

**Oral Report**

**by**

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**Agenda item 20  
Other Matters**

**Contribution of UNFPA to the Implementation of the Brussels  
Programme of Action for LDCs for the decade 2001-2010**

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Mr. President, distinguished delegates:

## **Introduction**

UNFPA is committed towards working with the Least Developed Countries (LDCs) to achieve the goals and objectives of the Brussels Programme of Action (Brussels POA), 2001-10, and has been incorporating, wherever relevant, the goals of the Brussels POA within UNFPA's policies and programmes.

National poverty reduction is central to UNFPA's agenda, and it is believed that investments in reproductive health, women's empowerment and gender equality can break the cycle of poverty that traps millions of people in the developing world. Slower population growth allows countries more time and resources to combat poverty. Since the Poverty Reduction Strategy (PRSP) process started in 1999, UNFPA has been increasingly engaged in this process in the poorest countries to reduce poverty and improve the welfare of disadvantaged people. An analysis of the PRSPs undertaken thus far in LDCs indicates that an increasing number of countries have factored population dynamics, reproductive health and gender into the poverty analysis. However, it is important that countries also include population and RH issues in their policy matrix and provide increasing resources for these important areas in their budgets.

In line with UNFPA's commitment to the poorest countries, the resource allocation system was revised in 2004 to further strengthen the share of resources going to the poorest countries. With this new classification, all LDCs automatically fall into the A category and as a result, nearly two thirds of the Fund's country programme resources went to UNFPA's Category A countries (57 countries which include all LDCs).

I would like to provide a brief review and assessment of UNFPA activities in LDCs during the period 2000-05. In doing so, may I once again stress that UNFPA is working very much under the leadership of national governments and in close collaboration with our other UN partners.

## **1. Maternal Health and Sexual and Reproductive Health Services, including Family Planning**

A key action identified in the Brussels POA was the strengthening of the basic health system and increasing access to and availability of the widest range of quality health care, including RH. During the review period, UNFPA supported programmes in maternal health (MH), sexual and reproductive health (SRH), and family planning activities in all of the 50 LDCs. In several countries which faced emergency situations including Afghanistan, Democratic Republic of Congo and the Maldives, UNFPA provided a wide range of RH and family planning services. These led to increased access both to modern contraceptives and to integrated reproductive health services.

A large part of UNFPA's maternal health and sexual and reproductive health initiatives in the LDCs were capacity building activities in the form of training and provision of equipment. Between 2000 and 2005, UNFPA initiated or supported RH training in 48 of the LDCs, covering STI treatment, diagnosis, and prevention, counselling skills, gender mainstreaming, life saving skills, contraceptive service techniques and family planning technology, basic RH services, basic and emergency obstetric care, post abortion care, management and communication skills, infection prevention, gender-based violence, and fistula diagnosis and repair. The capacity of the LDCs to provide RH services by providing equipment, drugs,

medical supplies and supporting the rebuilding and refurbishing of health centers, hospitals, and maternity wards was also strengthened.

In the area of family planning, UNFPA played a major role as provider of contraceptives in all the LDCs. The provision of commodities was usually accompanied by training for service providers. Religious leaders have been educated and trained on the importance of RH and family planning in order to encourage their advocacy in ten LDCs. More efforts are needed to increase male involvement.

UNFPA has supported adolescent reproductive health (ARH) initiatives in over three-quarters of the LDCs both inside and outside of schools. In 14 LDCs UNFPA is supporting the Population and Family Life Education curriculum to teach adolescents about ARH, gender, STIs, including HIV and women's rights. Outside of schools, UNFPA is supporting Youth Centers, Youth Friendly Services (YFS), and peer educators in 34 of the LDCs.

## **2. Data support, including censuses and Demographic Health Surveys**

The Brussels PoA identified severe inadequacies in demographic data as a major constraint that restricted effective policy formulation and requested assistance from development partners. In this respect, UNFPA provided assistance in the area of data collection, analysis, and dissemination in approximately three-quarters of the LDCs and more specifically in the collection and analysis of data from Demographic Health Surveys (DHS) and/or Censuses. Key activities included training of planners, demographers, statisticians, and government officials; and provision of equipment such as computers, vehicles, data processing equipment and GIS equipment. In Afghanistan, for example, where a census had previously

never been completed, UNFPA worked with the Central Statistics Office to design a national population and housing census that responded to an urgent need for up-to-date and reliable information to aid the reconstruction process.

