ICPD AT 15: PRIORITY CHALLENGES FOR ASIA AND THE PACIFIC

A Regional Review of ICPD Implementation





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International Council on the Management of Population Programmes (ICOMP)
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SECTION 1. INTRODUCTION

A. ICPD Programme of Action

Background to ICPD

The International Conference on Population and Development (ICPD), held at Cairo in 1994, adopted a comprehensive, and in many ways path breaking, Programme of Action (POA) that has led to the reorientation of population policies and programmes worldwide. The experience gained in implementation of the Plans of Action adopted at earlier global population conferences, particularly those held in Bucharest in 1974 and in Mexico City in 1984, the Declaration and the Plan of Action of the World Summit for Children, 1990, Agenda 21 adopted at the United Nations Conference on Environment and Development held at Rio de Janierio in 1992 and the Vienna Declaration and POA adopted by the 1993 World Conference on Human Rights shaped the ICPD POA (United Nations, 1994) in its emphasis on sustainable development, child health and child survival, reproductive health and gender equality as central to achieving development goals. The POA called for a rights-based approach to the formulation and implementation of population policies and programmes that were responsive to individual needs and aspirations.

Subsequent world conferences of the 1990's, namely the Fourth World Conference on Women held in Beijing in 1995 and the World Summit for Social Development in Copenhagen in 1995, were influenced by ICPD and the principles that govern the POA. ICPD also laid the foundation for the adoption of the Millennium Declaration in 2000 by Heads of States and Governments of 189 countries and its eight related goals, known as the Millennium Development Goals (MDGs).

The 20 year POA adopted at ICPD (referred to as the ICPD POA or the Cairo Agenda) is very comprehensive and includes a number of objectives, actions and goals, as appropriate, relating to a broad set of issues of population and sustainable development. The POA places emphasis on national actions, international cooperation and partnership with NGOs and the private sector in implementing the POA. It calls for periodic review of progress by national governments and international organizations in the implementation of the POA.

ICPD+5, ICPD+10 and ICPD at 15

In response to the above call periodic reviews of the implementation of ICPD POA have been conducted at the national, regional and global levels. At the regional level, for Asia and the Pacific, the Economic and Social Commission for Asia and the Pacific (ESCAP) in cooperation with the United Nations Population Fund (UNFPA) undertook a review of implementation of ICPD POA and the Bali Declaration on Population and Sustainable Development during 24-27 March 1998 in Bangkok.

The review identified important issues and challenges and recommended a number of "Key Future Actions" (United Nations, APSS No.153, 1998) for improving the policy and institutional

framework, programme implementation, national capacity building and for resource mobilization. These formed important inputs for the global review of ICPD implementation that took place at a Special Session of the United Nations General Assembly in New York during 30 June -2 July, 1999. "Key Actions for further implementation of ICPD POA" (United Nations, 1999) adopted at the end of this meeting, while reaffirming ICPD POA, added a number of additional objectives and goals and made refinements to a number of others. Together, these goals and objectives contributed to the development of MDGs in 2000.

The Fifth Asian and Pacific Population Conference (APPC), organized by ESCAP and UNFPA, and held in Bangkok during 11-17 December 2002 reviewed progress in the Asia Pacific region in implementing the recommendations contained in ICPD POA and in the Key Actions adopted at ICPD+5. After intense debate the Conference reaffirmed the ICPD POA and adopted the Asia-Pacific Plan of Action on Population and Poverty and agreed on a set of recommendations (United Nations: 2003). The Conference deliberations highlighted the increasing importance of ageing and international migration in the context of efforts to alleviate poverty in the region.

To mark the 10th anniversary of ICPD a number of countries undertook national reviews of the implementation of ICPD POA during 2004. Moreover, based on the field inquiry administered by UNFPA and the country reports and background papers submitted to Fifth APPC, ESCAP, jointly with UNFPA, prepared a status report on the implementation of ICPD POA in Asia and the Pacific (United Nations, 2004). Also, utilizing the field inquiry and other documents a separate and more detailed report covering the unique challenges faced by Pacific Island Countries was prepared by the UNFPA Office for the Pacific (UNFPA Office for the Pacific, 2004).

ESCAP, with support from UNFPA, most recently convened an Expert Group Meeting during 3-5 February, 2009 in Bangkok to take stock of progress in achieving ICPD objectives and goals as we approach the fifteen year mark. (United Nations, 2009b) A regional review meeting also took place in Bangkok during 16-17 September 2009 to mark ICPD at 15 and to identify priorities for the coming five year period.

Partners in Population and Development (PPD), an intergovernmental alliance of 24 developing countries, six of which are from Asia, convened an International Forum in Kampala (Uganda), where the first preparatory meeting for ICPD was held, during 24-25 November 2008 to commemorate the fifteenth anniversary of ICPD and to take stock of progress and prospects in achieving its goals. (PPD, 2009).

There have also been many other reviews organized by NGOs and other development partners to advance the implementation of ICPD POA and to realize its goals and objectives.

Key Objectives and Goals: ICPD and ICPD+5

The ICPD POA recommended a number of interdependent objectives and goals to be realized by 2015 and called upon countries and development partners to take specific actions to attain them. Broadly stated, the goals and objectives include universal access to comprehensive reproductive health services, including family planning and sexual health; reduction in infant, child and maternal mortality; universal access to basic education, especially for girls; and gender equality, equity and empowerment of women.

The five year review conducted in 1999, reaffirmed the goals and objectives of ICPD, and based on the experience gained during the five

year period added additional goals in the Key Actions for further implementation of ICPD POA adopted at the end of the meeting.

Taken together, the ICPD POA and Key Actions adopted at ICPD+5 called upon countries to achieve the following goals: (rephrased and condensed: see UNFPA, 2002)

- Universal access to reproductive health care, including family planning and sexual health by 2015; (ICPD POA para 7.6)
- Halving the 1990 illiteracy rate for women and girls by 2005; (ICPD+5 para 35c)
- Enrolling 90 percent of boys and girls in primary schools by 2010 and ensuring universal access to primary education by 2015; (ICPD POA para 11.6 and ICPD+5 para 34)
- Reducing infant mortality to below 35 deaths per 1000 live births and under-5 mortality to below 45 per 1000 by 2015; (ICPD POA para 8.16)
- Reducing maternal mortality rates to half the 1990 levels by the year 2000, and by half again by 2015; (ICPD POA para 8.21)
- Increasing life expectancy at birth to 75 or more by 2015; those countries with the highest levels of mortality should aim to attain at least 70 by 2015; (ICPD POA para 8.5)
- Reducing the unmet need for contraception by half by 2005 and eliminating it altogether by 2015; (ICPD+5 para58)
- Ensuring that 60 percent 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 percent do so by 2010; (ICPD+5 para 53)
- Ensuring that 90 percent of all births are assisted by skilled attendants by 2015; (ICPD+5 para 64) and
- Reducing HIV infection in youth by one quarter by 2010; guaranteeing that 95 percent of 15-24 year olds have access to information and services by 2010 to help them avoid HIV infection-including condoms, voluntary testing, counseling and follow-up. (ICPD+5 para 70) In addition, it calls upon countries to:
- Raise the quality of life through population and development policies and programmes aimed at achieving poverty reduction, sustained economic growth in the context of sustainable development;(ICPD POA para 3.16) and
- Integrate population issues into formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development; (ICPD POA para 3.5)

The ICPD POA urges countries to adopt a rights based approach in the provision of reproductive health, including family planning services, that meet the needs of individuals and couples (Principle 8). In this regard, the POA calls on countries to make accessible through the primary health-care system, reproductive health to all individuals by 2015. (para 7.6)

ICPD and Millennium Development Goals

The MDGs are derived from the Millennium Declaration, a Resolution of the United Nations General Assembly passed on September 8 2000. The Millennium Declaration was a reiteration and reinforcement of the values and principles of the United Nations and a call to intensify international efforts to eradicate extreme poverty and promote sustainable social and

economic development. The eight MDGs and their statistical indicators and targets were formally approved by the UN General Assembly in September 2001 and over the subsequent eight years the MDGs have provided a universal framework for addressing poverty and underdevelopment at the national level. Many developing countries in the Asia-Pacific region have adopted the MDGs as their own development goals and almost all countries have prepared at least one MDG Report describing their current level of achievement and their prospects for achieving the goals by the target date of 2015.

Although the MDGs did not originally contain an explicit reference to population or reproductive health as such, it was apparent at the outset that there was a close relationship between the MDGs and the ICPD POA. On the one hand, some of the MDG targets for maternal health, child health, and gender equality reflected similar, or identical, aims contained in the ICPD POA. On the other hand, the ICPD POA provides a wide range of recommended actions that governments could take to achieve the MDGs while also implementing the POA. In 2005 the overlap between the MDGs and the ICPD POA was further increased by the incorporation of "universal access to reproductive health by 2015" as a target under MDG5: improve maternal health. Three of the four indicators to be used to measure progress toward this goal were derived from the ICPD POA. There is a widely-held consensus that efforts to achieve the ICPD POA will contribute to the achievement of the MDGs, either because the goals or targets overlap or because the strategies outlined in the POA provide an effective means to achieve those MDGs focused on poverty, health, gender and sustainable development.

B. The Asian and Pacific Context

Population Dynamics

The population of Asia (excluding North and Central Asia, but including the developed countries), estimated at 3.9 billion in 2009, is projected to increase to 4.5 billion by 2025, representing an average increase of 37 million annually. The populations of the three sub-regions East and North-East Asia, South-East Asia and South and South-West Asia total approximately 1.6, 0.6 and 1.7 billion respectively. The region as a whole has recorded a significant decline in the rate of growth of population since 1990 from around 1.8 percent in 1990 to 1.0 percent in 2009. The decline is reflected in all the sub-regions and all countries, with the possible exceptions of Afghanistan (due to lower mortality) and Singapore (due to immigration). For example, the rates declined from 1.3 to 0.5 in the East and North-East, from 2.0 to 1.2 in the South-East, and from 2.3to 1.5 in the South and South-West. (UN ESCAP, 2009)

Countries in Asia are continuing their transition to a low-fertility/low mortality scenario. While the region's developed countries have reached the final stage of this transition, most developing countries are at the intermediate stage except Afghanistan and Timor-Leste which still remain at the early stage and are characterized by high fertility and high mortality.

The decline in the rate of population growth, contributed mainly by the developing countries of the region, is mainly due to declines in fertility even as mortality declined, albeit at a slower pace. For example, the Total Fertility Rate (TFR) declined from 4.6 in 1990 to 2.8 in 2009 in South and South-West Asia; from 3.5 to 2.2 in South-East Asia and from 2.3 to 1.7 in North and North-East Asia while expectation of life at birth increased from 58 to 65; 62 to 71; and 71 to 74 respectively in the three sub-regions. While TFRs vary among the countries (see Table 1) it

is below three in most countries and the declining trend is likely to continue, even in countries where it remain high.

Table 1 also shows the variations in mortality, as reflected by the expectation of life at birth, that exist among the countries of Asia. While China, Indonesia, Iran, Malaysia, Philippines, Sri Lanka, Thailand, and Viet Nam are likely to achieve 75 years of life expectancy by 2015, many other countries will attain only the target of 70 years by 2015. However, for large segments of some populations, particularly in South-Asia, attaining the goal of 70 years by 2015 will prove difficult.

As a result of declines in mortality and fertility, particularly the latter, the age structure of Asian populations has also undergone change with the proportion of population below age 15 declining from around 26 in 1990 to 20 in 2000 in North and North-East Asia, and from 37 to 28 and 39 to 32 in South-East Asia and South and South-West Asia respectively. The proportion of population above age 65 has increased significantly (from 6 to 14 during 1990-2009) in East and North-East Asia and from 4 to 8 and 9 in the other two sub-regions. These changes manifest themselves in an increase in the working age population and declining dependency ratios, particularly in the countries of South-East Asia and South and South-West Asia which is conducive to increased savings, investment and economic growth.

Although the sea area of the Pacific Islands is immense, the total population of the sub-region is small by Asian standards with about 9.7 million people in 2009. As in Asia, the rate of population growth has been declining steadily since the 1990s but from a higher level. The population growth rate in the Pacific as a whole is currently 1.9 percent per year. This is a 10 percent decline over the past five years but still almost double the current growth rate of the Asian region. The high overall growth rate of the Pacific sub-region is a function of the fact that the countries with high growth are also those with the largest populations. The high growth countries are concentrated in Melanesia, with Solomon Islands having the highest rate (2.7 percent) followed by Vanuatu (2.5 percent) and Papua New Guinea (2.2 percent). Growth is 1.4 percent in Micronesia and 0.8 percent in Polynesia, with some Polynesian countries having negative growth due to net emigration.

The fertility transition has been underway for several decades in Micronesia and Polynesia and more recently in Melanesia but still has a long way to go. Several countries across the Pacific still have a TFR between 4 and 5. While some countries in the developing Pacific have achieved a TFR of 3, only one (Palau) has reached the replacement level of 2.2.

In most Micronesian and Polynesian countries, low population growth is not a result of having completed the demographic transition or having achieved population "stabilization". Rather, low growth has been achieved by emigration while natural increase has remained relatively high. Rates of natural increase vary much less widely across the region than overall population growth and several countries have had persistently high natural increase (2 percent or more) even though total growth is low. In several Micronesian and Polynesian countries, net migration is sufficient to remove the equivalent of 80 percent or more of natural increase. Very few countries in the Pacific have achieved moderate or low population growth by means of low rates of fertility rather than emigration and these are mainly dependent territories.

As in parts of Asia, the pace of mortality decline in the Pacific has been slow and in some countries life expectancy has stalled. Only four Pacific Island countries had achieved the ICPD target of above 70 years by 2005 and these were all in Polynesia. Several Micronesian countries are close to the 2005 target but do not appear likely to achieve the ICPD target of above 75

years by 2015. A number of countries fall well short of the 2005 ICPD target, most notably Papua New Guinea, which had a life expectancy of only 54 years in 2000-the latest year for which data are available. Given that HIV/AIDS has reached an adult prevalence rate of 1.6 percent (Government of Papua New Guinea 2009), it is unlikely that Papua New Guinea's life expectancy will improve by much between now and 2015 and it will therefore not reach the ICPD target. In Fiji, one of the more developed countries in the Pacific, male life expectancy reached a plateau of about 65 years in the mid-1980s and has remained at approximately that level ever since. The main reason for this is that while infant and child mortality have improved, adult mortality has increased due to the growing prevalence of non-communicable diseases.

The majority of Pacific countries therefore have quite some distance to go before completing their demographic transitions. While the mortality transition has progressed quite far with life expectancy above 70 years in some countries, the fertility transition has lagged. The availability of migration outlets has reduced the incentive at the family level to reduce fertility, although this relationship is complex and in the Fiji case the relationship may be the other way around-especially among the Indian minority. Thus, the recommendation of the ICPD POA that governments should take effective steps to complete the demographic transition remains relevant in the majority of Pacific Island countries.

Economic and Social Change

Many countries in Asia have been experiencing rapid economic growth during the last two decades. The high rate of growth of GDP, experienced by a few countries--the Asian tigers--during the 1970's and 80's, has spread to other countries, most notably China and India--the two most populous countries of the world, as they began the process of trade liberalization and embraced free market principles. The 1997 Asian financial crises and the global meltdown of 2008 have had their impact on the rate of growth and its potential for reducing poverty in the countries of the region. Yet, they remain remarkably resilient and Asian economies may recover sooner than previously expected.

Many Asian countries have also recorded significant reductions in the level of poverty, as measured by the proportion of population living on less than $1.25 a day, since 1990. The decline has been dramatic (from 54.7 percent in 1990 to 16.8 percent in 2005) for the countries of East Asia while it has been modest (51.7 percent to 40.3 percent during the same period) in South Asia. The total number of people living below poverty also declined from 1.45 billion to 912 million during the same period, owing mainly to rapid reductions in China and South-East Asia. However, if the threshold is raised to US$2.0 per day the number and percent of people living below this threshold will be considerably higher-38.7 percent in East Asia and the Pacific and 73.9 percent in South Asia--reflecting persistence of poverty in the region. Moreover, even as the percent of population living below $1.25 and $2.0 has declined, the actual numbers living below these thresholds have increased in South Asia, during the same period. (Jones, 2009)

Improvements in education; access to basic health services; nutrition; and access to clean water have also taken place in most Asian countries during the same period. However, large sections of the population in South Asia, and the disadvantaged and vulnerable population groups in a number of other countries are still deprived of, or only have very limited access to, these basic services, such as clean water and sanitation. (see Table1)

Women in Asia are becoming educated, marrying later, entering the formal labour

market and getting involved in public life in larger numbers than ever before, as indicated in later sections. Steps are also being taken to promote gender equality and equity and empower them to exercise their human rights. Yet, in many Asian countries women continue to be subjected to age-old prejudices and biases. In some countries and communities, the practice of selective abortion of female feotuses continue and has increased in recent years resulting in highly imbalanced sex-ratios in the population with severe social and economic consequences for the society.

