are limited to the area of RH.

Under the first programme cycle (1985-1989), support was provided for MCH and FP services. The Second Country Programme (1990-1997) focused on the areas of population and development; the strengthening of RH/FP services; and the expansion of IEC activities in support of RH/FP. The first modern census took place in 1993 with UNFPA support for capacity building of staff to collect, analyze and disseminate population data and statistical information.

In addition to the regular programme, UNFPA supported DPRK in 1997 and 2001 with emergency assistance, including essential drugs and some medical equipment. In the current Third Country Programme of assistance (1998-2003), in the amount of US$3.6 million, the focus is on strengthening RH covering three provinces: South Hwanghae, North Pyongyang and Pyongyang City and its suburban districts. Capacity building is an integral part of the programme. Male involvement and gender aspects in RH/FP are emphasized in the advocacy workshops for policy makers, leaders of social organisations, mass media, programme managers and service providers. To overcome apathy among men, an attempt has been made

to involve men in every activity and campaign, and to raise awareness on the importance of shared responsibility. 32 *ri*, county and provincial hospitals are included in the programme executed by UNFPA and International Planned Parenthood Federation (IPPF). Basic medicines and medical equipment for RH care, including 15 ambulances have been provided to the hospitals concerned.

To provide exposure to health-care workers in new international developments and trends in health promotion, treatment practices and patient care management, the Ministry of Public Health in collaboration with IPPF and UNFPA reviewed and revised the Reproductive Health Clinical Guidelines & Protocols to meet international standards. The new guidelines are of a very high standard and have been adopted as State-Standard guidelines to which all medical institutions in the country have to compulsorily refer when dealing with RH cases.

To promote more comprehensive RH services, six implementing agencies are producing IEC materials – pamphlets, booklets, flipcharts, newsletters, videos – on general RH, information on various contraceptives, prevention of abortions, male responsibility and maternal health. They are also mobilising health motivators and service providers at county and *ri* level to organize seminars/lectures for couples (or just men if more appropriate); mobile IEC campaigns to promote male responsibility among factory workers and co-operative farms; as well as workshops and seminars for the public on RH-related issues such as male role and responsibility, physiological and psychological development of adolescents and gender equity laws. The World Population and International Women's Day celebrations are taking place in several provinces. The Health Education Institute in cooperation with TV and radio stations is producing and broadcasting programmes on RH-related issues with special emphasis on male participation. The Declaration of the Cairo Conference and the Report from The Hague were translated into Korean language, distributed all over the country and also broadcast through mass media channels.

UNFPA/Photo

Challenges Ahead

In the coming years, there is a strong need for continuity in strengthening RH efforts in the country through increased awareness building and advocacy, especially among policy makers; improving access to quality RH services; service providers' training with a special emphasis on the newly adopted *Reproductive Health Clinical Guidelines and Protocols;* and strengthening RH programme management. Capacity-building will remain a vital part of the programme. There is also a need to increase knowledge and sense of responsibility about RH issues among the adolescent and youth.

HIV/AIDS is currently not a problem in DPR Korea, with no official reported cases. However, several emerging risk factors, including cross border movements, increased international travel, tourism and lack of awareness among the population/health staff, might increase the risk of an HIV/AIDS problem in the coming years. It is, therefore, essential to increase awareness and knowledge of prevention on HIV/AIDS.

East Timor

East Timor became the first new country of the 21st century when it achieved independence on 20 May 2002. In late 1999, the country's infrastructure, institutions and economy had been almost completely destroyed by those opposed to independence. Today, East Timor is a small, post-crisis, low-income developing country with a population of about 800,000 growing at a rapid annual rate of about 3 per cent. It is a Category "A" country for UNFPA assistance.

Facts and Issues

The country's recent history, particularly the transition to independence, has been extremely costly in human and economic terms. In the period of anarchy and violence in 1999, about 70 per cent of the country's infrastructure was destroyed; almost 75 per cent of the total population was externally or internally displaced; and civil services were severely damaged. The constitution of East Timor, formally adopted on 22 March 2002 with United Nations support, provides the basis for democratic governance for the first time in the country's history.

Human development indicators (income, health, education) place East Timor among the 10 poorest countries in the world. It has a per capita GDP of approximately US$400 a year and life expectancy of 50 years. About 35 per cent of the population lives below the poverty line of US$0.70 per day. Illiteracy is high, with a national average of 53 per cent (46 per cent for males and 60 per cent for females). The economy is predominantly subsistence and rural, with almost 75 per cent of the work force engaged in agriculture. However, since 1999 there has been significant rural-urban migration, as a result of which urban poverty and unemployment have become serious issues. The combined numbers of refugees and returnees represent a significant proportion of the total population.

Reported maternal mortality is very high, with estimates varying widely from 450-850 per 100,000 live births in the absence of adequate and reliable population data. Presently, only 20-30 per cent of the births are attended by trained personnel. Likewise, alarmingly high infant and under-5 mortality rates are a cause of serious concern. Poverty reduction and sustainable development in East Timor are the paramount goals of the new government and the focus of cooperation with United Nations agencies. Until about 2005-2006, when the country will benefit from the exploitation of offshore petroleum and natural gas resources, the economy is likely to remain heavily dependent on external assistance.

Achievements through Collaboration

UNFPA has had a presence in East Timor since November 1999, not long after the referendum held in August 1999. Responding to the crisis, UNFPA stepped in to provide emergency RH kits, including clean and safe delivery kits, blood bank equipment and supplies, and contraceptives.

In the post-crisis period, the Fund has been working to improve the RH status of the people of East Timor. The country has a system of publicly funded midwives, and UNFPA has worked with other agencies to upgrade their skills and to provide them with the needed equipment. There is, however, a serious shortage of local obstetricians and gynaecologists. During the reconstruction period, UNFPA, in collaboration with the Ministry of Health, sponsored expatriate obstetricians/gynaecologists who not only provided necessary obstetric services, but also on-the-job training to health workers.

The focus of the Fund's First Country Programme for East Timor (2003-2005) will be on reducing the high level of maternal mortality through continued upgrading of the skills and accessibility of midwives; expanding and improving the emergency referral system; and promoting FP for improved maternal and child health.

UNFPA is the major player in meeting contraceptive needs in the country. In addition, in 2001, when RH-related laboratory supplies (i.e., reagents, pregnancy tests, STI and HIV/AIDS testing kits) were exhausted, UNFPA stepped in and was able to fill in the gap immediately. Using a client-centred approach to ensure provision of quality RH information, services and supplies, UNFPA will continue to work closely with the Ministry of Health, WHO and UNICEF within the context of the Joint Plan of Action for Reproductive Health.

UNFPA has been an active partner of the government and other United Nations sister agencies in HIV/AIDS prevention. Recently, training for facilitators of HIV/AIDS information and education was conducted with a view to building a pool of East Timorese trainers in this area. The Fund is also supporting the first baseline surveillance survey of populations considered vulnerable to HIV infection as a way of monitoring efforts to stop the spread of the disease.

Domestic violence is believed to be very widespread in East Timor, although reliable figures are unavailable. In response to a request of the country's Office of Promotion of Equality following deliberations at the First Women's Congress, UNFPA supported a project aimed at strengthening national capacity to address gender-based violence. Since 2001, UNFPA has also been actively involved in a working group concerned with improving the quality of services for survivors of sexual and gender-based violence. A Round-Table Meeting on Formulation of Domestic Violence Legislation was held in November 2001 that included participation by key sectoral ministries, the church and local NGOs. The meeting succeeded in gaining a consensus among the participants about the need for legislation on domestic violence in East Timor, and a coalition of advocates for domestic violence legislation was formed. As a follow-up, in February 2002, UNFPA sponsored training for advocates on how to consult with local communities in the development of domestic violence legislation.

In the area of population and development, the Fund has been asked by the government to take the lead in helping the country carry out its first national census, which will be a major undertaking of the upcoming UNFPA country programme.

Challenges Ahead

Unemployment, poverty and hunger are the most significant and urgent development challenges of East Timor. These, combined with poor health and education standards; the disadvantaged, low status of women in society; high levels of gender-based violence; poor infrastructure and environmental degradation, pose added challenges. As its contribution to improving the well-being of the East Timorese people, UNFPA will work in the areas of reproductive health, population and development, and gender to develop capacity in government and civil society organizations; provide technical assistance in its areas of expertise; and advocate for reproductive health and rights, for gender equity and equality and the empowerment of women. It will also assist in the mobilization of necessary resources to address the country's needs in these areas.

UNFPA/ Photo

Gender-based violence is a serious issue in East Timor. About 40 per cent of incidents reported to the Civilian Police concern domestic violence. Here, a training workshop on Consultation on Domestic Violence Legislation, a collaboration between UNFPA and the Office of Promotion of Equality, held between 18-22 February 2002, is in progress.

Indonesia

Indonesia is the fourth most populous country in the world with about 210 million people (national estimate) spread out over the world's largest archipelago of more than 13,600 islands. From the sparsely populated province of Kalimantan to the crowded island of Java, Indonesia is a country of great contrasts and rich diversity. While continuing to grapple with economic and political crisis from previous years, Indonesia has succeeded in meeting its population objectives. It is a Category "B" country for UNFPA assistance.

Facts and Issues

Indonesia's national family planning (FP) programme started in 1960s in the provinces of Jakarta, East Java and Bali, where population problems were most pressing. Since then, substantial progress has been achieved: The population growth rate had declined to 1.4 per cent by the year 2000; life expectancy averages 67 years; over 90 per cent men and around 80 per cent women are literate; infant mortality stands at 40 per 1,000 live births; and total fertility has declined from 6 children per woman in 1950s to 2.27 in 2001.

However, despite success in FP efforts, maternal mortality ratio (MMR) continues to remain high among the Southeast Asian nations at 373 per 100,000 live births. Likewise, the incidence of abortion is high accounting for 25 to 30 per cent of maternal deaths. Contraceptive prevalence rate seems to have stagnated at about 57 per cent, and there is a large unmet need for contraception. The burden of contraception is unevenly shouldered by women. Gender inequities and disparities persist and women continue to be victims of violence.

HIV/AIDS incidence is on the increase, particularly among high-risk groups: sex workers, injecting drug users, truckers, miners. As a result, the epidemic in Indonesia has transitioned from being "low-level" to a "concentrated" one.

Due to various political, racial and religious clashes over the past few years, Indonesia has experienced several emergency situations, resulting in an increasing number of internally displaced persons (IDPs) and refugees. In February 2002, the number of IDPs had swelled to over 1.3 million. These IDPs, in addition to suffering trauma and stress, have no access to basic RH, which has increased the risk of maternal and neonatal mortality and morbidity, as well as transmission of STDs/HIV/AIDS.

In the past, Indonesia's population programmes concentrated on building MCH/FP services and maximizing the acceptance of contraception as part of an overall effort to achieve demographic goals, regulate fertility and reduce mortality. The current strategy, however, is based on individual needs and broad-based RH care.

Achievements through Collaboration

Collaboration with UNFPA began in 1972, when the Fund joined the World Bank in financing the country's first five-year population project. Since then, UNFPA has provided over US$ 100 million in assistance in strengthening FP and motivational services; training service providers and demographic researchers; and launching major population education programmes in public and private schools throughout the country.

The Fourth Country Programme, 1991-1994, supported the Indonesian Government in the decentralized implementation of the FP programme at district and provincial levels; improving the quality of care in FP services; decentralising IEC services; strengthening research capabilities in the fields of biomedical technology, demography, FP management and operations research; developing population studies centres at regional universities; strengthening the International Training Programme of BKKBN (the National Family Planning Coordination Board); and supporting the development and implementation of the Law in 1992 on Population and Development of Happy and Prosperous Families.

The Fifth Country Programme, 1995-2000, in the amount of US $30 million marked a transition to a stage of self-reliance on the part of Indonesia. The nation's "South-South" capabilities were expanded through technical capacity building and exchange of information between developing countries. The Fund's assistance was especially helpful in increasing awareness and adoption of the RH concept and improving the quality of services, including counselling and informed choice.

Good progress was made in addressing the high MMR in three pilot provinces by training midwives, raising community awareness on the risks of pregnancy and facilitating preparedness for rapid interventions. Male responsibility in case of obstetrical emergencies was highlighted. Good headway was made in providing RH information and services to adolescents; promoting the use of condoms among commercial sex workers; and mainstreaming gender concerns into RH through advocacy. A One Stop Crisis Centre, where RH, counselling and legal services are provided to victims of violence against women, has been pilot tested and will be further promoted under the Sixth Country Programme (CP6).

In response to ICPD and ICPD+5, Indonesia has been advocating for the elimination of violence against women, implementing the zero tolerance policy through the National Plan of Action launched in November 2000. This plan of action is a joint initiative between the government, NGOs and donor agencies (UNFPA, UNIFEM). Another achievement has been the formation of a Forum of Parliamentarians on Population and Development in October 2001. This forum aims at accelerating the revision of laws and regulations on the elimination of violence against women.

Under CP6 (2001-2005) in the amount of US$28 million, UNFPA will be implementing 11 projects, of which 6 are in RH, 3 in PDS, and 2 in the Advocacy subprogramme. Emergency RH initiatives in two conflict areas of Indonesia, namely West Timor and North Mauku, were successfully implemented in 2001 and RH support and counselling services were provided to women survivors. A project on RH support for emergency situations will primarily focus on the conflict areas of Aceh and North Sumatra, West Kalimantan, Southeast Sulawesi, Maluku and West Timor. This project aims at reducing maternal and neonatal mortality, sexual violence and transmission of HIV in emergency situations.

UNFPA has been playing a critical role in helping Indonesia mobilize financial resources for population and RH programmes from the European Union, the Netherlands, Canada, Japan and Australia. The bulk of the recent support has been for the procurement of contraceptives.

Challenges Ahead

Enhancing the quality of and increasing access to RH services in the country remains a crucial area of intervention. Integrating an essential RH services package into local health-care systems; training and improving skills of health-care field workers and midwives; increasing the number of service outlets, particularly in remote and less populated areas; enhancing counselling and clinical skills of providers; promoting male responsibility in FP and male methods, particularly vasectomy; and providing RH support in emergency situations to IDPs constitute the major challenges ahead that will be included in the range of services offered in future. Efforts will continue to be directed towards building capacity of the BKKBN and other government agencies and NGOs in carrying out IEC activities in support of RH, gender issues, male involvement, and the prevention of STDs and HIV/AIDS.

UNFPA/ Photo

It is feared that the actual level of HIV/AIDS infection in Indonesia is much higher than the reported number of cases. Therefore, it is necessary to expand the quality and scope of contraceptive information and services. Reducing high rates of maternal mortality and abortions in the country, and providing Indonesia's large adolescent population (over 44 million persons in 2000) with youth-friendly RH information and services to protect them from the negative consequences of unwanted pregnancy and infection from STDs/ HIV/AIDS are some of the other challenges that lie ahead.

LAO People's Democratic Republic

With a population of 5.2 million (Lao Reproductive Health Survey 2000) growing at an average annual rate of 2.8 per cent, and a per capita GDP of only US$330 in 2001, Lao PDR remains a priority "A" country for UNFPA assistance. Despite recent gains in living standards, sustained efforts are required to assist the government realize its goal of freeing the country from its least developed status by the year 2020.

Facts and Issues

Although fertility rates have dipped from a high of 6.5 in 1994, most Lao mothers have their first child before the age of twenty and on an average give birth to about 5 children. High frequency of pregnancy coupled with poor nutrition, low literacy levels, and limited access to quality health care services contribute to the country's high infant and maternal mortality rates. According to the national Reproductive Health Survey (2000), for every 100,000 live births, 530 mothers die, and for every 1,000 infants born alive, 82 do not survive beyond the first year and almost one in ten die before their fifth birthday. The contraceptive prevalence rate has tripled since 1995, but remains low at around 32 per cent. The unmet demand for family planning is estimated at nearly 40 per cent.

Achievements through Collaboration

UNFPA began its assistance to the Lao PDR in 1976. Initially, the assistance included support for data collection, MCH services, and a national fertility survey that revealed a large unmet demand for contraceptive services. In 1991, the *Ministry of Health* began providing birth spacing services on a pilot basis in Vientiane and developed a birth spacing policy with UNFPA's assistance.

In the Second Country Programme (1997-2001), under a US$ 3.4 million project jointly executed by the *Ministry of Health,* UNFPA and the *Japanese Organization for International Cooperation in Family Planning* (JOICFP), FP and select RH services were introduced at almost all the 700 primary health-care facilities and referral hospitals of the country. Additionally, over 10,000 village volunteers from one-third of all villages nationwide were trained to provide RH and FP information to their communities.

UNFPA included HIV/AIDS prevention topics in the nationwide training of service-providers and procured most of the RH commodities for the public sector programme, and for the innovative condom social-marketing project of the *National Committee for the Control of AIDS* carried out in partnership with *Population Services International.*

The Fund also supported an initiative on RH, advocacy and awareness-raising by the *Lao Women's Union* and *Lao Youth Union* in collaboration with JOICFP, which targeted men, women and adolescents. The information was disseminated in selected provinces through the network of volunteers of these two mass organizations. In collaboration with the *Ministry of Education,* sexual health and population education have been integrated into the general school curriculum and the non-formal education programme in some 223 educational facilities in 7 provinces.

UNFPA has been supporting the government in developing and implementing the 1999 *National Population and Development Policy* (NPDP), and integrating population issues into development planning at all levels of government. A *Population Studies Centre* has been established in Vientiane at the *National University of Laos* that will be able to train graduates by 2005 in applying population analysis to socio-economic issues. UNFPA continues its support and partnership with the *National Statistics Centre* (NSC) to improve the national database for population and development planning and to incorporate gender issues into their analysis.

The Lao PDR is one of the countries covered by the European Commission (EC)/ UNFPA Reproductive Health Initiative for Asia (RHI) which focuses on providing RH information and services to adolescents.

