



UNECE

Fulfilling the Potential of Present and Future Generations

Report on ICPD Programme of Action Implementation
in the UNECE Region



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Preface

Five years after the regional ICPD Beyond 2014 review process and the adoption of the *2013 Chair's summary*, UNECE and UNFPA have collaborated to report on the achievements and challenges faced by member States in the implementation of the recommendations contained in that outcome document. This report highlights key population and development trends affecting the UNECE region since the adoption of the *2013 Chair's summary*, outlines replicable solutions to common issues, and puts forward action-oriented recommendations to further advance the implementation of the International Conference on Population and Development (ICPD) Programme of Action in the region.

The UNECE region is at the forefront of a global demographic transformation from population growth to population ageing, coupled with increasing and complex international migration flows. In this context, UNECE countries have made some progress in the implementation of the *2013 Chair's summary* recommendations. This is evidenced by improvements in individual social and economic outcomes at the regional level. However, progress has been uneven across and within subregions and countries, and multiple and overlapping forms of inequality and discrimination continue to impede individuals from realizing their full potential, even in the most advanced countries.

Therefore, protecting and promoting human rights across generations without distinction, including sexual and reproductive health and rights and gender equality, remains central to ensure inclusive and sustainable societies across the region.

In response to the *2013 Chair's summary* recommendation to create a mechanism for continuous follow-up of implementation of the ICPD Programme of Action, this report presents the *UNECE Monitoring Framework for the ICPD Programme of Action*. The Monitoring Framework is aligned with the 2030 Agenda for Sustainable Development, has served to take stock of progress towards implementing the *2013 Chair's summary* recommendations and can be further tailored to national realities.

As efforts in the UNECE region are accelerated to implement the 2030 Agenda for Sustainable Development, the report articulates the conceptual linkages and synergies between the ICPD Programme of Action and the Sustainable Development Goals, which in turn need to be reflected in policy processes at the national and local level to maximize impact and available resources.

This report was prepared to inform the UNECE Regional Conference 'Enabling Choices: Population Dynamics and Sustainable Development' (1–2 October 2018, Geneva), which marks the 25th anniversary of the ICPD held in Cairo in 1994. Both the report and the outcome of the conference discussions have the potential to contribute towards more equitable development and prosperity for generations and societies across the UNECE region.

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Abbreviations and acronyms

CEDAW	United Nations Convention on the Elimination of all Forms of Discrimination Against Women
CRPD	United Nations Convention on the Rights of Persons with Disabilities
CSO	Civil society organization
ECOSOC HLPF	United Nations Economic and Social Council High-Level Political Forum on Sustainable Development
EECARO	UNFPA Eastern Europe and Central Asia Regional Office
EU	European Union
GBV	Gender-based violence
HPV	Human papillomavirus
ICPD	International Conference on Population and Development
ILO	International Labour Organization
IPPF EN	International Planned Parenthood Federation European Network
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MIPAA	Madrid International Plan of Action on Ageing
NCD	Non-communicable disease
NEET	Not in employment, education or training
OECD	Organisation for Economic Co-operation and Development
PoA	Programme of Action
PLHIV	People living with HIV
RHM	Roma Health Mediators
SDG	Sustainable Development Goal
SOGI	Sexual orientation and gender identity
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNFPA	United Nations Population Fund
UPR	Universal Periodic Review
WHO	World Health Organization

Executive summary

ICPD+25 review: Towards sustainable development in the UNECE region

In 2014, the international community reviewed progress on the 20-year implementation of the Programme of Action (PoA) of the International Conference on Population and Development (ICPD). The United Nations Economic Commission for Europe (UNECE), in close collaboration with the United Nations Population Fund (UNFPA), led the ICPD Beyond 2014 regional review, which concluded with the UNECE Regional Conference 'Enabling Choices: Population Priorities for the 21st Century' (1–2 July 2013, Geneva). The Chair's summary of the 2013 Conference (hereafter *2013 Chair's summary*) was presented as the outcome document of the 20-year review in the UNECE region, containing recommendations for member States. In its Resolution 2014/1, the Commission on Population and Development (CPD) requested the Secretary-General, in collaboration with the United Nations system and relevant organizations, to continue assessing and reporting on progress towards the full implementation of the ICPD PoA. Resolution 2016/1 emphasized that outcome documents of regional conferences should provide region-specific guidance on population and development beyond 2014.

The ICPD+25 regional review undertaken by UNECE and UNFPA in 2018 builds on the analysis of population and development outcomes since 2013 in key areas highlighted by the *2013 Chair's summary*. Relevant indicators and data sources were identified in the *UNECE Monitoring Framework for the ICPD Programme of Action Beyond 2014*, which includes a significant number of Sustainable Development Goal (SDG) indicators to align with the 2030 Agenda for Sustainable Development. Unlike the ICPD Beyond 2014 regional review, the 2018 review did not draw on national reports by UNECE member States. Instead, it is based on secondary sources of

information from international databases, including the Voluntary National Reviews database on national and subnational progress on the 2030 Agenda for Sustainable Development, reports from international and intergovernmental organizations, country and regional reports to recent reviews of international action plans, country reports to international human rights processes and binding instruments, and academic research.

The Regional Report on ICPD+25 was prepared to inform the UNECE Regional Conference 'Enabling Choices: Population Dynamics and Sustainable Development' (1–2 October 2018, Geneva). It reviews progress in implementing the ICPD PoA and, specifically, the priorities identified in the *2013 Chair's summary* for the UNECE region. Building on the persistent and emerging population and development issues identified in the ICPD Beyond 2014 regional review, the report provides an overview of key trends and challenges that have affected UNECE countries since the adoption of the *2013 Chair's summary*, presents replicable solutions to common issues and puts forward action-oriented recommendations to further expand and accelerate the full implementation of the recommendations of the *2013 Chair's summary* going forward.

Over the past five years, UNECE countries have made some progress in the implementation of these recommendations. This is evidenced by aggregate improvements in individual social and economic outcomes related to the three central themes of the *2013 Chair's summary*: population dynamics and sustainable development; families, sexual and reproductive health over the life course; and inequalities, social inclusion and rights. Yet progress has been uneven across and within regions and countries. Multiple and overlapping forms of inequality and discrimination continue to impede individuals from realizing their full potential, even in the most advanced countries.

Population dynamics and sustainable development

The *2013 Chair's summary* underscored the need to take a long-term, holistic, rights-based approach to population dynamics and its linkages with sustainable development. In this regard, it called on member States to invest in human capital across generations by enhancing their citizens' access to quality education, decent work and health and social care services, promoting healthy lifestyles and supporting their involvement in decision-making. The *2013 Chair's summary* also encouraged UNECE member States to reduce carbon dioxide (CO₂) emissions and strive for energy efficiency.

The current demographic and socio-economic context reaffirms that the UNECE region is at the forefront of a global demographic transformation from population growth to population ageing, coupled with increasing and complex international migration flows. By 2030, population is projected to decline in 20 of the 56 UNECE member States; by 2050, 10 countries in the eastern part of the region are projected to experience population declines of at least 15 per cent.

The region's average total fertility rate was estimated at 1.8 children per woman of reproductive age in 2015, the same level as in 2010, and it remained below replacement level in 49 of the 56 UNECE countries. Mortality rates for adults (15–60 years old) continued to decline across the region, yet in most countries in the eastern part of the region, including the new European Union Member States, it remains unacceptably high, particularly among men.