In contrast to many Asian countries, particularly the "tiger" economies, economic growth in the Pacific Islands has been slow over recent decades (AusAID, 2009). In several countries GDP growth has been lower than population growth, resulting in a decline in per capita GDP. Prior to the recent global recession, however, economic growth was on the increase in Papua New Guinea, Solomon Islands and in some of the Polynesian countries that have a significant tourist trade. In Fiji, one of the main tourist destinations in the Pacific, political instability combined with the global recession resulted in a 23 percent decline in tourist arrivals in 2009 relative to the previous year contributing to increasing unemployment and exacerbating poverty. Fiji's economic output in 2007 dropped by 6.6 percent relative to the previous year. (AusAID 2009)

In several Polynesian countries, migrant remittances contribute significantly to GNP and help to maintain per capita incomes in difficult economic conditions at home. In Tonga, for example, migrant remittances were equivalent to 42 percent of GDP in 2004 (World Bank 2006). Remittance income has also been increasing rapidly in Fiji and in 2006 an estimated $US127 million was received from migrants overseas. (ESCAP Statistical Yearbook, 2008) In general, migrant remittances have improved the distribution of income and alleviated poverty (World Bank, 2006) so the decline in migration opportunities caused by the current global economic crisis may worsen poverty at home.

Extreme poverty, hunger and destitution are considered rare in the Pacific Islands due to the nearly universal access to land and other subsistence resources. (Abbott, 2006) Data on poverty using standard international definitions of such as the proportion of the population living on less than $US1.00, $US1.25, or $US2.00 have rarely been collected in the region on the grounds that they are inappropriate in a culture and economy characterized by traditional forms of exchange and sharing. One exception is Papua New Guinea where a World Bank study (Jones 2009) reported that 35.8 percent of the population was living on less than $US1.25 in 2004. Earlier studies indicated that about 10 percent of Papua New Guinea's population was below the "food poverty line" in 1996. Food poverty was overwhelmingly a rural phenomenon.

In the context of MDG-based development planning in the Pacific Islands, extreme poverty has been replaced by the "basic needs" concept and "basic needs poverty lines" have been calculated for several countries (see Abbott, 2006). This concept is essentially a measure of relative rather than absolute poverty because it requires a judgment as to what needs are basic in any given society. The proportion of the population falling under the basic needs poverty line in Pacific developing countries ranges from 13 percent to 50 percent (AusAID 2009). Where time series are available, more rises than falls have been observed and there is a strong impression in the data and in anecdotal reports that relative poverty is increasing. An indirect measure of poverty can be obtained by the proportion of the population having access to improved water and sanitation. In most Pacific countries, over 90 percent of the population has such access, but in Kiribati, Papua New Guinea and Solomon Islands, access to an improved water source is only 30, 40 and 53 percent,

respectively. Access to improved sanitation ranges from 22 to 45 percent in these countries.

Environment and Climate Change

Environment and climate change and their linkages with high rate of population and health are emerging as an important issue in most Asian countries because the number of people affected by the adverse consequences of deteriorating environment and climate change has been increasing. Pacific Island countries, the Maldives in the Indian Ocean, and other islands spread across Asia; and low-lying countries such as Bangladesh are severely at risk should the sea level rise as projected by the Intergovernmental Panel on Climate Change (IPCC). People living in the coastal areas of many other countries would also be impacted by sea level rise should strong international action to combat greenhouse gas emissions not be taken soon.

Countries of Asia and the Pacific had raised alarm about environmental deterioration and sea level rise during the Fourth Asian and Pacific Population Conference held in Bali in 1992. The Bali Declaration on Population and Sustainable Development adopted at the Conference (United Nations, 1992) noted that: "In many countries and areas, high rate of population growth and concentration have caused environmental problems, such as land degradation, deforestation, air and water pollution, threats to biological diversity from habitat destruction and rising sea level due to green-house effect." This was further highlighted and expanded in the Conference on Environment and Development held in Rio de Janierio in 1992.

The recommendations contained in the Bali Declaration and Agenda 21 are becoming more relevant today as the number of people whose livelihood, health and very existence are threatened by the continuing deterioration of the environment and changes in climate is increasing.

Efforts to understand the linkages between population, health and environmental change and to address the needs of those affected should, therefore, be on the agenda of development and humanitarian assistance for many countries in the Asia and the Pacific.

Emergencies and Conflicts

Countries in Asia and the Pacific have also experienced a large number of natural calamities such as volcanic eruptions, tsumami and earthquakes, that have displaced large number of people, rendered large numbers homeless and caused death and destruction. The most recent example is the Tsunami that struck the Samoa islands on 29 September 2009, causing destruction of property and loss of life. The destructive Indian Ocean Tsunami that struck the region in 2004 wiped out entire villages in Indonesia, Thailand, India and Sri Lanka and made hundreds of thousands homeless. Another Tsunami struck the North coast of Papua New Guinea in 1999 destroying villages and causing significant loss of life and injury. Devastating earthquakes have also hit Pakistan, Iran, India and Indonesia in recent years. Extreme weather events are also affecting Asian and Pacific countries periodically. In addition, a number of Asian and Pacific countries have gone through or are currently engaged in civil and military conflicts which have either displaced large numbers of people or have made it difficult for them to have access to basic services.

The population affected by such conflicts is large and is increasing. A significant proportion of them are children and women who are most vulnerable to abuse, including sexual abuse, and exploitation. Responding to their needs has stretched the limits--financial and human resources--of many countries, and, therefore, must remain a priority for international development assistance.

C. Scope, Methodology and Organization of the Report

This report presents the findings of a review of national experiences in implementing the ICPD POA, and the recommendations contained in the Key Actions adopted at ICPD+5, in the developing countries of Asia (East and North-East Asia, South-East Asia and South and West Asia) and the Pacific Islands (See Table 1 for the list of countries).

While the ICPD POA contains a wide range of interrelated objectives and actions, this 15-year review focuses on the progress made in achieving the goals and objectives specified in the preceding section and takes stock of the situation and measures taken to address such issues as ageing and international migration. The review also covers a number of interrelated issues, including the role and importance of partnerships in advancing the implementation of the ICPD POA, and the shortfall in financial resources.

This report is based primarily on the findings of prior reviews referred to in the preceding section, in particular those carried out in preparation for the ICPD+5 and ICPD+10 global reviews. National experiences since 2004 and the reports of regional conferences and consultative meetings, including the Expert Group Meeting and the Asia-Pacific Regional Forum organized by ESCAP in 2009 and the 2008 International Forum organized by PPD, have been consulted in preparing this report. To supplement the assessments contained in earlier and recent reviews, this report presents statistical data on a selected number of ICPD and MDG indicators (Table 1). Given data limitations, it is not possible to present a data-set for the identical reference year for all countries.

During the past fifteen years of experience in implementing the Cairo Agenda governments, non-governmental organization and other partners have developed and adopted a number of "best practices" and successful approaches. This report draws on the rich experience of a number of Asian and Pacific countries that have already been highlighted in the national and regional review reports prepared in connection with ICPD+5 and ICPD+10 and, therefore, does not cover all the successful approaches or the challenges and priorities of any particular country or any sub-region in detail. The report is to be understood as an overview of the progress made, challenges to be faced and priority actions to be taken by one or more countries in the region to move the ICPD agenda forward. Advancing the ICPD POA is central to achieve the MDGs.

The report is organized into three major sections. Following this introductory section which highlights the goals and objectives of ICPD and its link with the MDGs, Section 2 examines progress made by the Asian and Pacific countries towards the achievement of the goals and objectives during the fifteen year period and are subdivided into four areas, namely, population and development, reproductive health, gender equality and partnerships and resources. Section 3 highlights progress made and the major challenges faced by countries and recommends forward-looking priority strategies for the next five years and beyond.

SECTION 2: ASSESSMENT AND REVIEW OF PROGRESS SINCE ICPD

A. Population, sustainable development and poverty

Population and Poverty

Poverty reduction is an important Goal of the Millennium Declaration (MDGs) and rapid economic growth is central to poverty reduction--as evidenced by the low incidence of poverty in the more advanced countries of the region. The pockets of poverty seen in these countries are due mainly to the mal-distribution of income. However, available evidence suggests that the declining incidence of poverty in Asian countries is also closely correlated with reductions in fertility and population growth, advances in education, improvements in health, increasing urbanization and women's greater participation in economic activity.

Poverty is caused by a multitude of factors and low levels of health, high fertility and a high rate of population growth are important among them. This is fully recognized in the ICPD POA as it calls upon countries to "raise the quality of life through population and development policies and programmes aimed at achieving poverty reduction, sustained economic growth in the context of sustainable development." (para 3.5) The Fifth Asian and Pacific Population Conference held in Bangkok in 2002 concluded that "countries that have been most successful in reducing poverty are also those that have done most in reducing high levels of population growth and balancing population and development dynamics as well as meeting reproductive health needs". (ESCAP, 2003)

Countries in Asia are well aware of the relationship between high fertility and population growth and their impact on poverty, and those with a high rate of population growth have continued their policies and programmes aimed at reducing fertility and population growth. However, as discussed in the preceding section, high levels of poverty are still prevalent in large parts of South Asia encompassing Afghanistan, India, Pakistan, Nepal and Bangladesh and in a few other countries, namely Cambodia, Lao PDR and Timor Leste, and among ethnic minorities and vulnerable population groups across Asia. While improving access to education and health services, including reproductive health and family planning services, is critical to getting poor people out of poverty, efforts to date in these countries are not promising. This is reflected in the following statement: "An objective assessment of the provision of public facilities for education and health in many countries of the ESCAP region would have to conclude that such provision not only does not serve to narrow the wide gaps between the welfare of the poor and that of other sections of the population, it actually serves to widen them." (Jones, 2009)

A similar view was expressed by Purnima Mane, Deputy Executive Director of UNFPA, in her Statement at the opening session of the Asia-Pacific High-Level Forum on ICPD at15 in September 2009:

"People who have the most resources-whose needs for health care are often less-tend to consume most care, whereas those with the least means and the greatest health problems consume the least. Data shows that public spending on health services most often benefits the rich rather than the poor in high-and low income countries alike." She added that addressing inequities, therefore, should be a top priority. (Mane, P. 2009)

Hence, a pro-poor approach to the provision of basic services, including improving access to reproductive health/family planning services, should be a policy and programme priority to alleviate poverty and improve the quality of life.

Recent dialogue on population and economic growth in Asia has also focused on the impact of the rapidly changing age-structure of the population, currently being experienced by many countries, on savings, investment and incomes at household and societal levels as a result of increases in the working age population and declining dependency ratios. This so-called "demographic dividend" is estimated to have contributed up to one third of the growth in per capita income of East-Asian economies in recent years. Realization of the "dividend" by other countries in Asia depends upon the investments countries make in improving the quality of the labour for (especially education and health standards) and on the policies that they adopt in creating employment opportunities for the growing number of labour force entrants. This is particularly important because the populations of these countries are still young and those entering adolescent and young ages will comprise a high and increasing proportion in many countries in the coming decades. In a number of the more advanced countries of Asia the discussion centers on rapid population ageing and its implications for health and social security.

Migration, both international and internal migration, has increased dramatically during recent years in Asia and the Pacific, and has contributed to the region's economic growth and the efforts to alleviate poverty through remittances and other forms of asset transfers.

In the Pacific Islands, sustained economic growth has proven to be elusive over the past two decades. While some countries have achieved positive GDP per capita growth in some years, growth has frequently been a result of a short-term resources boom or a temporary jump in tourist arrivals. Where GDP growth has been achieved through mining, forestry and fishing either resource depletion or environmental damage has offset the monetary gains. In most of Polynesia and Micronesia, as well as in Fiji, the level of living is not determined by domestic production alone. In these countries, GNP is significantly higher than GDP because of the impact of migrant remittances. The type of rapid and sustained GDP growth that has occurred in many Asian countries as a result of a development strategy focused on "export-driven" manufacturing has not occurred in the Pacific Islands.

Poverty reduction has not been a major feature of development planning in the Pacific Islands until recently. The MDGs highlight "extreme poverty", a concept that was believed not to apply in the Pacific Islands setting. For the MDGs to become accepted at the country level as a framework for development planning, the concept of poverty had to be re-cast as "basic needs poverty", "poverty of opportunity" or "poverty of access" to basic social services, education and employment (Abbott, 2006). In theory the relationship between basic needs poverty (BNP) and population dynamics is clear. Any list of basic needs would have to include the need for reproductive health services and family planning, along with access to education, occupational training, clean water and sanitation. The MDG framework emphasizes the interrelationships between all the MDGs, and this argument finds some empirical support in an analysis by the UNFPA in the Pacific (UNFPA 2008) which finds strong correlations between maternal health, access to improved water and sanitation, and the proportion of women in paid employment.

Understanding of the emerging population dynamics and their relationship to economic growth and poverty in Asia-Pacific economies remains limited. Building knowledge through collection of data, analysis and research on the links between these trends and economic growth should therefore be a priority.

Infant and Child Mortality

Improved child health is an important goal of the ICPD POA and also one of the MDGs. The ICPD POA set quantitative targets for infant and child mortality for the years 2000, 2005 and 2015 in the following terms:

"Countries should strive to reduce their infant and under-5 mortality rates by one third, or to 50 and 70 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 and an under-5 mortality rate below 60 per 1,000 births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-5 mortality rate below 45 per 1,000." (para 8.16)

While the IMR is included in the MDG framework as an indicator for monitoring progress, neither a level nor a rate of change is specified. Instead, the MDG target indicator is the under-5 mortality rate (U5MR) and the target is to reduce this rate by two-thirds between 1990 and 2015.

The MDG report 2009 (United Nations, 2009a) has reported progress in reducing child mortality in all the sub-regions of Asia. Yet, it notes that many countries in South Asia have made little or no progress. According to ESCAP estimates (See Table 1; ESCAP, 2009) infant and child mortality in East and North-East Asia and South-East Asia are well below the respective targets of 35 and 45 by 2015. In contrast, estimates of infant and under-five mortality in South Asia are well above the targets, averaging 54 and 78 respectively.

Countries with infant and under-five mortality well above target levels include Cambodia, Myanmar, and Timor Leste in South-East Asia and Afghanistan, parts of India, Nepal and Pakistan in South Asia. Available evidence suggests that infant mortality rates are much higher among the poorest segments of the population (Jones 2009), which is also likely to be true among children as most deaths among them are due to avoidable causes. Inequities in the provision of health care and other social services contribute to the persistence of high infant and child mortality among the poor. Reduction in these inequities through a pro-poor approach should, therefore, be a priority because greatest gains in infant and child survival depends on effectively reaching the poorest and most marginalized, who suffer the greatest burden of disease. (UNICEF, 2009)

Infant mortality has been declining in all Pacific Island countries since the 1990s, although the pace of decline has varied. The ICPD target of an infant mortality rate of 50 per 1,000 in 2000 was achieved in all but two countries, but very few countries achieved a one third reduction between 1990 and 2000. Again, only two countries-Papua New Guinea and Kiribati-fell short of the 2005 target and these are also the only countries that may have difficulty achieving the 2015 target. All other Pacific Island countries have already achieved the ICPD goal of an IMR below 35 by 2015 (Table 1).

The ICPD goal for the under-5 mortality rate (U5MR) by 2000 and 2005 were achieved in most Pacific countries by 2005 or earlier. Achieving the MDG target of reducing the U5MR by two-thirds between 1990 and 2015 is more difficult because the normal pattern in the mortality transition is for the pace of decline to slow down as the U5MR reaches lower levels, and several Pacific countries already had low levels by year 2000. Nevertheless, several countries-including Vanuatu, Marshall Islands and most of Polynesia--are on track to achieve this target. The larger Melanesian countries of Papua New Guinea, Solomon Islands and Fiji may not be able to achieve the necessary rate of reduction. Only two countries (Kiribati and Papua New Guinea) are not presently on track to achieve the ICPD goal for under-5 mortality by 2015.

One of the key factors that explains country performance on the U5MR in the Pacific sub-region is immunization coverage. Where the U5MR remains high or is improving slowly, the proportion of 1-year old children immunized against measles is well below the average for countries in which under-five mortality is already low or falling more rapidly. It is also notable that the countries making the least progress in reducing the under 5 mortality rate are those that have the worst access to an improved water supply and sanitation.

Population Ageing

As discussed in the preceding section, a secular decline in fertility rates together with declining mortality and increasing life expectancy is transforming the age structure of populations in most countries of Asia, and some in the Pacific. The changing age structure of population manifests itself in significant increases in the number and proportion of population at working ages relative to other age groups and opens up a "window of opportunity" to benefit from the potential "demographic dividend" that it offers.

Advanced stages of age structure transition will inevitably result in population ageing, a process whereby the population at older ages (60 and over) will begin to comprise an increasing share of the total population. For instance, it is estimated that older persons will constitute about 15 percent by 2025 and by 2050 it is expected to increase to 25 percent for the region as a whole. Furthermore, more and more countries in Asia will enter this stage; and population ageing, which was until recently limited to the more advanced countries, will become more rapid and an important feature of population dynamics of all countries in the not too distant future.