UNFPA/ Photo

In LAO PDR, the Fund continues to advocate for gender sensitive approaches in population and development planning; the need to address the growing levels of teenage pregnancies and unsafe abortions; reducing gender disparities; and increasing preparedness to the problem of growing HIV/AIDS incidence.

Under the Third Country Programme (2002-2006) in the amount of US$9 million, the main strategic focus would be on the effective implementation of the NPDP; consolidating existing partnerships and interventions; expanding partnerships for advocacy, awareness raising and population research; continuing support for in-school and out-of-school sexual health programmes; expansion of FP nationwide; providing ARH information and services; and collaborating with other donors in the area of RH, including support for the national HIV/AIDS prevention programme.

The purpose of the RH subprogramme is to improve access to and utilization of quality RH services by women, men and adolescents. In addition to supporting the nationwide expansion of FP services, the programme will implement a core package of RH services in three under-served provinces and other selected districts of the country. The purpose of the PDS subprogramme is to contribute to the full implementation of the NPDP and its ten-year action plan in accordance with the ICPD PoA, and to increase political and community support for improving the status of women. This will be achieved through: strengthening the capacity of the relevant implementing agencies; improving socio-demographic data analysis and dissemination; strengthening the research and training capabilities of various national institutions; and promoting greater understanding of the linkages between population issues, environment, socio-economic development and gender equality.

Challenges Ahead

Based on current growth rates, the population of Laos is projected to double to over 10 million people by 2025. Improving the quality of life of the people of Laos through sustainable economic development; better RH services; reduced levels of infant and maternal mortality and morbidity; improved education and socio-economic status for girls and women; enhanced capacity of national institutions; and integration of population concerns into development, constitute the major challenges ahead. This would imply substantial investments in capacity building, especially human resource development at all levels; expanding coverage of education and health services delivery sectors; providing and improving access to quality RH services and FP commodities in rural and remote areas; increased provision of RH services for adolescents nationwide; concerted efforts in STD/HIV/AIDS prevention; and sustained advocacy for the implementation of the NPDP in order to achieve the ICPD goals.

Malaysia

With a total population around 23 million increasing at an annual average rate of 2.6 per cent (national Census 2000), and a per capita gross national income of US$7,640 in purchasing power parity terms, Malaysia is a Category "C" country for UNFPA assistance.

Facts and Issues

The National Health Programme launched by Malaysia aimed at achieving "health for all by the year 2000". Through efforts made by the government and despite the recent Asian financial crisis, the family health programme has made impressive strides over the last three decades. Rapid declines have been achieved in perinatal mortality, though declines in infant mortality rates (presently just 10.3) have been even more substantial. Likewise, there has been a steady decline in maternal mortality ratios, from 63 per 100,000 live births in 1980 to 39 in 2001.

Overall life expectancy in Malaysia is presently around 73 years. Almost a third of the population is under 15 years of age. The rising incidence of HIV/AIDS is posing a serious challenge for the government. In the year 2001 alone, there were 5,868 new reported cases of HIV/AIDS causing 934 deaths *(Ministry of Health).*

Achievements through Collaboration

Initially, UNFPA's assistance to Malaysia was broad-based. It began in 1973 in the context of the First Malaysia Plan (1966-1970), which aimed at the overall reduction of the country's population growth rate. From 1978 through 1996, UNFPA disbursed approximately US$15 million towards RH/FP, training, research, institution-building activities, and support for population and development activities. But in view of the commendable economic and social performance of Malaysia, its rapid strides towards attaining self-reliance and its notable success with population strategies, the Fund's assistance since 1997 has been directed towards selected critical areas. Ongoing projects pertain to formulating health strategies and strengthening the national family health programme; strengthening community participation in RH activities; and promoting adolescent reproductive health (ARH).

With UNFPA's assistance, the *National Population and Family Development Board* (NPFDB) has developed a strategic plan for the implementation of the *National Population Policy* and the national Programme of Action as a follow-up to the ICPD. UNFPA is assisting the *Ministry of Health* (MOH) in strengthening the capacity of its Family Health Division to undertake studies on the colour coding system for improving the management of the high risk approach and reducing perinatal mortality as well as maternal morbidity and mortality. Malaysia has also adopted an integrated approach in providing comprehensive health care within the primary health care system encompassing both urban and rural clinics – an ongoing project assisted by UNFPA.

Gender concerns have been fully integrated into the various programmes supported by UNFPA. RH issues, including HIV/AIDS, are being supported through funding to the *Regional Steering Committee for Advancement of Rural Women for Asia and Pacific* (RSC-AP). Gender-sensitive healthy living practices are being promoted in collaboration with the *Women's Affairs Department and University Putra Malaysia* (UPM) to enhance family health status. In addition, UNFPA has assisted an NGO, *Federation of Family Planning Associations Malaysia* (FFPAM), in producing the *Women Health Education Module* (WHEM), a comprehensive reference on women's health. This module is being widely used as a reference by other organisations involved in the promotion of women's health. FFPAM has also developed a module on ARH with the Fund's assistance and is conducting training and establishing pilot service models for the delivery of ARH care.

UNFPA is supporting the *University of Malaya* in strengthening community participation in

programmes that address RH/disease prevention (including HIV/AIDS) and environmental issues. With a clear trend towards population ageing (people aged 60 years and above) and a declining dependency ratio as per the recent 2000 population census, this strategy has been particularly successful in utilizing the skills and participation by older persons, especially retired people.

Challenges Ahead

As a result of declining fertility and improved life expectancy at birth, the number of elderly in the population is increasing. By the year 2025, Malaysia will experience a demographic transition from a youthful population to an ageing population. It is estimated that the proportion of the elderly (60+) will reach 7.2 per cent by 2005 and 11.3 per cent by 2020. Hence, addressing the needs of the older population is becoming an urgent issue.

Malaysia has experienced an alarming increase in documented and undocumented migrant workers since the 1980s that is impacting society and raising socio-economic concerns. The lack of reliable official statistics on migration flows, in particular undocumented migration flows, is posing problems for policy makers and this challenge needs to be addressed.

Between 1986 and 2001, there were 44,208 reported cases of HIV/AIDS *(Ministry of Health).* ARH and improved male participation are areas that need continued support and focus to counter the threat of HIV/AIDS.

For the future, UNFPA foresees offering targeted assistance in three areas: RH, ageing, and family development programmes. Environmental concerns will be promoted along with population and development issues. In recognition of the progressive population programme adopted in Malaysia, with its emphasis on family development, integrated population-development planning and a community-based implementation strategy, UNFPA hopes to partner the government in packaging this as a model for South-South collaboration initiatives.

Strengthening Community Participation in RH-related Concerns

In its efforts to reach grassroots through activities involving community level participation, since 1999 UNFPA has been assisting the Petaling Jaya Community Centre (PJCC) (http://pjcc.cjb.net) through the University of Malaya, in advocacy activities.

To date, 11 new community centers have been set up in various states of the country and most of the on-going community programs are self-sustaining. Training workshops are held regularly to enhance skills of coordinators and volunteers in running the centers and organizing awareness programs on RH and environmental issues.

UNFPA encourages the smart partnership concept adopted by PJCC, involving cooperation between the government, NGOs and the private sector. Some of the programme highlights include:

- Environmental activities aimed at waste reduction and removal of household hazardous wastes;
- The Robin Good Health Program that aims at increasing public awareness and enthusiasm in adopting preventive healthcare measures;
- Imparting basic computer skills to students and older persons in the community;
- The Robin Food Program (RFP) makes food available, either free or at nominal rates, for the older members of society.

Bearing testimony to the huge success of the programme, PJCC has won several coveted national awards in the last 2 years, including the Government Services of Malaysia Award 2000.

UNFPA/ Photo

Older persons receiving donated items at the Robin Food Program.

Mongolia

Mongolia is a sparsely populated, predominantly agricultural economy. With 2.4 million inhabitants living in a vast area of 1,565,000 sq km, it has one of the lowest population densities in the world. Decades of strong government commitment to health and education have led to a high literacy rate of 97.8 per cent and a widespread system of health care delivery. The steady decline in fertility has impacted the population growth rate, which now stands at 1.4 per cent. Mongolia initiated its peaceful transition to democracy and market economy during the last decade of the 20th century. However, issues of equal access, poverty, regional and socio-economic disparities, rising migration and urbanisation and the need to introduce internationally accepted standards are imposing increasing challenges.

UNFPA/ Photo

Facts and Issues

Over the years, there has been a marked shift from the earlier pro-natalist population policy. Today, Mongolia is a country where reproductive health (RH) services, information and counselling are, in principle, available to all and the general public knows about family planning (FP) and contraceptives. Hence, population concerns stem from issues of quality care. According to a 1998 RH Survey, 94 per cent of deliveries were attended by trained birth attendants. However, infant and maternal mortality remain relatively high because of the poor health of many rural women. The contraceptive prevalence rate has been steadily increasing. In 1998, 33 per cent of all women and 46 per cent of married women were using modern contraceptives. The abortion rates, though still high, have also witnessed a steep drop over the course of the 90s and have come down from 442 to 180 per 1,000 live births.

Mongolia's population is young: about 59 per cent of the population is less than 25 years of age. Teen pregnancies have been on the rise: roughly 25 per cent of 19 year-old girls have started childbearing. Almost half of these pregnancies are unwanted and about one fifth are terminated. So far there are only a few known cases of HIV/AIDS, though the incidence of STIs is high and increasing. The knowledge about STIs/HIV/AIDS among adolescents, however, is scant and the public health system is not able to respond adequately to the needs for tests, treatment and counselling. Besides, the men are too often forgotten, as the services and insurance system cover only women. With increase in women selling sex, unprotected casual sex among youth, and the high incidence of HIV/AIDS in neighbouring countries, there is risk of an HIV/AIDS epidemic in Mongolia.

Gender inequality exists in Mongolia, but in a unique manner. More girls go to school (and for longer) than boys who are needed to assist their herding families. Yet, in high decision-making positions, men still dominate and unemployment is higher among women, especially educated.

Achievements through Collaboration

Mongolia is a Category "B" Country for UNFPA assistance. Cooperation between Mongolia and UNFPA began in 1979, but since 1992, UNFPA has been the only donor providing comprehensive support in RH and population development strategies (PDS).

The projects implemented under the Second Country Programme (1997-2001), with a total budget of US$ 9.3 million, include a comprehensive RH programme aimed at strengthening RH services; adolescents reproductive health (ARH) and sexuality education for in-school and out-of-school adolescents; a fee-for-service RH clinic; and the strengthening of the institutional capacity of the National Statistical Office.

With UNFPA support, the Government of Mongolia developed a National Population Policy and a National RH Programme in 1996 and 1997 respectively. A RH Needs Assessment in 1998 enabled planners to redirect programmatic efforts on the basis of gaps and needs identified. Subsequently, RH standards and protocols are being revised, and in-service RH training materials for health workers are being prepared. The National RH Programme was reviewed and updated in 2001 and a high-level meeting on Population and Development held in 2001 reviewed the achievements of the past and laid out the priorities for the future population policy. UNFPA is practically the sole provider of contraceptives and obstetric drugs in the country. In 2001, the Fund sponsored 17 courses for obstetricians, 76 for family doctors, 53 for midwives and 20 for local service providers.

One of UNFPA's most important achievements in 2000 was support for Mongolia's Population and Housing Census. A wealth of high quality data was collected with the 2000 Census, the 1998 RH Survey and the 2000 Micro Study on Migration. This data was widely disseminated and repackaged for policy-makers; research capacity was enhanced; and policy-relevant research undertaken on a variety of topics, including emerging issues like ageing.

The Fund continued with its support for Marie Stopes International RH clinic in Ulaanbaatar. This for-fee clinic is a model for service provision in the entire country. In 2001, over 48,000 clients (of which 5 per cent were men) used its integrated package of services, which represents a 50 per cent increase over 2000. The clinic is already 80 per cent self-sufficient from fees.

Marie Stopes also launched a UNFPA supported social marketing programme for condoms in 2000 under the "Trust" brand name. Demand for condoms has been increasing rapidly as a result of public information campaigns and access to services. In 2001, social marketing of condoms was extended to all 21 provinces.

Limited outreach activities among sex workers and street children have begun. IEC materials aimed specifically at the needs of adolescents have been developed and a 13-week training course on ARH has been completed. A very successful and innovative curriculum on sexuality education has been introduced in all schools. Radio programmes on ARH needs have been aired, and newspapers for teenagers produced. Substantive training for master trainers has also been developed.

Challenges Ahead

Decreasing maternal and infant mortality remains a priority for the government. Prenatal care, available to all women, is still inadequate in terms of quality, and the referral system needs further improvement in this large country challenged by poor transport infrastructure and severe climate.

In January 2002, Mongolia and UNFPA renewed their collaboration with a new five-year programme. Efforts will concentrate on furthering the quality of RH services to maximise their positive impact on the population; fully institutionalising RH in the health system; increasing access to quality services and information by remote and vulnerable population and stimulating more community participation. ARH will be the area of major challenge in coming years in the light of the threat of HIV/AIDS. In PDS, efforts to improve data collection, dissemination and research will continue and more attention will be given to strengthening capacity for translating data and research into effective planning and programming. By and large the legal environment for reproductive health and gender equity is quite positive, but enforcement of laws in these matters needs strengthening.

Mongolian Teenagers Demand More "Love"!

Mongolian Teenagers just love the *Love* newspaper! The *Love* newspaper was first published in August 1998 with 5,000 copies, but on popular demand, the circulation of this quarterly newspaper for adolescents has jumped to an impressive 100,000 copies! In a country of 2.4 million people, this is quite an achievement!

This UNFPA-funded publication is distributed nationwide mainly through schools. The teenagers themselves produce the publication under the supervision of a professional journalist, in close consultation with experts. The journal is primarily educational with a focus on sexuality and reproductive health issues and also has entertaining material for teens. It addresses subjects of popular interest, such as puberty, sexual health, relationships and communication, body image and self-esteem, gender, sexual violence and sexual orientation. *Love* is the most popular teen magazine in Mongolia.

The paper gives the youngsters a voice – each issue answers questions Mongolian teens send to the Editor. Questions they do not know whom to ask...

Myanmar

With an area of about 680,000 square kilometres, Myanmar is about the size of France and United Kingdom combined. It is a country of rare natural beauty, a rich cultural past, and has a population of about 51 million, growing at an annual rate of 2.02 per cent (Ministry of Immigration and Population). Income is low and reproductive health indicators are poor. Myanmar is a Category "A" Country for UNFPA assistance.

Facts and Issues

Poverty is widespread in Myanmar and especially acute in remote rural areas where about 75 per cent of the population lives. In 1998/99, the per capita GDP was estimated at $275 (Human Resources Development Indicators, 2000). Spending on social sector programmes is very low, and external assistance amounts to just over $1 per capita a year. Given that almost one quarter of households have incomes below the minimum subsistence level, it is difficult for many families to afford even basic health services. In such circumstances, women and children are the worst sufferers.

There are about 13 million women of reproductive age and 10.5 million youth. Maternal mortality ratio in Myanmar is high, though estimates vary from 255 to 580 maternal deaths per 100,000 live births. Total fertility rate is just under 3 and contraceptive prevalence rate among married women of reproductive age is low at around 33 per cent. The incidence of abortion, which is illegal, is estimated to be very high. Unsafe abortions account for around 50 per cent of maternal deaths. Around 8 per cent of maternal deaths occur to women under 20 years of age. According to UNAIDS/WHO estimates, HIV prevalence rate among pregnant women is startlingly high at 2 per cent and about 2 per cent of Myanmar youth are HIV positive. About 54 per cent of injecting drug users and 37 per cent of female sex workers are infected with HIV.

Though overall literacy levels are good, the secondary enrolment ratio is only about 37 per cent (HRDI, 2000), and about 90 per cent of out-of-school youth are unemployed. It is therefore important to ensure that RH services and information are made more accessible to adolescents and youth, especially since RH services have traditionally targeted only married women of reproductive age.

There is a big unmet demand for RH in Myanmar. RH activities could probably yield significant results due to high levels of literacy in the population; the existence of an extensive basic primary health-care system with trained personnel; a highly structured administrative system and effective reporting of health statistics.

Achievements through Collaboration

UNFPA has provided small-scale, limited assistance to RH activities in Myanmar since 1973. In the absence of a country programme, this was done on a year-to-year basis with annual allocations of less than US$1 million. The main areas for support have been: training in RH service provision, including birth spacing; information, education and communication (IEC) activities; collection of clinical data; and procurement of contraceptives and drugs to treat STIs. Prior to 1991, Myanmar had a pro-natalist policy that changed later. Since then, UNFPA has expanded its support for birth spacing services from 20 townships in 1992 to a total of 72 out of 324 townships in 2000, thus reaching approximately 30 per cent of the country's needy population. The Fund supported two censuses in 1973 and 1983 and a "Population Changes and Fertility Survey" in 1991. It also supported various RH-related studies, among them, the national "Fertility and Reproductive Health Survey" in 1997 to collect and analyse data on RH and HIV/AIDS situation and a cross-border migration and RH study in 1999 and 2000 in three townships bordering Thailand and China. The latter study investigated factors linking cross-border migration with transmission of STIs,

including HIV. Approximately 400 female sex workers were among the groups interviewed. The studies highlighted the need for greater IEC efforts, in particular the need to increase male responsibility in HIV/AIDS prevention through greater condom usage among high-risk groups.

For the period 2002-2005, UNFPA has approved a special programme of humanitarian assistance to Myanmar in the amount of US$12 million from regular resources, to be supplemented with an additional US$4 million through co-financing modalities. The overall objective is to serve the urgent needs of the poorest and most vulnerable segments of the population in terms of preventing HIV/AIDS and other STIs and to reduce high levels of maternal mortality through support for RH information and services and the provision of RH commodities, including condoms and other contraceptives. The proposed programme would also support collection and analysis of data to better understand the RH and HIV/AIDS situation in the country and to provide the basis for monitoring and evaluating programme results.