Life expectancy has increased for both men and women across the region and reached an average of 74.9 years for men and 81.1 years for women in 2015. Persons aged 65 years and older accounted for 15 per cent of UNECE's total population in 2015, a proportion

projected to increase to 21 per cent by 2030 and to 24 per cent by 2050. According to the United Nations Department of Economic and Social Affairs (UN DESA) World Population Policies Database, ageing was perceived as a major concern by 45 of the 56 UNECE member States in 2015, and 34 of these member States were implementing or considering policy measures to address low fertility levels in recent years.¹

In several countries in the eastern part of the region negative population growth rates are exacerbated by significant out-migration of working-age populations, while net migrant inflows of working-age populations are witnessed by countries in the western part of the region. Unemployment, poverty and the insufficient social protection faced by rural populations is leading to the depopulation of rural areas in some countries in the eastern part of the region, potentially impacting the utilization of productive land as well as the quality of infrastructure and services, including the quality of education. Recent years were also characterized by an increase in forced displacement across international borders, with some UNECE countries hosting large refugee populations.

For the first time since the 2008 global financial crisis, positive economic growth was observed in 2017 in all UNECE countries. Overall, however, over the past five years the region has experienced a difficult and uneven recovery from the global financial crisis, which has added significant pressure on social spending.

Investing in human capital development across the life course contributes to addressing the implications of population ageing, as well as to more inclusive and sustainable development. Levels of pre-primary, primary and lower secondary school completion vary across and within UNECE countries, as do learning outcomes, stressing the importance of ensuring universal access to

¹ United Nations Department of Economic and Social Affairs (2016) *World Population Policies*

Database. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

quality education from early childhood through adolescence. Similarly, access to lifelong learning and actual participation in education and training programmes among older persons differ noticeably across countries.

Youth unemployment in the region declined from 20 to 18 per cent between 2010 and 2015, yet it remains unacceptably high, particularly in some countries in southern Europe. The proportion of youth not in education, employment or training amounted to 14 per cent in 2015. Guaranteeing smooth transitions from education to employment and access to decent work remain prominent strategies to secure the income of young persons and reverse the out-migration of qualified young professionals. In 2014 and 2015 the proportion of parliamentarians aged under 40 amounted to just 15 per cent in the UNECE region, hence youth participation in political life can be further enhanced.

Overweight and obesity are among the fastest-growing health issues for children and adolescents, notably affecting boys and the most deprived groups in society. Physical inactivity rates among children and adolescents are also increasing rapidly, and although alcohol use has decreased among adolescent girls and boys since 2010, it continues to represent a public health concern. Health at later ages is shaped by accumulated experience and adopted lifestyles throughout the life course, thus highlighting the need to prevent unhealthy behaviours that are often established during childhood and adolescence.

The current working-age population (25–64 years old) faces specific challenges deserving policy attention. Women's increased participation in the labour force, economic uncertainty and constraints in combining parenthood with professional careers are factors contributing to the inability of couples to realize fertility aspirations. In below-replacement fertility contexts, higher fertility levels were observed in countries where holistic family policies support parents to reconcile family and working life. Countries in

Central Asia where fertility is presently well above replacement level can reap the benefits of a potential demographic dividend, if adequate investments in education and economic reforms which result in more open economies and business-friendly environments are made.

UNECE countries have achieved progress in promoting healthy, active and independent living among older persons. However, the impact remains uneven across countries and subregions, with life expectancy in Eastern Europe and the Caucasus and in Central Asia still markedly below the region's average, particularly for men. This is partly due to the burden of non-communicable diseases, the rate of which remains highest in these two subregions, disproportionately impacting men. Further improvements require the promotion of healthy lifestyles and behavioural changes in dietary intake, alcohol consumption and smoking across generations, and the eradication of inequalities and disparities in access to services that may serve as risk factors.

The labour force participation rate of persons aged 60–64 increased from 39 to 44 per cent between 2010 and 2016, while that of persons aged 65 and older remained stable at 11 per cent. Women belonging to these two age groups were less likely to engage in the labour force than men. When engaged in the labour force, older persons can lead satisfying professional lives, support their families and contribute to the productivity of economies and the sustainability of social security systems. Participation in education and training among persons aged 55–74 is on the rise but still at very low levels in the eastern part of the region. As workforces age and economies evolve rapidly, maintaining and updating skills throughout working life and the promotion of and access to lifelong learning remain essential.

The region's societies increasingly rely on informal care when confronted with population ageing and growing needs for long-term care. Middle-aged women are likely to be

the first responders to informal care needs, often bearing a triple burden as they care for the younger and older generations while remaining engaged in the labour force, with implications for their own health and well-being. Older generations play an important role in the provision of care to their children and grandchildren, as well as their partners, older relatives and relatives with disabilities. The long-term viability of such intergenerational support systems is debatable, as family size declines and women increasingly participate in the labour force into older ages. Policies that holistically address the needs of older persons in terms of housing, transport, social and civic life, among others, remain key, as do policies facilitating the reconciliation of employment and care work in all life phases.

UNECE countries achieved significant reductions in CO₂ emissions between 2000 and 2014, yet these continue to impact livelihoods and ecosystems within and beyond the region. A shift in consumption behaviours and the development of innovative technologies that reduce consumption without declines in well-being are required to achieve sustainable development.

Families, sexual and reproductive health over the life course

The *2013 Chair's summary* called on member States to guarantee universal access to sexual and reproductive health (SRH) care. It encouraged them to strengthen comprehensive sexuality education programmes, including the training of professionals, and remove barriers that limit access to contraceptive methods, eliminating preventable maternal mortality and morbidity and ensuring the prevention and treatment of HIV and other sexually transmitted infections (STIs), among other measures. The *2013 Chair's summary* also recognized the increasing diversity in family structures and the need to protect vulnerable family members.

Meeting the SRH needs of all persons requires the removal of access barriers, commitments to advancing gender equality and the strengthening of health systems for the universal provision of an essential package of SRH services and information from birth to old age that responds to changing SRH needs without financial overburden. Integrating this package of SRH services at the primary health-care level remains central to success. Recent aggregate trends in SRH outcome indicators confirm that UNECE countries have made some progress in enhancing access to quality SRH care, although progress has been uneven across package components, and across and within countries. Much remains to be done to guarantee the availability of an essential, integrated package of SRH services and information to all persons.

Sexuality education has been implemented in many UNECE countries, yet it can only be considered comprehensive in a few contexts. With some exceptions, teachers remain insufficiently trained. Access to modern contraception in many countries is limited by availability, choice, costs, including the lack of subsidization or reimbursement, poor-quality information and misconceptions, and discriminatory policy barriers such as a requirement for third-party authorization. Between 2010 and 2015, the demand for family planning satisfied by modern contraceptive methods increased slightly from 76 to 77 per cent, although it remained noticeably lower in some subregions such as South-Eastern Europe, rising from 52 to 55 per cent during the same period. Since 2013, a number of UNECE countries have also made steps in revising restrictions in existing abortion laws and in removing barriers to access to safe abortion services, yet more can be done to remove barriers denying women timely access to safe abortion care where it is legal.

Aggregate decreasing trends in abortion confirm an expansion in access to contraception and knowledge, including comprehensive sexuality education, and progress towards achieving gender equality.

However, measures are still lacking in ensuring universal access to a wide range of effective, evidence-based, acceptable and affordable modern contraceptive methods, with special attention paid to adolescents and youth to protect themselves from STIs and unintended pregnancies.

Maternal and neonatal mortality declined moderately between 2010 and 2015, although considerable subregional differences prevail. While antenatal care and skilled attendance at birth are almost universal in the region, these rates evidence gaps in the quality of such services, as well as in emergency obstetric care and perinatal and post-partum care, which deserve policy attention.