To address this emerging issue, the ICPD POA has called on countries "to develop systems of health care as well as systems of economic and social security in old age, where appropriate, paying special attention to the needs of women." The POA also calls on countries "to enhance the self-reliance of elderly people to facilitate their continued participation in society." (para 6.18 and 6.19) International efforts to respond to the challenges posed by population ageing culminated in the adoption of "The Madrid International Plan of Action on Ageing (MIPAA)" at the Second World Assembly on Ageing in 2002 which has since become the basis for action on population ageing.

The 10 year review of the implementation of ICPD POA undertaken by ESCAP in 2004 has indicated that countries in Asia have taken a number of measures to address the needs of older persons. (United Nations, 2004 p.13-14) The five-year review of MIPAA undertaken by ESCAP in Macao, China, during 9-11 October 2007 has highlighted various national initiatives as well as progress made in developing plans, policies and programmes and in setting up institutional mechanisms to prepare for an ageing society. (UN ESCAP 2007). The EGM held in Bangkok to review the implementation of the Fifth APPC plan of action has considered the broad issue of age structure transition and its implication for development.

In the Pacific, most countries had youthful populations with a median age of around 17-19 years up until the 1970s. The proportion of youth in these populations has remained relatively high due to population momentum, but as in Asia, the mortality and fertility transitions have begun to have an impact on age structures and several countries now have ageing populations. The proportion of the population aged 60 years and over has been increasing steadily over the past two decades. The growth rate in this age group currently exceeds the total growth rate by a considerable margin in several countries. Between 2000 and 2050, the elderly population of the Pacific Islands is projected to grow from 376,000 to 2.25

million, and the "oldest old" (80 years and over) is projected to grow from 18,900 to 266,400 over the same period (UNFPA Pacific Sub-regional Office, 2009). By the year 2050, some Pacific Island countries will have a median age of 40+ years. Because female life expectancy is generally higher than male, the majority of the elderly population is already female but this trend will likely accelerate in the future.

Ageing is currently most advanced in the Micronesian and Polynesian countries and in Fiji. The double impact of the demographic transition and net outward migration is particularly evident on outer islands and remote areas where the population of labour force age is shrinking while the elderly population is growing and becoming more feminine. In Western Melanesia, the mortality and fertility transitions started later and have proceeded more slowly-hence these populations are still youthful and will not start ageing for another decade or more.

Where ageing is occurring, Pacific governments have yet to examine in detail the implications for health care and social welfare. As in Asia, most elderly are cared for in a family setting, but this arrangement will come under increasing strain in the coming years as higher proportions of the elderly population reach 80 years of age and over and suffer from disability, infirmity, chronic illness and a shortage of care-givers due to the impact of emigration.

Most Polynesian and Micronesian countries have reached, or are about to reach, the "window of opportunity" provided by an age structure in which the population in the working age range (15-64) is proportionally larger than the population of dependants (0-14 + 65 and over). Few Pacific countries are aware of the implications of the so-called "demographic bonus" (Ogawa, Chawla and Matsukura 2009) for economic development and public policies to promote economic growth. As discussed below, at family and individual levels, Polynesians and Micronesians have reacted to the window of opportunity by seeking opportunities in external labour markets because opportunities for paid work are extremely limited-especially in outer islands and remote areas. This situation also applies to Fiji and it is highly likely that political instability will delay the potential benefits of the demographic bonus emerging in that country.

Thus, both regionally and at national levels efforts are being made to place the issue of ageing on the agenda for development. Regional review of MIPAA has shown that the initiatives taken by countries include development of policies and plans, establishing national mechanisms, and raising public awareness of the benefits of healthy lifestyles and active ageing. Countries are also taking measures to provide social security and social protection for older persons.

A number of countries in Asia and the Pacific have collected data on older persons and many have undertaken studies on ageing and related issues, such as disability. There have also been comparative studies on ageing in the countries of South Asia, South-East and East Asia, and the Pacific. These studies are providing valuable information for policy development and for initiating programmatic responses. (Mujahid, G 2006 and Mujahid, G et al. 2009)

The following is a list of salient features of ageing in Asia and in some Pacific countries that must be considered in the national development agendas:

1. Population ageing will occur and encompass most Asian countries in the not too distant future as well as many Pacific countries,
2. It will occur more rapidly than ever before and there is only limited time to respond and adjust,
3. It is occurring at much lower levels of development and incomes,

4. Social security systems are not developed and cover only a small proportion of the population in most countries,
5. Health systems are not prepared to meet the emerging epidemiological transition, and with persistence of poverty, poor among the elderly will suffer most,
6. With increases in life expectancy and improved health, older persons can remain productively engaged well after 60 years of age,
7. Women significantly outnumber men among older persons,
8. Mostly widowed and with no independent source of income, older women will be considerably disadvantaged, a situation only aggravated by the cultural norms that discriminate against women in many countries,
9. Family remains the foundation for economic and social support for older persons, but it is undergoing change and with increasing education, migration and smaller family size the role of the family in caring for older persons would diminish,
10. Women are the major care givers for older persons at home and nurses in hospitals and other institutions are mainly women in all Asian and Pacific countries. While ageing would increase the demand for nursing and, therefore, employment opportunities for women, increasing female employment in formal sector occupations will limit their ability for the care of older persons at home.
11. Public financing for health care and social security will be under stress, and
12. Knowledge base and policies to accumulate wealth from the "demo graphic dividend" that would cushion the impact are still unclear and not known to policymakers.

The following are a list of priorities that must be considered by Asian and Pacific countries in preparing for an ageing society:

1. Expand the coverage of social security systems to include those not covered by formal system; assess the sustainability of current systems and make necessary changes that would ensure their sustainability;
2. Reorganize health systems and service delivery infrastructure to meet the emerging needs of older persons, including the special needs of older women;
3. Establish and support mechanisms for self reliance of older persons through community involvement; provide appropriate support to families for care of the elderly;
4. Encourage and facilitate the participation of older persons in productive activity through continuous learning and, where possible by increasing the age limit for retirement;
5. Encourage healthy life styles among the young through appropriate health education;
6. Promote the participation of the private sector and NGOs in old age care, including health care and in setting up community based self help schemes;
7. Support research and knowledge base development, particularly for benefitting from the potentials of demographic dividend and the accumulation of wealth;
8. Disseminate knowledge including national experiences widely to planners and policy makers through appropriate modalities.

International Migration

International migration, particularly labour migration, from and within Asia has increased significantly during recent decades. This is caused by income disparities and uneven opportunities between countries of origin and destination, imbalances in the supply and demand for labour between them, and improvements in communication, transport and the increasing role of government and private agencies in the management of these flows. It was estimated that the total number of migrant workers deployed by selected Asian countries totaled 2.4 million in 2000, which is an increase of 1.4 million from 1990. (Huguet, 2002) This number is likely to have increased significantly since then, and scattered evidence does not indicate return migration of significant magnitude as a result of current downturn in the economies of receiving countries.

The ICPD POA recognized the emergence of international migration, in particular labour migration, as an important component of population dynamics and the significant impact it has for development, poverty reduction and the empowerment of women. It identifies diverse forms of international population movements and categorized them as documented, undocumented, refugees and asylum seekers.

The objectives of ICPD POA in addressing the multi-faceted issues of international migration are broadly to: derive maximum benefit for both sending and receiving countries from these movements; to promote rights of migrants and their families, provide protection and eliminate discrimination; to ensure that those in vulnerable situations, particularly women and girls, are protected from abuse and have access to basic needs and services.

A review of the international migration patterns from and within the Asian and Pacific countries was undertaken at Fifth Asian and Pacific Population held at Bangkok in 2002 and dealt with its impact on issues such as development and poverty, family and remittances and noted the increase in the number of women among international migrants during recent years. The Plan of Action adopted at Fifth APPC agreed on the actions contained in the ICPD POA, but called for the regularization of desirable migration (unauthorized migration that is tacitly accepted by destination countries), better utilization of remittances, and the promotion of regional cooperation to manage the migration flows.

A review was again undertaken by ESCAP in 2009 as part of its review of the implementation of the Plan of Action on Population and Poverty adopted at Fifth APPC. The review has identified a number of initiatives taken by both sending and receiving countries to regulate migration and to protect migrants and their families. Examples include: the establishment of the Ministry of Expatriate Welfare and Overseas Employment in Bangladesh in 2001; the establishment of the National Agency for placement and protection of Indonesian Overseas Workers in 2006; and the establishment of Overseas Employment Administration in Thailand in 2006. Philippine Overseas Employment Administration and Sri Lanka Bureau of Foreign Employment are other examples. Likewise, a number of receiving countries have also established systems to regulate the flows of migrants. The review has revealed significant increases in cash remittances through formal channels during recent years. For example, the top 10 countries received a total of US$110 billion in 2006 and US$121 billion in 2007 which is more than double the volume in 2000. These remittances constitute more than twice the amount received from official development assistance and is nearly two-thirds of foreign direct investment flows. The trend is likely to continue and there is no evidence that indicates a decline in remittances since the 2008 global financial meltdown. The nature and direction of the impact of remittances for

families, communities and for the receiving countries is debated but in most countries this has been a safety valve that has mitigated high levels of youth unemployment and provided the finance for improving the health and education of family members. At the national level it has proved to be a major source of foreign exchange for many countries.

The review also highlights the adoption of a number of regional and bi-lateral agreements to coordinate and manage the flow of migrants and to provide protection for them and their families. The review notes that most Asian countries have not ratified international Conventions on labour migration that call for the protection of migrant rights, and that only a few have ratified protocols relating to refugees, and smuggling and trafficking. Countries have been more willing to reach agreements on smuggling and trafficking and not on labour migration and protecting migrant rights. Moreover, as noted above, countries have been more forthcoming in forging sub-regional and bi-lateral agreements than ratifying international Conventions and Protocols.

There have also been improvements in data and research on the economic and social impact of international migration in response to calls made at various Asian regional and sub-regional fora. (for more details see: Huguet, 2009)

International migration also plays a significant role in both the population dynamics and the economies of many Pacific Island countries-mostly in the Micronesian and Polynesian sub-regions. All the Polynesian developing countries have net outward migration as do four out of five Micronesian countries. Fiji has also emerged in recent years as an important sending country for migrants to Australia, New Zealand, USA and further abroadóincluding the Middle-East. Most emigrants are in skilled or semi-skilled occupations, including predominantly doctors, nurses and teachers, but also including security guards and tradesmen.

International migration plays a significant role in reducing overall population growth as well as unemployment and underemployment. Migration streams to and from the Pacific are many and varied as to their country of origin, destinations, skill composition, degree of permanence, and gender balance. Some countries have open access to New Zealand and some Island citizens can move without restriction. In others, migration is controlled by the receiving countries (mostly Australia, New Zealand and the United States). Other than Fiji, the Melanesian countries do not have easy access to international migration and migration plays a negligible role either in their population dynamics or their economies. It is clear that the economic function of international migration is to transfer labour from a location in which it cannot be absorbed into the labour force to a location where it can-an inevitable result of "globalization".

International migration from some Pacific countries is therefore vulnerable to the global economic recession, particular from countries providing semiskilled or unskilled workers on temporary labour contracts. Seafarers and temporary agricultural workers are two of the occupations likely to be affected in the coming years. A slowdown in recruitment of these occupations is likely to increase hardship in the Pacificóespecially in the more remote islands with few other opportunities for wage work. If world economic growth returns to previous levels, the downturn in migration may prove to be temporary. Efforts to design bi-lateral agreements on unskilled labour mobility between Pacific countries and Australia and New Zealand that would enhance economic growth in Island economies are still in early stages. (World Bank, 2006).

International migration will continue to increase in volume and complexity in the coming decades, even if inter country disparities in labour supply and demand as well as incomes that propel migration will begin to diminish. Development that is taking place in developing

countries will further increase migration flows as it will provide the resources needed for migration. Improvements in communication and transport and the growing pool of migration in destination countries will contribute to further migration. However, the future would also see skilled migrants moving to today's sending countries as a result of increased opportunities in them. Therefore, as indicated earlier, international migration will be an important factor in shaping the demographic, economic and social contours of Asia and the Pacific in the twenty-first century. It is inevitable, therefore, that it is accorded high priority in the national development plans and priorities of Asian and Pacific countries in the future.

Development partners including the United Nations, therefore, have a major role to play in according high priority to build knowledge base on international migration and its impact on development and to promote and facilitate dialogue among countries to recognize that international migration contributes to development of both sending and receiving countries.

Population in Planning and Poverty Reduction Strategies

The ICPD POA reiterated calls to "integrate population issues into formulation, implementation, monitoring and evaluation of policies and programmes relating to sustainable development" (para 3.16) in line with the World Population Plan of Action adopted during the earlier conferences. The POA recognizes that "efforts to slow down population growth, to reduce poverty, to achieve economic progress, to improve environmental protection, and to reduce unsustainable consumption and production patterns are mutually reinforcing." (para 3.14) Previous reviews have revealed that population issues were at the centre of development efforts in Asian countries and that they have taken a number of measures to integrate them into national development strategies and planning. However, the 10 year review of ICPD implementation revealed that the degree of integration of population in development strategies among the Asian countries vary in scope and depth because of differing views on the relationship between population and sustainable development, competing developmental priorities, and inadequate national capacity and methodologies. The changing national contexts and planning systems adopted during recent decades by many Asian countries have added another dimension of challenges. (United Nations, APSS 162)

With the adoption of the MDGs in 2000, however, efforts to integrate population, reproductive health and gender equity considerations into national development and poverty reduction strategies have gained added importance, as achieving the ICPD Goals is seen as pivotal to the attainment of the MDGs, particularly the goal of eradicating poverty. A systematic review of the current status of the integration of population, reproductive health and gender issues into national development plans and poverty reduction strategies is lacking. However, a review of national initiatives, plans and strategy documents indicates that in most countries increased efforts are being made towards this goal. These efforts include, inter alia, preparation of position papers, organizing national policy dialogues, and taking active part in discussions leading up to the formulation of national development plans and poverty reduction strategies. These efforts are helped by the progress made during recent years in the collection of data and development of indicators to monitor progress in the MODGs and ICPD Goals, as highlighted in the preceding section.

While these efforts are impressive, it is uncertain whether they have contributed to an increased allocation of resources and in the scaling-up of initiatives to improve reproductive health, including family planning and sexual

health services, in ways that have significantly improved access to these services among the poor. Available evidence points to the contrary. For example, it should be noted that public expenditure for health services remains very low and in most developing countries of Asia it is between 1 and 3 percent of GDP, with most of them spending less than 2 percent or below.(UNFPA, 2009) These are also reflected by the fact that indicators of maternal and child mortality, unmet need for family planning etc are much higher among people with lowest levels of income. The inequities between the poor--who still comprise a very large segment of the population in most countries of Asia--and the rich are also seen in access to such basic needs and services as safe water and sanitation.

Therefore, added efforts are needed to improve national capacity in the collection and analysis of data to reflect the inequities and their impact on health and educational outcomes and to improve skills to communicate these findings and their relevance to developmental priorities to high level planners and policy makers. Much effort, therefore, is also needed to convince planners and policy makers to translate the commitments to action by increasing investment in human capital-health and education-and their full utilization in development. It must also be highlighted that investments in education and health, will not only contribute towards ensuring that the basic needs and rights of the poor are met but, given the current demographic scenario that many countries are going through, would add significantly to the growth of GDP, by optimizing the benefits of the "demographic dividend".

Although reference to population policies is pervasive throughout the ICPD POA, the paradigm shift to reproductive health and rights in the POA was interpreted by many planners in the Pacific Islands to mean that population policies were neither necessary nor useful. Only one country in the sub-region (Papua New Guinea) prepared and ratified a national population policy after ICPD '94. Several other countries commenced the process of policy formulation but development stalled when technical support ran out.

During the 1990s, government-led macreconomic planning in the Pacific sub-region was downplayed in favour of a more free-market approach that emphasized private sector development, the privatization of government commercial arms, and the deregulation of trade, foreign exchange, transport and communications, and labour markets. Under these arrangements there was very little room for population dynamics to be incorporated into plans. Most governments adopted short-term (2-3 year) development strategies, which made little or no reference to population trends. With the arrival of MDG-based development planning in 2000-01, population policy formulation was further downplayed.

In Papua New Guinea, however, the multi-sector, ICPD POA-inspired National Population Policy (NPP) 2000-2010 has played an important and useful role in the development of the country's poverty reduction strategy as well as in the preparation of MDG reports. This is especially true at the sub-national level, as almost all provinces have used the NPP to formulate their provincial development plans. Population policies still have a useful role to play in the region and the ICPD POA provides an appropriate framework to guide their formulation-fully consistent with human rights. MDG-based planning can benefit from a more comprehensive approach to population that a multi-sector population policy can provide and renewed efforts to develop such policies is required.