Apart from capacity building, UNFPA also supported directly the data collection process in several countries including Burundi, Ethiopia, Timor-Lesté, Uganda, Gambia and Eritrea. The results of such support were often instrumental in revising national population policies, enhancing dialogue on population and development issues, developing integrated development databases and identifying key development challenges to support the analysis of priorities for future development interventions.

### **3. HIV Prevention and Services**

UNFPA country offices in 38 of the LDCs worked on HIV prevention issues, with the majority of interventions (19 countries) being youth-related initiatives. While in many of the countries, UNFPA programmes employed behavioural change communications (BCC) techniques, including peer educators to raise awareness about HIV, in several others UNFPA focused on prevention by working with high risk groups, including IDPs, women, refugees, commercial sex-workers, students, and peacekeepers. Other programs included support for voluntary counseling and testing (VCT), supporting services for persons living with HIV/AIDS (PLWHA), and working to lessen mother-to-child transmission rates. UNFPA-supported capacity building took place in 13 of the LDCs in a variety of formats which often included teacher training, curriculum development, development of student activity books and teacher guides, and trainings of teachers, healthcare workers, and police

officers. These programmes have been a catalyst in promoting and creating demand for RH services.

#### **4. South-South cooperation**

UNFPA supports South-South cooperation in all its mandated areas and encourages the sharing of good practices. During 2000-05, UNFPA facilitated South-South cooperation on a variety of subject areas in over half of the LDCs. South-South cooperation has been encouraged in several ways, but during the reporting period it most often took the form of study tours and/or training at institutes or universities in other developing countries. These study tours not only encouraged information sharing but also helped in building partnerships between countries with common challenges and problems. The countries most commonly visited included Egypt, Tunisia, Ethiopia, the Philippines and Malaysia. Areas of interest included dealing with RH and gender issues from a religious perspective, curriculum development and awareness raising skills on population, building national capacity in data collection, census taking and Census data processing. In addition to study tours and educational exchanges, the sharing of experiences has also taken place through partnerships as well as participation in Conferences and meetings organized by the Fund.

Through South-South cooperation, LDCs also benefited from technical expertise of other developing countries such as in the areas of health system improvements at the district level, understanding of population and poverty linkages, use of GIS mapping equipment, Census implementation, and RH care. UNFPA's facilitation in South-South cooperation has been important in helping countries in similar circumstances share experiences, gain knowledge, identify common problems and build partnerships.

## **5. Integration of Population, Reproductive Health and Gender into National Development Strategies**

In almost all LDCs, UNFPA worked with the Governments to develop population policies and integrate population factors including RH and gender into national development strategies and plans. UNFPA is providing and supporting capacity building efforts and raising awareness among government officials in almost half of the LDCs on the linkages between population and poverty as a way to integrate population issues into national development or poverty reduction frameworks. The Fund worked for the inclusion of Gender, including GBV in national development strategies and policies in many LDCs, many of whom have developed National Plans for the Protection of Women, National Gender Policies, and National Family Law Codes.

## **6. Gender advancement and mainstreaming, and advocacy for women's rights**

UNFPA is working on gender advancement issues in almost all of the LDCs. The main gender areas in which UNFPA is involved are Gender Based Violence and Female Genital Mutilation, with main interventions through programs in delaying early marriage initiatives, skills training and women's centers, girls education, and women's legal rights, including inheritance, marriage, land, divorce, and child custody. UNFPA's capacity building efforts in the LDCs has been very broad ranging from advocacy and specific project activities that contributed to improving the numbers of girls being educated, increasing boys' understanding of their roles in partnerships and increasing the confidence of girls to effectively negotiate issues

related to their reproductive health. Although much has been done in the area of gender, more needs to be done to address the feminization of poverty, girl's education and GBV and FGM as these are critical for addressing the MDGs and the Brussels POA.

**Conclusion:**

UNFPA remains committed to supporting LDCs implement the Brussels Programme of Action. We will continue to work with our national partners and UN partners to ensure effective and coherent support to national implementation of the Brussels Programme of Action, building on successes and learning from experience to date.

Thank you, Mr. President.