Across Europe, the Caucasus and Central Asia, sexual transmission of HIV continued to increase, accounting for 71 per cent of all new HIV diagnoses in 2016. The HIV epidemic continued to grow at a fast pace in the eastern part of the region, where over 120,000 new HIV infections occurred in 2017, representing an increase of 30 per cent since 2010 and reflecting insufficient political commitment and domestic investment in national AIDS responses. Less than half of persons living with HIV in Eastern Europe and the Caucasus and Central Asia received antiretroviral therapy in 2016. Reversing these trends requires increased prevention, testing and treatment efforts, as well as fighting growing stigma and discrimination against people living with HIV and key at-risk population groups (injecting drug users, men who have sex with men, and sex workers) and youth. Low levels of knowledge among youth about HIV transmission, coupled with those related to condom use and increases in the sexual transmission of HIV, call for a specific policy focus on this population group.

The risk of primary and secondary infertility among women and men increases with STI infections and, to some extent, with postponements in childbearing. While the demand for infertility information and services as well as assisted reproductive technologies is likely to continue to grow in the

coming years, reducing infertility risk factors such as obesity, smoking and alcohol and drug abuse, which particularly affect men, as well as unsafe abortions, STIs and post-partum infections should remain high on the agenda. The burden of cervical and breast cancer can be reduced by investing in national screening programmes that target at-risk population groups, intensifying human papillomavirus vaccination coverage among girls (9–13 years), and strengthening screening registries.

Over recent decades, UNECE countries have witnessed transformations in family formation, with trends towards cohabitation, single-parent families and reconstituted families, among others. Family support policies need to be oriented to family diversity and ensure the delivery of universal, integrated and locally based services which guarantee equality of opportunity, irrespective of family type, and with more intensive delivery for at-risk populations.

Inequalities, social inclusion and rights

The *2013 Chair's summary* highlighted that equality and non-discrimination are necessary preconditions for all individuals to enjoy their human rights and realize their potential. It called on member States to achieve gender equality and guarantee the social inclusion of marginalized groups, which continue to suffer multiple and intersecting forms of inequality, disempowerment and discrimination. The *2013 Chair's summary* placed a special emphasis on ensuring individuals are able to find the desired work–life balance to realize their fertility aspirations.

Aggregate gender gaps in labour force participation and median earnings have moderately narrowed in the region, yet women remain less likely to participate in employment and continue to be paid less than men for equal work. Additional efforts are required to address the underrepresentation of women in leadership positions at all levels of public life.

Achieving a successful and more gender-balanced reconciliation between work and family responsibilities remains a challenge. Entitlements around childbirth remain focused on mothers, and only a few countries have introduced gender-sensitive leave entitlements that favour the involvement of fathers. The proportion of children aged 0–2 enrolled in formal childcare and pre-school has moderately increased in the western and central parts of Europe. Further efforts need to be directed at ensuring an adequate work–family reconciliation, including affordable childcare, compensating for women’s lost income during full-time childcare, avoiding long-term maternity leave that excludes women from the labour market, and providing non-transferrable paternity leave and other measures fostering the participation of men in childcare and the equal sharing of responsibilities, including through flexible working arrangements for employees with care responsibilities.

Gender-based violence remains a pervasive challenge to the region’s societies, requiring coordinated responses from the health, education, social and legal sectors through rights-based, life-course preventive and response measures. The Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention) entered into force in 2014 and has been signed by 45 UNECE member States, 32 of which have ratified it. UNECE countries have made progress in developing legal and policy frameworks to strengthen prevention mechanisms, provide effective assistance to victims and access to social services for perpetrators, strengthening the judicial system and implementing information campaigns, among others. Gender-biased sex selection as well as child and forced marriages remain of concern in some societies in the eastern part of the region.

The at-risk-of-poverty rate declined between 2010 and 2016 in many countries, yet children, single mothers and older women are still more likely to face poverty and experience greater

inequalities. Alongside universal and equitable access to quality services, social protection systems that adopt a life-course approach remain central to mitigating the impacts of poverty and breaking inequality cycles.

Policy efforts that support the integration of migrants are more common in the original 15 countries of the European Union (EU15). As the intensity and complexity of international migration deepens, member States can further protect the rights of migrants and facilitate safe, orderly and regular migration. UNECE countries hosted over 17 per cent of the world’s total estimated 25.9 million refugees and asylum seekers in 2016. Additional efforts can be directed at strengthening their protection and social inclusion.

In a number of countries, minority groups, including ethnic minorities, such as the Roma, and persons with disabilities, continue to face persistent exclusion, material deprivation, as well as inferior educational and health outcomes, calling for enhanced investments in their capabilities and social protection. Efforts are also required to combat the stigma, discrimination and violence faced by persons of diverse sexual orientation and gender identity (SOGI). An analysis of Universal Periodic Review (UPR) country reports on accepted recommendations on discrimination and violence on the basis of SOGI shows that various countries have achieved progress in this area.

The way forward: Addressing persisting and emerging population and development issues

The analysis presented in this report points to persisting and emerging population and development issues that deserve high policy priority. Some affect the entire UNECE region, while others significantly impact specific subregions, UNECE countries, or population groups within and across countries.

Holistically addressing them at the national and local levels through a multi-stakeholder approach will contribute to the achievement of

the ICPD PoA goals and objectives, the *2013 Chair's summary* recommendations and the Sustainable Development Goals (SDGs), and to capitalize on the integrated nature and linkages among these agendas. This demands increased policy coherence at national and local levels to maximize impact and available resources, as well as coordination and collaboration among and within governments, donors, the United Nations, civil society organizations (CSOs), the private sector and intended beneficiaries.

Allocating domestic human and financial resources, strengthening the funding and capacity of CSOs and creating enabling environments remain key to deliver on commitments. The removal of barriers hindering access to services, including SRH services, deserves priority. Meaningfully engaging younger and older generations alike and capitalizing on their energy, innovation, experience and expertise can contribute to the realization of sustainable societies.

UNECE countries have implemented a wealth of good practices across diverse contexts, highlighting the potential of international cooperation and collaboration in mobilizing and transferring resources, knowledge and technologies, and devising common solutions to common issues.

Some population and development issues, however, have seen only limited research, measurement and implementation. This is the case of healthy habits and physical activity, comprehensive sexuality education, the SRH of

older persons, primary and secondary infertility, gender-based violence, child and forced marriages, trafficking, and social attitudes and values, among others.

In addition, the limited availability of disaggregated data for marginalized population groups remains one of the most prominent challenges. The *UNECE Monitoring Framework for the ICPD Programme of Action* presented in the report represents a first step in this direction, serving as an accountability mechanism for all relevant stakeholders to monitor progress towards the implementation of the ICPD PoA and the *2013 Chair's summary* recommendations.

UNECE and UNFPA will continue to facilitate the generation of timely, high-quality knowledge, support advocacy and policy dialogue processes, develop institutional capacities and foster partnerships and coordination.

The findings of the Regional Report on ICPD+25, alongside the 2018 UNECE Regional Conference deliberations, will inform the global review of the ICPD at the 52nd Session of the Commission on Population and Development in 2019, the 2019 UNECE Regional Forum on Sustainable Development, and the 2019 United Nations Economic and Social Council High-Level Political Forum on Sustainable Development. To better integrate the review and follow-up of the ICPD PoA and the 2030 Agenda on Sustainable Development, future review cycles of the ICPD PoA will be aligned with the SDG review cycle and take place every four instead of five years.

ICPD+25 review:

Towards sustainable development in the UNECE region

In 2014, the international community completed the review on the 20-year implementation of the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) at national, regional and global levels under the title of *ICPD Beyond 2014*.

Regional reviews were led by the United Nations Regional Commissions in close collaboration with the United Nations Population Fund (UNFPA). In the UNECE region,² the ICPD Beyond 2014 review concluded with the UNECE Regional Conference 'Enabling Choices: Population Priorities for the 21st Century' (1–2 July 2013, Geneva). The Chair's summary of the 2013 Conference³ was presented as the outcome document of the 20-year review in the UNECE region, containing recommendations for member States.