Data and Research

The ICPD POA called on Governments to strengthen their national capacity to carry out

sustained and comprehensive programmes on the collection, analysis, dissemination and utilization of population and development data. In this regard, the POA calls upon countries to pay particular attention to the monitoring of population trends and the preparation of demographic projections and to the monitoring of progress towards the attainment of health, education, gender, (ethnic?) and social security goals, and of service accessibility and quality of care. The POA also calls for socio-cultural and economic research as well as policy research on a diverse set of issues to be built into population and development programmes and strategies. (Chapter XII)

In response to the above and with the emphasis placed on the periodic monitoring of the MDGs, most countries in Asia have increased their efforts to collect, process and tabulate data that will yield the required indicators for monitoring progress in achieving the MDGs and ICPD goals. However, data and research gaps to reflect the inequities in incomes, health and educational outcomes, and access to basic services between different segments of the population, e.g poor and non-poor, migrant and non-migrants, ethnic minorities and indigenous peoples, and those living in vulnerable conditions, as well as on issues such as international migration and ageing are still wide in most countries.

It may be mentioned in this context that many Asian countries have had a long tradition of collecting data through periodic censuses and special purpose sample surveys. While these provide valuable data base for policy analysis, efforts to analyze the data have fallen short in recent years due to limited national capacity and declining support for in depth analysis and research.

In the Pacific Islands, the monitoring of population trends has had a long history. All countries have conducted censusesóat least since the 1960s-and some participated in the World Fertility Survey in the 1970s. Pacific countries have carried out censuses in every census round to date-either at 5-year or 10-year intervals. Building national capacity in census-taking has been an important priority for countries and donors alike over the past two decades. In spite of these efforts, dissatisfaction continues to be expressed by development partners regarding the infrequency, poor quality or limited range of statistical indicators-including many population-related indicators (AusAID 2009). It has been argued that the quality of the 2000 round of censuses in the Pacific declined relative to the 1990 round (Hayes 2006). UNFPA, among other agencies, is now returning to census support for the 2010 round in an effort to improve census quality and promote more extensive analysis of census data.

Demands for statistical data have increased significantly since ICPD '94 but, paradoxically, the post-ICPD period also coincided with a decrease in donor support for censuses and surveys. Many of the indicators required to measure the implementation and results of the ICPD POA were not available for the base year of 1990 and many are still not available. The measurement of "unmet need" for family planning, for example, has been erratic and only one country in the Pacific sub-region has data for two points in time. The advent of the MDGs has highlighted the deficiencies in data collection in the Pacific and new efforts are underway by several agencies (including AusAID, SPC, NZAID, UNESCAP, UNFPA, IMF) to improve statistical capacity in the sub-region. Particularly urgent is the building of local capacity to analyze census and survey data to make the data more relevant for public policy formulation. A major advance in data collection occurred when Demographic and Health Surveys (DHS) were conducted in five Pacific Island countries over the period 2006-2008, but more analysis of the results is needed for planning purposes.

Demographic training and research in the Pacific sub-region at university level was heavily supported by UNFPA in the 1980s but this support declined in the 1990s and thereafter. The study of Pacific Island populations at Pacific-rim universities in Hawaii, Australia and New Zealand also reached a peak in the 1990s and has been in decline since. The Pacific Islands still lack sufficient local expertise in census and survey operations, demographic estimation, analysis and interpretation. There remains no dedicated research institution on population subjects in the sub-region.

Efforts to bridge these gaps both for data and research should, therefore, be accorded priority in the national development strategies, and in the agenda of development partners, as called for in the ICPD POA.

B. Reproductive Health and Reproductive Rights

Reproductive Health and Rights in ICPD and ICPD+5

The International Conference on Population and Development, while underscoring the integral and mutually reinforcing linkages between population and development, made a significant departure from the earlier World Population Conferences in calling on countries to shift their population policies and programmes away from their focus on human numbers to a focus on human lives. It placed emphasis on improving the lives of individuals and increasing respect for their human rights.

Rooted in the rights and freedoms set forth in the Universal Declaration of Human Rights, Principle 3 of ICPD states that "...While development facilitates the enjoyment of all human rights, the lack of development may not be invoked to justify the abridgement of internationally recognized human rights..."

Furthermore, Principle 8 states that "...States should take appropriate measures, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."

In Chapter VII, entitled "Reproductive Rights and reproductive Health", the POA also states that "...The promotion of the responsible exercise of these rights for all people should be the fundamental basis for government-and community-supported policies and programmes in the area of reproductive health, including family planning." (para 7.3)

The "Key Actions" adopted at the 5-year review called upon Governments to "ensure that policies, strategic plans and all aspects of the implementation of reproductive and sexual health services respect all human rights, ..." (para 5.2b)

ICPD POA calls upon countries to "...strive to make accessible through primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015." It defines reproductive health care in the context of primary health care to include, inter alia,:"family planning counselling, information ,education, communi-cation and services; education and services for prenatal care, safe delivery and post natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as defined in paragraph 2.5 including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and

information, education and counselling on human sexuality, reproductive health and responsible parenthood..."

The 10 year review has indicated that most countries in Asia and the Pacific have taken one or more steps to promote reproductive rights. The measures taken include formulation of policies and/or enactment of laws on reproductive rights, setting up institutional mechanisms and strengthening advocacy for the promotion of these rights. The 10 year review has also noted policy and programme related developments in many countries that are building a conducive environment for women to exercise these rights.

The report of the 10 year review states that: "However, even in a favourable policy and programme environment, countries in which educational levels of and employment opportunities for women are low and where socio-cultural and religious factors play a pivotal role, progress towards ensuring the reproductive rights of women remains slow.", a statement that still remains true even today. The report also highlights factors such as provider bias, and their lack of knowledge, understanding and skills as hindering progress towards achieving the delivery of reproductive health including, services that meet the informed and voluntarily determined needs of clients.

The 15 year Asia-Pacific review meeting held in Bangkok during 16-17 September, 2009 took stock of the progress made in implementing the ICPD POA from a "rights perspective" and confirmed that there are many factors that limit access to the full range of reproductive health services among the countries of the region. The relative importance of these factors is determined by the level of economic and social development, cultural mileu, policy environment as well as access to and quality of services in the different countries. Available evidence indicates that rights are more often denied to the poor, the marginalized and vulnerable groups, such as migrants, refugees, and internally displaced persons as well as ethnic minorities and indigenous populations in many countries of the region. Similarly, women, adolescents, and unmarried young adults in many countries are also deprived of their rights, including reproductive rights, despite significant efforts made during the past fifteen years.

However, countries of the region have made progress in achieving the specific objectives and goals with regard to selected components of reproductive health during the past 15 years. As discussed below, however, major challenges still remain.

Safe Motherhood and Maternal Health

As indicated earlier, reducing maternal mortality rates to half the 1990 levels by the year 2000, and by half again by 2015 is one of the objectives included in the ICPD POA. Improving maternal health is also an important MDG and related targets include: (i) the proportion of births attended by trained personnel and (ii) the Maternal Mortality Ratio (MMR).

Data given in Table 1 show that the proportion of births attended by skilled staff is nearly universal in the countries of East Asia, and in Malaysia, Thailand in South-East Asia and in Iran and Sri Lanka in South and West Asia. Most other countries, with the exception of a few, are a long way off to ensure that all births are attended by skilled staff which is a manifestation of inadequate infrastructure and shortages of skilled attendants.

In the Pacific Islands, several countries have had universal coverage for some time and all but two countries have already achieved the ICPD target of 90 percent attendance by skilled personnel by 2015. Papua New Guinea is the country least likely to achieve this target. Kiribati currently falls short but with effort could achieve the 2015 target.

Access to and utilization of prenatal care, as measured by women 15-49 years old attended four or more times during pregnancy by skilled health personnel is only 36 percent in Southern Asia during 2003/2008, and that it has changed very little since 1990, according to the global MDG Report, 2009. (United Nations, 2009) For South-Eastern Asia it is much higher and averages around 74 percent. Data on this indicator is scarce in the Pacific Islands but the proportion of all women (15-49) attended four or more times during pregnancy ranges from 55 to 88 percent. The lowest figures are found in countries with the highest Maternal Mortality Ratios.

Partly as a result of the above, the goal of reducing MMR by two-thirds between 1990 and 2015 will not be achieved by many of countries in Asia and some in the Pacific (ADB, 2008). According to the MDG Report 2009 (United Nations 2009) MMR for Southern Asia remains highest in Asia. At 490 maternal deaths per 100,000 live births, the region has recorded only a modest decline of 20 percent from the 1990 level of 620. According to the report, South-Eastern Asia ranks second in Asia with an average MMR of 300, which represents a decline of one third from the 1990 level of 450. Western Asia ranks third and has an estimated MMR of 160, down from 190 in 1990, and East Asia has the lowest MMR: 50, down from 95 in 1990.

In the Pacific, most of the Polynesian and Micronesian countries, as well as Fiji, have reduced maternal deaths to a low level with some Polynesian countries not recording a single maternal death in recent years. In Papua New Guinea, Solomon Islands, Federated States of Micronesia, and Kiribati, however, the situation is quite different. The last recorded MMR in Papua New Guinea (referring to 1994) was 733. This figure is now being used as the 1990 baseline for the MDGs and ICPD goals. Although reliable statistics are unavailable, health authorities and experts believe that this ratio has not improved over the past decade. Accordingly, the MDG target of a 75 percent decline in MMR by 2015 will not be achieved in Papua New Guinea. The Solomon Islands has made more progress; its current MMR is about 100-a decline of 70 percent since the 1990-94 period.

The maternal mortality ratio is perhaps the most difficult health indicator to measure accurately and estimates vary considerably. However, available estimates suggest that the disparities in MMR among and within countries are very high and reflect the high and persistent inequities in access to and quality of basic services, including health services, among the countries and population groups within them. Countries with very high to high MMR in Asia are: Afghanistan (1,800), Bangladesh (570), Bhutan (440), India (450), Nepal (830) and Pakistan (320) in South Asia, Cambodia (540), Indonesia (420), Laos PDR (660), Philippines (230) and Timor-Leste (380) and Vietnam (150) in south-East Asia, in DPRK (370) in East Asia, and Federated States of Micronesia (140), Vanuatu (148) and Kiribati (284) in the Pacific Islands.

It is estimated that worldwide more than half a million women die each year giving birth, of which 44 percent occur in the Asia and Pacific region. The major causes of maternal deaths in Asia include hemorrhage, eclampsia, obstructed labour, sepsis and abortion. Indirect causes include anaemia, jaundice, and heart problems. Violence against women also contributes to maternal deaths. (Mathai, Saramma, 2009) Most of these deaths are preventable through proven and cost-effective interventions, but poverty and remoteness are major impediments to obtaining services for many women.

Recent literature points to three primary factors that contribute to high maternal mortality. These are called the "three delays": (i) delay in making the decision to seek medical help for an obstetric emergency (due to cost), (ii) delay in reaching facility (due to distance); and (iii) delay in receiving adequate care due to shortage of skilled staff.

While these delays due to shortages of skilled staff, difficulty of access to emergency obstetric care and cost considerations retard progress in reducing MMR and improving maternal health, high unmet need for family planning, unplanned pregnancies and recourse to unsafe abortions, particularly among adolescents and young women also contribute to high maternal mortality in a number of Asian and Pacific countries. The 10 year review of ICPD noted that of the countries worldwide that had reported taking a number of steps to reduce MMR, only 15 percent reported establishing RH/FP clinics as a strategy (UNFPA, 2004) and in Asia only 7 out of 44 countries reported doing so (United Nations ,2004), a situation that is unlikely to have changed since. This reflects a lack of or even a declining importance given by planners and policy makers in many countries of the region to family planning, as it is seen mainly as a means of fertility reduction and not as a cost-effective strategy to improve maternal and child health.

Unsafe abortion is a major public health concern in many Asian countries and account for an estimated 12 percent of all maternal deaths in Asia. The incidence of unsafe abortion is high in countries where unmet need for family planning is high, abortion is illegal and where quality of care is poor. (United Nations, 2004; see also Raj Karim, 2009) Abortion is illegal except to save the life of the mother in all developing Pacific countries, but deaths from illegal abortion are not unknown in the sub-region. Where family planning access is poor, women will seek abortions whether they are legal or not (Raj Karim (2009).

It is also reported that efforts to get pregnant women at risk to hospitals during emergencies through incentives and support does not always prevent maternal deaths as women were often discharged soon after delivery due to lack of facilities at the hospital, and died soon after due to complications that could have been prevented if services had been available. It was observed that, as a consequence, maternal mortality during the post natal period is on the increase among women who received emergency care at delivery. In addition, lack of basic services such as clean water and sanitation facilities, together with poor nutrition, hold back progress in improving maternal health and reducing maternal mortality.

Furthermore, as the Executive Secretary of ESCAP, Mrs. Noeleen Heyzer, points out "social exclusion, gender inequality, poverty, and violence all act as barriers to women trying to access health services even when they are available". (Heyzer, 2009)

It should also be noted that inadequate care during pregnancy and delivery will have adverse impacts on women's health, and that women who become pregnant during adolescence and women who are malnourished will be at greater risk of prolonged ill health, if not death, due to conditions such as obstetric fistula.

The limitation of financial resources for public health is a major factor holding back progress. In most Asian and some Pacific countries public health expenditure as percent of GDP is very low. Shortfalls in donor support for maternal health and family planning and inefficiencies in the utilization of available resources, which was cited repeatedly at the ICPD@15 Asia Review meeting, only compounds the problem.

Improving maternal health and reducing maternal mortality will, therefore, remain one of the most daunting challenges in the region and calls for the following interrelated strategies:

(i) Expand access to basic health services, safe water and improved sanitation;
(ii) Expand access to and improved choice of family planning methods, and make abortion safe where it is legal;
(iii) Improve prenatal care coverage and identify high risk pregnancies;

(iv) Train skilled attendants and improve infrastructure for emergency obstetric care;
(v) Reduce the three delays: delay in decision to seek care, delay in transport and delay in providing appropriate care during and after delivery;
(vi) Target programmes to benefit the poor, socially excluded, marginalized and the vulnerable;
(vii) Address gender inequality and advocate for the rights of women to safe motherhood and family planning; and
(viii) Advocate for increased allocation of resources for health and its efficient utilization.

Family Planning

One of the objectives of the ICPD POA is "To help couples and individuals meet their reproductive goals in a framework that promotes optimum health, responsibility and family well-being, and respect the dignity of all persons and their right to choose the number, spacing and timing of the birth of their children". (para 7.14a) In this regard the POA calls on countries to "...take steps to meet the family planning needs of their populations as soon as possible, and should in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods and related reproductive health services which are not against the law." (para 7.16)

These calls marked an important shift away from a "target centered" approach to a "needs-based, client-centered" approach that, for the first time, recognized the rights of couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and means to do so. It explicitly stated that "demographic goals should not be imposed on family planning providers in the form of targets and quotas for the recruitment of clients", a practice that was previously followed in many Asian countries.

The 10 year review reported that "Since ICPD in 1994, all the countries that had pursued policies involving the setting of targets or quotas and incentives to meet fertility goals have abandoned them in spite of the reservations expressed by some that this, together with the integration of family planning with broader reproductive health care, might have a negative impact on the acceptance of family planning and on the contraceptive prevalence rate." (United Nations, 2004) A review conducted as part of the Fifth APPC has also shown that "The integration of family planning into reproductive health programmes that provide men and women with choice in planning their reproductive lives, while still incomplete, has not led to reversals in fertility decline." (Guest, 2003 cited in United Nations, 2004)

Evidence available from recent surveys indicate that though there has been no reversal in fertility decline, in a number of countries the decline in fertility rates has halted or its rate of decline has slowed. Moreover, even as contraceptive prevalence has increased, unmet need for family planning remains high in a number of countries in Asia and the Pacific and is 20 percent or more in Afghanistan, Cambodia, DPRK, Laos PDR, Malaysia, Nepal, Pakistan, and Papua New Guinea. (see Table 1) In a few Asian and Pacific countries the desired number of children remains high while in a number of others there is a wide gap between the desired and actual number of children. Moreover, there is significant variation among the countries with regard to their contraceptive prevalence rates and in the availability and use of modern methods-as can be seen from Table 1. Countries with high CPRs (more than 60 percent) are China, DPRK, Iran, Mongolia, Sri Lanka Thailand, and Vietnam. Countries with especially low CPRs include Timor-Leste (10) Afghanistan (10), Kiribati (22), Papua New

Guinea (24) and Pakistan (28). Likewise, there are variations among countries with regard to the choice of methods available to clients.

In the Pacific Islands, moreover, CPRs remain well below the average for developing countries and in some countries the CPR has hardly changed in the past 20 years. (see the 1980s data in Lucas and Ware, 1981)

These trends have set off an alarm bell during recent years in various national and international fora, because, if they persist, they will result in increased rates of population growth. This is seen by many as an obstacle to poverty reduction and as contributing to the deterioration of the environment and climate change. Moreover, it is also seen as hindering efforts to achieve other reproductive health goals, including reduction in MMR and child mortality as well as for stemming the spread of HIV/AIDS, as discussed in the following section. Therefore, there has been a growing chorus of calls to reposition and revitalize family planning as part of the development agenda in the coming years.