Swiftwinds Travels and Tours/ Photo by Sonny Nyein

Challenges Ahead

So far there is a dearth of reliable information on ARH, gender, and male involvement in RH. In addition, information is required on the interrelationships between cross-border migration, RH, HIV/AIDS and gender concerns, including commercial sex work and trafficking.

There is a high unmet need for contraception. Public Sector contraceptive services outside the UNFPA-supported 72 townships are currently very limited and contraceptives sold through the private sector are expensive. The lack of availability of RH commodities contributes towards the increasing prevalence of HIV and results in unwanted pregnancies and recourse to unsafe abortions, a major factor in the high maternal mortality ratio. Under the proposed programme of assistance, UNFPA would ensure increased availability of contraceptives, including condoms, oral pills, injectables and IUDs, which would be distributed largely through public-sector health and social marketing channels at community levels for maximum outreach, especially to vulnerable groups. So far RH services have focussed only on married women of reproductive age and unmarried women, youth and men have not been adequately reached. Male participation in contraception is extremely low and condoms account for only 0.1 per cent of contraceptive methods being used.

In response to Myanmar's HIV/AIDS crisis, UNFPA would be increasing the availability of condoms to be distributed through a social marketing programme in collaboration with international NGOs. The emphasis would be on cross-border areas, targeting such vulnerable groups as female sex workers, adolescents and youth, especially girls. Moreover, UNFPA would support initiatives to prevent HIV/AIDS by raising awareness of the epidemic through IEC campaigns and by promoting behavioural change.

Philippines

In 2000, the National Census placed the Philippine population at 76.5 million, increasing very rapidly at 2.3 per cent annually. At this rate, the population will double by 2030 and the Philippines from its present rank of 14 would become the 12th most populous country in the world by 2050. It is a Category "B" Country for UNFPA assistance.

Facts and Issues

Today, more Filipino mothers die from pregnancy-related complications than from any other cause. Though both infant and maternal mortality have registered a steady decline over recent decades, inadequate prenatal and delivery care, lack of information and means to manage obstetric complications, as also unsafe abortion practices are factors contributing towards continuing high rates of maternal mortality. Women continue to bear 3.7 children on an average (NDHS 1998), and only 56 per cent births are attended by trained staff. There has been a steady increase in contraceptive use, presently estimated at 49.5 per cent (FP Survey 2001). In 2001, 33.1 per cent (FP Survey) were using modern methods of contraception; the unmet need for family planning is therefore high. Most married couples do not use any method of contraception and male participation in FP is low.

In 2000, over 57 per cent of the population was below 25 years of age. Adolescents are becoming sexually active at younger ages, premarital sex is common, and STDs are on the rise. The prevalence of HIV/AIDS is low, infecting only 0.1 per cent men and women aged 15-49 years. The dominant mode of HIV transmission is through sexual intercourse.

Though gender disparities have narrowed over the past two decades, women still face unequal opportunities in employment, health-care and decision-making. Domestic violence is an issue of concern.

Achievements through Collaboration

UNFPA has been providing assistance to the government since 1969. Under the Fourth Country Programme (CP4), a total of US$41.4 million was approved for the period 1994-1999, 80 per cent being allocated to reproductive health.

Some of the key outputs of the CP4 were: integration of RH in the government's portfolio of health service delivery; provision of specialized RH services in selected national institutions; explicit specification of bio-medical standards for RH services; development of a local model for delivery of an integrated package of RH services in the pilot province of Nueva Vizcaya; addressing quality-of-care issues in delivering FP and maternal care at the village and municipal levels; provision of STDs/HIV/AIDS services in 21 provinces and 3 cities; successful establishment of birthing centers; introduction of health-cum-livelihood activities; use of adolescent peer counsellors and community-based monitoring. Support was also provided to several NGOs that demonstrated innovative strategies in RH.

UNFPA expanded its commitment to peace and confidence building in post-conflict areas of Mindanao by securing a grant of approximately US$ 1 million from the Government of Netherlands. The 1.5-year project is part of a joint Government of Philippines and United Nations Multi-Donor programme of assistance to Mindanao that includes elements such as vocational training, agriculturally based livelihood and human resource development.

Under the fifth cycle of assistance (2000-2004) in the amount of US$30 million, the objective is to improve the life of all Filipinos through better RH services, with focus on: FP and responsible parenthood; prenatal, postnatal and emergency obstetric care along with FP counselling; RH information and counselling for adolescents; and promotion and control of RTIs including HIV/AIDS.

The total RH model will be expanded in the province of Nueva Vizcaya to cover all 15 municipalities, and assistance will be provided to 8 other provinces and four urban pilot ARH projects. Violence against women (VAW) will be addressed in 8 of the 9 provinces. Emphasis will be on ARH instead of only high-risk pregnancies. Gender issues will be crosscutting. Local Government Units will work in collaboration with the Department of Health, regional hospitals and local NGOs.

Under population and development strategies, support will be provided for the annual publication, *The State of the Philippines Population Report.* Advocacy will focus on establishing common guidelines; strengthening the capacity of NGOs, Local Government Units, government information agencies and the mass media; and increasing support for population and RH activities among various influential groups.

The Fund is currently supporting 30 projects in 9 provinces in the country. Nueva Vizcaya continues to pilot the implementation of a RH package consisting of IEC and clinical services delivered by the primary health care facilities. The preliminary activities conducted to date include RH baseline surveys; an assessment of the training needs of health programme managers and non-health personnel; the development and use of integrated training modules for health professionals and volunteers; and RH community mapping. In 2001, a total of 885 health personnel were trained in the integrated RH module. In addition, local study tours were organized and fellowships were granted to programme managers for learning innovative approaches being implemented in community-based RH services in other countries. Local AIDS councils and ARH and VAW Task Forces were also established.

Major interventions have been undertaken by the provinces towards improving awareness and knowledge of RH issues that include development and production of gender-based IEC key messages and materials; observance of national campaigns such as cancer prevention, Women's Month, AIDS Day, Population Day; and multi-media campaigns on identified RH issues.

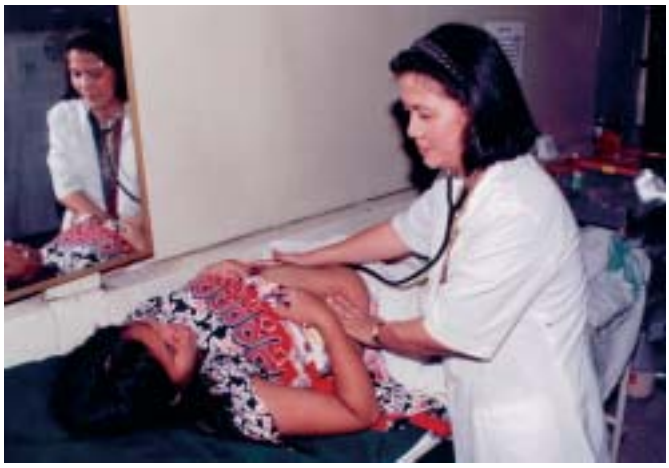
Advocacy at the national level has resulted in better networking between legislative representatives, NGOs, Muslim religious leaders, media and government in support of various RH issues. At the local level, advocacy teams have been created and trained. As a result of their efforts, population concerns have been integrated with local development plans.

Efforts have been ongoing to integrate and synchronize RH, advocacy and population and development activities, to maximize the ensuing gains. Monitoring and evaluation tools have been prepared and a Quality of Care survey has been completed.

Challenges Ahead

The country recently restated the *Philippine Population Management Programme* (PPMP). However, limited preparedness and capacity of local government units, and insufficient community participation are major impediments in provision of quality RH services. Capacity of NGOs, community action groups and government agencies needs to be strengthened and support of policy-makers, religious and community leaders, media and health practitioners needs to be sought to improve awareness and support for population and RH programmes.

Improving access to quality RH, male involvement, adolescent and youth concerns, gender equality and women's empowerment continue to remain challenges in order to improve the well-being of an average Filipino.



UNFPA/ Photo

Republic of Korea

In a period of 50 odd years, the Republic of Korea has managed to emerge from being a desperately poor least developed country to an industrial and economic powerhouse. As a member of the Organization for Economic Cooperation and Development (OECD), the Republic of Korea is an emerging donor country with a wealth of talent and expertise that could be shared with other developing countries through South-South collaboration.

Facts and Issues

The Republic of Korea (ROK) is a story of a dramatic modern miracle, in which the United Nations has played a series of crucial roles. From the time of its birth and freedom from colonial clutches, to repelling of external aggression by military intervention, to post war relief and reconstruction, to technical cooperation and assistance in the long term development process - ROK has been one of the most active member governments that has enjoyed a "synergistic" relationship with the United Nations system. It has 21 memberships in United Nations Councils and Committees, including membership to the Economic and Social Council (ECOSOC) for 1998-2001.

In 2001, the ROK had a population of about 47.1 million, growing at an average rate of 0.7 per cent per annum. About 82 per cent of the total population lives in urban areas. Infant mortality ratio is 7 per 1,000 live births; maternal mortality ratio is 20 per 100,000 live births; almost 98 per cent of births are attended by skilled attendants; and literacy is almost universal. Total fertility is well below replacement level at 1.51. With a per capita gross national income of US$ 15,530 measured in purchasing power parity terms, ROK is now an industrialized country and is placed in the highest income ranks among developing countries.

As one of the "Four Dragons" of East Asia, the ROK has achieved an enviable record of growth. The Asian financial crisis of 1997/98 exposed certain long-standing weaknesses in the country's development model, including high debt/equity ratios, massive foreign borrowings and an undisciplined financial sector. However, as a result of concerted efforts, the country seems to be gradually recovering from the economic downturn.

Achievements through Collaboration

The partnership between the ROK and UNFPA dates back to 1974 when the first Country Programme was signed to incorporate activities included in MCH/FP, IEC, and support for training and research at the Institute of Reproductive Medicine and Population and the Seoul National University. But in view of the commendable economic and social performance of the ROK, including rapid self-reliance and notable progress in the population field, UNFPA assistance has been limited and directed to selected areas of intervention in recent years. In 1997, UNFPA approved a project to support the Korea Institute of Health and Social Affairs (KIHASA) to organize the "International Symposium on Population and Development Policies in Low Fertility Countries: Challenges of Changing Age Structures". In addition, the UNFPA Technical Advisory Team (CST) in Bangkok has promoted the exchange of experiences from KIHASA by sharing information and inviting national officials and experts from neighbouring countries to come for training in KIHASA, under joint financial support from KIHASA.

Challenges Ahead

Sharing its knowledge and experience in implementing successful RH and FP programmes through South-South collaboration with other developing countries in the region is the major challenge that lies ahead for the Republic of Korea.

Thailand

Thailand has been a democratic constitutional monarchy since 1932, and one of the fastest growing economies in Southeast Asia. After decades of sustained growth, the Thai economy has suffered severe disruptions since the second half of 1997. The government budget has been cut and social spending slashed. Yet, despite recent troubles, Thailand's overall social and demographic profile presents a generally favorable picture.

Facts and Issues

In 2001, the population of Thailand, predominantly rural, was over 62 million *(Ministry of Interior, 2001)* and growing at a rate below 1 per cent. With women currently bearing only 1.8 children on an average, Thailand has achieved below replacement level fertility. The GNP per capita in 2000 was estimated at US$ 1,662 and overall literacy was high at over 95 per cent. Life expectancy at birth is around 70 years for men and 75 years for women. The contraceptive prevalence rate of married women of reproductive age (15-44 years) is about 75 per cent, with almost universal knowledge of contraception.

Thailand has thus achieved remarkable success in general health and family planning (FP). As a result, reducing the population growth rate is no longer an overriding national goal. However, several RH and population challenges still remain in Thailand. There is a considerable unmet need for FP and other RH services among single women, men, adolescents and youth, since such services have traditionally been directed only towards married women. Due to the recent economic crisis, the government's budget for contraception has been substantially reduced, which has created an obstacle in providing integrated RH services, especially to under-served groups. Also, the percentage of the elderly (over 60 years of age) in the population is rising rapidly and is expected to reach 15 per cent by the year 2020.

According to UNAIDS, Thailand has the second highest rate of adult HIV prevalence in Asia and the Pacific, though actual number of HIV/AIDS cases are believed to be much higher than those reported. In 2000, about 1.5 per cent of women attending antenatal clinics were infected with HIV (Ministry of Public Health), and they gave birth to an estimated 4,000-5,000 HIV-infected children. Although the overwhelming majority of HIV transmission is through sexual intercourse, the infection rate among injecting drug users has continued to rise to over 45 per cent (Ministry of Public Health).

Apart from AIDS, there are other urgent ARH-related challenges:

- Relatively high number of abortions (200,000-300,000/year);
- High rate of teen pregnancy (13 per cent of all births, Ministry of Public Health, 1999);
- High incidence of STIs among 15-24 year-olds.

UNFPA/ Photo

In Pattani Province, southern Thailand, the Muslim Traditional Birth Attendants (TBAs) have played a significant role with pregnant mothers. Here at a UNFPA funded training workshop on improving the quality of care, local health officials and TBAs learn and share their experiences in reducing risks mothers and infants face during pregnancy, delivery, and postpartum.

Despite high levels of literacy among Thai women, a gender gap still persists in the country. According to UNDP's Human Development Report for 2000, Thailand falls in the middle tier of countries insofar as gender-related development indicators are concerned. While women comprise 46 per cent of the labour force, wages for men are 15-20 per cent higher than those for women. Also, women presently hold only around 9 per cent of the seats in parliament *(The Parliament House, March 2002).* The proliferating sex industry and girl trafficking within and from neighbouring countries is becoming an increasing cause of concern.

Achievements through Collaboration

Collaboration with UNFPA began with the First Country Programme in 1971. Since then, UNFPA's assistance to Thailand has evolved to respond to the changing picture of the country's population and development needs. A total of seven country programmes, amounting to US $37 million, have supported the following: maternal and child health and FP programmes; information, education and communication (IEC) initiatives; data collection and analysis; gender, population and development; population and environment concerns; population dynamics (migration); and emerging issues such as HIV/AIDS and ageing.

With Thailand achieving the five main thresholds of the ICPD indicators, in the Seventh Country Programme (1998-2001), Thailand was classified as a "C" category country for UNFPA assistance with only one subprogramme in RH comprising three main projects: (1) Pilot Projects on the operationalization of RH Services in Phayao and Pattani Provinces; (2) Research on Gender and RH; and (3) South-South Cooperation in RH.

But in view of the high HIV epidemic, in the Eighth Country Programme (2002-2006), Thailand has been reclassified as a "B" category country with more funding than the previous Country Programme (CP). The two subprogrammes on RH and PDS in the new CP will address: (1) improved access to integrated RH services; (2) improved access to RH education by youth and adolescents, including HIV/AIDS prevention and services; (3) emerging RH and population & development issues; and (4) South-South cooperation.

Using the experience gained in the two pilot provinces in Phayao and Pattani, RH and PDS activities will be carried out in selected provinces in the north and south of Thailand where the HIV/AIDS epidemic is spreading and the unmet need for RH is high. UNFPA will assist the Thai Government in HIV/AIDS prevention activities. Currently UNFPA is the Chair of the UN Thematic Working Group on HIV/AIDS in Thailand.

Challenges Ahead

Despite technological advances in data collection in Thailand, there is still no comprehensive database for RH and PDS. Thus, important information concerning contraceptive practices and abortions among unmarried adults and youth, and the much-needed data on rural-to-urban migration, international migration, ageing, population and environment, and cross-border transmission of HIV is missing. The availability of such data is crucial for policy-making, human resource development and service provision.

There is an urgent need to provide and improve access to quality, gender-sensitive, integrated and age-specific RH services (including HIV/AIDS prevention and counselling) by men, women and particularly youth. Involvement of religious and community leaders to maximize impact of comprehensive RH services; peer education programmes for disseminating useful information and services to adolescents; quality sexuality education for in- and out-of-school youth with appropriate curricula and qualified teachers; and improved male participation in RH programmes – all are greatly needed to address RH issues, including teenage pregnancies and unsafe abortions. Issues of poverty (there are some 10 million poor in Thailand according to *The World Bank, 2001*), trafficking in women and children, gender inequality, population and environment concerns and other emerging issues, such as rural-to-urban migration, cross-border migration with implications of HIV transmission, and ageing population are some of the other major challenges facing Thailand today.

Viet Nam

Viet Nam has a current population of around 79 million growing at an annual rate of 1.3 per cent and expected to reach approximately 91.3 million by 2015. Fertility, however, has been dropping steadily since the early 1970s, from an average of 6 to today's average of 2.3 children per woman. With a high population density per hectare of arable land, low per capita GNP of US $375, tremendous economic constraints and formidable development challenges, Viet Nam can still feel proud of high adult female literacy rates of 88.2 per cent and a very high ratio of girls to boys enrolled in primary education.

UNDP/ Photo/ Nguyen Van Thanh

Facts and Issues

Though Viet Nam started implementing population policies in the 1960s, these were assigned high priority on the national agenda only in the 1980s. The government has shown firm commitment towards reducing population growth and improving maternal and child health (MCH) by extending family planning (FP) services and increasing contraceptive availability. The National Committee for Population and Family Planning, established in 1984 as the country's coordinating agency for population matters, has been playing an important role in managing the national population programme. Substantial progress has occurred since 1993, when the Communist Party approved a resolution on a new population and family planning policy and the government adopted an operational strategy for the policy's implementation. Subsequently, Vietnam has stepped up efforts to reduce the population growth rate and fertility rate through an extensive FP programme.

Today, Viet Nam can claim success in the implementation of the population programme. Between 1989 and 1999, the total fertility rate dropped from 3.8 to 2.3. The contraceptive prevalence rate increased from 58 per cent in 1988 to 75 per cent in 1997. Over this same period, substantial improvements were also achieved in MCH, and in achieving literacy and gender equality in education. Abortions, however, are common in Viet Nam and alarmingly high.