Outcomes of regional reviews contributed to the global assessment of *ICPD Beyond 2014*, which took place at the 47th session of the Commission on Population and Development in April 2014 and culminated in the 29th Special Session of the United Nations General Assembly in September 2014. In its Resolution 2014/1, the Commission requested the Secretary-General, in collaboration with the United Nations system and relevant organizations, to continue to assess and report on progress towards the full implementation

of the ICPD PoA. Resolution 2016/1 emphasized that outcome documents of regional conferences should provide region-specific guidance on population and development beyond 2014.

In preparation for the ICPD+25 review, the UNECE Population Unit and the UNFPA Eastern Europe and Central Asia Regional Office (EECARO) have worked with government experts, civil society partners, young people and other stakeholders to assess progress made, and to identify challenges and gaps in the implementation of the recommendations outlined in the *2013 Chair's summary*.

This UNECE Regional Report on ICPD+25 is the result of this collaboration. It highlights key population and development trends affecting the UNECE region since the adoption of the *2013 Chair's summary*. It outlines replicable solutions to common issues and puts forward action-oriented recommendations to further advance the implementation of the *2013 Chair's summary* over the next reporting cycle. It does so by articulating the linkages and synergies between the ICPD PoA, the *2013 Chair's summary* and the 2030 Agenda for Sustainable Development, as the latter incorporates the foundations and vision from the former.

This report was prepared to inform the UNECE Regional Conference 'Enabling Choices:

² The UNECE region comprises 56 member States in Europe, North America and Asia: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, Monaco, Montenegro, Netherlands, Norway, Poland, Portugal, Republic of

Moldova, Romania, Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom of Great Britain and Northern Ireland, United States of America, and Uzbekistan.

³ For brevity, henceforth referred to as the *2013 Chair's summary*.

Population Dynamics and Sustainable Development' (1–2 October 2018, Geneva), which concludes the regional five-year assessment. Alongside the outcomes of the conference discussions, it will inform the following key regional and global processes scheduled for 2019:

- the UNECE Regional Forum on Sustainable Development (March 2019, Geneva);
- the 52nd Session of the Commission on Population and Development, at which the first quadrennial global review of the ICPD will be discussed (April 2019, New York);
- the United Nations Economic and Social Council High-Level Political Forum on Sustainable Development (ECOSOC HLPF), where the theme 'Empowering People and Ensuring Inclusiveness and Equality' will be discussed (July 2019, New York); and
- the 69th Session of the World Health Organization (WHO) Regional Committee for Europe, at which progress on the implementation of the Action Plan for Sexual and Reproductive Health will be reported (September 2019).

The themes and sub-themes of the *2013 Chair's summary* guide the core structure of this report:

Chapter 1. Population dynamics and sustainable development presents the demographic and socio-economic context and trends of the UNECE region and argues that adapting to the population dynamics requires a life-course approach that expands individual choices across generations and supports transitions through different stages in life. This chapter also elaborates on the linkages between population dynamics, production and consumption patterns, and environmental sustainability.

Chapter 2. Families, sexual and reproductive health over the life course stresses that meeting the SRH needs of all persons requires the removal of access

barriers, commitments to advancing gender equality and the strengthening of health systems for the provision of an essential, integrated package of SRH services and information from birth to old age that responds to changing SRH needs without financial overburden. This chapter also addresses the need to develop tailored family support policies that factor in the heterogeneity of family formation patterns in the UNECE region and that target vulnerable family members.

Chapter 3. Inequalities, social inclusion and rights takes stock of progress towards achieving gender equality and eliminating persistent inequalities and discrimination faced by minority groups such as international migrants, refugees, ethnic minorities, persons with disabilities, and persons of diverse sexual orientation and gender identity.

Chapter 4. The way forward: Addressing persisting and emerging population and development issues calls for holistic public policy responses to issues that will condition the implementation of the ICPD PoA, the *2013 Chair's summary* recommendations and the 2030 Agenda for Sustainable Development over the next four years. This chapter also addresses the need to generate, analyse and disseminate quality data and research, an issue covered in the 'cross-cutting issues' theme of the *2013 Chair's summary*. Lastly, it presents concluding remarks for the way forward.

The *2013 Chair's summary* theme of 'partnerships and international cooperation' is not discussed in isolation but, rather, addressed in a cross-cutting manner throughout the report, as the multidimensional nature of population and development issues requires multi-stakeholder responses. Through reviews of regional and subregional intergovernmental outcomes elaborated since 2013 and country case studies, the report primarily discusses the progress made by member States in implementing the recommendations of the *2013 Chair's*

summary. However, the support of other key actors in the implementation of the ICPD, such as international organizations, civil society organizations (CSOs), including youth organizations, and the private sector, is also discussed.

Therefore, two coloured boxes are displayed throughout the report:

Green boxes display relevant **regional and subregional intergovernmental outcomes** elaborated since 2013 that support the implementation of the *2013 Chair's summary* recommendations.

Yellow boxes display **individual and multi-country case studies** outlining efforts by member States, international organizations, CSOs and the private sector to implement the *2013 Chair's summary* recommendations.

Three common elements can be identified in the discussion of population and development issues across the report:

- situation analyses, focusing on progress made and persisting challenges;
- select policy responses, in the form of detailed individual and multi-country case studies. These reflect efforts by individual member States to implement the recommendations of the *2013 Chair's summary*, and might describe either well-established best practices or outstanding commitments to address pressing population issues holistically; and
- evidence-based, action-oriented recommendations for member States to further engage in the implementation of the *2013 Chair's summary* over the next four years.

Situation analyses significantly rely on indicators contained in the *UNECE Monitoring Framework for the ICPD Programme of Action beyond 2014* (www.unece.org/fileadmin/DAM/pau/age/icpd/ICPD-25/Monitoring_Framework.pdf). This Regional Monitoring Framework is the result of a multi-stakeholder consultative process on monitoring the ICPD that included the Expert

Group meeting 'Towards a regional monitoring framework for ICPD beyond 2014' (13–14 December 2017, Geneva) and further electronic expert consultations through May 2018.

The *2013 Chair's summary* recommended the creation of a mechanism for continuous follow-up of implementation of the ICPD PoA, and the Regional Monitoring Framework responds to this request by setting the foundations for conducting systematic, consistent and periodic monitoring of national, subregional and regional progress. Dataset for select Regional Monitoring Framework indicators including subregional and regional averages will be made available on the UNECE Population Units website.

The Regional Monitoring Framework also serves to feed the region's perspectives into global ICPD review processes, and into regional and global reviews of the 2030 Agenda for Sustainable Development, given the strong linkages and synergies between both agendas. Indeed, around half of the indicators contained in the Regional Monitoring Framework are part of the Global Indicator Framework for the Sustainable Development Goals and Targets of the 2030 Agenda for Sustainable Development.

Unlike the ICPD Beyond 2014 regional assessment, the 2018 review did not draw on national reports by UNECE member States to identify policy responses to population and development challenges. Instead, it is based on secondary sources of information from international databases, including the Voluntary National Reviews database on national and subnational progress on the 2030 Agenda for Sustainable Development, reports from international and intergovernmental organizations, country and regional reports to recent reviews of international action plans, country reports to international human rights processes and binding instruments, and academic research.

To develop individual and multi-country case studies, information from country and regional reports to recent reviews of international conferences, such as Beijing+20, the Madrid International Plan of Action on Ageing (MIPAA) +15, SDG National Voluntary Reviews, as well as reports from international and intergovernmental development organizations have been used. Moreover, country and outcome reports to international human rights processes and binding instruments, such as the Universal Periodic Review (UPR), the UN Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), the UN International Covenant on Economic, Cultural and Social Rights (CESCR), and the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention), have also been considered.