For example, the Declaration adopted at the 15 year review meeting in Bangkok on 17 September, 2009 has called for enhanced "political commitment to reposition and revitalize family planning as a development agenda for achieving reproductive health outcome as well as broader poverty reduction goals".(ESCAP and UNFPA, 2009) Earlier, the Declaration adopted by the International Forum on ICPD@15 organized by PPD in Kampala during 25-26 November, 2008 calls on Governments 'to emphasize the importance of family planning to the attainment of the MDGs and increase support for family planning in national development budgets and donor supported programmes". (PPD, 2008)

The 2009 MDG report (United Nations, 2009) notes that "Funding gaps are conspicuous for programmes needed to meet MDG 5, the goal towards which least progress been made." The report concludes that "the strengthening and expansion of family planning programmes can make a major contribution to improvements in maternal and child health, but require adequate funding and access to supplies. Yet, since the mid 1990's, most developing countries have experienced a major reduction of donor funding for family planning on a per woman basis."

One of the major priorities in moving the ICPD agenda forward, therefore, is to "reposition" family planning as central to the development agenda by allocating adequate resources for ensuring the supply and availability of family planning commodities and making it accessible and affordable to those for whom access is presently severely limited.

HIV and AIDS

One of the objectives of the ICPD POA is to "prevent, reduce the incidence of, and provide treatment for, sexually transmitted diseases, including HIV/AIDS, and the complications of sexually transmitted diseases such as infertility, with special attention to girls and women." (para 7.29). The Key Actions adopted at the five year review called on Governments to "ensure the prevention of and services for sexually transmitted diseases and HIV/AIDS are an integral component of reproductive and sexual health programmes at the primary health care level. (Key Actions, para 68).

The Millennium Declaration calls on Governments to halt by 2015 and begin to reverse the incidence of HIV/AIDS.

At the regional level, the Fifth Asian and Pacific Population Conference, held in Bangkok in 2002 reviewed the HIV/AIDS situation in Asia and the Pacific and called on Governments and all development partners to: "Establish (a) national prevention programmes, recognizing and addressing the factors leading to the spread

of the epidemic, reducing HIV incidence for those identifiable populations with high or increasing HIV infection or indicated through public health information as at the highest risk of infection, (b) information and education programmes aimed at risk-taking behavior and encouraging responsible sexual behavior and expanded access to essential commodities.." (United Nations, 2003, p 28)

The 10 year review found that most Asian countries have taken steps to stem the spread of HIV/AIDS but noted that in most instances prevention programmes reach only a small proportion of those who are infected or could potentially be exposed to HIV/AIDS infection. The review also noted that accessibility and affordability of testing for HIV and subsequent treatment is limited in most countries. It also highlighted the social and cultural constraints that inhibit the promotion of safe-sex practices particularly among adolescents and unmarried youth, who are most vulnerable. The review has cited Cambodia and Thailand as leading examples to contain and reverse the spread of HIV through effective programmes to promote awareness and condom use. (United Nations, 2004)

The Report of the Commission on AIDS in Asia published in 2008 (see for details Commission on AIDS in Asia, 2008) is the most recent and comprehensive survey of the situation of HIV/AIDS in Asia. According to the report though HIV prevalence rates in Asia are low the numbers infected are high, and it is estimated that the number of people living with HIV is around 4.9 million (estimates range from 3.7 to 6.7 million) in 2007. It is estimated that 440,000 people are newly infected each year with HIV in Asia and that about 300,000 succumbed to the disease in 2007.

The report notes that the incidence and prevalence of HIV and AIDS vary considerably among the Asian countries. For example, HIV prevalence among 15-49 year old men and women are highest in Papua New Guinea (1.8 and 1.2 percent), Thailand (1.7 and 1.2 percent), Cambodia (1.2 and 0.5 percent), and DPRK (1.1 and 1.6 percent). It is also high in Myanmar (0.8 and 0.6 percent), Malaysia (0.8 and 0,3 percent), Vietnam (0.8 and 0.3 percent), Nepal (0.7 and 0.3 percent and India (0.4 and 0.3 percent). In Indonesia, Iran and Lao PDR the rates are 0.3 and 0.1 percent respectively for males and females. In all other countries the rates are around 0.1 percent for both sexes. It is also evident that in Asia HIV prevalence rates are much higher among males than among females. (UNFPA, 2008) In the Pacific, HIV prevalence rates are gradually becoming more equal between males and females.

According to the Commission on AIDS in Asia report, transmission of HIV in Asia is mainly due to unprotected paid sex, sharing of contaminated needles, and unprotected sex between men. The report makes the following conclusions with regard to the future of the pandemic in Asia:

- Men who buy sex, most of who are from 'mainstream society', are the single most driving force in Asia's HIV epidemics and constitute the largest infected group. Because most men who buy sex are married or will get married, significant numbers of ostensibly 'low-risk' women who only have se with their husbands are exposed to HIV. *Effective means of preventing HIV in fections in the female partners (wives or girlfriends) of these men have yet to be developed in Asia, but are clearly essential.*
- Because relatively few women in Asia have sex with more than one partner, the chain of infection tends to end with their wives or girlfriends, though infected mothers might transmit the virus to their unborn or new born infants.
- Hence HIV epidemics in Asia is unlikely to sustain in the general population, independently of commercial sex, drug injecting and sex between men.

- Hence, *prevention efforts that drastically reduce HIV transmission among and between these most-at-risk populations will bring the epidemics under control.*

The report further highlights that stigma and discrimination undermine Asia's response to the epidemic and prevents people from accessing services such as counseling and testing.

Thus, in Asia, HIV transmission is largely driven by male behavior and the conventional wisdom of marriage, instead of protecting women, has become a risk factor for women in contracting HIV. Therefore, preventing men from getting infected through targeted efforts at most-at-risk groups is one way to contain the spread of AIDS. However, it ignores the fundamental right of women to protect themselves and their children from contracting HIV. In addition, gender-based violence, which is widely prevalent in many Asian countries, is reported to increase the risk of HIV among women by 50 percent. Empowering women, therefore, should also be a priority strategy to contain the spread of HIV/AIDS. (PPD, 2008)

Furthermore, preventing men from getting infected through targeted at most-at-risk groups will not protect unsuspecting wives and girlfriends from getting infected with HIV from an unfaithful partner. In this regard, the Commission calls for a strategy to be developed to prevent infections among these women and girls who would not contract HIV except from their husbands or boyfriends.

The Commission notes that "Despite the relatively low numbers of people in Asia who currently need antiretroviral therapy (ART), only one in four (26 percent) people are receiving it." (Commission on AIDS in Asia, 2008)

In the Pacific Islands sub-region, surveillance remains insufficient to determine the precise scale and pattern of HIV infection in all countries. It is clear, however, that Papua New Guinea is the most affected country with HIV prevalence estimated at 1.6 percent of the adult population in 2007 (National AIDS Council Secretariat, 2007; Government of Papua New Guinea, 2009). Elsewhere in the Pacific HIV prevalence in the adult population remains low. Although the annual rate of HIV reporting shows an upward trend from the mid-1980s, the number of reported cases per year in Polynesia has remained relatively constant since 1996. In Micronesia, reported cases peaked in 1999 and have leveled-off since. (SPC 2007) As of 2007, 99 percent of new notifications of HIV infection in the Pacific Islands originated from Papua New Guinea. However, continued vigilance and prevention programmes are essential throughout the region in order to limit the further spread of the epidemic and to roll it back.

The predominant mode of HIV transmission in the Pacific is heterosexual (50%) followed by male-to-male sex (29%) and Injecting Drug Users (6%). As the injection of drugs is rare in the Pacific, this mode of transmission probably occurred outside the region, but was reported locally. Risk factors vary from country to country. In Tuvalu and Kiribati, migrant seamen are known to have brought the infection home to the Pacific and subsequently infected their partners. In Papua New Guinea, the infection has been carried from the coasts to the Highland interior by long-distance truck drivers who buy sex along the highway, as well as by other routes. The primary group at risk of contracting HIV is sexually active young people, especially those who have multiple partners. Men who have sex with men, including transgender individuals, are a second major group at risk (Sladden 2005). The UNAIDS Progress Report on HIV and Aids in Asia and the Pacific (2009) cited reports of surveys indicating that more than one in ten young men said that they had sex with men and condom use was reported to be rare.

An underlying condition that is conducive to

the heterosexual transmission of the HIV virus in the Pacific is the high prevalence rates of other STIs. Recent clinical surveys (WHO 2006) found high rates of Chlamydia (up to 41 percent) and gonorrhoea (up to 1.7 percent) in women under 25 years of age. Such rates are significantly higher than in neighbouring Australia (see: NSW Minister of Health 2007). Expert opinion is that little improvement in these prevalence rates is evident in recent years. Contributing to this pessimistic outlook is the low level of condom use and poor access to treatment-especially for adolescents. Although condom use has been increasing, the use of condoms in "high risk" sex remains below 20 percent in the countries surveyed. Adolescents also find it difficult to obtain non-judgmental treatment in the Island countries where health services are mostly provided by governments. NGOs have had more success in reaching young people.

Family planning programmes can be an effective way to reach out to women at risk of HIV infection with information and services, including counseling, on HIV transmission and prevention. The call for providing integrated reproductive health services, including family planning, in the context of primary health care made at ICPD is important because, among other things, it would protect the confidentiality of women seeking information and services on HIV/AIDS and avoid their stigmatization. It would also reduce the risk of mother to child transmission of HIV. Linking HIV/AIDS and safe motherhood/family planning services would provide synergy and contribute to the attainment of ICPD goals and MDGs.

The Report of the Commission on AIDS in Asia recommends that "Reproductive health services should be used as an entry point to increase women's access to HIV prevention, testing and referral services." Family planning is a central component of reproductive health and family planning programs have reached these women successfully in all countries of Asia. Therefore, efforts to integrate the provision of HIV/AIDS and family planning services should be a priority strategy, as it would give married women a chance to protect themselves from contracting HIV.

This is in line with suggestions made elsewhere: For example, a joint IPPF, UNFPA, WHO, and the joint United Nations Programme on HIV/AIDS (UNAIDS) in 2005 has produced a framework for such priority linkages as a guide for countries to effectively link and integrate SRH and HIV. The review showed that linking SRH and HIV is beneficial and feasible, especially in family planning and HIV testing centres. Cost-effective studies suggested net savings when HIV and STI prevention are integrated into maternal and child health services. (See Raj Karim, 2009)

In spite of the obvious benefits and synergies, efforts to integrate components of RH services, even on a limited scale between HIV/AIDS and safe mother hood/family planning services, have had limited success and face severe constraints in many Asian countries, as discussed in the 10 year review report (United Nations 2004). Yet, advocating for the integration of HIV/AIDS and family planning should be a priority during the coming years.

Meeting the needs of adolescents and young people, particularly girls, for information and services, including counseling, on STD and HIV/AIDS is a challenge for Asian countries because in most countries conventional family planning services are accessible only to married women and men. Progress and challenges in meeting their needs are discussed in the next section.

Adolescent Reproductive Health

The ICPD POA is perhaps the first international agreement to explicitly address the reproductive health needs of adolescents. Despite an ever

increasing number of adolescents in most Asian countries and evolving behavioural patterns among them, including in matters to related to sex, the issue was never before placed on an international agenda. The main objective, as stated in the ICPD POA, is "To address adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion, and sexually transmitted diseases, including HIV/AIDS, through the promotion of responsible and healthy reproductive and sexual behavior, including voluntary abstinence, and the provision of appropriate services and counseling specifically suited for that age group." (ICPD POA para 7.44a)

The ICPD POA called on Governments 'to meet the needs of adolescents and to establish appropriate programmes to respond to those needs." The Key Actions adopted during the five year review further called on Governments 'to protect and promote the rights of adolescents to the enjoyment of highest attainable standards of health" and, towards this end, "provide appropriate, specific, user-friendly and accessible services to address effectively their sexual and reproductive health needs,..."

A regional assessment of progress carried out in preparation for Fifth APPC in 2002 noted the progress that is being made in the countries of Asia. (Jejeebhoy, 2002) While noting that Asian adolescents are not a homogenous group and live in diverse social and cultural contexts called for interventions that are flexible and responsive to the disparate needs. It also noted that (i) sexual and reproductive health needs of adolescents are highlighted in national agendas of Asian countries; (ii) young people's knowledge and awareness on reproductive health is increasing but remain superficial, and (iii) lack of communication with parents and other trusted adults keep young people ill informed.

Accordingly, the Fifth APPC Plan of Action called on Governments to ì Provide adequate access to youth-friendly, age appropriate, evidence-based sexual and reproductive health information, education and counseling, and services on the sexual and reproductive health of adolescents; provide appropriate life-skills training for adolescents to promote female empowerment and male responsibility in reproductive health;..."

The 10 year review undertaken in 2004 (United Nations, 2004) indicated that countries have taken a number of measures that include, among others, (i) introduction of out-of-school youth programmes, (ii) training of teachers on adolescent health issues, (iii) peer education. It was clear during the review that while progress was made in a number of countries it was limited to the formulation of policies/strategies and/or the provision of education, information and counseling. RH services were not available in most countries to adolescents and unmarried young people. In countries with very low age at marriage, social factors limited access to RH/FP services to adolescents and young people, even if they were married. The important role played by NGOs in a number of countries in Asia in initiating innovative interventions to meet the needs of adolescents was also highlighted during the review.

One of the major initiatives undertaken in seven countries of Asia (Bangladesh, Cambodia, Laos PDR, Nepal, Pakistan, Sri Lanka and Vietnam) is the RHIYA (Reproductive Health Initiative for Youth in Asia) project, a collaborative effort by the European Union and UNFPA. The project, implemented with the active involvement and participation of many national NGOs, piloted new and innovative approaches to reach adolescents, in different settings, with information, counseling and services on reproductive and sexual health.

In addition, efforts to create an enabling environment through supportive policies and to reach adolescents, in diverse settings, with information and counseling have continued in

most countries of Asia. (Raj Karim, 2009) Many countries in the region have also conducted special surveys on sexual behavior and sexual and reproductive health issues among adolescents and youth or have included such information on other surveys such as the demographic and health surveys. These are providing valuable information to guide policies and programmes.

The ICPD POA stresses the need to "substantially reduce all adolescent pregnancies". (para 7.45) The teenage fertility rate (births per 1,000 women aged 15-19) is normally used to measure adolescent fertility, and it can be seen from table 1 that teenage fertility rates remains high in many countries of Asia and the Pacific. It is very high in Bangladesh (125 per 1000 women), Nepal (115), and Afghanistan (113). Teen age fertility is lowest in DPRK (1) and China (8) and is approaching low levels in Malaysia (13), Myanmar (16), Vietnam (18) Iran (20) and Sri Lanka (25). It should be noted that in most Asian countries teenage fertility mostly occurs within marriage, and as was indicated earlier, in most of these countries, social and cultural factors limit adolescent's access to reproductive health, including family planning, services. This exposes them to early pregnancies that pose high risk to themselves, the unborn and the newborn. Increases in unprotected sex among unmarried adolescents exposes them to the risk of unwanted pregnancies leading to unsafe abortion and complications or death arising from them. Available evidence indicates that a significant proportion of maternal deaths in Asia occur among adolescents and young women and that an important cause of these deaths is unsafe abortion.

Teenage fertility in the Pacific Islands has historically been high relative to more developed regions but in recent years several Island countries have experienced declines of 20 to 40 percent since the 1990s. In Polynesia and Fiji, teenage fertility is now below the average for the South-Eastern Asia region, but some Micronesian and Melanesian have had persistently high rates in the range of 67-95 births per 1,000. In the Marshall Islands, the 2007 DHS found that over one quarter of girls aged 15-19 were either pregnant or had already given birth. Unlike the situation in Asia, adolescent pregnancy in the Pacific occurs mainly among unmarried girls. The main consequence is disrupted schooling and reduced life prospects, although unsafe abortion and maternal death can also result.

Thus, although there have been major national and regional efforts by Governments, NGOs and other development partners during the past 15 years to improve access to reproductive health services to adolescents, these efforts, at best, have reached only a small proportion of population of adolescents and young people, whose numbers are now at a peak in Asia and much of the Pacific. Significant hurdles for meeting the reproductive health needs of adolescents and young people include, among other factors, social and cultural norms, gender inequality, attitudes of parents, teachers and service providers, and low levels of enrolment and the gender gap in secondary schools that still persist in many countries of Asia.

Addressing these constraints, therefore, must constitute a high priority in future years.