Achievements through Collaboration

UNFPA has been providing assistance to Viet Nam since 1977. Since then, it has significantly assisted in strengthening the capacity of the Vietnamese Government in formulating population policies and managing the national programmes on reproductive health (RH) and population issues. Till date, the Fund has provided US$112 million towards assistance in the areas of MCH, FP and RH. It is a Category "B" country for UNFPA support.

RH has been the core area of support with 71 per cent of the programme funds. Viet Nam now meets the ICPD threshold level for maternal mortality, which is estimated at 100 per 100,000 live births (Ministry of Health 2001), although with wide regional variations. An estimated 88 per cent

of maternal deaths, however, are preventable. With UNFPA's support, population education has been integrated into the public school curricula and is being further strengthened and expanded. With roughly 55 per cent of the population being below 25 years of age, of which 35 per cent constitute those below 15 years (Population Census 1999), Viet Nam is one of the countries covered by the EC/UNFPA Initiative for Reproductive Health in Asia, with a focus on adolescent reproductive health.

In 1999, in recognition of the sustained efforts made by Viet Nam in the field of population and development, the United Nations presented its Population Award to the National Committee on Population and Family Planning (NCPFP).

In the course of the implementation of Viet Nam's population programme in meeting the goals specified in the ICPD and ICPD+5, certain limitations were recognized, namely, the narrow focus on family planning and fertility reduction. Accordingly, the government has developed a new population strategy for the period 2001-2010, as well as a new RH strategy with technical assistance from UNFPA that follows a holistic approach. These strategies reflect the broader concerns and issues of the ICPD *Programme of Action* and current needs in the area of population, including: RH and FP; gender equity and equality; migration and urbanization.

The Sixth Country Programme (CP6) of assistance to Viet Nam (2001-2005) will continue to build on the strategies developed in the past for improving reproductive health in the country as well as integrating population and development issues in policy making and planning.

UNFPA will assist the Ministry of Health in implementing the first RH Strategy of Viet Nam and the NCPFP in implementing the new National Population Strategy. Advocacy activities will be enhanced to raise awareness on RH, population and development issues among legislators, policy makers, planners, administrators and the mass media. Furthermore, UNFPA will continue to aid in the further analysis and utilization of the data collected during the last population census (1999), carried out with UNFPA support.

Eleven provinces have been earmarked for UNFPA assistance. The Fund will focus on increasing both quality and access to RH services by women, men and adolescents through an integrated package of gender-sensitive services and IEC/BCC activities. The objective is to reduce the number of unwanted pregnancies, maternal mortality rates, infections due to STDs including HIV/AIDS by increasing the use and availability of contraceptives.

Challenges Ahead

Despite improved promotion and delivery of FP methods, RH information and services are not uniformly available in the country and particularly limited in remote areas and among adolescents and young unmarried adults. The incidence of induced abortions is very high and rising among adolescent groups, with over 40 per cent seeking to terminate unwanted pregnancies. Other RH concerns include high levels of maternal mortality, and high incidence of RTIs/STIs among women of reproductive age. HIV/AIDS is emerging as a major public health problem. According to a report by the National AIDS Committee in September 1998, an estimated 135,000-160,000 people were projected to be infected with HIV by the year 2000. Considering the young age structure of the population, effectively tackling ARH issues is a major concern. There is also a need to integrate population, RH and gender concerns in socio-economic development policies and programmes.

South and West Asia

In 2001, the population of this region was in excess of 1.5 billion, and it is expected to exceed 2.5 billion by 2050. Thus, every fourth person in the world today is from South and West Asia. With over one billion people, India alone accounts for two thirds of the total. Though the region has experienced declines in fertility, mortality and population growth levels in the past decade, the region as a whole continues to grapple with low per capita income, poor standard of living, inadequate infrastructure, critical shortages in housing, rising unemployment in urban areas, and widespread environmental degradation. In several countries of the region, women continue to bear more than four children on an average, that is neutralizing economic and development gains, and adding to the poverty in the region. Rural to urban migration has been increasing rapidly, further stressing the civic and municipal services and increasing pollution and crime in the cities. Issues of gender inequality and violence against women continue to be areas of major concern region-wide. The next biggest threat, however, is the rising emergence of HIV/AIDS.

In South and West Asia, UNFPA has programmes in the following countries:

Afghanistan
Bangladesh
Bhutan
India
Iran
Maldives
Nepal
Pakistan
Sri Lanka

With increasing support from governments, international organisations and committed NGOs, there has been socio-economic progress in the region. But it is neither enough nor equally distributed. UNFPA continues to complement the efforts of the countries in implementing effective reproductive health programmes and building national and institutional capacities.



Afghanistan

More than two decades of armed conflict and three years of drought have led to widespread human suffering and massive displacement of people in Afghanistan. The last census was aborted in 1978; hence reliable data is scarce. However, for planning purposes, the current population of Afghanistan is estimated between 20-25 million, growing at an average rate of 3.7 per cent per annum. Total fertility rate is amongst the highest in the world with women bearing 6.8 children on an average. Contraceptive use, estimated at around 2 per cent, is abysmally low.

Facts and Issues

Decades of war and conflict have significantly eroded the economic resources and exacerbated poverty and deprivation in the country. There are currently over 9 million Afghans who need humanitarian assistance. There are also an estimated two million Afghan refugees in Pakistan and 1.5 million Afghan refugees in Iran, in addition to an estimated 1.2 million internally displaced persons. Three to four million Afghans are severely affected by the current drought and an almost equal number are dependent on food aid.

The long drawn civil strife and war have taken a heavy toll on the country's infrastructure and national institutions of governance. The nation's transportation and communication systems, heavy and small-scale industries, education, and agricultural infrastructure are almost entirely damaged. Largely dependent on subsistence agriculture, the country has witnessed diminishing income levels, declining food security, and reduced access to essential services. An estimated 23 per cent of the total population has access to safe water, and only 12 per cent to adequate sanitation.

Afghanistan's poor Human Development indicators, therefore, are no surprise. Infant mortality rates are among the highest in the world at 165 per 1000 live births; one in four children do not survive their fifth birthday; and thousands die each year of measles, diarrhea, pneumonia and other preventable causes. Maternal mortality is estimated at 1,700 per 100,000 live births, the second highest in the world, with nearly 99 per cent of the deliveries taking place at home and only 9 per cent being attended by trained personnel. There is an average of one doctor per 50,000 people in Afghanistan. Literacy rates are estimated at overall 30 per cent, and only 13 per cent for females. The primary gross enrollment rate is estimated at 39 per cent for boys and a meager 3 per cent for girls.

Achievements through Collaboration

In the 1970s and early 1980s, UNFPA's assistance to Afghanistan consisted primarily of preparatory support to the population census and strengthening the country's efforts in demographic data collection, initial support for family planning and IEC activities. UNFPA supported training of medical personnel and female health workers and midwives, especially at the village level, in order to improve access to and quality of RH/FP services.

In the late 1980s, the UNFPA programme of assistance was disrupted and the office moved to Islamabad, Pakistan. UNFPA was relocated back to Kabul briefly in 1990. The outbreak of the civil war shortly thereafter, once again resulted in UNFPA being evacuated back to Islamabad along with other UN agencies.

Since December 1997, after a break of over 8 years, in response to the UN General Assembly Resolution– *Emergency Assistance for Peace, Normalcy and Reconstruction of War Stricken Afghanistan,* UNFPA has resumed support for Afghanistan and has provided assistance of over US$ 3 million. The Fund has been supporting ten projects inside Afghanistan and for Afghan refugees in Pakistan and Iran. The focus is on EOC; provision of supplies and emergency RH kits; basic training of health care

ADB/Vincent De Witt

Afghanistan has the second highest maternal mortality ratio in the world. An estimated 15,000 women die each year from pregnancy-related causes and only 12 per cent of pregnant women have access to maternal and emergency obstetric care.

personnel and birth attendants; and IEC on RH issues to improve the access of women to MCH services. This support has been extended with the collaboration of several large international and national NGOs that have continued to operate inside Afghanistan despite a rather hostile environment.

Following the earthquakes that struck Afghanistan in May 1998 and February 1999, UNFPA provided emergency assistance for the procurement of medical equipment, emergency kits and supplies for earthquake victims through the *International Federation of Red Cross and Red Crescent Society.*

In response to the post September 2001 Afghanistan crisis, UNFPA prepared contingency plans; stockpiled health supplies; recruited additional local staff; airlifted US$500,000 worth of medical equipment and supplies for three maternity hospitals, including life saving medicines, operation theatre equipment and ambulances; supplied emergency RH kits; and is rebuilding a vocational school for women and a school for girls. The Fund is participating in Afghanistan's reconstruction as part of the integrated UN assistance mission. It has been actively involved in the joint needs assessment missions on Health and Urban Planning and Housing and has been designated by the *Ministry of Public Health* in Afghanistan as the focal coordinating agency for RH issues in the country. It will also be playing a lead role in data collection and analysis, leading to a population census.

Even during the war years, UNFPA had a presence in Afghanistan by way of an office staffed by local personnel. Soon after the cessation of hostilities, a full-fledged office was established with a Chief Operating Officer. Inside Afghanistan, UNFPA has been working with the *International Red Cross* and *Red Crescent Society, Swedish Committee for Afghanistan, Ibn Sina* (an Afghan health NGO with 19 clinics throughout Afghanistan), *Afghanistan Institute of Learning* and *Aide Médicale Internationale,* inter alia. In Pakistan and Iran, UNFPA is working in partnership with the *BBC Radio* (RH advocacy) and *UNHCR.*

Challenges Ahead

With RH and population indicators being very poor, the most urgent need and biggest challenge is making services available and rebuilding the health and education infrastructure in the country. The already damaged infrastructure will also have to take the burden of a large number of returnees. There is an acute shortage of trained service providers, since a large number of doctors and health workers have fled the country and in the last two decades this cadre has not been replenished. Further, the existing health services have limited geographical coverage – only 35 per cent of the districts have health services and 18 per cent reproductive health. To cope with the current crisis, saving lives depends on having health workers in the field along with sufficient medical supplies and equipment both in the peripheral and referral centers.

Despite the tragic circumstances for which Afghanistan now finds itself the centre of world attention, it is critical now that the people of Afghanistan reap the peace dividend that they so richly deserve. The international support needs to be sustained to deal with systemic issues upon which a viable development process can be launched.

Bangladesh

Bangladesh is one of the world's most densely populated nations. The predominantly agrarian and rural economy has a population of roughly 130 million, growing at an average annual rate of around 1.48 per cent. At this rate, the population of Bangladesh will double by 2050. It is a priority "A" country for UNFPA assistance.

Facts and Issues

Concerted and sustained efforts by the government have led to significant achievements in family planning (FP) over the last three decades. There has been a dramatic lowering of the total fertility rate (TFR) from an original 6.3 in the late 1970s to a present rate of 3.3 (DHS 1999-2000). The government has been pursuing active advocacy and social marketing programmes throughout the country, successfully introducing a variety of contraception methods, provided free of charge at government clinics or at a nominal charge at non-governmental clinics. As a result, contraceptive use has increased to 54 per cent.

Maternal mortality ratio is very high at 400 per 100,000 live births (MMR Household Survey 2001), with about 12,000-15,000 women dying yearly from pregnancy and childbirth-related complications. The morbidity rate for women is higher than men; roughly 45 per cent women have a low body mass index (BMI); and 53 per cent of breastfeeding mothers are malnourished. Only about 13 per cent women access skilled assistance at birth. Infant mortality rate remains one of the highest in the world at 67 per 1,000 live births and almost one in ten children born die before their fifth birthday.

The situation is further exacerbated by endemic and chronic poverty, rural areas being worse off. Critical poverty indicators reveal low educational attainment of the rural poor, especially girls; poor quality and inadequate availability of proper health care, particularly in the rural areas; poor nutritional status of women; and insufficient access to income-generating opportunities for disadvantaged groups. Marriages occur at a young age and the first child follows shortly thereafter. Incidences of violence against women remain high and there are inherent cultural biases against women.

Achievements through Collaboration

UNFPA's involvement in Bangladesh dates as far back as 1974. In the first two country programmes, the focus was mainly on FP. In the third country programme (CP3), emphasis was placed on women's health by providing technical support and training for strengthening the MCH/FP service delivery system and improving the institutional capacity of the *Ministry of Health and Family Welfare* (MoHFW). Further gains in RH were posted under CP4 by upgrading *Maternal and Child Welfare Centres* (MCWC).

UNFPA/ Photo

Promoting Safe Motherhood through Mother and Child Healthcare Centres.

In the Fifth Country Programme (1998-2002), with a total budget of $US 35 million, focus has once again been on the RH subprogramme which aims at extending the coverage of RH services, including efforts to improve safe motherhood, quality obstetric care, clinical methods of contraception and the management of RTIs and STIs. Efforts have also been made to introduce crosscutting aspects such as gender equity and equality and reproductive rights into mainstream programmes in education, law enforcement, religious affairs, the garment and tea plantation industries, and other sectors. The strategy has been designed as a deliberate effort

to respond to the Cairo agreement to integrate RH and gender with the country's overall sustainable social development and poverty reduction strategies. UNFPA also executed a joint programme with the Home Ministry to raise awareness on RH and gender issues among nearly 4 million defence and police personnel. The project is a part of an overall effort to sensitise law enforcement personnel about women's rights and decrease violence against women and girls.

Another key feature of CP5 has been the completion of a phased programme to upgrade a network of 64 MCWCs with proper equipment and training of staff in emergency obstetric care (EOC) so that these can offer a package of comprehensive maternal health services. These centres have ambulance services to facilitate quick transfer in times of emergency, trained women doctors in obstetric care and even trained anaesthetists. In addition, with the decrease in clinical contraceptive methods and a high incidence of RTIs, there has been a strong emphasis on improving service providers' understanding and awareness of both clinical contraception and the management of STDs in an effort to improve their education and counselling efforts with clients.

The Sixth Country Programme (2003-2005) will continue to focus on areas of greatest need in RH and population: safe motherhood, reduction in total fertility, and advocacy for vulnerable groups. Under the Safe Motherhood programme, EOC services will be strengthened through MCWCs and urban clinics, increased skilled birth attendance and improved counselling. Efforts in detecting, preventing and treating RTIs/STDs/HIV/AIDS will continue. A broader choice and better quality of contraception will be offered. UNFPA will help ensure that Bangladesh remains a low-prevalence country in HIV/AIDS.

Working in concert with the Government of Bangladesh, other donors, NGOs and civil society, UNFPA takes a holistic and life-cycle approach to addressing RH, population and poverty issues, linking and integrating activities in these areas to other sectoral development priorities. The goal is to make RH a social development objective, not just a health issue. Reaching men and youth will figure prominently in the sixth programme. There will be a strong emphasis on behaviour change communication (BCC), in which messages will be focused in their content and targeted to specific groups. Advocacy campaigns will continue to play a major role in shaping perceptions and enabling people to make informed decisions on RH. In an unprecedented effort to reach the rural poor, women and youth, UNFPA has enlisted the help of parliamentarians, religious, political and other leaders. The Fund will also play the lead role in enhancing the technical and institutional capacity of the Behavioural Change Communication Unit (BCCU) within the MoHFW. In this, male participation will be especially addressed.

UNFPA will increase policy and programme level interventions for reducing TFR. There will be continued efforts to influence related policy making, ensuring strong commitment to ARH in both the formal and the informal sectors; and selective in-depth analysis and dissemination of the 2001 population census results.

Challenges Ahead

Despite serious challenges along the way, Bangladesh has achieved impressive reductions in fertility and infant and child mortality over the past three decades. Nonetheless, the population continues to grow rapidly and TFR is still very high; chronic poverty and illness further deny many families the opportunity for long, healthy, productive lives. Dependency ratio is high at around 70 and gender inequality is widespread. Even now, almost 65 per cent of the women receive no antenatal care and over 90 per cent of the deliveries are done at home. Continued emphasis on RH/FP is required to reach replacement level fertility, and quality of basic health services must be improved. It is estimated that by 2025 almost half the population of Bangladesh will be urban. Inhospitable urban environment, lack of jobs, congestion and squalor and the rate of growth in urbanisation are increasing poverty and unemployment. With the majority of the population being under the age of 25 years, combined with large cross-border migration and the serious threat of HIV/AIDS spreading rapidly in the region, the need for addressing ARH issues has acquired significant urgency.

Bhutan

Situated between India and China in the Eastern Himalayas, Bhutan has a rugged, mountainous terrain and a scattered rural population. Though estimates vary widely, the total population according to national estimates is around 700,000 and growing at an annual rate of 2.6 per cent. At this rate, the population will double in less than 30 years. With only one of the ICPD threshold levels being met, namely, access to basic health services, Bhutan remains a Category "A" country for UNFPA assistance.

Facts and Issues

Overall, Bhutan has recently shown improvement on all ICPD indicators. Substantial declines have been recorded in maternal and infant mortality and improvements have been made in life expectancy and adult literacy levels. Economic performance has been commendable at 6.7 per cent per annum and has been accompanied by high investments in social sector spending.

Over the past decade, even though contraceptive use has doubled, only 30 per cent use contraception according to national sources. Consequently, there has been only a minor drop in the total fertility level, which remains high at close to 5 children per woman. Bhutan has a young population with 43 per cent below the age of 15 years. Close to 85 per cent of the population lives in rural areas. However, the urban population has increased rapidly from an estimated 5 per cent in 1990 to 15 per cent in 2000 and is expected to grow at an exponential rate of 6 per cent in the period between 2000-2005. Maternal mortality ratios are high at 400 per 100,000 live births. Per capita income is very low and poverty widespread.

Achievements through Collaboration

UNFPA started its assistance to Bhutan in 1981. While the First Country Programme (1988-91) provided substantive support for strengthening infrastructure, the Second Country Programme (1992-1997) helped Bhutan establish a number of Basic Health Units (BHUs), MCH Centres, a National Institute of Family Health and a storage facility for drugs and equipment needed to promote maternal and child health.