State Parties Reports and State Parties Replies to the List of Issues (LOIs), conclusions and recommendations identified by the Council/Committees monitoring the above-mentioned processes and instruments may be interpreted as the member States' unfinished business in terms of the protection, promotion and fulfilment of human rights, including those related to the ICPD PoA and echoed in the *2013 Chair's summary*. The resulting selection of case studies aims to ensure a balanced geographical representation among UNECE countries and to be illustrative of the region's diverse socio-economic development contexts.

Inequality analyses feature prominently throughout this report and are not limited to Chapter 3 ('Inequality, Social Inclusion and Rights'). Since the 2019 ECOSOC HLPF will review the theme 'Empowering People and Ensuring Inclusiveness and Equality', this report focuses on those most left behind.

Vulnerability is often the result of the interaction between individual characteristics and environmental factors such as group

membership. Therefore, where data availability permits, analyses go beyond regional, subregional and country-level aggregates and examine inequalities faced by individuals on the basis of socio-economic factors or due to their belonging to specific population groups, conditions which more often than not overlap. Through case studies, member States' responses to improve the well-being of such individuals and population subgroups are discussed.

Quantitative and qualitative sources of information relating to UNECE are analysed, to the extent possible, using the following subregional groupings:

- *South-Eastern Europe (SEE)*: Albania, Bosnia and Herzegovina, Montenegro, Serbia, the former Yugoslav Republic of Macedonia and Turkey
- *Eastern Europe and the Caucasus (EEC)*: Armenia, Azerbaijan, Belarus, Georgia, Republic of Moldova, Russian Federation and Ukraine
- *Central Asia (CA)*: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan
- *European Union 13 new Member States (joined in 2004 and later) (EU13)*: Bulgaria, Cyprus, Croatia, the Czech Republic, Estonia, Hungary, Lithuania, Latvia, Malta, Poland, Romania, Slovakia and Slovenia
- *European Union 15 pre-2004 countries (EU15)*: Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and the United Kingdom
- *Western European countries without EU membership (non-EU WE)*: Andorra, Iceland, Liechtenstein, Monaco, Norway, San Marino and Switzerland
- *North America and Israel*: Canada, Israel and the United States of America.

Regional and subregional averages have been weighted by the total population of each country. In cases where data availability is limited, averages for a reduced set of countries within subregions are presented.

Chapter 1. Population dynamics and sustainable development

The *2013 Chair's summary* underscored the need to take a long-term, holistic, rights-based approach to population dynamics and its linkages with sustainable development. In this regard, it called on UNECE member States to invest in human capital across generations by enhancing their citizens' access to quality education, decent work and health and social care services, promoting healthy lifestyles and supporting their involvement in decision-making. The *2013 Chair's summary* also encouraged member States to reduce carbon dioxide (CO₂) emissions and strive for energy efficiency.

The current demographic and socio-economic context and trends reaffirm that the UNECE region is at the forefront of a global demographic transformation from population growth to population ageing, coupled with increasing and complex international migration flows. In 2015, ageing was perceived as a major concern by 45 of the 56 UNECE member States, and policy measures aimed at addressing low fertility were implemented / considered by 34 countries.⁴ Yet the interrelationships between ageing, low fertility and migration, both internal and international, play out differently across the region.

Preparing for and realizing the potentials of ageing populations in the region require a life-course approach. This approach is in line with the core message of the ICPD PoA: investing in individual capabilities, dignity and human rights, across multiple sectors and throughout the life course is the foundation of sustainable development. Expanding the individual choices of adolescents and youth (15–24 years old), the middle-aged generation (25–64 years old) and older

persons (65 years and older) and supporting their life transitions, therefore, remains essential.

Lastly, achieving sustainable development demands reconciling a tight emissions pathway with development aspirations. The current development paradigm is based on a model that favours the increasing production and consumption of goods and services to improve individual well-being. While it has improved the lives of many, the gains have been unevenly distributed and frequently at the expense of the environment.

1.1. The demographic and socio-economic context in the UNECE region

- Population will decline in 20 of the 56 UNECE member States by 2030. By 2050, 10 countries in the eastern part of the region are projected to experience population declines of at least 15 per cent.
- The region's total fertility rate stood at 1.8 children per woman of reproductive age in 2015, the same level as 2010. Fertility rates remained below replacement level in 49 of the 56 UNECE countries.
- Life expectancy has increased for both men and women across the UNECE countries, reaching an average of 74.9 years for men and 81.1 years for women in 2015. Longevity differences between the western and eastern parts of the region persist, in particular due to much higher mortality rates among men in the east.
- The region's population is ageing. Persons aged 65 years and older accounted for 15 per cent of the UNECE's total population in 2015, a proportion projected to increase to 21 per cent by 2030 and to 24 per cent by 2050.

⁴ United Nations Department of Economic and Social Affairs (2016) *World Population Policies*

Database. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

- Negative net migration was a prominent feature in most countries in the eastern part of the region, while western countries witnessed positive net migrant inflows. Recent years have also been characterized by an increase in forced displacement across international borders.
- In 2017, for the first time since the 2008 global financial crisis, positive economic growth was observed in all UNECE countries.

The *2013 Chair's summary* underscored the need to better integrate population dynamics into development planning at national and subnational levels to comprehensively respond to demographic change and its implications.

Implementing the ICPD PoA and the *2013 Chair's summary* recommendations at national and local levels becomes even more relevant today, as efforts in the UNECE region are intensified to implement the 2030 Agenda for Sustainable Development. Population dynamics remain closely linked to poverty reduction (SDG 1), health, including SRH (SDG 3), education (SDG 4), gender equality (SDG 5), economic growth and decent work (SDG 8), inequalities (SDG 10), urbanization (SDG 11), consumption and production patterns (SDG 12), climate change (SDG 13), environmental sustainability (SDGs 14 and 15), as well as data and statistical systems capacity (SDG 17). Similarly, the monitoring of population trends remains a central element in the measurement of progress towards achieving the SDGs.

Population dynamics in the UNECE region reflect the economic, social and cultural diversity characterizing its 56 member States, as well as the irreversibility of the ageing process in the foreseeable future, which will shape generations and the achievement of

sustainable development in the decades to come.

Rapid population growth in Central Asia, but net population declines in other eastern subregions

In 2015, the total population of the UNECE region amounted to 1.27 billion people, a 2.4 per cent increase from 1.24 billion in 2010.⁵ The region's population is projected to increase to 1.33 billion at the end of the lifespan of the 2030 Agenda for Sustainable Development, and to 1.37 billion by 2050. While the average annual population growth over the period 2010–2015 was 0.46 per cent, it is expected to drop to about 0.09 per cent annually during the period 2045–2050.

Population growth, however, has not been and is not projected to be uniform across UNECE countries. While Central Asia experienced rapid population growth between 2010 and 2015, many other countries in the eastern part of the region witnessed net population declines. A certain degree of heterogeneity in population growth rates was also observed among countries in the western part of the region. Current trends indicate that by 2030 population numbers will decline in 20 of the 56 UNECE member States. Between 2015 and 2050, 10 countries in the eastern part of the region are projected to experience population declines of at least 15 per cent.