Access, Quality and Integration of Services

Access to reproductive health care: The ICPD POA calls upon all countries to "strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible but no later than the year 2015". (para 7.6) Key Actions adopted during the Five year review in 1999 put it more specifically, calling on Governments to "strive to ensure that by 2015 all primary health-care and family planning facilities are

able to provide, directly or through referral, the widest achievable range of safe and effective family planning and contraceptive methods; essential obstetric care; prevention and management of reproductive tract infections, including sexually transmitted diseases; and barrier methods such as male and female condoms and microbicides if available, to prevent infection. By 2005, 60 per cent of such facilities should be able to offer this range of services and by 2010, 80 per cent of them should be able to offer such services" (para 53).

The inadequacies of Health Information Systems in Asia and the Pacific make it difficult to assess the extent to which primary health-care and family planning facilities across the region are able to provide the range of reproductive health, including family planning, services envisioned by the ICPD POA and ICPD+5. However, realization of this goal is contingent upon the attainment of the Goal of universal access to basic health services through a primary health care approach, as called for in the Declaration of Alma Ata adopted at the International Conference on Primary Health care in 1978, in Alamaty (formerly Alma Ata). While majority of Asian and Pacific countries have achieved this goal there are a number of countries in Asia and the Pacific (e.g Afghanistan, Cambodia, India, Indonesia, Laos PDR, Pakistan, Papua New Guinea, and the Philippines) where large segments of the population do not have access to basic health services. Lack of access to basic health services, therefore, is a major bottleneck in these countries to improved access to the full range of reproductive health services at the primary health care level or through referrals to higher levels of care.

Available information indicates that more than 95 percent of the service delivery points (SDP) in most countries of Asia and the Pacific provide three or more contraceptives. Afghanistan (83), Bangladesh (70), India (90+), Pakistan (70), and Sri Lanka (50+) Kiribati (68) and Samoa (78) are countries in which a significant proportion of SDPs do not provide three or more contraceptives. (UNFPA, 2008) Though information on the specific type of contraceptive available in an SDP is not available, it is likely that the three methods dispensed at most SDPs will include pills, male condoms and injectable (Depo Provera). Availability of other methods (e.g., IUD, norplant, and sterilization that require a skilled staff to provide it) will be limited to secondary and tertiary level facilities, and may be accessed through referral. Emergency contraception and female condoms are unlikely to be available in most SDPs, and this would limit choice.

The ICPD at 10 report for Asia and the Pacific has highlighted the steps taken by a number of countries to improve access to a range of reproductive health, including family planning services through out-reach programmes, community based distribution of contraceptives and through NGO outlets.

In recent years, emphasis is being placed on reviewing service gaps and barriers to address the unmet needs for reproductive health and family planning, and to address needs of marginalized groups-those with higher vulnerability and populations living in crisis and post crisis situations.

Though Government is the main provider of health, including reproductive health, in most Asian countries, NGOs and the private sector play a complementary role in improving access to reproductive health services and commodities, including contraceptives, in a number of countries; with NGOs, by and large, addressing the needs of poor and hard to reach segments, and the private sector largely catering to the needs of the urban and non-poor segments of the population.

Lack of service delivery points/primary health center or outpost, lack of inadequate integration of reproductive health, including family

planning, services, and factors such as poverty, distance, terrain, gender inequality, and cultural norms that limit or constrain access to women, adolescents and young people, and retard progress in achieving the goal of universal access to reproductive health in many Asian countries, resulting in the adverse health outcomes discussed in the preceding sections. It should be noted that it is the poor, the marginalized and those in vulnerable conditions have least access and suffer the most adverse consequences.

Access to supplies and services in the Pacific is determined by the proximity of the service delivery point (SDP) to the population and the likelihood that the SDP will have the required commodity in stock and staff on hand qualified and willing to dispense it. In many rural areas access in this sense remains poor. Secondly, the prospective client must be seen as eligible to receive the service in the view of the service provider. Most if not all Pacific countries have now dropped the requirement that a husband's signature is required before a married woman can be provided with contraceptives. But impediments remain in the case of young unmarried people. In some countries, service providers demand parental approval before dispensing contraceptives to unmarried men and women under 20 years of age.

Available evidence in the Pacific suggests that only general hospitals (located in the national capital), or district hospitals in the larger countries, would be able to deliver the full range of reproductive health, including family planning, services. But even in these locations, services may not necessarily include the female condom, which has only recently been introduced in the region. Recent studies suggest that it is not uncommon for hospital-based RH clinics to offer four alternative methods of contraception (pills, injectibles, condoms, IUDs) as well as male and female sterilization, but health centres and primary health facilities in rural areas are unlikely to be able to offer such choices.

Quality of reproductive health care: If information on access to reproductive health care is limited, as noted in the preceding section, it is less likely that information on quality of care and its various elements is collected, even using sampling methods, in most countries. Key elements of quality of care include: client choice of methods, information for and counseling of users, the technical competence of service providers, interpersonal relations between providers and clients, mechanism for follow-up and continuity of care and an appropriate constellation of services.

Based on the information collected through a field inquiry, country reports presented at the Fifth APPC, and ICPD at 10 reports for Asia and the Pacific, it must be concluded that factors such as inadequate skills of service delivery personnel, lack of client orientation in the delivery of services, insufficient mechanisms for follow-up and supervision and the limited choice available to clients impede progress towards high quality reproductive health care. The reports also noted that progress is being made and cited specific examples of the steps taken by countries to improve quality of care which include, among others, capacity development through training of service providers, establishment of standards of care and protocols, adoption of guidelines for "gender sensitive" care, and strengthening of logistics to ensure supply and availability of RH commodities, including a mix of contraceptives.

In all likelihood these efforts and other interventions to improve service quality have continued at the national level. However, in most countries and at the regional level insufficient importance is given to the collection and analysis of information on quality of care, and this makes it difficult to draw any definitive conclusions on the rate of progress in improving the quality of reproductive health care. Monitoring progress in quality of care is particularly important to assess whether reproductive health, including family planning,

information, counseling and services, that are provided in the Asian and Pacific countries respects the rights of individuals and couples, as called for in the ICPD POA.

Integration of reproductive health services: As noted earlier in this report, the ICPD POA calls upon countries to "...strive to make accessible through primary health care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015." The POA has also identified the major components of reproductive health care. Specifically, the Key Actions adopted at the 5 year review has called upon countries to ensure that 60 percent 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 percent of SDPs will do so by 2010.

The ICPD@10 report for Asia and the Pacific noted that countries in the Asia-Pacific region have made efforts to integrate the various components of reproductive health, including family planning, by identifying essential services package of reproductive health services in the respective national contexts. The review report also noted that countries with well developed health infrastructure and in which family planning services formed part of the health services are moving closer towards fuller integration of services. However, in countries that had vertical programmes for family planning, the move towards integration is proving to be difficult due to a number of factors, and this remains true even today. (United Nations, 2004)

Full integration of services requires management arrangements to facilitate an integrated system of service delivery, including logistics and information support, and the development of human resources. Constraints or obstacles to the integration of the different components of services, which have obvious benefits, are both country- and donor-driven. At the country level they include weak infrastructure, vertical planning, limited community involvement and lack of focus on integration during in-service and pre-service training. Constraints that emerge from donors include misalignment between country and donor priorities, donor competition, and poor harmonization. (PPD, 2008)

Given that integration of major components of RH, safe-motherhood, family planning and HIV/AIDS, is cost-effective and has proven benefits to improve health outcomes--including reduced maternal and child mortality and constraining the spread of HIV--efforts to integrate these services should be pursued as a priority through active advocacy at the highest echelons of Government and in the context of health sector reforms.

Reproductive Health Commodity Security (RHCS)

ICPD POA and the Key Actions of ICPD+5 have stressed the need to ensure reliable and adequate supply of a range of reproductive health commodities, including contraceptives. Increased demand arising from the large number of people currently in the reproductive ages in most Asian and Pacific countries is stretching the ability of countries to meet the increasing demand, a situation which is only aggravated by the economic and financial crisis that hit the countries of the region in 1997 and again in 2008.

Ensuring commodity security has different dimensions. These include, among others, the following: ability to forecast and respond to demand when the need arises; improvements in procurement and logistics management to ensure supply at SDPs; ensuring availability and affordability for the poor, marginalized and the vulnerable; and ensuring adequate resources

for reproductive health commodities, including contraceptives. It also includes that reproductive health commodities, including contraceptives, meet the needs of clients who have their own preference and choice for one or the other methods.

Ensuring reproductive health commodity security has been an important concern for national Governments and development partners, as it is a central to the achievement of ICPD goals and MDGs. Failure to meet the requirements of reproductive health equipment and supplies, including contraceptives, would result in unwanted pregnancies, unsafe abortion and limit the ability to manage the complications arising from them. In significant number of cases these will lead to maternal death. It will also retard efforts to fight the continuing spread of the HIV/AIDS pandemic, particularly among adolescents and young people.

The ICPD at 10 review report for Asia and the Pacific has noted that countries in Asia and the Pacific have taken variety of measures to improve RHCS. These efforts include: promotion of partnerships with NGOs and the private sector in improving access to reproductive health commodities, including contraceptives; making improvements in the procurement and distribution of reproductive health commodities and supplies and strengthening logistics management and information systems, secure technical and financial support from international agencies, including donor agencies.

However, the capacity of countries to plan and manage an efficient logistics management information system, and to procure, store and distribute the reproductive health commodities to SDPs in time, and to ensure access to contraceptives for the poor and vulnerable vary among the countries of Asia. Religious and other factors play a role in determining policies on the method mix made available to the clients in some countries. A shortfall in resources, as discussed below, is another concern for a number of countries in the region.

Assessments of Reproductive Health Commodity Security (RHCS) have been conducted in several Pacific Island countries in recent years, and while some improvements are evident significant impediments to RHCS remain-even in the more developed countries. Several Pacific countries have also developed strategies to improve RHCS-often within the context of a broader Reproductive Health Strategy. But few countries have made specific allocations for RH commodities in their national budgets, in spite of ministerial-level commitments to do so. All developing Pacific countries remain totally or predominantly dependent on UNFPA and/or other donors to provide RH supplies. UNFPA has recently up-graded its purchasing and distribution system at the regional level, so the countries are well-served, but many countries have not complemented this support by improving warehousing and distribution systems at the national level. Despite some progress and high-level political commitment, much remains to be done to ensure that RH commodities are physically available when and where required.

Challenges facing Pacific islands include: maintaining supply under difficult geographic conditions, building the capacity of countries to manage the logistics of medical supplies of all types including RH commodities, and developing skills of estimating and projecting demand, ordering stock, and maintaining inventories. Maintaining the quality of supplies is a further challenge due to a combination of climatic conditions and an insecure supply-chain that exposes goods to deterioration.

C. Gender Equality and Empowerment of Women

Education

The ICPD POA called upon countries to go beyond the achievement of the goal of universal primary education by 2015 and ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational and technical training. (para 4.18)

The Key Actions adopted at ICPD+5 urged all countries to eliminate the gender gap in primary and secondary school attendance by 2005 and to raise primary enrolment to 90 percent by 2010. (Key Actions, para 34) Similarly, the MDG target is to "eliminate the gender disparity in primary and secondary education, preferably by 2005 and in all levels of education no later than 2015".

Regional reviews undertaken during the Fifth APPC, and as part of the 10 year review of ICPD implementation, have shown marked improvements in enrolment in primary and secondary education and in bridging the gender gap. (United Nations, 2004) The review highlighted specific measures that have been taken by Governments to ensure universal primary education and to bridge the gender gap.

According to recent data (UNFPA, 2008) the gross enrolment ratio (the ratio of pupils of all ages enrolled at primary level to the number of children in primary school ages) at primary level is 100 or more in most Asian countries, which is indicative of progress towards the achievement of universal primary education for both girls and boys, except in Pakistan where female enrolment lags considerably behind at 74 percent. (See Table 1) However, net enrolment figures (ratio of pupils of primary school ages enrolled at primary level to the estimated number of children of primary school ages) for 2005 indicate that in some countries (Pakistan, Papua New Guinea, Nepal and Laos PDR) these are lower for girls than boys, and that even among boys the ratios are well below 100. (Osteria, 2009)

Gross enrolment ratios at secondary level, on the other hand, are low in most Asian countries and the ratios vary significantly among them. There are also variations among countries with regard to gender gap at secondary level, with some countries having higher ratios among girls than boys (e.g., Mongolia, Malaysia, Philippines and Thailand) while in many others they are lower among girls (e.g. Cambodia, Laos PDR, and all countries in South and West Asia except Bangladesh and Sri Lanka).

In the Pacific, based on gross enrolment, the gender gap in primary and secondary education is generally small although there are notable exceptions. At primary level, the gap ranges from 0 to 13 percent, while at secondary the range is wider-from 1 to 24 percent (in some countries more girls than boys are enrolled in school). The gender gap at secondary level is greatest in the less-developed Melanesian countries of Papua New Guinea and Solomon Islands and smallest in Micronesia and Polynesia. Net primary enrolment is near or above 90 percent in most Polynesian and Micronesian countries but falls well short of this level in Papua New Guinea and the Solomon Islands.

Gender equality in education is close to being achieved at the primary level across the Pacific sub-region but there is some distance to go before the gap is closed at the secondary level. Because much tertiary education takes place outside the region, it is difficult to estimate the gender gap at the tertiary level; however, most governments and international scholarship providers do strive to maintain a gender balance in the provision of tertiary scholarships.

Employment and Wages

ICPD POA has urged all countries to adopt "appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve self reliance, and ensure women's equal access to the labour market and social security systems." (para 4.4d)

Large numbers of women are economically active in a number of Asian countries. In a number of countries many women work for paid employment in the agricultural sector and while many others work as unpaid family workers. Many women also work in their own homes producing products for sale in the market.

Patterns of employment among women in Asia have been undergoing significant change as a result of the improved education of girls and in response to growing demand for labour. In addition, the number of migrant women workers from a number of Asian countries, including those who move across countries, have increased significantly during recent years. While these trends have been favourable to the advancement of women and for their empowerment and equality with men, many women face discrimination in wages, career development, etc., and experience work place harassment and sexual abuse.

An important indicator used for monitoring progress toward gender equality and the empowerment of women in the MDG framework is the proportion of women employed in paid, non-agricultural work. Available evidence indicates gradual increases in women's participation in paid employment outside agriculture in most countries of Asia, though the situation varies considerably across countries. A recent review has indicated that women constitute less than half of the paid workers in the non-agricultural sector in all the Asian countries and their share is very low in a number of countries. (Osteria, 2009) In the Pacific the female proportion of the paid labour force outside the agricultural sector ranges from only 5 percent in Papua New Guinea to a maximum of 45 percent in the Cook Islands. Access to paid employment, therefore, is far from balanced by gender in Asia and the Pacific.

Political Participation

The Key Actions adopted at ICPD+5 reaffirmed the call made at ICPD to " establish mechanism to accelerate women's participation and equitable representation at all levels of the political process and public life in each community and society... and ensure the full and equal participation of women in decision making processes in all spheres of life." (para 43)

The 10 year review noted that countries have taken a number of measures, including affirmative action and constitutional provisions, to promote the participation of women in political and decision making levels at all levels. As a result, and with improved education, women's role in political processes and decision making is gradually improving in a number of countries in Asia. However, a recent regional review has noted that the percentage of women in ministerial level positions and in the national parliaments is lower than 20 percent in most Asian countries. (Osteria, 2009)

Political participation in the Pacific has shown little improvement over the past decade and the proportion of seats in parliament presently held by women remains below 10 percent in most Pacific Island countries. Papua New Guinea, with 109 seats in Parliament has only one woman member, and this has been the case for the last two parliaments. In spite of efforts to appoint women directly to parliament, an option provided for in the Constitution, no such appointments have been made to date.

Gender-based Violence (GBV)

The ICPD POA urged countries to "eliminate violence against women" (para 4.4e) and to "...take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children". (para 4.2) and to foster "zero tolerance" towards violence against girls and women. The urgent need to address GBV is also highlighted in the Fifth AAPC plan of Action (United Nations, 2004, para E.3)

Gender-based violence is recognized as a major human rights issue in many international development agendas, including the ICPD POA and the Beijing Platform for Action. It includes a wide range of violations of human rights, including trafficking in women and girls, rape, spousal abuse, sexual abuse of children, and harmful practices that irreparably damage the reproductive and sexual health of girls and women. (UNFPA, 2004)

Gender-based violence, in various forms and severity, is prevalent and pervasive in all countries; women, throughout their life cycle are exposed to and suffer from its consequences. The 10 year review of ICPD implementation has indicated that there is a growing awareness of the problem among senior policy makers in many Asian countries and that a number of countries have taken measures to minimize its occurrence and to protect those affected. These include enactment of legislation, instilling respectful attitudes towards girls and women among boys through education, and enabling men to support women's rights and their empowerment. The review has also highlighted a number of religious, cultural and social factors that constrain efforts to reduce the incidence of GBV.