With assistance from the Third Country Programme (1998-2002), the government has broadened the scope of the contraceptive method mix. The institutional capacity of Ministry of Health and Education to provide surgical contraceptive services i.e., vasectomy, non-scalpel vasectomy and tubal ligation, has been strengthened.

UNFPA has been the main supporter of RH initiatives in Bhutan, including education and advocacy, and is the only agency providing access to a full range of safe, reliable family planning methods. This has been significantly complemented by the commitment of Bhutan's Royal Family and their keen interest in promoting responsible reproductive health attitudes and behaviours.

In the Fourth Country Programme (2002-2006), the focus is on two main subprogramme areas: reproductive health and population and development strategies that also contain an advocacy component. Gender is a crosscutting issue and will be addressed in both subprogrammes.

UNFPA has adopted a comprehensive support programme in Bhutan. About 70 per cent of the funds are earmarked for improving availability and accessibility of information and services on quality RH, particularly for adolescents. Other areas of cooperation are aimed at advocating increasing primary school enrolment and continuation rates, particularly for girls, and at building capacity for collecting and analyzing population and health data.

UNFPA has been instrumental in raising gender as a priority issue with the government through advocacy. UNFPA collaborates closely with UNDP, WHO, UNICEF and DANIDA to maximize

the inputs and complements the efforts of other donors towards achievement of the country's health and population goals.

Challenges Ahead

A poor rural population, dispersed over a large, difficult mountainous terrain has always posed impediments to economic development and logistical difficulties in the provision of effective health delivery systems. Adolescents and youth comprise a significant proportion of the population. Early marriage, early pregnancy, high fertility, low use of contraception and STDs are common among them. Bhutan's existing RH/FP services tend to target married couples. There is limited information, counselling and services currently available for adolescents. In addition, The Royal Government of Bhutan is facing serious challenges in providing youth employment and curbing rural-urban migration that has worsened labour scarcity in rural areas, increasing the burden on women.

The number of STD cases, although under-reported, show an upward trend. Approximately 35 per cent of the reported STD cases are among women. Even though HIV prevalence is presently at a low level (only 22 reported cases), it is a matter of concern given the high HIV prevalence rate reported in neighbouring countries and the risks involved due to cross-border transmission.

More than two thirds of the population today has access to primary health care. Yet, despite economic progress and general improvements in the quality of life, levels of maternal and infant mortality are among the highest in the region; fertility and population growth rates are still alarming; and poverty, illiteracy, disease combined with gender inequalities and discrimination continue to pose serious challenges.

UNDP/ Photo

India

India is a country of striking contrasts, rich diversity and a culture dating back 5000 years. With a population of 1.03 billion people, growing at an average annual rate of 1.6 per cent, India from its present second place ranking is expected to become the most populous country in the world by the year 2050 with over 1.5 billion people. Despite being a predominantly agrarian economy with high levels of poverty, widespread illiteracy, gender inequality and environmental degradation, India ranks among the top ten industrial powers.

Facts and Issues

In the past two decades, India has achieved progress on almost all selected ICPD indicators: from declines in total fertility (presently below 3), infant and child mortality levels to improvements in literacy levels and an economic growth rate averaging around a respectable 5 per cent a year. However, despite some progress, infant mortality continues to remain high, averaging 65 deaths for every 1,000 live births. In some of the poorer states, one in ten children born do not live to see their first birthday. Maternal mortality exceeds 500 deaths for every 100,000 live births and gender inequalities are widespread.

Adding to India's existing woes is the problem of rapid urbanization. At the present rate of urban growth, it is estimated that by 2021, 50 per cent of India's population will be urban dwellers. Mumbai, Delhi and Calcutta are already counted among the megacities of the world with populations over 10 million each.

The year 2000 saw the birth of India's one billionth baby and the release of the National Population Policy that stressed the importance of achieving a stable population, while making RH services accessible and affordable to all; increasing access to education; extending basic amenities such as safe water and sanitation; tackling gender inequalities; and dealing with poverty.

Achievements through Collaboration

In recognition of the vast, complex and multidimensional nature of the country's population and development problems, India, a Category "A" country, is the largest recipient of UNFPA assistance in the world.

India was the first country in the world to launch family planning (FP) as part of its socio-economic development plan in 1952. UNFPA's assistance began in 1974 with an allocation of US$46 million, mainly for improving FP services, establishing a population database and promoting activities in the organized sector.

Over the years, UNFPA has provided commodity assistance for contraceptives and equipment, helped improve communication programmes and introduced population education on a major scale. The Fourth Country Programme (1991-96) focused on MCH/FP projects in three states (Rajasthan, Himachal Pradesh and Maharashtra), advocacy and IEC initiatives and innovative interventions to enhance women's role in development.

In the Fifth Country Programme (1997-2002), US$100 million were proposed for operationalizing the new RH approach that was to replace the old target-oriented approach. A major part of Fund's resources have been committed to the Integrated Population and Development (IPD) projects in six states, namely, Orissa, Gujarat, Maharashtra, Madhya Pradesh, Kerala and Rajasthan.

UNFPA is making an effort to create decentralized models of quality health service delivery systems. The India programme of assistance operates at two levels. A little over 55 per cent of the resources are being utilized for decentralized projects in 33 districts of the country for meeting the demand for quality RH services; for creating a sensitive and supportive programme environment and for strengthening women empowerment strategies. There has been an increased emphasis on building capacity of

local government bodies; enhancing community empowerment through self-help groups; and increasing involvement of NGOs. The balance resources are being utilized at the national level to assist the government in integrating population issues in the wider development context; implementing the national policy on empowerment of women; and strengthening the logistics and management system for the distribution of contraceptives and other RH supplies.

UNFPA has made a difference both at the policy as well as the service delivery levels. In the past, the Fund has contributed substantially towards helping India meet its contraceptive needs through imports, facilitating local production of condoms and IUDs, and providing raw material for oral pills as well as medical equipment for surgical contraception. In the current programme, it is helping evolve mechanisms for district-level, decentralized, needs-based, gender-equality driven programme planning and implementation. Through training of health staff and medical providers, it has been building technical capacity among providers of RH. A nine-element quality framework is being employed to make a more comprehensive package of quality RH services available at the district level. To reduce maternal mortality, medical officers and paramedics are being trained in basic emergency obstetric care. Prevention of HIV/AIDS and counselling has been included in UNFPA's interventions.

At the policy level, UNFPA has been actively supporting the Government of India in holding a dialogue with the states to ensure that population/health policies are in tandem with the National Population Policy, which is largely reflective of the ICPD goals. Along with UNIFEM and UNICEF, the Fund played a key role in "engendering" Census 2001 by training and sensitising enumerators on gender issues. UNFPA continues to work in close association with the Union Ministry of Health and Family Welfare and the state governments where IPD projects are located. It has also played a catalytic role in fostering effective partnerships between the government and grassroots NGOs. As many as 42 NGOs are being supported for implementing activities in the areas of combating violence against women; promoting women's empowerment through social mobilization; ARH and day care support services.

Challenges Ahead

With almost 350 million still living in absolute poverty, some 17 million being added annually to the population base, and the AIDS epidemic looming large, the challenges facing India are huge. Among the prime areas of concern are promoting gender equality and equity through sensitisation of communities; strengthening the quality of RH/FP services by addressing the existing and unmet needs for contraception; improving health infrastructure; ensuring serious implementation of a participatory approach based on community needs assessment; training and motivating service personnel at all levels; and integrating the service delivery for basic reproductive and child health care.

At the societal level, gender bias seems to be deepening. Though there has been a substantial increase in female literacy (up from 39.3 per cent in 1991 to 54.2 per cent in 2001), there are still deeply entrenched negative attitudes towards women and girls. This is partially reflected in the adverse sex ratio at birth evident in some parts of the country. The high prevalence of violence against women, even in a state like Kerala known for its achievements in literacy, is a matter of concern.

Adolescents (between 10-19 years) constitute 23 per cent of the population, with less than one fifth in schools and a high dropout rate at the elementary stage. The transmission of HIV is affecting mostly people under 25 years. HIV carriers in India are estimated at 3.86 million (UNAIDS/WHO, 2001), the second highest number in the world. In the absence of vigorous prevention efforts, there is considerable scope for further HIV spread.

UNFPA/ Photo

Women continue to be the disadvantaged group with high levels of poverty and illiteracy; empowering women through income generation activities remains an area of concern.

Iran

The Islamic Republic of Iran, situated in western Asia, is a Category "C" country for UNFPA support. It has an estimated population of 64.5 million (SCI, 2001), increasing at an average annual rate of 1.4 per cent. Over the years, the total fertility rate has declined steeply from 6.4 children per woman in 1986 to 2.0 in 2000 (DHS 2000). During the last decade, the country has made significant progress in terms of education, reduction in maternal and infant mortality and improvements in life expectancy. Notwithstanding the social progress, the economic situation in the country has been uneven, due to, inter alia, the decline in oil prices and the high rate of inflation.

UNFPA/Photo

During the last decade, improved promotion and delivery of family planning methods, RH/FP information and services, has led to a sharp fall in total fertility. Population growth, however, is expected to continue due to the young age structure of the population.

Facts and Issues

As a consequence of the baby boom of the early 1980s, the age structure of Iran's population is quite young with 57.5 per cent being under the age of 25 years. Presently, the median age of the population is around 20 years. People are also marrying late, with the mean age at first marriage having risen to 26.1 and 23.4 years for male and female respectively.

Since ICPD (1994), the government has shifted its emphasis from a target-driven to a qualitative approach and has embarked upon improving the quality of RH/FP services. These, however, are not evenly available in the country and are particularly limited in some remote, disadvantaged and hard-to-reach areas where rates of maternal and neonatal mortality still remain higher than the national average. Cultural and social barriers further impede the utilization of available services in some areas.

Despite concerted efforts to promote gender equality and to raise the status of women through enhancing girls' education and promoting income-generation programmes for women, gender disparities persist. This is particularly evident from lower employment and income levels for women and their low participation in decision-making. Although the government is yet to ratify the *Convention on the Elimination of all Forms of Discrimination Against Women* (CEDAW), it is committed to improving the status of women and has established the *Centre for Women's Participation,* affiliated with the President's Office, in order to mainstream gender concerns in the development process.

Achievements through Collaboration

In 1990, UNFPA resumed regular support to the Islamic Republic of Iran under an interim country programme (1990-1993). In the Second Country Programme (1994–1999), UNFPA

continued to support reproductive health services and research through technical assistance and training. It also helped the government to develop appropriate tools and indicators to be used for assessing the impact of reproductive health and related information, education and communication (IEC) activities in the formal and non-formal school systems.

Under the present Third Country Programme (2000-2004), with an outlay of US$ 11 million, the focus has been on specific thematic issues and remote geographic areas in order to assist the country in fully achieving the ICPD and ICPD+5 objectives.

The objective of the current Country Programme is to improve the RH status and ensure reproductive rights; achieve sustainable balance between population, economic development and resources; create an enabling environment to reduce gender disparities; and further promote favourable conditions for RH/FP. The programme is being implemented both at the national and provincial levels. However, its main focus is to improve the RH status and quality of life of the people in five hard-to-reach and deprived areas. In this respect, four provinces and one semi-urban area in metropolitan Tehran, where the general health indicators, in particular the RH status, are lower than national average, have been selected.

The programme follows an integrated approach, and is a collaborative effort between the Ministry of Health and Medical Education (MOHME), Ministry of Education (MOE), Literacy Movement Organization, Centre for Women's Participation, Statistical Centre of Iran and Shiraz University.

UNFPA/Photo

The government is adopting serious measures in mainstreaming gender concerns in the development process to improve the socio-economic conditions of women.

In addition to the regular programme, the Fund is supporting a project for Afghan refugees in Mashad, Shahr-e-Ray and Zahedan and Zabol since 1999.

Challenges Ahead

The major challenges in the area of RH are: increasing male involvement; improving the quality of care; addressing adolescent reproductive health issues; preventing and treating STDs/HIV/AIDS; and reducing unwanted pregnancies. Some of the other crucial areas are: raising awareness on population issues and gender; enhancing national capacity to formulate strategies and manage and implement integrated programmes in the area of population and RH/FP; mainstreaming gender concerns in the development process and promoting partnerships with civil society.

ICPD Goal Indicators and Situation in Iran:

Indicators	ICPD Thresholds	Iran's Situation
Proportion of deliveries attended by trained health personnel	60%	89.6%
Contraceptive prevalence rate	55%	73.8%
Proportion of population having access to basic health services	60%	over 90%
Infant mortality rate	50 per 1,000 live births	31
Maternal mortality ratio	100 per 100,000 live births	37
Gross female enrolment rate at the primary level	75%	over 95%
Adult female literacy rate	50%	75.9%

Source: MOHME/MOE

Maldives

Maldives is an Indian Ocean archipelago composed of 1,190 small coral islands scattered over 90,000 sq km. The majority of the present population of around 300,000 lives on 200 islands grouped in 19 atolls; a quarter of the population resides in Male, the capital. Only 10 per cent of the total land area of 298 sq. km is arable. Most of the income comes from the tourism industry and commercial fisheries. Maldives remains a priority "A" country for UNFPA support.

Facts and Issues

Over the past few decades, Maldives has made numerous strides in terms of overall socio-economic and human development. According to national estimates, population growth rate has declined from a high of 3.4 per cent between 1985-1990 to a present rate of 1.9 per cent (Census 2000). Likewise national estimates reveal a substantial decline in infant and maternal mortality ratios. A 1995 UNICEF study showed that about 35 per cent of all deaths among women aged 12-49 years were due to pregnancy-related causes, young age at marriage and early and frequent pregnancies. Adolescents form 27 per cent of the population. Life expectancy is around 68 years.

The situation with regard to gender equality and women's empowerment in the Maldives is generally positive (GDI index 69) as demonstrated by equality in terms of literacy and education enrolment at primary and secondary levels. The adult female literacy rate is 78 per cent (Census 1995). However, women participation in the labour force, politics and public life is low; divorce rates are high. The Family Law Act, which came into force in July 2001, is a landmark achievement and is expected to bring about significant improvements in gender equality and improvements in the status of women in relation to marriage, divorce, child-support and custody. It also brings into effect a minimum age of 18 years at marriage for both men and women.

Achievements through Collaboration

UNFPA's assistance to the Maldives began in 1977 with the first census, followed by support to the 1985 and 1990 censuses. UNFPA provided assistance for two MCH/FP projects and two population education projects executed respectively by WHO and UNESCO.

The first UNFPA-supported country programme for US$ 1.5 million began in 1995. It created a breakthrough in awareness and understanding of population issues and improvement in service delivery. The Second Country Programme, 1998-2002, in the amount of US$ 4.5 million seeks to: (a) improve the RH status of the population by increasing the use of comprehensive RH services; (b) mobilize support for population and RH issues among policy makers, community leaders, and young people; (c) empower women and enhance their status through raising awareness and promoting gender equity and equality in secondary education and employment. The programme is being implemented in close collaboration with other development partners, including bilateral donors, national and international NGOs and United Nations agencies.

The completion of a comprehensive baseline survey on RH by the Ministry of Health in association with the *CIET International* has been one of the most significant achievements under the current programme. The survey covers a nationally representative sample and investigates knowledge and practices relating to RH/FP as well as STDs/HIV/AIDS.

The UNFPA programmes have contributed substantially towards strengthening national capability in RH technical and managerial areas. Apart from international trainings, locally provided refresher courses have helped in upgrading the skills of service providers. With continuing efforts being made by the Department of Public Health and NGOs on IEC, there is an increased understanding of RH in the country. A number of

posters and leaflets produced annually on RH/FP with the Fund's support provide the public with reliable RH/FP information.

With UNFPA support, the Ministry of Planning and National Development has adopted an inter-sectoral coordination approach on population issues. The Fund's support for the government's advocacy efforts has been instrumental in bringing about broad-based support for the RH/FP programme from a number of influential groups and key leaders such as atoll and island chiefs, religious authorities, magistrates, Women's Development Committees as well as sports clubs.

The *European Commission* was the first donor to support a comprehensive project addressing the issue of gender equality and equity in the Maldives. Under UNFPA execution and working with a number of government departments including the Ministry of Women's Affairs and Social Security, the project was successful in initiating a micro-credit scheme for women, a girls scholarship scheme, advocacy seminars on gender equality as well as supporting NGO interventions on RH.

Overall, UNFPA has played a pioneering role in assisting the government in the introduction and strengthening of RH/FP services throughout the country and remains the only donor to provide safe, reliable and free FP methods. UNFPA also provides considerable support to the NGO sector, in particular to the *Society for Health Education* (SHE) in the area of RH/FP services, including counselling.

Challenges Ahead

The challenges posed by a widely dispersed and scattered population, the lack of an efficient transport system and the high costs of infrastructure are the biggest obstacles to the provision of equitable services in this small island nation. While some islands have very sparse populations, some others, such as the capital Male, face problems of severe overcrowding and congestion (37,000 people per sq km). Lack of skilled human resources continues to be a constraint in development efforts. Despite improvements in delivery and increased utilization of RH/FP services, a major constraint has been lack of male involvement. More focussed interventions are required to promote male participation and support for RH/FP and gender equality issues. There is still a high unmet need for contraception (42 per cent) that needs urgent addressing. Focused and coordinated efforts are needed to further reduce maternal mortality by strengthening EOC, antenatal and postnatal care and addressing the issues of anaemia and poor nutrition amongst pregnant women. Promotion of male methods and specifically condom usage through social marketing is necessary for the future. Additional advocacy work is required to create and maintain a supportive environment for RH/FP services.