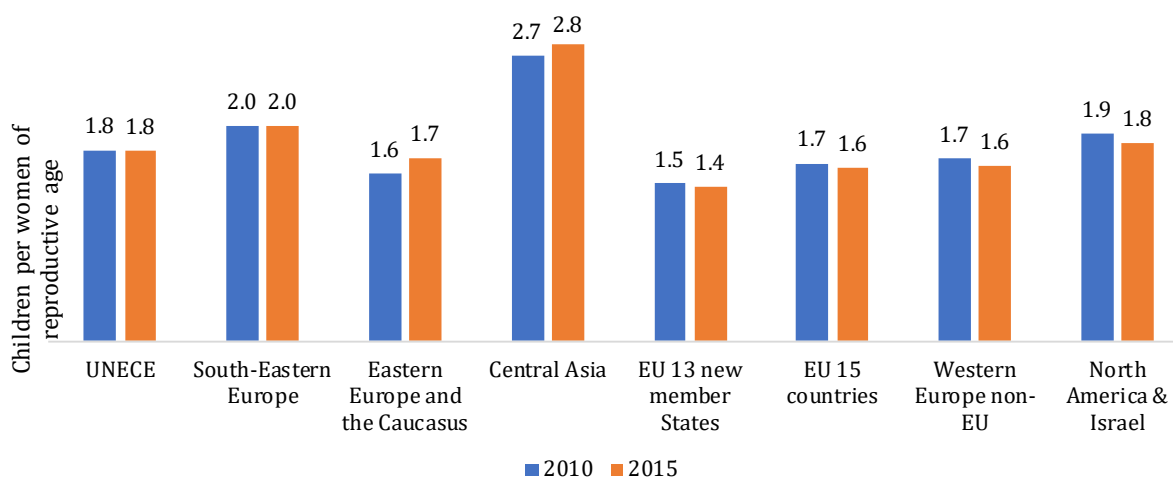
Fertility remains below replacement levels in 49 of the 56 UNECE countries

In 2015, the region's average total fertility rate was estimated at 1.8 children per woman of reproductive age, the same level as 2010 (Figure 1). In 2015 fertility remained high in Central Asia (2.8 children), the only subregion where it exceeded below-replacement levels.

⁵ Unless otherwise stated, the demographic data analysed in this chapter have been drawn from the United Nations Department for Economic and Social Affairs (2018) *World Population Prospects:*

the 2017 Revision. United Nations, New York. Available at: <https://esa.un.org/unpd/wpp/>. Where applicable, medium (or standard) variant projections are used.

Figure 1. Total fertility rate, 2010–2015



Source: UN Population Division. World Population Prospects: The 2017 Revision.

In fact, below-replacement fertility was observed in all but 7 UNECE countries, with fertility rates remaining below 1.5 children per woman of reproductive age in 11 of them (1.2 in Portugal and the Republic of Moldova; 1.3 in Greece, Poland, Spain, and Bosnia and Herzegovina; and 1.4 in Cyprus, Slovakia, Italy, Malta and Hungary). In the eastern part of the region fertility continued the moderate rebound that commenced at the turn of the 21st century, after the significant fertility declines experienced at the start of the transition around 1990. In the western part of the region, the fertility rebound witnessed during the 2000s came to a halt at the start of this decade, as fertility slightly decreased in 16 of the 21 countries between 2010 and 2015. In contrast, fertility remained unchanged in Canada (1.6 children per woman of reproductive age), France (2.0) and Switzerland (1.5), and increased slightly (from 1.4 to 1.5) in both Austria and Germany.

The projections indicate that the total fertility rate for the UNECE region will remain at current levels (1.8 children per woman of reproductive age) during the periods 2025–2030 and 2045–2050, although these are subject to greater uncertainty.

The trend in delaying childbearing has continued, with women’s mean age at first birth increasing by one year between 2010 and 2014, from 26.4 to 27.4 years. On average, in 2014, women delivered their first child earliest in Eastern Europe and the Caucasus (25.1 years) and latest in Western European countries without EU membership (29.8 years). Between 2010 and 2015, the share of live births by women aged below 20 decreased from 5 to 3 per cent of all live births, with the highest incidence (7 per cent) remaining in Eastern Europe and the Caucasus and Central Asia in 2015.

In delaying childbearing to advanced reproductive ages, women may face increased risks of being unable to conceive or carry a pregnancy successfully to term. Moreover, a number of women in the region suffer secondary infertility resulting from STIs or lack of access to safe, quality emergency obstetric or abortion care. Although current knowledge on male infertility is low, one recent study showed that sperm counts of European and North American men declined

by 50 to 60 per cent between 1973 and 2011.⁶ These factors explain the increased demand for health literacy, including on SRH, among young people, as well as for access to information on infertility treatment and quality health services. Many countries across the region also implement assisted reproductive technologies programmes.

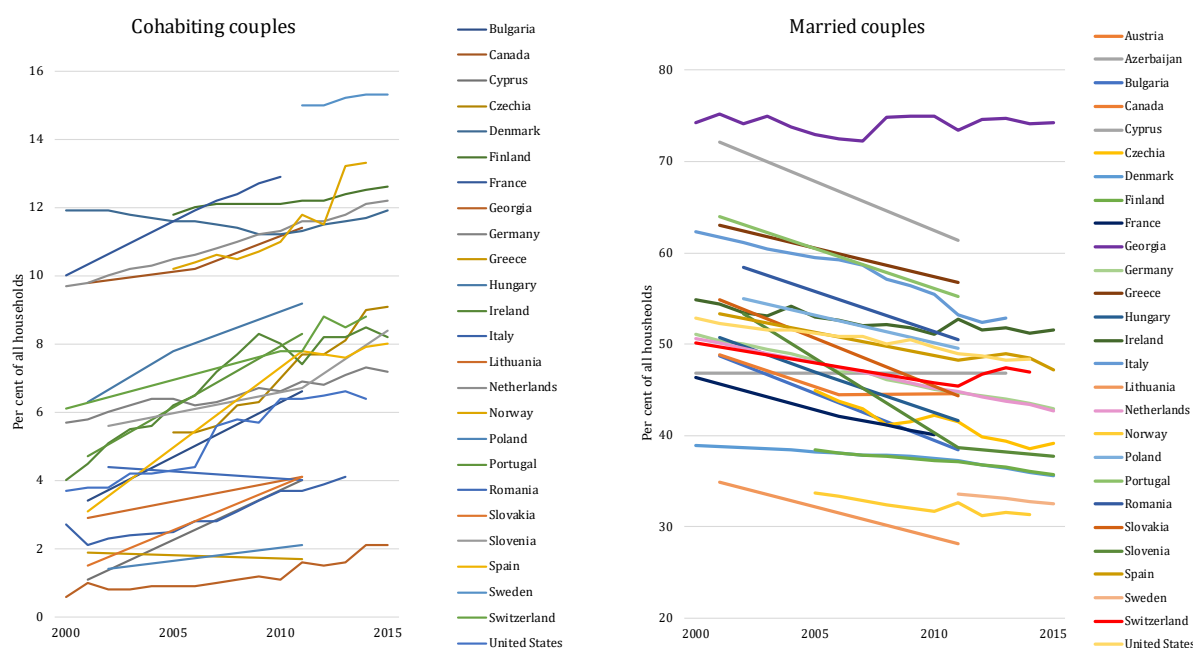
Increasing diversity in patterns of household composition

Families, households and living arrangements continue to go through major changes in the UNECE region, with patterns of family formation, dissolution and reconstitution

becoming more heterogeneous, and family boundaries more ambiguous.⁷

Marriage is becoming less central in shaping life-course transitions, with trends showing notable rises in the proportion of people marrying late or not at all. Decreases in marriage rates are partly offset by increases in cohabitation, which can represent an alternative or a prelude to marriage. The proportion of cohabiting couples with and without children does not exceed the proportion of married couples with and without children in any UNECE country, yet a general uptrend is observed in the former and an overall downtrend in the latter (Figure 2)

Figure 2. Proportion of cohabiting and married couples with and without children among all households, 2000–2015



Source: UNECE Statistical Database.

⁶ Levine, H. et al. (2017) "Temporal trends in sperm count: a systematic review and meta-regression analysis", *Human Reproduction Update*, vol. 23, issue 6, pp.646–659.