Good quality data on various forms of gender-based violence are scarce in Asia and those available from records of reported cases often underestimate its prevalence. Recent surveys, such as demographic and health surveys (DHS), have begun to collect information which possibly will yield more accurate information in the future. The WHO Multi-country study on Women's Health and Domestic Violence against women (WHO 2005) included one rural and one urban site in Bangladesh and Thailand and one urban site in Japan. In the urban sites, the proportion of women who had ever experienced physical or sexual violence (or both) was 53 percent in Bangladesh, 41 percent in Thailand and 15 percent in Japan. In the rural locations the rates were 62 percent in Bangladesh and 47 percent in Thailand. These rates are among the highest of all the countries surveyed by WHO.

Domestic violence is a common phenomenon in most countries and is often considered as "normal". Most women who are victims of domestic violence do not report such abuse for fear of persecution from the family and the community and further abuse from authorities-even those who are expected and obliged to provide protection. There are also reported cases of sexual harassment and gender-based violence in the work place in many countries. As discussed in the preceding sections, gender-based violence is detrimental to women's reproductive health and is a factor in maternal death and the transmission of HIV.

Indirect as well as direct evidence indicate that in some Asian countries and communities there are many instances of extreme forms of violence against women. These include dowry and honor killings and acid throwing, to mention a few. Educational campaigns have been launched and laws have been enacted to prevent these heinous practices, but they continue.

There is also clear evidence of trafficking of girls and women from and to a number of countries in Asia and the number is increasing. As noted in an earlier section, agreements have been reached between some countries of the region to deal with this issue and to provide help for the victims when they are found.

The number of people displaced by natural disasters and civil and military conflicts has increased the number of internally displaced persons and refugees in many Asian countries. Women and girls who live in conflict areas and in the camps are not only exposed to severe health risks due to lack of access to services, including reproductive health and family planning services, but often are also victims of violence, sexual harassment and abuse.

In the Pacific, the ICPD+10 review of the implementation of ICPD shows that most Pacific Island countries have taken some steps to address gender-based violence; but recent research suggests that these steps have been insufficient. There has also been some regression as one Pacific government has recently refused to ratify CEDAW on the grounds that it is against its "culture".

Representative studies of GBV have now been conducted in each of the three sub-regions of the Pacific using standardized methodology developed by WHO. In the countries studied, the incidence of "physical partner violence" among ever-partnered women aged 15-49 ranged from 41 percent in Samoa to 46 percent in Solomon Islands and 60 percent in Kiribati. In Solomon Islands and Kiribati, 64 and 68 percent of women, respectively, had experienced physical and/or sexual partner violence. These rates are among the highest reported in the world by WHO. (WHO 2005) Somewhat lower, but still high rates of violence against women were found in the recent Marshall Islands DHS: 28 percent of women aged 15 and over reported having experienced violence and 72 percent of these women indicated that their husband or partner was the perpetrator. (Republic of Marshall Islands, 2009) Although most men and many women believe that physical violence on women by men is approved or permitted by "culture", the incidence of violence is higher in urban areas than in the more "traditional" rural villages. Factors conducive to violence include unemployment and access to alcohol. Some evidence suggests that more educated women are less likely to experience sexual violence than less educated women. Nevertheless, there is little doubt that violence against women remains a serious social issue in the Pacific across all social groups.

D. Partnerships and Resources

Partnerships

The ICPD POA stressed that the achievement of population and development goals would require enhanced partnerships at various levels. The importance and effectiveness of international cooperation between donor and recipient countries, and the role of non-governmental and private sector organizations were acknowledged and encouraged. The comparative advantages of NGOs in addressing culturally-sensitive issues and in reaching constituencies that may be poorly served by government agencies was highlighted. The POA also stressed the importance of coordination of the activities and programmes of all development partners to avoid unnecessary duplication and to ensure congruency between programmes. (ICPD POA, Chapt. 14).

Similarly, the Key Actions adopted at ICPD+5 stressed the need for enhanced collaboration and cooperation between governments, multilateral donors, non-governmental organizations, civil society, community based organizations, etc. to advance the ICPD POA. (paras 76-86) The important role that parliamentarians and national legislatures can potentially play in advocating for the implementation of the POA was also highlighted. Similarly, the Fifth Asian and Pacific Population Conference reiterated the on-going importance of greater cooperation and partnerships between governments, NGO, the private sector and community-based organizations. The further involvement of parliamentarians in advocacy for and awareness-raising of ICPD and the need for

more South-South cooperation were again stressed. (ESCAP, 2003)

The MDGs has as one of its Goals: "Develop a global partnership for development" across a range of substantive areas-including the international trading system, addressing the special needs of Land-locked and Small Island Developing States, debt relief, affordable drugs, and information and communication; and has set of targets to be achieved.

The regional reviews undertaken as part of ICPD+5 and ICPD+10 have shown that NGOs and Civil Society Organizations have played a pioneering role in highlighting issues that are culturally sensitive that the national Governments are reluctant or slow to address. For example, it has been noted earlier that NGOs are actively involved in improving access to reproductive health services for adolescents in many Asian countries. The review also found that since ICPD direct donor support to NGOs-with the concurrence of the Governments- for population and reproductive health programmes has increased and it was estimated that for the region as a whole one third of the total expenditure for population activities was channeled through NGOs.

At the regional level, NGOs have mobilized themselves periodically (e.g., during the Fifth APPC and the 15-year regional reviews) to take stock of progress in meeting ICPD Goals and propose strategies for moving the agenda forward. NGOs take active part in the Asia-Pacific Conference on Reproductive and Sexual Health (APCRSH) which provide a forum for sharing of experiences in promoting reproductive rights and in improving access to reproductive health services among the countries and participants from the region.

Many countries included NGO representatives in their national delegations during the Fifth APPC. At the national level, however, the role and importance of NGOs in population and reproductive health programmes vary considerably among the countries. In a few Asian countries NGOs are given voice in the planning and policy processes while in others they have had only limited role in implementing small scale projects or programmes. There are also example of countries in Asia earmarking funds in the national budgets for NGO programmes and activities.

A number of Asian countries have sought cooperation from religious leaders and other influential groups at the community level to promote reproductive rights and reproductive health and to improve access to information, counseling and services for adolescents and young people. Efforts have also been made in the Pacific Island countries to involve the churches and national church bodies in population programmes, including those addressed to adolescents.

However, the view was expressed during the Asia-Pacific NGO consultations to mark ICPD@15 that the role played by NGOs has diminished and needs to be strengthened. Hence the Asia-Pacific NGO Forum "urged Governments to recognize NGOs as equal partners and create inclusive mechanism for meaningful NGO and civil society participation."

Parliamentarians have played an important role in population programmes in Asia for well over three decades. The Asian Forum of Parliamentarians on Population and Development (AFPPD) and the affiliated national committees of members of parliaments in 24 Asian countries have become active in promoting the Cairo Agenda at the global, regional and national level. (Singh, J. 2002) In a number of countries they have played important role in promoting legislation in support for reproductive health rights and programmes and for promoting gender equality and equity.

One of the important modalities for sharing of experiences among the countries is South-South

cooperation. Partners in Population and Development (PPD), formed during the ICPD, promotes sharing of experiences among its membership, which includes six countries from Asia; and plays an active advocacy role at various global and regional and national fora.

There are a number sub-regional intergovernmental organizations consisting of Asian countries (e.g ASEAN, SAARC, BIMSTEC, ECO, and Pacific Islands Forum) with potential for advancing the ICPD agenda. Efforts to involve SAARC and ECO at the early stages did not go beyond organizing a few sub-regional conferences during the 1990's.

PRSPs, SWAps, UNDAF and the efforts to advance MDGs have provided added opportunity for improving civil society participation in setting the agenda for development and for their implementation in a number of Asian countries.

In the Pacific, the scale and intensity of collaboration and cooperation between national governments, multilateral agencies, donor countries, NGOs, Civil Society and community based organizations has increased substantially in recent years. This is exemplified by the institutional arrangements put in place to address HIV and other STIs. The "Pacific Regional Strategy on HIV and other STIs 2009-13", along with its implementation plan and technical working groups has provided an effective umbrella framework for cooperation and collaboration between national governments, donors, NGOs, and multilateral organizations that was previously lacking. A similar regional approach has been developed in the area of reproductive health services and commodities. The "Pacific Policy Framework for Achieving Universal Access to Reproductive Health Services and Commodities 2008-2015" agreed to by Pacific Ministers of Health provides a framework for collaboration-especially between governments and NGO service providers. NGOs have already played a significant role in providing reproductive health services to adolescents and youth, but mostly at national levels and on a small scale. The recently-approved Pacific Policy Framework should enhance the opportunities for NGOs involvement in providing services to youth, an area in which they have been more successful than government-run clinics.

Some progress has also been made in introducing the "sector wide approach" (SWAp) to health policies. Three countries (Papua New Guinea, Solomon Islands and Samoa) have adopted the SWAp in the health sector, bring together a wide range of organizations to address the common purpose of improving the delivery of health services.

An important milestone in the creation or fostering of partnership in support of the ICPD POA in the Pacific was the creation of the Pacific Parliamentarians Assembly on Population and Development (PPAPD) in 2002. The PPAPD has provided an effective forum for policy dialogue within which legislators have improved their understanding and knowledge of population issues and the goals of the ICPD POA.

Examples of south-south cooperation in the Pacific Islands can be found but this modality of cooperation remains underutilized.

Partnership, collaboration and coordination in the Pacific has undoubtedly increased in scale and importance at the national and regional level since the advent of the UNDAF modality closely followed by the MDG framework. The inclusion of the target of "universal access to reproductive health" under MDG 5 has provided an entry-point for population issues in strategies to achieve the MDGs. All international agencies and the major donor countries firmly support the MDGs and have achieved a significant level of cooperation in doing so.

Resources: Domestic and International

One of the objectives included in the ICPD POA is to "achieve an adequate level of resource mobilization and allocation, at the community, national and international levels, for population programmes and for other related programmes, all of which seek to promote and accelerate social and economic development, improve the quality of life for all, foster equity and full respect for individual rights, and by doing so contribute to sustainable development." (para 13.21)

It was estimated at the time that the implementation of the costed package which includes family planning services; basic reproductive health services; STD, HIV and AIDS prevention activities; and basic research, data and population and development policy analysis would cost US$ 17.0 billion in the year 2000 and increase to 21.7 billion by the year 2015. It was also noted that two-thirds of the projected costs should be mobilized from domestic sources and the remaining one third should be borne by international donor community. It should also be noted that the costed packages of services does not include broader population and development objectives included in Cairo Agenda and there has been no attempt to estimate the resources required for meeting these broad development objectives. Resource requirements using more robust estimates of demand and the rising costs of commodities and equipment are currently being undertaken, which when available, will provide a more accurate picture of the situation.

Monitoring of resource flows indicates that by 2000 international population assistance totaled $2.6 billion, which was only 46 percent of the goal of $5.7 billion and represented considerable shortfall in resources at that time. Since 2002, however, international assistance has steadily increased to 7.4 billion in 2006, which surpasses the goal set at the ICPD.

A recent UNFPA report notes that "although the total financial target has been surpassed, the increase has not been evenly distributed over the costed population categories." Moreover, it is noted that "significant amount of resource flows goes to other population-related activities that address broader population and development objectives of the Cairo agenda, but that have not been costed out and are not part of the agreed target..." The report notes that funding for family planning is well below target, according to the estimates.

Estimates of domestic expenditure, though more difficult to track and estimate, is reported to be US$11.1 billion in 2007, which is slightly lower than the goal set at ICPD.

The Asia and Pacific region was the second largest recipient of population assistance and final expenditure figures indicate an increase from $365.1Imillion in 1997 to $885.5 million in 2007. Of these nearly half are channeled through NGOs while the remainder is channeled through bi-lateral (19 percent) and multi-lateral (34 percent) support. India ($149.9 million), Bangladesh ($92.0 million) and Indonesia ($76.3 million) are the three major recipient countries.

With increasing demand and increasing cost and with the inclusion of the components that were not costed in 1994 it is very likely that the available resources will be considerably below what is actually needed. In this regard, it should be highlighted that public expenditure on health as percent of GDP, as indicated earlier, is woefully low in most Asian countries.

Available estimates for the Pacific suggest that total international resources increased from $7.8 million in 1997 to $41.7 million in 2007-a five-fold increase. But 79 percent of this increase was in Papua New Guinea and undoubtedly can be explained by very large increases in funding for HIV and AIDS programmes. In 2007,

three-quarters of all international population assistance in the Pacific sub-region went to Papua New Guinea. When Papua New Guinea is excluded, international resources in the remaining countries increased from $2.7 million to $8.9 million over the 1997-2007 period. While this is a considerable increase, it is highly likely that some of it can also be attributed to increased allocations for HIV prevention in other Pacific countries. More detailed analysis of the data would need to be conducted to confirm this.

It is also probable that family planning programmes in Papua New Guinea have not received a proportional increase in funding over the decade as a result of the flows of resources to HIV prevention. In general, support for family planning in the Pacific sub-region has been falling, as in other regions (Robertson 2007a, 2007b). The lack of resources may partially account for the low level of contraceptive prevalence and high unmet need in the Pacific sub-region. While HIV prevention remains a high priorityóespecially in Papua New Guinea-ensuring that family planning programmes receive an increasing share of aid flows is also crucial if unmet need is to be reduced across the sub-region.

When Papua New Guinea is excluded, the Pacific Island countries receiving the largest shares of international financial assistance over the past decade were Solomon Islands (21.3%), Fiji (21.2%), Federated State of Micronesia (12.0%) and Tonga (8.4%). However, on a per capita basis, the smaller Island countries of Niue, Tuvalu, Cook Islands, Palau and Marshall islands were the largest recipients.

It is imperative that Governments in the Asia-Pacific region should increase their budgetary allocation to population and development programmes and to use their resources more efficiently in order to reduce the shortfall in resources. It is particularly important that adequate funding should be provided to expand access to family planning services in order to reduce the unmet demand which is still high in many countries.

SECTION 3: PROGRESS, CHALLENGES AND PRIORITY STRATEGIES

Progress

Periodic reviews undertaken in Asia and the Pacific have shown that progress is being made in advancing the Cairo Agenda in nearly all the countries of the region. Important gains are the following:

1. Reorienting population programmes, particularly family planning programmes, away from a "target driven" approach to "a rights-based, need based approach", including in countries which had previously resorted to methods that were coercive or had used various forms of incentives and disincentives to clients and service providers to meet specified targets. The practice of target driven and coercive approach, it can be said, is a thing of the past and there will be no return to "pre-Cairo" ways of meeting population and fertility goals.
2. Progress towards achieving universal primary education in nearly all countries of Asia and the Pacific and in reducing the gender gap at primary level of schooling. Most countries have achieved universal primary education for both boys and girls and others are well on their way in achieving it.
3. Reducing infant and child mortality in most countries, though it remains high in some countries and in the poorer segments of the population.
4. Arresting or slowing the spread of HIV and AIDS in countries with high prevalence, although it constitutes a significant threat to women's and men's health in a number of countries. The HIV epidemic continues to spread in some sub-national areas and countries.
5. Placing the reproductive and sexual health needs of adolescents and young people firmly on the national agenda of most countries of the region.
6. Recognition that gender-based violence and its impact on women's health and welfare are important issues to be addressed in national agendas.
7. Reduction in poverty, as measured by the proportion of people living below $1.25 a day, in most countries and for the region as whole.

Challenges

While these are notable achievements there are major challenges that need to be addressed to achieve ICPD Goals and MDGs by 2015. For example:

1. Inequities in access to health and other basic services remain high and are possibly increasing in many countries, in spite of rapid rates of economic growth and reductions in poverty in most Asian countries.
2. Universal access to reproductive health, as called for in the ICPD POA, is far from being achieved in the Asia-Pacific region. Achieving this goal will remain elusive until the inequities in access to basic services, including health services, are significantly reduced.
3. The unmet need for family planning remains high and funding for family

planning programmes has declined even as demand for such services has increased due to an increase in the number of people entering the reproductive ages and increasing demand for contraceptive choice. Reproductive health commodity security, including for family planning commodities, is yet to be realized in many countries.

4. Access to services for making pregnancy, delivery and the post-partum period safe is limited for women in poor households and hard to reach locations. In particular, access to Emergency Obstetric Care is severely restricted for many women due to reasons of cost, distance and delay in providing appropriate care.
5. Asian and Pacific women, who have "low-risk" of contracting HIV, are at "high-risk" due to the sexual behaviour of their husbands, and most of them do not have access to information and counseling to protect themselves. HIV continues to spread rapidly in some areas and STI prevalence is high in some countries.
6. Adolescents and young people constitute the largest ever cohort in many Asian countries. Yet, most of them have limited or no access to secondary and/or vocational education, decent employment, and are denied access to information, counseling and services on reproductive and sexual health.
7. Rates of gender-based violence are unacceptably high in many countries of the Asia-Pacific region. Women also face discrimination, and are often denied access to services.
8. Ageing and international migration are emerging as priority issues in many countries of the region. Yet, there is only limited information and knowledge about these emerging trends and what impact they might be having on development.
9. National capacity to address the many challenges identified above, though not addressed in detail in the report, remains limited in a number of countries.
10. Resources for family planning are declining even as the requirements are increasing, and public expenditure for health as percent of GDP in most Asian countries is very low.