UNFPA will continue to support and further strengthen the capacity for data collection and analysis, a particularly weak area at the moment. The regular tracking of indicators is vital for monitoring the programme and strengthening the focus on Results-Based Management. In coming years, UNFPA inputs will focus on expanding quality RH/FP services and addressing emerging issues related with adolescents, STDs/HIV/AIDS. The Fund will assist the government in reducing gender disparities, gender mainstreaming, promotion of male involvement and addressing violence against women.

UNFPA/ Photo

More hospitals/health centres have been established at the regional and atoll level. The number of births taking place with skilled attendants has increased to 90 per cent.

Nepal

Nepal is a small, remote, landlocked country in the Himalayas. After the restoration of democracy in 1990, Nepal initiated a number of development reforms including liberalization of the economy. Despite significant progress in access to education, health, drinking water, transport and communication, almost 38 per cent of the population continues to live in absolute poverty (less than US$1 per day). It is a Category "A" country for UNFPA assistance

Facts and Issues

Nepal's population according to national estimates was 23.2 million in 2001, growing at around 2.3 per cent a year. If this growth rate prevails, population will double in about 30 years. In 2000, 41 per cent of the population was below 14 years of age and youth (15-24 years of age) comprised one fifth of the total population. Agriculture is the mainstay of the economy, providing livelihood to over 80 per cent of the population. Although the size of the urban population is still small (14.2 per cent according to 2001 Census), it is increasing at a rapid rate of around 5 per cent.

Total fertility rates have registered a decline in the past few years, yet women continue to bear over 4 children on an average. However, urban fertility rate of 2.1 children per woman is in stark contrast to the national average. Though knowledge of family planning (FP) is almost universal, only 39 per cent use contraception. Marriages are early and teen pregnancies are very common. 19 per cent of maternal deaths occur among adolescent mothers. About 12.7 per cent of the deliveries are attended by trained healthcare providers. Maternal and infant mortality rates at 539/100,000 and 64.2/1,000 life births respectively (DHS 2000) are reckoned to be among the highest in the region. Almost 30 per cent of children of school-going age still do not attend schools and girls are particularly disadvantaged, more so in remote areas and among the disadvantaged populations. Female literacy rate in Nepal (6 years and above) is 45 per cent in contrast to 70 per cent for men (UNICEF/CBS). The threat of HIV/AIDS is now a major concern with an estimated 2,197 HIV positive cases and 572 known AIDS cases as of February 2002 (MOH, National Center for AIDS and STD Control and UNAIDS).

Achievements through Collaboration

UNFPA's assistance to Nepal's population programme began in 1970. Up to 1996, the first three country programmes supported FP, maternal and child health (MCH), population education, expansion of the population database, development of a national plan of action for women in development and the introduction of an integrated health management information system (HMIS).

Following Nepal's endorsement of the ICPD PoA, the government undertook a major initiative in 1996 to operationalize RH in Nepal. The cornerstone of this policy was a shift in focus from FP orientation to RH care; women to male participation; quantity to quality; vertical to integrated and life-cycle approach; control to reproductive rights. The government formulated the population and health policies in the Ninth Plan (1997-2001) incorporating the spirit and goals of the ICPD PoA. Establishment of the Population and Environment and Women, Children and Social Welfare Ministries as the focal points for population, environment and women's issues has been a major institutional realignment in the post ICPD era. However, integration of population and gender issues in sectoral plans remains weak despite heightened concern and awareness in plan documents and national policy statements.

The Fourth Country Programme (1997-2001) aimed at improving the coverage, access, quality and continuity of gender-sensitive RH services. The national RH policy, operational guidelines and the RH clinical protocols for each level of service providers were developed and disseminated along with the appropriate tools for managers at all levels in the system. HIV/AIDS prevention was

integrated into IEC messages. The RH Research Strategy and the National Adolescent Health and Development Strategy were also developed.

UNFPA provided support in strengthening the infrastructure of the country's health facilities and in strengthening FP services, counselling and training. Maternal mortality as a specific area of concern is reflected in the Nepal Safe Motherhood Plan, 2001. Emergency Obstetric Care (EOC) interventions were enhanced with the provision of EOC kits to front-line service providers. The Reproductive Health Coordination Committee was supported to ensure coherence at the policy and operational levels.

In the area of PDS, population issues are being steadily integrated within the development plans and programmes. Support to the Ministry of Education was provided for integrating family life education into school curricula. Support was also provided to the Central Bureau of Statistics for conducting the census and analysing, disseminating and incorporating its results for planning purposes.

Engendering the 2001 Census was a programme in which most of the donors participated. As a result, more gender-desegregated data is likely to be available. Advocacy efforts were directed towards creating awareness on population and RH issues among the community leaders, policy makers, government officials and civil societies. Institutionalisation of RH in government's women development programme has been one of the most highly appreciated areas of UNFPA's assistance.

A total of US$ 35.5 million has been approved for the Fifth Country Programme (CP5) of assistance that began in January 2002. Selected needy, backward districts and villages that are also areas of high risk of HIV/AIDS will be the focus for technical and financial assistance. The goal of CP5 is to improve the quality of life of Nepalese people, inter alia, through:

- Increased utilization and access of quality RH services by women, men and adolescents;
- Capacity building of referral centres, including skills training for service providers, provision of supplies and equipment, increase in number of FP service delivery points and a better mix of FP methods;
- Improved planning, implementation, monitoring and evaluation of the RH programme;
- Increased access to appropriate (audience specific) RH information, especially on HIV/AIDS, utilizing a variety of communication channels and formal and non-formal education through advocacy and IEC activities;
- Ensuring RH commodity security through collaboration with other donors and improving the contraceptive management information system;
- Strengthening national capacity to implement sustainable population and development policies as well as increasing national support for gender equity and empowerment of women.

UNFPA/ Photo

Nepal is one of the seven countries to be included in the EC/UNFPA Initiative for Reproductive Health in Asia with emphasis on community participation in RH services. A large numbers of grassroots NGOs and community based organisations (CBOs), including mothers groups and youth clubs are actively involved in raising awareness of RH in remote and under-served rural areas and among marginalized urban populations.

Challenges Ahead

Political instability has created a heightened concern on the future course of development. While physical access continues to be a major problem in Nepal due to the mountainous and hilly terrain, access is also affected by inadequate quality of care, supply and distribution problems, lack of awareness, weak outreach, poverty and some socio-cultural practices that are not conducive to effective utilization of services. Hence, the strategy to increase access will have to go beyond questions of mere physical access and will need to cover aspects such as quality of care, advocacy, support and promotion of health-seeking behaviours.

Presently, HIV/AIDS is a concentrated epidemic among sex-workers and injecting drug users. All-out efforts will be required to prevent the epidemic from spreading into the general public. Issues of poverty, labour migration, lack of access to information and RH commodities, gender inequality, human trafficking, lack of effective adolescent and youth programmes, harmful socio-cultural norms and practices will need to be comprehensively tackled with determination to counter this threat.

Pakistan

Pakistan borders Afghanistan on the northwest, Iran on the west, India on the east and China on the northeast. National estimates place the population at 142 million that makes it the seventh most populous country in the world, and fourth in the Asian region. If annual population growth rate continues at the present rate of around 2.5 per cent, Pakistan will become the fourth most populous country in the world by 2050. On the Human Development Index, Pakistan ranks 135 out of 174 countries. It is a Category "A" Country for UNFPA support.

Facts and Issues

Pakistan's economy is heavily dependent upon agriculture, which accounts for a quarter of the GDP and employs over half the population. The population and reproductive health (RH) indicators for Pakistan are not very encouraging. According to national estimates, women continue to bear around 5 children on an average; contraceptive prevalence rate is 27.6 per cent; infant mortality rate is 85 per 1,000 live births and more than one in ten die before their fifth birthday; maternal mortality ratio in the absence of reliable figures has been assumed at 350-400 per 100,000 live births; and about 25 per cent of the births are assisted by skilled birth attendants. Public expenditure on health and family planning (FP) is a mere 0.7 per cent and 0.05 per cent of GNP respectively. Pakistan today has a very young population structure, with 43 per cent below the age of 15 years.

Gender disparities in Pakistan are pervasive: women are less educated than men; their health and nutritional standards are poorer; and their access to employment and income generation activities is limited. Deep rooted cultural biases and institutional constraints restrict Pakistani women from playing an active role in public decision-making.

Almost a third of Pakistan's total population continues to live in absolute poverty. Unemployment and underemployment are widespread. An exponential growth in urban population, increasing at an annual rate of around 4 per cent, is posing serious threats to the surrounding environment leading to high levels of water and air pollution and land degradation and increasingly stressing the already weak social, health, housing and sanitation services in urban areas.

Achievements through Collaboration

UNFPA has been providing assistance to Pakistan since 1970. In the past, UNFPA support has contributed towards enhancing the capacity of the government and non-governmental organizations (NGOs) in delivering quality RH/FP services. Both access and coverage have increased, especially in the rural areas. UNFPA support has focused on increasing the availability of contraceptives, training community health workers and service providers, and improving contraceptive logistics management. This has led to an increased awareness on population issues through focused information, education and communication (IEC) programmes. It has provided support to the Population Education Programme of the Ministry of Education for the development and inclusion of family life education (FLE) materials in the curricula of the formal education sector at the primary level and for the development of training materials for teachers. In addition, UNFPA support has helped in strengthening the technical capability of national institutions in undertaking policy-oriented research, collecting and analysing population data, and conducting the population census.

Under the Fifth Country Programme (1993-1999), FP services were expanded, particularly in rural areas and the number of service outlets was increased. Later during the programme, in projects like Institutionalisation of Reproductive Health Services in Primary Health Care and through advocacy projects, a shift towards the ICPD agenda was made.

The ongoing Sixth Country Programme (CP6), 2000-2003, has adopted a multi-sectoral approach to population issues. The objective is to improve the quality of life of the people of Pakistan by enhancing their RH status by promoting reproductive health and rights, and gender equity and equality. The programme also aims at achieving sustainable development in the context of the government's Ninth Five-Year Plan. The RH subprogramme aims at improving the quality and scope of RH information and services, particularly in the rural areas and among younger couples; enhancing institutional capacity to manage and implement RH programmes; and increasing the involvement of men in RH matters and responsible parenthood. The subprogramme on population and development strategies aims at forming a wide consensus on and support for the National Population Policy. It also aims at improving the research and analysis capacity of the Census Commission to carry out an in-depth analysis of the census and enable it to provide sound advice on policy matters. The advocacy subprogramme seeks to mobilize active support from community and religious leaders, policy makers and the media for promoting RH information and services, girls' education and the elimination of laws and practices that discriminate against women. It also aims at generating a better understanding among legislators, community leaders and policy makers on population, gender and development issues.

Pakistan is one of the countries under the EC/UNFPA Initiative for Reproductive Health (RHI) in Asia with emphasis on community participation in RH. The staff of 91 community-based organizations have been trained by one of the RHI projects in Pakistan as a result of which community attitudes are becoming more receptive to RH issues.

Challenges Ahead

Though population, health and family planning indicators do not give an encouraging picture, there are other signs that hold out promise. Firstly, there is a near universal level of knowledge about FP and the concurrent unmet need is 33 per cent. This, if properly exploited, can bring dividends in a short period. Secondly, in the last decade, a network of paid

UNFPA/ Johnette Stubbs

community level female workers for domiciliary and referral services has been established on ground. There are now 60,000 trained workers, which will increase to 100,000 in the next few years. And finally, the Health and Population sectors, which previously worked separately, have now started functioning in closer collaboration. They have jointly prepared a document titled "National Reproductive Health Package for Health and Population Welfare Service Delivery Outlets".

The two weak areas that pose the biggest challenge are continuity of political will and support, and the management and implementation capacity. Besides, the potential of NGOs and civil society is still to be fully realized. Though presently HIV/AIDS prevalence rates are low, focused preventive programmes will need to be implemented to avert the potential spread of the epidemic.

Sri Lanka

Sri Lanka is an island country in the Indian Ocean off the southeastern coast of India. The government's early commitment to social development and support for a strong family planning programme, combined with pioneering work done by NGOs, have enormously contributed towards the success story of Sri Lanka in reaching its demographic goals. With a current population around 18.6 million, growing at just under 1 per cent, and a total fertility rate approximating 2.0 (DHS Survey 2000), Sri Lanka has achieved replacement level fertility. It is today, a Category "C" country for UNFPA support.

Facts and Issues

Sri Lanka has fared well on most social and demographic indicators: Over 90 per cent of the population is literate (female literacy is almost 90 per cent as well); about 93 per cent have access to free basic health care; life expectancy at birth is around 72 years; infant mortality ratio is 16.5 per 1,000 live births (Registrar General's Department 1995); maternal mortality ratio is 60 per 100,000 live births (Family Health Bureau 2000); contraceptive prevalence rate is as high as 71 per cent (DHS 2000); and the proportion of births assisted by skilled attendants at 96.6 per cent (DHS 2000) is close to being universal. However, traditional methods of contraception, though unreliable, continue to be widely used leading often to large number of unwanted pregnancies and induced abortions which continue to pose a serious problem in Sri Lanka.

UNFPA/Photo

Using innovative ways in creating RH awareness among adolescents on HIV/AIDS. Here a street drama produced by the National Youth Services Council in Sri Lanka is in progress

Sri Lanka's demographic success can be attributed largely to the efforts of a committed government; a strong primary health care infrastructure; high levels of female education; the integration of mother and child health care (MCH) into family planning (FP) programmes; and the fact that, on the whole, these programmes have been designed to meet individual needs.

HIV infection was first reported in Sri Lanka in 1987. It is estimated that around 8,500 adults and children are currently living with HIV/AIDS. Though the rate of infection is small when compared to other countries in the region, urgent action is required to prevent the disease from spreading to wider segments of the population.

Achievements through Collaboration

UNFPA assistance for population activities began in1969. Since then, UNFPA has completed five country cycles of assistance to Sri Lanka, and the sixth country cycle is currently under way.

Up to the Fourth Country Programme (1992-1996), support to Sri Lanka focused mainly on strengthening FP/MCH service delivery through supply of contraceptives; providing health care facilities with equipment and supplies; training public health personnel in FP methods and counselling; supporting population policy and data collection; and providing population and family life education. With Sri Lanka endorsing the 1994 ICPD PoA, in the Fifth Country Programme (1997-2001), the focus shifted from

an MCH/FP approach to a more comprehensive RH approach.

UNFPA assisted the Government of Sri Lanka in formulating a National Population and Reproductive Health Policy and Action Plan in 1998 which has eight goals: Maintaining current declining trends in fertility; Ensuring safe motherhood; Achieving gender equality; Encouraging responsible adolescent and youth behaviour; Providing adequate health care and welfare to the elderly; Migration and urbanization; Increasing public awareness on population and RH issues; Improving population planning.

UNFPA successfully promoted Government/NGO collaboration in the delivery of RH services and information and involved civil society through community based organisations. NGOs involved in FP were provided with assistance in integrating a broad spectrum of RH components into their programmes.

With UNFPA support, Well-Women Clinics were established to screen apparently healthy women aged 35 and above for cervical and breast cancer, diabetes and hypertension. RH awareness was promoted among fresh university entrants, Free Trade Zone workers and people living in under-served geographic areas. In addition, RH education was provided to out-of school youth through youth clubs and vocational training centres all over the Island; RH issues were incorporated into the secondary school curricula; teachers and peer communicators were trained on RH topics; and teacher-counsellors were trained in RH counselling. Adolescents were further reached through a joint EC /UNFPA Reproductive Health Initiative, through which RH information, counselling and services were provided to adolescents and youth. Furthermore, as a result of UNFPA's support, the quality and access to RH services has improved for nearly 800,000 internally displaced persons and communities affected by the ongoing conflict.

UNFPA's advocacy activities have focused on creating a greater understanding of RH issues and support amongst parliamentarians, elected members, community leaders and journalists. In 2001, a census was conducted, despite difficulties in obtaining a full enumeration in some areas in the North and the East due to the prevailing conflict.

Challenges Ahead

Sri Lanka has witnessed an economic growth that has elevated the country from the rank of a low-income country up to the threshold of middle-income countries. Nevertheless, problems of severe youth unemployment, rising cost of living, continuing armed conflict in the northern province, pose a big challenge for the government. Though overall Sri Lanka has performed well with regard to population, RH and women's empowerment, there are still vulnerable and disadvantaged socio-economic groups and under-served geographic areas where the socio-economic indicators are far less favourable than the national averages. These include the districts affected by the ongoing conflict, marginalized rural areas, the plantation sector, adolescents and youth, women working in the Free Trade Zones (FTZ) and urban slum dwellers. Considering the adverse fiscal situation in the country and decline in support from foreign donors, contraceptive security is an area of concern. In addition, high numbers of abortions; increasing number of STDs/RTIs and HIV/AIDS cases; high reliance on traditional methods of FP; rapid population ageing (proportion of those over 60 years is expected to double from present rate of 10% to 20% in 2025); ARH concerns; and low male involvement are other issues that need urgent addressing.

Consequently, the Sixth Cycle of UNFPA's assistance (2002-2006) aims to assist the Government of Sri Lanka in close coordination with NGOs, civil society and other UN agencies in meeting these challenges.

Pacific Island Countries

Scattered over 30 million square kilometres of the vast Pacific Ocean are 22 island countries and territories, comprising some 7,500 islands. Of these, only about 500 are inhabited. The Pacific Islands encompass a wide variety of ethnic, cultural and linguistic groupings broadly divided into three main sub-regions: Melanesia, Micronesia and Polynesia.

Secretariat of the Pacific Community

Facts and Issues

The diversity of the region is reflected in its demographic profile. Current estimates suggest a regional population of around 8 million with a growth rate of approximately 2.1 for the region as a whole. Its distribution ranges from Papua New Guinea's (PNG) estimated 5 million that accounts for 65 per cent of the Pacific region's total population, to Pitcairn's 50 inhabitants. In terms of sheer size, the five Melanesian countries and territories to the west, which account for 98 per cent of the land area and 85 per cent of the total population, dominate the region. Rates of annual population growth also vary widely with high growth rates (above 2 per cent) persisting in the Melanesian sub-region (with the exception of Fiji), and negative growth rates occurring in Niue (-3.1 per cent) and in the Cook Islands (-0.5) due to migration. Population density likewise varies from 558 persons/sq km in Nauru to 7persons/sq km in Niue. Some Pacific countries have experienced rapid urban growth and some capitals (like South Tarawa in Kiribati) are facing serious environmental problems related with overcrowding, inadequate sanitation and urban planning.