⁷ UNECE (2011) *Measurement of different emerging forms of households*. UNECE, Geneva, p.3.

In 2017, Finland⁸ and Germany⁹ passed laws allowing same-sex couples to marry, and since 2016, same-sex couples in Israel¹⁰ desiring to create a family can benefit from the same entitlement terms granted to heterosexual families. Currently, national or regional laws allowing same-sex couples to marry exist in 17 UNECE countries.

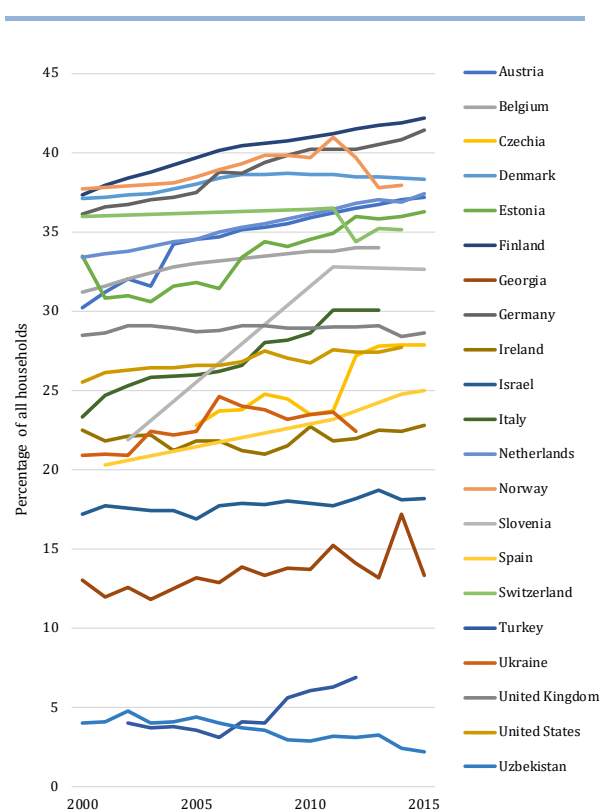
The intensified prevalence of divorce is leading to rises in the number of single-parent families and reconstituted couples or families. These may face increased vulnerability to poverty and decreased capacity to sustain family ties and informal care systems.¹¹ In 2011, single-parent households accounted for 11 per cent of all households in new EU Member States, 10 per cent in Eastern Europe and the Caucasus, and 9 per cent in North America and EU15 countries.

These changing patterns in family and household formation, coupled with gains in life expectancy, are leading to an increase in one-person households (Figure 3), which exceed a quarter of all households in most countries in the western part of the region and the EU 13 new Member States.

Continuing gains in life expectancy and narrowing gender differentials

In 2015, life expectancy at birth in the UNECE region was estimated at 74.9 years for men and 81.1 years for women, increasing from 71.0 and 78.2 years, respectively, in 2000. By 2025–2030, average life expectancy is projected to increase to 77.1 years among men

Figure 3. **Proportion of one-person households among all households, selected countries, 2000–2015**



Source: UNECE Statistical Database.

and to 82.6 years among women, and to 80.6 and 85.2 years, respectively, by 2045–2050. These regional trends, however, mask considerable subregional variations (Figure 4) as well as differences across population subgroups within countries.

⁸ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Finland*. A/HRC/WG.6/27/FIN/1. United Nations, Geneva, para.141.

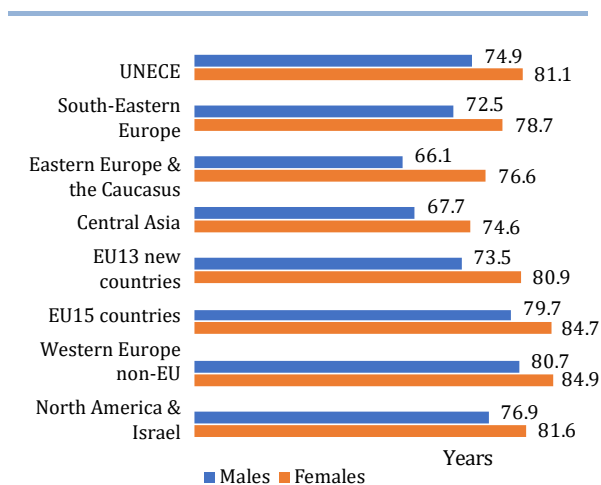
⁹ UNHRC, Working Group on the Universal Periodic Review (2018) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Germany*.

A/HRC/WG.6/30/DEU/1. United Nations, Geneva, para.54.

¹⁰ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Israel*. A/HRC/WG.6/29/ISR/1. United Nations, Geneva, para.25(b).

¹¹ OECD (2011) *The Future of Families to 2030. A Synthesis Report*. OECD, Paris, p.13.

Figure 4. Life expectancy at birth by sex, 2015



Source: UN Population Division. World Population Prospects: The 2017 Revision.

The lowest life expectancies are observed in countries of Eastern Europe and the Caucasus and Central Asia, even though the rebound that started during the 2000s is continuing. Life expectancies are noticeably higher and gender differentials lower in the remaining eastern subregions and in the western part of the region.

Mortality and morbidity differentials between the eastern and western parts of the UNECE region remain concerning among middle-aged populations, and particularly among men. While countries in the western part of the region have made significant progress in reducing the prevalence and severity of cardiovascular disease, it remains the main contributor to losses in life and healthy life expectancy years in the eastern part of the region.¹² This highlights the need to reduce risk factors such as smoking, alcohol consumption, unhealthy diets and physical inactivity, and strengthen the detection of circulatory system diseases. In the future, the worse health and increased functional limitations experienced by middle-aged

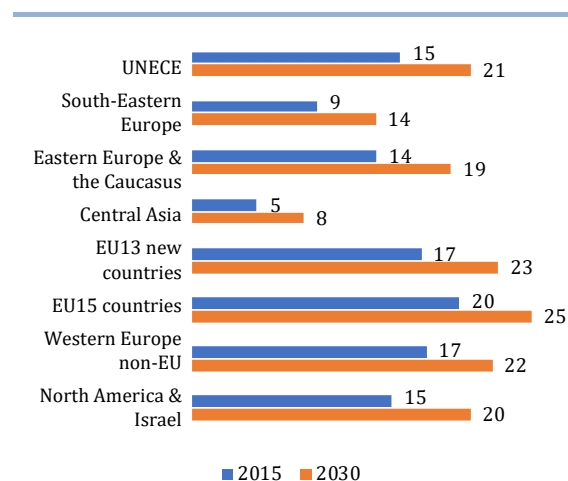
¹² World Bank (2015) *What's next in ageing Europe: Aging with Growth in Central Europe and the Baltics*. World Bank, Washington, DC, p.45.

populations in the eastern part of the region are expected to be exacerbated by increases in the prevalence of other non-communicable diseases such as cancer and dementia.¹³

All subregions except Central Asia continue to age rapidly

Gains in life expectancy, coupled with low fertility levels, have resulted in the absolute and relative growth of the population aged 65 and older. These people accounted for 15 per cent of UNECE's total population in 2015, a proportion projected to increase to 21 per cent by 2030 and to 24 per cent by 2050 (Figure 5). Although the impact of aggregate migration is positive for the region, the prevailing out-migration flows add to this older population growth in many countries of the eastern part of the region. The share of older persons has already reached or exceeded 20 per cent in seven European countries. Of the seven UNECE countries where the share currently remains below 10 per cent, only four are projected not to reach this threshold by 2030.