Priority Strategies

The following are a set of priority strategies to address the above challenges:

1. Restore family planning as a major component in national development agendas such as national development plans and poverty reduction strategies, and allocate adequate resources. This is important to enable women to exercise their reproductive rights, and to protect themselves from unwanted/unplanned pregnancies; contracting HIV and AIDS; and to minimize the risk of ill health and/or death due to pregnancy and delivery. Stronger family planning programmes will also contribute to the goal of reducing child mortality.
2. Improve access to pre-natal, safe delivery and post natal care for pregnant women especially from poorer households and marginalized segments of the population.
3. Promote and facilitate the integration of safe-motherhood, family planning and HIV prevention services.
4. Strengthen quality of care of RH services, including family planning, and take steps to monitor progress.
5. Expand access to reproductive health information and services, including counseling, for adolescents and young people, particularly girls, and advocate for improved access to secondary education and gainful employment.

6. Address gender based violence by advocating for changes to national laws, policies and practices and by empowering women to realize their full potential through expanded access to education and employment. Address the special needs of women in vulnerable situations, such as natural disasters and civil and armed conflicts.
7. Promote the involvement of men and boys in enhancing reproductive rights and the reproductive health of women.
8. Plan for an ageing future as there is no "luxury of time" and "no luxury of resources". This will include, among others, investing in youth, to benefit from the demographic dividend, promoting healthy ageing, re-orienting health systems and services to meet the health needs of older persons, establishing and expanding old age social security, and supporting the participation of older persons to remain active.
9. Optimize the benefits afforded by international migration through policies that are supportive of migrants and the promotion of the rights of migrants and their families.
10. Adopt a pro-poor approach to planning and programming for the delivery of services, including safe-motherhood and family planning, to reduce the inequities in access.
11. Advocate actively for increases in the allocation for health, including for family planning, in the national budgets, and with the international community to meet their commitments.
12. Build the population and development knowledge base and its utilization through improved data collection, analysis, research and capacity development.
13. Strengthen cooperation among countries, and with NGOs, CSOs, the private sector, members of parliament, and other development partners for advocacy, building knowledge base and, as appropriate, for the delivery of services.

Finally, it should be highlighted that capacity development efforts, particularly in the above mentioned areas, should receive high priority. In a number of Asian and Pacific countries national capacity to implement the ICPD POA remains limited, even after 15 years into the 20-year POA.

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Table 1: Selected ICPD and MDG Indicators ca 2008-2009 (South and South-West Asia)

	ICPD		ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG
Sub-region/Country	**Expectation of life at birth(2009)***		**Infant mortality rate (per 1000 live births)***	**Under five mortality rate (per 1000 live births)***	**Maternal mortality ratio (per 100,000 live births)****	**Unmet need for family planning (%)****	**Contraceptive prevalence rate (%)****	**Teenage fertility rate (births per 1000 population 15-19 years)****	**Births attended by trained personnel (%)****
	Male	**Female**							
South and South-West Asia									
Afghanistan	44	44	154	31	1800	23.0	19	13	14
Bangladesh	65	68	43	54	570	11.3	58	125	20
Bhutan	65	68	43	61	440	----	31	37	51
India	63	66	53	79	450	12.8	56	62	47
Iran(Islamic Republic of)	70	73	28	32	140	5.9	74	20	97
Maldives	70	74	22	26	120	--	--	--	84
Nepal	66	68	48	61	830	24.6	48	115	19
Pakistan	66	67	62	86	320	30.0	26	36	54
Sri Lanka	70	75	15	19	58	8.0	70	25	97
East and North-East Asia									
China	72	75	22	28	45	--	87	8	98
Democratic People's									
Republic of Korea	65	70	47	82	370	21.0	69	1	97
Mongolia	64	70	41	43	46	4.6	66	45	99

Source: *ESCAP: Population data sheet, 2009, Bangkok, 2009; **UNFPA APRO: Selected Population and Reproductive Health Indicators for Asia and the Pacific.,2008, Bangkok, 2009;***UNICEF:2008, State of the World's Children,2009: Maternal and Newborn Health, New York, 2009;

****Osteria, T. Asia Pacific population Journal, 24(1), p 129, 2009, #refers to 2007

Table 2: Selected ICPD and MDG Indicators ca 2009 (South and South-West Asia)

	ICPD/MDG		MDG		MDG		MDG	ICPD	ICPD
Sub-region/Country	**Antenatal coverage - at least one visit and at least four visits*** **		**Proportion of population using improved water source and sanitation (%)**		**Ratio of girls to boys in education (girls per 100 boys in school)**** (Based on netenrolment, 2005-2007)**		**Proportion of seats held by women in national parliament (%)****	**Gross enrolment ratio, primary****	**Gross enrolment ratio, secondary****
	1 visit	**4 visits**	**Water**	**Sanitation**	**Primary**	**Secondary**		**Boys/Girls**	**Boys/Girls**
South and South-West Asia									
Afghanistan	16	--	39	34	--	--	--	126/75	28/9
Bangladesh	51	21	74	39	1.04	1.04	15.1	101/105	43/45
Bhutan	88	--	62	70	1.00	1.01	2.7	103/11	51/46
India	74	37	86	33	0.96	0.74(2001)	9.0	116/113	59/49
Iran(Islamic Republic of)	77@	94@	94	--	1.10	0.94	--	104/132	83/78
Maldives	81	--	83	59	1.00	1.09	12.0	--	--
Nepal	44	29	90	35	0.95	0.75(2000)	17.3	129/123	46/41
Pakistan	61	28	91	59	0.78	0.76	20.4	94/74	34/26
Sri Lanka	99	--	79	91	--	--	4.9	108/108	86/88
East and North-East Asia									
China	90	--	77	44	--	--	20.3	112/111	75/76
Democratic People's									
Republic of Korea	--	--	100	59	--	--	--	--	--
Mongolia	99	--	62	59	1.01	1.11	6.6	99/102	84/95

Source: *ESCAP: Population data sheet, 2009, Bangkok, 2009; **UNFPA APRO: Selected Population and Reproductive Health Indicators for Asia and the Pacific.,2008, Bangkok, 2009;***UNICEF:2008, State of the Worldís Children,2009: Maternal and Newborn Health, New York, 2009;

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Table 3: Selected ICPD and MDG Indicators ca 2008-2009 (South-East Asia)

	ICPD/MDG		MDG		MDG		MDG	ICPD	ICPD
Sub-region/Country	Antenatal coverage - at least one visit and at least four visits		Proportion of population using improved water source and sanitation (%)		Ratio of girls to boys in education (girls per 100 boys in school)*** (Based on net enrolment, 2005-2007)		Proportion of seats held by women in national parliament (%)***	Gross enrolment ratio, primary**	Gross enrolment ratio, secondary**
	1 visit	4 visits	Water	Sanitation	Primary	Secondary		Boys/Girls	Boys/Girls
South-East Asia									
Cambodia	69	27	41	17	0.96	0.86	11.4	127/118	43/34
Indonesia	93	81	77	55	0.96	1.00	11.3	116/112	64/64
Lao PDR	27	--	51	30	0.94	0.86	25.2	123/109	49/38
Malaysia	79	--	99	94	1.00	1.10	13.1	101/100	66/72
Myanmar	76	--	78	77	1.01	1.00	22.1	114/115	49/49
Philippines	88	70	85	72	1.02	1.21	24.5	110/109	79/88
Thailand	98	--	99	99	1.00	1.12	8.7	108/108	76/82
Timor-Leste	61	30	58	36	0.96	--	25.3	103/95	53/54
Viet Nam	91	29	85	61	0.94(2001)	0.92(2001)	25.8	92/88	76/75

Source: *ESCAP: Population data sheet, 2009, Bangkok, 2009; **UNFPA APRO: Selected Population and Reproductive Health Indicators for Asia and the Pacific.,2008, Bangkok, 2009;***UNICEF:2008, State of the World's Children,2009: Maternal and Newborn Health, New York, 2009;

****Osteria, T. Asia Pacific population Journal, 24(1), p 129, 2009, #refers to 2007

Table 4: Selected ICPD and MDG Indicators ca 2009 (South-East Asia)

	ICPD		ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG
Sub-region/Country	Expectation of life at birth*		Infant mortality rate (per 1000 live births)*	Under five mortality rate (per 1000 live births)*	Maternal mortality ratio (per 100,000 live births)	Unmet need for family planning** (%)	Contraceptive prevalence rate (%)**	Teenage fertility rate (births per 1000 population 15-19 years)	Births attended by trained personnel (%)**
	Male	Female							
South-East Asia									
Cambodia	60	63	80	84	540	25.1	40	42	44
Indonesia	69	73	25	30	420	9.1	58	40	66
Lao PDR	64	67	47	61	660	27.3	32	72	19
Malaysia	72#	76#	9	11	62	24.0	55	13	100
Myanmar	60	64	72	105	380	17.0	37	16	57
Philippines	70	74	22	28	230	17.3	51	47	60
Thailand	70	76	13	15	110	--	72	42	97
Timor-Leste	61	62	64	87	380	3.8	10	54	19
Viet Nam	73	77	19	22	150	4.8	76	18	88

Source: *ESCAP: Population data sheet, 2009, Bangkok, 2009; **UNFPA APRO: Selected Population and Reproductive Health Indicators for Asia and the Pacific.,2008, Bangkok, 2009;***UNICEF:2008, State of the Worldís Children,2009: Maternal and Newborn Health, New York, 2009;

****Osteria, T. Asia Pacific population Journal, 24(1), p 129, 2009, #refers to 2007

Table 5: Selected ICPD and MDG Indicators ca 2000-2008 (Pacific sub-region)

	ICPD		ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG	ICPD/MDG
Sub-region/Country	**Expectation of life at birth***		**Infant mortality rate (per 1000 live births)***	**Under five mortality rate (per 1000 live births)**	**Maternal mortality ratio (per 100,000 live births)**	**Unmet need for family planning (%)**	**Contraceptive prevalence rate (%)**	**Teenage fertility rate (births per 1000 population 15-19 years)**	**Births attended by trained personnel (%)**
	Male	**Female**							
Melanesia									
Fiji	65.3	69.6	13.1	26.0	43	20	45	32	99
Papua New Guinea	53.7	54.8	57.0	77.0	--	46	24	65	53
Solomon Islands	60.6	61.6	66.0	--	175	11	27	67	86
Vanuatu	65.6	69.0	25.0	30.0	148	--	38	--	74
Micronesia									
FSM	67.4	68.0	37.5	--	317	44	--	--	93
Kiribati	58.9	63.1	52.0	69.0	284	--	22	39	63
Marshall Islands	63.7	67.4	21.0	37.0	--	8	37	138	94
Nauru	55.2	57.1	38.0	--	--	--	25	69	97
Palau	66.3	72.1	20.1	--	--	--	17	29	100
Polynesia									
Cook Islands	68.0	74.3	15.3	--	--	--	44	44	98
Niue	67.0	76.0	7.8	29.0	--	--	23	28	100
Samoa	71.5	74.2	20.4	24.0	22	--	31	45	89
Tonga	67.3	73.0	19.0	25.0	136	--	28	24	95
Tuvalu	61.7	65.1	35.0	--	--	--	19	42	100

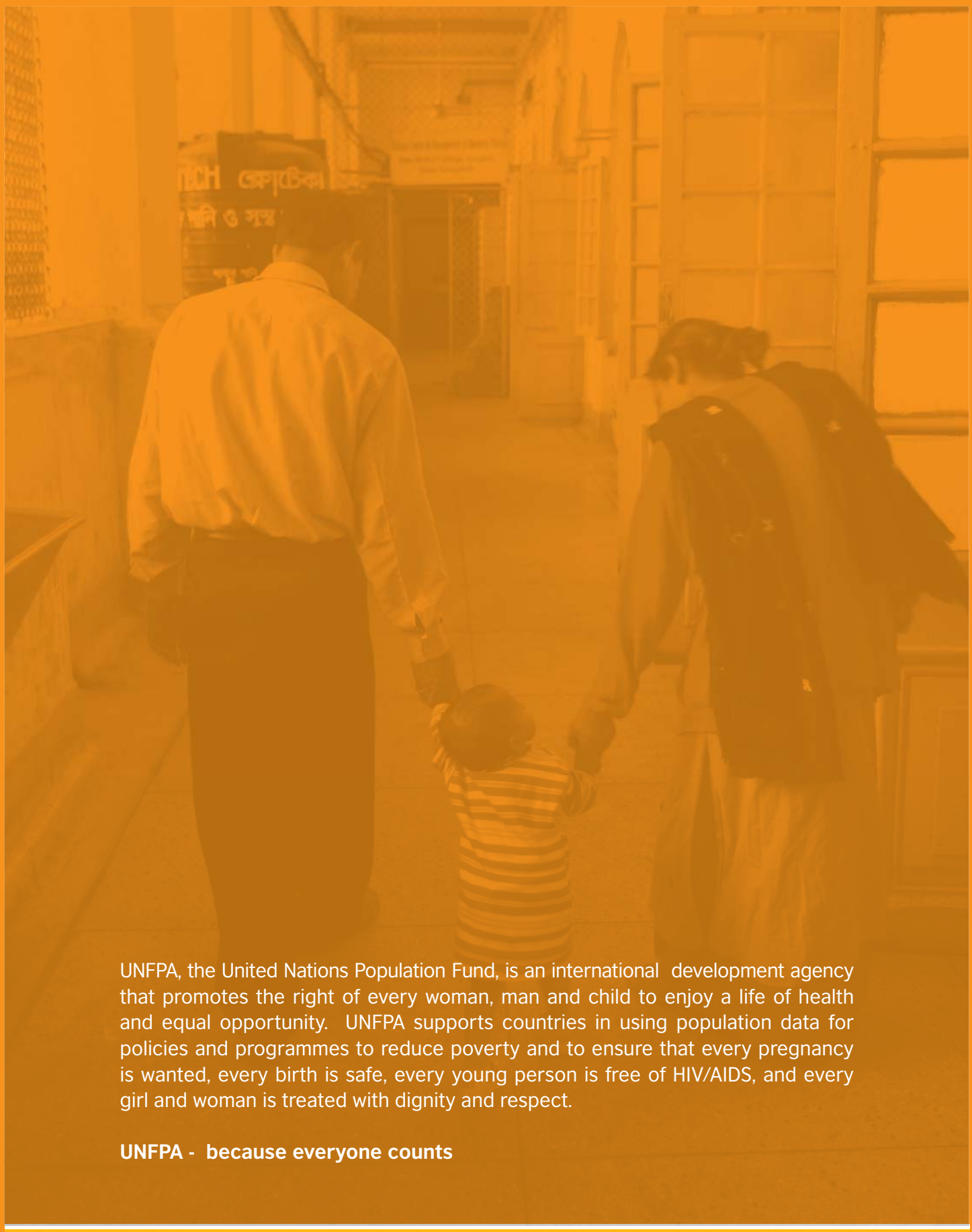
Source: UNFPA Sub-regional Office for the Pacific database. Secretariat for the Pacific Community (SPC), 2009 Population data sheet. Noumea. AusAID (2009).

Table 5: Selected ICPD and MDG Indicators 2000-2008 (Pacific sub-region)

	ICPD/MDG		MDG		MDG		MDG
Sub-region/Country	**Antenatal coverage - at least one visit and at least four visits**		**Proportion of population using improved water source and sanitation (%)**		**Ratio of girls to boys in education (girls per 100 boys in school)***		**Proportion of seats held by women in national parliament (%)**
	1 visit	**4 visits**	**Water**	**Sanitation**	**Primary**	**Secondary**	
Melanesia							
Fiji	100.0	--	92.7	98.8	98	107	8.7
Papua New Guinea	77.5	54.9	40.0	45.0	86	67	0.9
Solomon Islands	97.2	64.6	29.8	22.4	86	70	0.0
Vanuatu	67.0	--	75.3	95.2	91	93	3.8
Micronesia							
FSM	80.0	--	94.0	44.0	93	104	7.1
Kiribati	--	--	53.1	36.5	93	114	5.6
Marshall Islands	95.4	77.1	98.4	70.7	83	104	3.0
Nauru	94.5	--	81.7	96.9	115	84	6.0
Palau	100.0	88.0	100.0	100.0	97	100	3.7
Polynesia							
Cook Islands	100.0	--	95.1	99.3	89	94	8.0
Niue	--	--	99.0	100.0	86	83	10.0
Samoa	100.0	--	97.3	100.0	93	104	6.1
Tonga	--	--	98.0	99.0	90	99	1.0
Tuvalu	99.0	--	92.5	86.5	93	87	0.0

Source: UNFPA Sub-regional Office for the Pacific database. Secretariat for the Pacific Community (SPC), 2009 Population data sheet. Noumea. AusAID (2009).

*Not adjusted for sex ratio in population



UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity. UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

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