In the South Pacific region, UNFPA is supporting programmes in the following countries:

Melanesia
Fiji
Papua New Guinea
Solomon Islands
Vanuatu

Micronesia
Federated States of Micronesia
Kiribati
Marshall Islands
Nauru
Palau

Polynesia
Cook Islands
Niue
Samoa
Tokelau
Tonga
Tuvalu

Note: The total population of programme countries is 7.4 million or 92% of the population of the region. Countries shown in italics are priority "A" countries for UNFPA.

Life expectancy is approaching 70 years in the Polynesian countries and in much of Micronesia. In the less-developed Melanesian countries, only PNG has life expectancy below 60 years. Total fertility rates (TFRs) exceeding 4 and 5 are common in the region, though some countries now have TFRs around 3. As a consequence of high fertility in the past, there are now more youth and adolescents in the Pacific than ever before. Increasing access of this group to RH information and services, education and employment, is essential for accelerated social and economic development. The proportion

of the population aged 60 and above is likely to reach over 7 per cent by 2015, which will have implications for health provision and social security for the elderly.

Because of their small populations, the Pacific Island countries (PICs) are very sensitive to international migration. Most Polynesian countries and Fiji continued to experience net population loss in 2001 due to international migration. High levels of out-migration from the Pacific to Australia, New Zealand and North America seriously erode national capacity to deal with social and economic development concerns. Environmental degradation, changing weather patterns, global warming and rises in sea-level in coming years are likely to result in the emergence of "environmental refugees" to neighbouring countries like New Zealand and Australia. From UNFPA perspective, the continued emigration of trained health staff and trainers themselves undercuts the positive impact of UNFPA assistance that seeks to enhance national capacity building in population and RH.

Since the latter part of the 1990s, many PICs have adopted public sector reforms and made efforts to decentralize their economies. However, most PICs are still recovering from the Asian crisis of 1997-98. Setbacks due to decline in tourism, issues of governance and the negative effects of globalisation on the small, fragile and vulnerable economies of the Pacific have resulted in increased unemployment and poverty, particularly in urban areas, and raised the vulnerability of women. Gender equality and women empowerment remain culturally sensitive issues.

The prevalence of HIV/AIDS varies in the region with PNG being by far the most seriously affected country experiencing a high rate of 0.6 per cent and Fiji only 0.07 per cent. The low prevalence rates in Pacific Island countries are attributed to under-reporting. A *Regional Strategy for the Prevention of AIDS and STD in Pacific Islands and Territories* was developed by the *Secretariat of the Pacific Community* (SPC) and UNFPA also produced a Guide for Pacific Island RH Programme Managers titled *"Integrating Reproductive Health and STD/HIV Prevention Services".* Countries such as Fiji, Tonga and Cook Islands have developed country specific strategies for HIV/AIDS prevention. Though certain cultural and religious barriers hamper a discussion on AIDS and sexual topics, churches and community leaders are increasingly addressing the topic.

Achievements through Collaboration

In 1976, UNFPA established a sub-regional office for the Pacific in Suva, Fiji that is currently providing assistance to 14 countries. A second office for the region is based in Papua New Guinea. Regional interventions include, inter alia, provision of contraceptives and technical assistance; Population and RH Advocacy; an IEC project on RH; a RH Training Programme; RH Surveys; and a pilot project on youth-friendly Adolescent Reproductive Health (ARH) Services. The focus of cooperation is almost entirely on RH, with advocacy and IEC activities being subsumed under this category.

Under the current UNFPA programme of assistance (1998-2002) for an amount of US$10 million, approximately 86 per cent of the funds have been allocated towards ensuring quality RH /FP /sexual health (SH) information and services to PICs. The goal of the programme is to help PICs gain universal access to quality RH/SH; the primary objective being capacity-building to provide quality RH/SH services and to improve understanding of the centrality of population to development. The term MCH/FP has been replaced by the term Reproductive Health to address and focus on the broader RH concept. In Solomon Islands, a RH Division has been established. Special attempts are being made to ensure access to RH services to outer island populations: youth, adolescents and men. Budget for condoms increased from US$24,000 in 2000 to US$73,109 in 2001; significant increases have been recorded in the contraceptive prevalence rate which now stands at 44 to 53 per cent in some countries compared with 25-35 per cent in previous years. Concerted efforts have been made to integrate HIV/AIDS into existing RH projects and activities.

Multi-purpose *'Drop in Centers'* that provide adolescent-friendly RH services have been set up in Vanuatu, Tonga, Solomon Islands, Marshall Islands, Fiji and Samoa. There are increasing number of peer educators

in the Pacific. More than 300 traditional birth attendants have been trained in safe motherhood initiatives in Fiji, Kiribati, Marshall Islands, Samoa, Solomon Islands and Tonga. Midwifery courses have been incorporated into Nursing Schools' curricula in Solomon Islands, Cook Islands, Tonga, Kiribati and Fiji. 47 nationals from nine PICs have graduated with a Certificate in RH from the newly established RH Training Programme at *Fiji School of Medicine* that has been institutionalized into the school's curricula. There is strengthened national capacity to deliver quality RH services in all PICs. All health institutions now have trained personnel in RH.

In the population and development strategies sector, UNFPA has provided technical assistance in population policy reviews, technical support for the review of population and RH indicators and technical support for the development of model census questionnaires for the 2000 round of censuses in the Pacific region.

Partnerships between UNFPA and Regional Institutions, particularly SPC, Fiji School of Medicine and University of the South Pacific, have been strengthened. Additional funds have been secured through partnerships with UNFIP for the regional ARH project; UN Human Security Fund addressing human security in emergency situations; AusAid supporting ARH pilot project phase and use of theatre groups in IEC for RH; and NZODA supporting the *Men as Partners in Reproductive Health* project.

Challenges Ahead

It is becoming increasingly apparent that building national capacity in the Pacific is a much greater challenge than previously acknowledged. The on-going international migration of skilled persons from Polynesian countries and the recent build-up of migration from Fiji following the political unrest of 2000-2001 have contributed to a drain of human resources – including many professionals from areas of health and education. High levels of internal migration from rural and outer islands to urban areas throughout the Pacific are causing overcrowding of urban areas, extreme pressure on public utilities, and declining standards of health and nutrition. Population programmes need to be integrated into development planning. Of the 15 countries (including PNG) receiving UNFPA support, three countries have explicit and implicit Population Policies, eight countries are working on them and the rest have incorporated population in their development and sectoral plans. Technical assistance is required for analysis of data for policy purposes. There is also a need to establish a good health information system and upgrade RH information in all PICs. Besides, results-based approaches to population programmes need to be promoted by strengthening national capacity to conduct research and to establish baseline data. Strengthening project management capacities to efficiently and effectively implement country specific project activities is yet another challenge.

There is a need to mobilize additional resources to achieve the goals of ICPD and meet the benchmarks set by ICPD+5 and the Millennium Development Goals, particularly the need to improve accessibility of quality RH services by people in remote islands; prevention of STIs and HIV/AIDS; population and environment in Kiribati and Tuvalu; gender equality and women's empowerment in the Melanesian countries and achieving universal primary education, particularly in the Solomon Islands.

Papua New Guinea

Papua New Guinea is a tropical island nation with rich bio-diversity and resources situated on the rim of the southwestern Pacific Ocean. It occupies the eastern half of the island of New Guinea, and dense rain forests, rivers and swamps mark its rugged topography. The population of Papua New Guinea according to the 2000 Census had reached 5.1 million and was increasing at an annual average rate of 2.7 per cent. Fertility rates continue to be high, with women having 4 to 5 children. On the Human Development Index (2001), PNG ranks 122nd in the world. It is a Category "A" country for UNFPA assistance.

Facts and Issues

Almost all of Papua New Guinea (PNG) is classified as "Melanesian", even though there is considerable racial and cultural diversity, with over 800 local languages being spoken. The health status of the population is generally poor. Infant and child mortality have remained consistently high with only slight improvements. Low immunization rates; malnutrition; unsafe water; prevalence of infectious diseases like malaria, tuberculosis, pneumonia, measles; restricted access to health care; poor education and health of mothers are all contributing factors. Likewise, maternal mortality ratio averages 370 per 100,000 live births and ranges as high as 625 in the Highlands. Trained personnel supervise only 50 per cent of the deliveries. Too many children, short birth spacing, poverty, illiteracy, and lack of adequate RH services are the major causes of maternal mortality. There is a high unmet need for family planning, with only 20 per cent of eligible couples practicing modern methods of contraception. Life expectancy at birth has shown a moderate improvement over the past two decades, but it still remains the lowest in Pacific Islands region at around 57 years.

PNG has a young population with 41 per cent under the age of 15 years. Youth (15-24 years) comprise 20 per cent of the population. With a large number of HIV positive cases being reported, the country now faces a potential threat of a major HIV/AIDS epidemic. While adult prevalence remains below 1 per cent, the epidemic is spreading rapidly among young, vulnerable women.

Gender inequality and violence against women remain areas of serious concern, even though men and women have equal rights under the constitution and PNG is a signatory to CEDAW. Law and order problems, security concerns, continuing effects of the macro-economic crisis of 1994-95 and the Asian economic crisis, problems of governance, weak legislation and poor enforcement continue to plague PNG. A series of natural disasters (including a Tsunami in 1997, nationwide droughts in mid 1990s and a volcanic eruption in 1994) have added to the miseries of the people.

Collaboration with UNFPA

UNFPA has been contributing to population activities in PNG since 1973. Following the First Country Programme (1992-1997), a new cycle of assistance was approved in 1998 for five years for a total amount of US$ 6.5 million. UNFPA activities in strengthening RH services focus on four provinces: Central and East Sepik, Madang and Manus.

RH/ FP and training of health workers to improve service delivery continue to be the focus areas. In the education sector, UNFPA is providing training to trainers and teachers to incorporate population education into the school curricula. In the area of adolescent reproductive health (ARH), a peer-to-peer counselling centre was established at the University of PNG. Similar activities in this field have involved church groups and parents. UNFPA is assisting local women's NGOs in women empowerment and advocacy activities, such as, political education of potential women candidates contesting local government and national parliament seats and "Tok Stret" radio – a weekly radio programme on RH and population issues, which is broadcast nationwide.

Along with the *Department of National Planning and Monitoring* (DNPM), UNFPA has been strengthening the capacity of national and provincial planners to incorporate population factors in their development plans. The DNPN, with financial support from UNFPA and technical assistance from the International Labour Organization, has revised the National Population Policy. Through the National Statistical Office, UNFPA also provided technical assistance in planning the July 2000 Census and in processing its data.

UNFPA/Photo

The second National Population Policy (2000-2010), prepared with UNFPA assistance, is comprehensive and reflects the ICPD Programme of Action. It highlights PNG's wide demographic and economic disparities and the need for policy implementation at the provincial and district level.

Despite a number of setbacks in the early years, the UNFPA programme has succeeded in creating an enhanced awareness on population issues and the need to encompass the broader RH concept.

Challenges Ahead

Low levels of awareness on population and development issues; a diverse culture and language differences; ineffective government policy implementation; difficult terrain, poor infrastructure and communication facilities; low levels of literacy, particularly among women; poverty; human security problems – all have imposed constraints in improving the quality of life and health of the people of PNG.

Strengthening the management and RH outreach capacity of health workers, and increasing access to quality comprehensive RH services remains one of the biggest challenges for PNG if one has to bring down the high levels of infant and maternal mortality. Training more health workers; increasing awareness and knowledge of contraceptives; incorporating RH content in adult literacy programmes are some of the urgent measures required. With youth comprising a substantial percentage of the population, high priority needs to be accorded to ARH concerns. Considering the rising incidence of STIs/HIV/AIDS, these topics need to be incorporated in school curricula and IEC services on HIV/AIDS, especially targeting the youth, need to be enhanced. There is also a strong need for advocacy for enforcing laws pertaining to gender based violence; mainstreaming gender issues through government policies and plans; publicizing the rights of women; and providing support to victims of violence.

Recent governments have undertaken a series of initiatives aimed at improving the quality of governance and accelerating the pace of economic growth and human development. A range of public sector reforms is in the process of being implemented. In addition to help from international organizations, the role of civil society in meeting these challenges cannot be underscored enough.

Regional Programme

The Regional Programme for the Asia and the Pacific region covers the three core programme areas of UNFPA, namely, reproductive health, including family planning and sexual health; population and development strategies; and advocacy. The focus is on projects of regional dimension with the objective of sharing knowledge, experience and expertise in an effort towards enhancing South-South cooperation in helping countries of the region in operationalizing the RH approach at the country level; organizing advocacy activities on population and development, RH and gender issues; developing appropriate ARH strategies; creating prototype training packages for healthcare personnel and programme managers; and developing innovative RH and IEC strategies and tools. Towards this end, UNFPA provides technical and advisory backstopping services; organizes intra-regional meetings and workshops; conducts training and research; and disseminates population information using emerging information technologies, in collaboration with other United Nations agencies and national and international NGOs. Based on the lessons learnt from the previous regional programmes, the current programme pays particular attention to the needs of the countries and seeks greater involvement of programme countries and other development partners in ensuring outputs of higher utility and value.

Regional projects are executed by NGOs such as the *Asian Forum of Parliamentarians on Population and Development* (AFPPD), *Asian Population and Development Association* (APDA), *Asian Urban Information Centre of Kobe* (AUICK), *International Council on Management of Population Programmes* (ICOMP), *International Union for the Scientific Study of Population* (IUSSP), *Japanese Organization for International Cooperation on Family Planning* (JOICFP), and *Nihon University Population Research Institute* (NUPRI).

Our Strength: A Network of Partnerships

UNFPA programmes would not have been such a success without the tremendous support extended by some of our main partner United Nations agencies and non-governmental organizations (NGOs). The UN agencies include: Economic and Social Commission for Asia and the Pacific (ESCAP), United Nations Children's Fund (UNICEF), United Nations Educational, Scientific and Cultural Organization (UNESCO), International Labour Organization (ILO), Food and Agriculture Organization (FAO), the World Health Organization (WHO) and the office of the United Nations High Commissioner for Refugees (UNHCR).

In Asia and the Pacific, projects have been executed by several NGOs, which include among many others: Asian Forum of Parliamentarians on Population and Development (AFPPD), The Asian Population and Development Association (APDA), Japanese Organization for International Cooperation in Family Planning (JOICFP), Nihon University Population Research Institute (NUPRI), International Union for the Scientific Study of Population (IUSSP), Mailman School of Public Health (MSPH), International Council on Management of Population Programmes (ICOMP), Asian Urban Information Centre of Kobe (AUICK), Population Council, International Planned Parenthood Federation (IPPF), Margaret Sanger Centre (MSC), Asia and Oceania Federation of Obstetrics and Gynaecology (AOFOG), The Centre for Development and Population Activities (CEDPA), Asian Institute for Development Communication (AIDCOM), Women's Institute of Management (WIM), Centre on Integrated Rural Development for Asia and the Pacific (CIRDAP), Family Care International (FCI), Asia-Pacific Resource and Research Centre for Women (ARROW), International Federation of Red Cross and Red Crescent Societies, Marie Stopes International.

UNFPA will continue to build and expand on its cooperation with the non-governmental sector, particularly national NGOs operating at the grassroots level.

In December 1998, UNFPA conducted an important study in partnership with *Australian National University* on "Challenges to the Implementation of the ICPD Programme of Action" that were being posed as a result of the Southeast Asian economic crisis and their impact on population and development, RH and resource mobilization. Several other notable workshops were organized by UNFPA and CSTs between 1999 and 2001 that included, inter alia, inter-country workshops on *HIV/AIDS, Adolescent Reproductive Health in East Asia and Southeast Asia and Pacific Island Countries,* and a workshop on parliamentary advocacy for

the *Elimination of Violence Against Women.* These were organized in collaboration with AFPPD, AusAID, UNAIDS, UNESCO and the *Japan Trust Fund for Parliamentarians.*

The Economic and Social Council of Asia and the Pacific (ESCAP) and *United Nations Scientific and Cultural Organization* (UNESCO) are collaborating in executing a regional project "Compilation, Packaging and Regular Dissemination of Population Information for Advocacy Purposes," with ESCAP focussing on population and development and UNESCO on adolescent reproductive and sexual health (ARSH) and population education.

JOICFP, under its "Sexual and Reproductive Health of Adolescent" project, undertook research on ARSH behaviour, organized inter-country training on ARSH and conducted pilot testing of ARSH models in three developing countries of the region: Malaysia, Nepal and Sri Lanka. JOICFP's "Community-Based Reproductive Health/Family Planning Programme" pursued the goal of strengthening and institutionalising effective and operational strategies for IEC and advocacy; and at the country level, it reviewed, compiled and developed model IEC/advocacy strategies and tools for RH and FP.

The project "Advocacy Activities Among Asian Parliamentarians" executed by AFPPD seeks to promote the involvement of Asian parliamentarians in advocating the importance of population issues. Activities under the programme include national and regional seminars and study visits of parliamentarians on issues related with population and development in the region.

In June 2002, UNFPA collaborated with IUSSP in organizing a regional population conference to analyse the implications of changing demographic dynamics and macro-economic environment in the Southeast Asian context.

APDA is presently executing two projects in the Asia and Pacific region. The project, "Support to the Asian Population and Development Association," aims to deepen the understanding of both Japanese and other Asian parliamentarians on the correlation between domestic and global population issues and sustainable development. Seminars on population and development are also organized biannually for parliamentarians. Under the project "Awareness Creation for Policy Makers on Population Issues," APDA organizes the Asian Parliamentarians' Meeting on Population on a yearly basis in close cooperation with AFPPD. The topic of the 2002 Meeting is: Population and Environment.

Under the present Regional Programme, ICOMP is executing one project, "Strengthening NGO Capacity to Achieve ICPD+5 Benchmarks in Reproductive Health in India, Pakistan and Lao PDR", for which it has identified a partner NGO in each of the three selected countries for implementing a locally appropriate package of interventions, utilizing a participatory and community-based approach.

The Asia and Pacific Division and the Technical Support Division in collaboration with NUPRI organized a regional "Workshop on Health Expectancy" in 2002. The long-term objective was to encourage the collection of longitudinal data within the developing nations to facilitate better monitoring of each nation's health and improving the quality of life, and building a core set of researchers from a range of developing countries who will be equipped with up-to-date aspects of health expectancy using cross-sectional and longitudinal data.

Under a project being executed by AUICK, a Japanese NGO, training courses necessary for the development of policies and addressing population issues in urban settings have been organized.

In all regional projects, efforts are made to develop locally appropriate, integrated RH and ARH models that take into account gender concerns to ensure sustainability; enhance national institutional capacity; and build political will and community support for the implementation of the ICPD goals and key actions.

The EC/UNFPA Initiative for Reproductive Health (RHI) in Asia

Demonstrating mutual commitment to the goals and principles of the ICPD PoA, the European Commission (EC) and UNFPA launched the largest joint EC/UNFPA Initiative for Reproductive Health in Asia on 30 January 1997. What makes the Initiative distinct from other projects and programmes is its main strategy to bring the expertise and resources of international, regional and local civil society organisations and NGOs together, working towards the common goal of bringing quality sexual and reproductive health (SRH) information and services within the reach of the most vulnerable, deprived and under-served populations in seven South and Southeast Asian countries: Bangladesh, Cambodia, Lao PDR, Nepal, Pakistan, Sri Lanka and Viet Nam.

The total duration of the RHI is 4 years, with one year for preparatory activities. UNFPA is responsible for the overall management and implementation of RHI; NGOs and other non-profit organisations and foundations, local and European, are involved as operational partners, with local NGOs acting as the Implementing Agencies (IAs) at the country level and the European NGOs acting as the Executing Agencies (EAs). The EC plays a monitoring role, both at the central and country level. In order to meet the specific needs of the seven individual countries, National Advisory Groups have been formed which review and monitor project activities and provide policy guidance.

Special strategies have been formulated for all participating countries, with a varying focus:
- Community participation in full RH services: Nepal and Pakistan;
- Adolescent Reproductive Health: Cambodia, Lao PDR, Sri Lanka and Viet Nam;
- Improved quality of RH care: Bangladesh.

As a result, 42 projects are now operational, including 3 regional dimension projects (RDPs), supporting cross-cutting issues, such as gender, South-South cooperation, capacity building, monitoring and research. In order to strengthen coherence within the countries, Umbrella Projects (UPs) were added in six of the RHI countries (except Sri Lanka) to foster linkages and co-operation between operational partners within the country.

To date, the EC has committed a total of 29.9 million Euros for the RHI and 5 million Euros is to be contributed on a 50/50 basis by UNFPA and the participating NGOs.

Impressive Progress

The Annual Review Meeting (ARM) held in April 2001, showed that impressive progress had been achieved in all 7 RHI countries. The different projects are leading to the establishment of exchange mechanisms between several organisations, facilitating a synergy of actions leading to a multiplier effect on sustainable RH initiatives. Impressive programme successes have been registered with more local NGOs trained in RH/ARH and actively involved in RHI.

In Bangladesh, standard RH service protocols and guidelines for clinical services developed by the Government of Bangladesh in collaboration with NGOs have resulted in improved quality of care, better management of service delivery procedures, more sensitive staff behaviour towards clients, better cleanliness and a substantial increase in client attendance at clinics. The RHI project hospitals have expanded their RH/FP facilities for the under-served sections of the population which increased from 23,861 in 2000 to 35,527 in 2001.

In Lao PDR, Cambodia, Viet Nam and Sri Lanka, where the issue of adolescent SRH is new and the RH needs of adolescents are not recognised in the existing national RH programmes, there is evidence

suggesting that adolescents are increasingly engaging in unprotected pre-marital sex, resulting in unwanted pregnancies with high incidence of abortions and an increase in STD/HIV prevalence. Highly innovative, youth-friendly and sensitive approaches in handling adolescent sexuality have met with huge successes in all the four countries. Youth centres in Viet Nam, Cambodia and Lao PDR offer entertainment activities which helps reduce the clients' shyness when coming for RH services. Instead, young people can "drop-in" to the bookshop and "on-the-way" seek counselling and RH services. In Cambodia, for example, karaoke facilities and libraries make the centres an attractive place for young people to meet. The RHI project clinics in Viet Nam have an anonymous registering system to ensure client privacy. The youth centre in Vientiane in Lao PDR has more than 200 regular centre users attending activities, such as musical performances, language lessons, break dancing and sport activities. In addition, these centres operate at suitable timings and at locations where the youth can access them. In Cambodia, Viet Nam and Lao PDR trained peer educators and counsellors have proved very effective in addressing ARH concerns especially family problems, early sexual relationships, drug abuse and trafficking of women and children. All these activities, complimented by IEC campaigns and mass media involvement, have helped in raising the ARH profile within the national RH programme in these countries. In Sri Lanka, where the concept of adolescent counselling was new, the help of gatekeepers like parents, relatives, community leaders has been successfully sought in addressing the sensitive issue of adolescent sexuality.

In Nepal and Pakistan, the RHI country programmes have involved large numbers of grassroot NGOs and community based organisations (CBOs), including mothers groups and youth clubs, in raising awareness of RH in remote and under-served rural areas and among marginalised urban populations. Considerable efforts have been made in establishing community ownership in various RHI projects in order to reach a minimum level of sustainability beyond RHI funding. In Nepal, the effective linkages and networking between RHI partners, NGOs and government bodies have resulted in sharing of resources and increased efficiency in project implementation. Ninety-one CBOs trained by one of the RHI projects in Pakistan have succeeded in making community attitudes more receptive to RH issues.

UNFPA/Photo

Mothers' groups meet monthly to discuss Reproductive Health issues at one of the RHI projects in Nepal.

The RDPs too have greatly contributed towards strengthening partnerships among local and European NGOs. A wealth of information and useful insights on RH was generated and feedback on RHI project performances obtained through the Monitoring and Evaluation (M&E) data collection exercises. In 2001, a prototype Gender Training Manual completed and adapted to local contexts has become a useful instrument in effectively addressing gender issues. The ComNet project has contributed towards strengthening the information and communication skills of RHI partners, fostering South-South and North-South exchange and promoting the visibility of the Initiative. In addition, a RHI database for IEC materials has been created with the help of the ComNet project. Asian and European NGOs continue to share technical and practical experience, contributing towards the strengthening of national capacities in the field of RH. Encouraged by the achievements of all RHI projects and country programmes, EC has announced its readiness in funding a second phase of the RHI.

UNFPA/Photo

List of Selected Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ARH	Adolescent Reproductive Health
ARSH	Adolescent Reproductive and Sexual Health
AusAid	Australian Aid
BCC	Behavioural Change Communication
CBO	Community-based Organization
CCA	Common Country Assessment
CEDAW	Convention on the Elimination of Discrimination Against Women
CP	Country Programme
CPR	Contraceptive Prevalence Rate
CST	Country Technical Services Team
DANIDA	The Danish Agency for Development Assistance
DHS	Demographic Health Survey
EC	European Commission
EOC	Emergency Obstetric Care
ESCAP	Economic and Social Council for Asia and the Pacific
FP	Family Planning
FSW	Female Sex Worker
GBV	Gender Based Violence
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IDP	Internally Displaced Person
IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
IUD	Intrauterine Device
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
NGO	Non-Governmental Organization
NZODA	New Zealand Official Development Association
OECD	Organization for Economic Cooperation and Development
PDS	Population and Development Strategies
PoA	Programme of Action
RH	Reproductive Health
RTI	Reproductive Tract Infection
SRH	Sexual and Reproductive Health
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFIP	United Nations Fund for International Partnerships
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
USAID	United States Agency for International Development
VAW	Violence against Women
WHO	World Health Organization

Asia and the Pacific Expenditures 1971-2001

Countries	Expenditure (in US$)* 1971-2001
Afghanistan	10,967,683
Bangladesh	109,788,355
Bhutan	11,005,988
Cambodia	24,560,896
China	174,333,615
Cook Islands	1,316,226
Democratic People's Republic of Korea	12,434,467
East Timor	638,864
Federated States of Micronesia	2,321,269
Fiji	7,550,318
India	273,957,476
Indonesia	89,266,427
Iran (Islamic Republic of)	22,619,440
Kiribati	1,705,860
Lao People's Democratic Republic	11,573,007
Malaysia	16,054,051
Maldives	5,662,016
Marshall Islands	2,411,013
Mongolia	17,612,293
Myanmar	9,726,116
Nepal	61,639,446
Niue	60,833
Pacific Multi-Islands	6,429,588
Pakistan	70,756,817
Papua New Guinea	11,038,282
Philippines	72,284,489
Republic of Korea	14,197,965
Samoa	3,425,653
Solomon Islands	2,981,776
Sri Lanka	29,425,269
Thailand	37,289,487
Tokelau	135,272
Tonga	2,570,939
Tuvalu	779,162
Vanuatu	3,080,029
Viet Nam	102,885,961
Regional Programme	131,581,478
Total	**1,356,067,826**

***** The figures show total UNFPA expenditure between 1971 and 2001 from regular resources

Population Indicators

ASIA AND THE PACIFIC	Population (in millions) 2001	2050	Average growth rate (%) 2000-2005	Birth rate per 1,000 2000-2005	Death rate per 1,000 2000-2005	Life expectency M/F 2000-2005	Infant mortality per 1,000 2000-2005	Maternal mortality ratio /100,000 1995	Per cent urban 2000	Urban growth rate (%) 2000-2005	Total fertility rate 2000-2005
East and Southeast Asia											
Cambodia	13.4	29.9	2.4	34.9	10.6	53.6 / 58.6	72.5	590	15.9	4.2	4.77
China	1285.0	1462.1	0.7	14.3	7.0	69.1 / 73.5	36.5	60	32.1	2.3	1.80
Democratic People's Republic of Korea	22.4	28.0	0.7	16.7	9.9	62.5 / 68.0	39.1	35	60.2	1.6	2.07
East Timor	0.8	1.4	3.9	25.4	13.2	49.2 / 50.9	120.9	850	7.5	2.2	3.85
Indonesia	214.8	311.3	1.2	20.0	7.1	65.3 / 69.3	39.5	470	40.9	3.6	2.27
Lao People's Democratic Republic	5.4	11.4	2.3	35.7	12.6	53.3 / 55.8	88.0	650	23.5	4.9	4.80
Malaysia	22.6	37.8	1.7	22.3	4.7	70.6 / 75.5	10.3	39	57.4	2.8	2.90
Maldives	0.3	0.9	3.0	36.0	6.0	68.3 / 67.0	37.3	390	26.1	3.5	5.37
Mongolia	2.6	4.1	1.1	21.6	7.2	61.9 / 65.9	58.2	65	63.5	2.3	2.32
Myanmar	48.4	68.5	1.2	23.2	11.6	53.8 / 58.8	87.2	170	27.7	2.9	2.80
Philippines	77.1	128.4	1.9	26.0	5.2	68.0 / 72.0	29.0	240	58.6	3.1	3.24
Republic of Korea	47.1	51.6	0.7	12.8	5.9	71.8 / 79.1	7.1	20	81.9	1.4	1.51
Thailand	63.6	82.5	1.1	17.8	6.2	67.9 / 73.8	20.8	44	21.6	2.7	2.00
Viet Nam	79.2	123.8	1.3	19.7	6.4	66.9 / 71.6	33.6	95	19.7	2.2	2.25
South and West Asia											
Afghanistan	22.5	72.3	3.7	47.3	21.4	43.0 / 43.5	161.3	820	21.9	6.9	6.80
Bangladesh	140.4	265.4	2.1	29.9	8.7	60.6 / 60.8	67.0	600	24.5	4.0	3.56
Bhutan	2.1	5.6	2.6	34.8	8.6	62.0 / 64.5	53.6	500	71.0	6.0	5.10
India	1025.1	1572.1	1.5	23.8	8.4	63.6 / 64.9	64.7	440	28.4	2.8	2.97
Iran, Islamic Republic of	71.4	121.4	1.4	22.1	5.0	68.8 / 70.8	35.9	130	61.6	1.8	2.76
Nepal	23.6	52.4	2.3	34.0	9.9	60.1 / 59.6	70.9	830	11.9	5.1	4.48
Pakistan	145.0	344.2	2.5	36.3	9.7	61.2 / 60.9	86.5	200	37.0	4.1	5.08
Sri Lanka	19.1	23.1	0.9	17.3	6.3	69.9 / 75.9	20.1	60	23.6	2.8	2.09
Pacific Island Countries											
Melanasia	6.6	14.2	2.2	31.0	8.4	59.5 / 61.9	52.0	310	23.7	3.7	4.14
Micronesia	0.5	1.1	2.3	28.9	5.1	71.0 / 75.5	18.8	--	45.1	3.4	4.11
Polynesia	0.6	1.0	1.2	23.4	5.1	69.2 / 74.8	16.9	33	40.3	2.3	3.01

Social Indicators

ASIA AND THE PACIFIC	Contraceptive Prevalence Rate (%) All Methods 2001	Modern Methods 2001	% illiterate (>15 years) M/F 2000	Primary enrolment (gross) M/F 1999	Secondary enrolment (gross) M/F 1999	Births skilled attendants (%) 2001	Access to safe water (%) 2001	GNP per capita (US$) 2000	Population/ha. arable & perm. crop land 1999	HIVPrevalence Rate (%) M/F (15-24) 2000	(15-24) 2000
East and Southeast Asia											
Cambodia	13	7	20 / 41	123 / 104	31 / 17	33	30	260	2.0	2.36 / 3.51	4.04
China	83	83	8 / 23	122 / 123	74 / 66	67	75	840	6.3	0.12 / 0.02	0.07
Democratic People's Republic of Korea	62	53	--/--	--/--	--/--	--	100	--	3.7	--/--	<0.01
East Timor	--	--	--/--	--/--	--/--	--	--	--	8.8	--/--	--
Indonesia	57	55	8 / 17	115 / 110	55 / 48	56	76	570	3.0	0.03 / 0.03	0.05
Lao People's Democratic Republic	19	15	35 / 65	123 / 101	34 / 23	14	90	290	4.7	0.04 / 0.05	0.05
Malaysia	55	30	8 / 16	101 / 101	59 / 69	96	--	3,380	0.5	0.57 / 0.09	0.42
Maldives	--	--	4 / 4	130 / 127	67 / 71	90	--	1,960	26.3	--/--	0.05
Mongolia	61	25	--/--	86 / 91	48 / 65	93	60	390	0.5	--/--	0.00
Myanmar	33	28	11 / 19	122 / 117	29 / 30	56	68	--	3.1	1.04 / 1.72	1.99
Philippines	46	28	4 / 5	115 / 113	77 / 78	56	87	1,040	3.0	0.03 / 0.06	0.07
Republic of Korea	81	67	1 / 3	94 / 95	102 / 102	98	92	8,910	2.4	0.02 / 0.00	0.01
Thailand	72	70	3 / 6	98 / 96	38 / 37	--	80	2,000	1.5	1.18 / 2.32	2.15
Viet Nam	75	56	4 / 8	115 / 111	48 / 46	77	56	390	7.3	0.27 / 0.09	0.24
South and West Asia											
Afghanistan	2	2	47 / 77	64 / 32	32 / 12	--	13	--	1.8	--/--	<0.01
Bangladesh	54	43	47 / 69	77 / 66	25 / 13	13	97	370	8.6	0.01 / 0.01	0.02
Bhutan	19	19	--/--	--/--	--/--	15	62	590	11.8	--/--	<0.01
India	48	43	31 / 54	109 / 90	59 / 39	43	88	450	3.2	0.36 / 0.61	0.70
Iran, Islamic Republic of	73	56	16 / 29	102 / 95	81 / 73	86	95	1,680	1.0	--/--	<0.01
Nepal	29	26	40 / 75	129 / 96	51 / 33	9	81	240	7.2	0.14 / 0.20	0.29
Pakistan	24	17	39 / 68	87 / 42	33 / 17	18	88	440	3.5	0.06 / 0.04	0.10
Sri Lanka	66	44	5 / 11	110 / 108	72 / 78	94	83	850	4.6	0.04 / 0.05	0.07
Pacific Island Countries											
Melanasia	--	--	--/--	--/--	--/--	--	--	--	--	--/--	--
Micronesia	--	--	--/--	--/--	--/--	--	--	--	--	--/--	--
Polynesia	--	--	--/--	--/--	--/--	--	--	--	--	--/--	--

Sources:
% illiterate: United Nations Educational, Scientific, and Cultural Organization (UNESCO)
HIV prevalence rates: UNAIDS
Primary/Secondary Enrolment ratios: United Nations Educational, Scientific, and Cultural Organization (UNESCO)
Agricultural population per ha of arable and perm. crop land: Food and Agriculture Organization (FAO)
Maternal mortality ratio: consensus estimates of WHO/UNICEF/UNFPA
Births with skilled attendants: World Health Organization (WHO)
Access to safe water: United Nations Children Fund (UNICEF)
GNP per capita: World Bank Development Indicators
All other statistics are provided by the United Nations Population Division

UNFPA/Johnnette Stubbs

UNFPA adopts innovative measures in spreading awareness on HIV/AIDS. Muslim teenagers discuss problems and solutions relating to HIV/AIDS at a school in Pattani Province in Thailand.

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