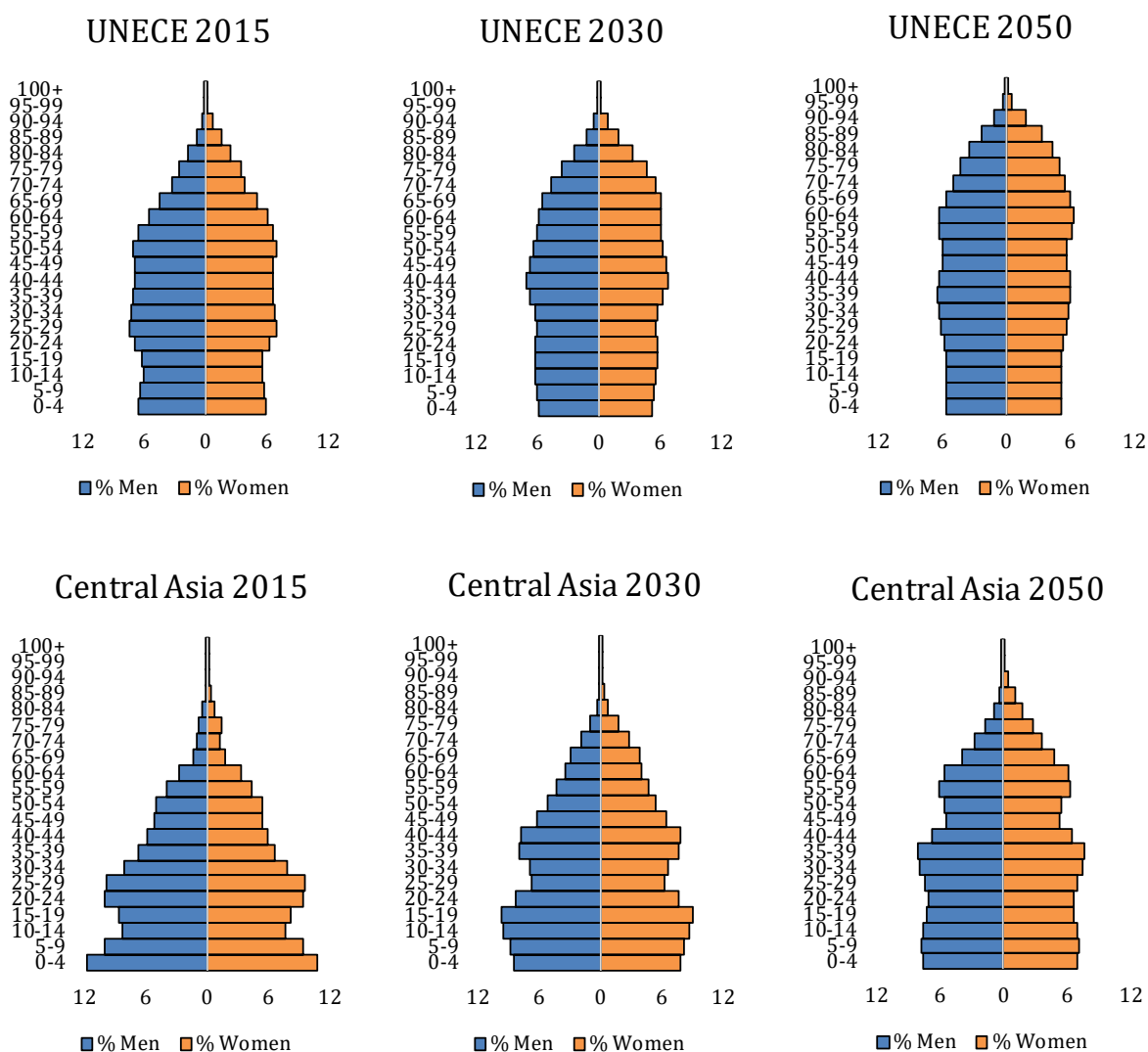
Figure 5. Proportion of the population aged 65 or older, 2015–2030



Source: UN Population Division. World Population Prospects: The 2017 Revision.

¹³ Ibid., p.47.

Figure 6. Population pyramids, UNECE and Central Asia, 2015, 2030 and 2050



Source: UN Population Division. World Population Prospects: The 2017 Revision.

In 2015, there were 23 persons aged 65 or older for every 100 persons aged 15–64 in the UNECE region, a ratio which is projected to increase to 33 persons in 2030 and 42 persons in 2050. Population pyramids clearly show the region’s unfolding ageing process, with Central Asia remaining the only subregion projected to host larger proportions of younger people in the coming decades (Figure 6).

Population projections also show that already by 2023 the share of the population aged 65 years and older will exceed that of children under 15 years in the UNECE region. In the upcoming decades the ageing process is likely to be characterized by the increasing number of older olds (aged 80 years and above), whereby the older population is itself in the process of ageing, particularly in the western

part of the region.¹⁴ In 2015, 4 per cent of persons in the UNECE region were aged 80 or older, a proportion that is projected to increase to 5 per cent in 2030 and 9 per cent in 2050.

In contrast, the relative weight of adolescents and youth aged 10–24, which accounted for 18 per cent of UNECE’s total population in 2015, is projected to remain at this level by 2030 and decrease to 16 per cent by 2050. In 2015, the proportion of adolescents and youth was highest in Central Asia (26 per cent), making most of its countries well placed to harness the potential benefits of the demographic dividend, followed by South-East European countries (24 per cent), primarily due to Turkey’s large adolescent and youth population (25 per cent), and North America and Israel (20 per cent).

A largely urban region

In 2015, three quarters of UNECE’s population lived in urban areas, a proportion that is projected to increase to 78 per cent by 2030 and 84 per cent by 2050. At least 70 per cent of the population lived in urban areas in all subregions, with the exception of the 13 new EU Member States (62 per cent) and Central Asia (48 per cent). In Central Asia, where the urban transition is still unfolding, the urban population is expected to increase to 51 per cent by 2030 and 60 per cent by 2050.

The complexity of international migration and forced displacement flows

In countries characterized by population ageing and low fertility, international migration significantly contributes to population growth, having even reversed population declines in recent years. According

to a recent report by UN DESA (2017), the size of Europe’s¹⁵ population would have declined by 1 per cent between 2000 and 2015 in the absence of a net migrant inflow, instead of growing by 2 per cent.¹⁶ In North America, net migration flows contributed to 42 per cent of the population growth observed during the same period. Population projections show, however, that the continuation of recent levels of net migration will not be sufficient to compensate for Europe’s natural population decline—i.e. an excess of deaths over births—between 2020 and 2025.

The UN DESA report also highlights that in 2017 two thirds of international migrants originating from Europe resided in a country located in their region of birth, while almost three quarters of international migrants from North America resided outside their region of birth. The report also stresses that the large majority of international migrants are of working age. Between 2000 and 2017, the median age of international migrants increased from 41.1 to 42.6 years in Europe and from 38.4 to 44.7 years in North America. A slightly higher proportion of female migrants in both regions is the result of the ageing of earlier migrants and women’s higher life expectancy.

Recent years have been characterized by an increase in forced displacement across international borders. The report stresses that in 2016 Turkey recorded the largest refugee population in the world—a result of the conflict in the Syrian Arab Republic—hosting approximately 3.1 million refugees and asylum seekers. This represents a sharp increase in the country’s refugee population since 2000, when it hosted just over 3,000 refugees. For the same reasons, Germany saw

¹⁴ Eurostat (2017) *People in the EU - Population projections*. Eurostat, Luxembourg. Available at: http://ec.europa.eu/eurostat/statistics-explained/index.php/People_in_the_EU_-_population_projections.

¹⁵ Excludes Central Asian countries, Armenia, Azerbaijan, Cyprus and Georgia.

¹⁶ United Nations Department for Economic and Social Affairs (2017) *International Migration Report 2017. Highlights*. United Nations, New York, p.18.

its refugee population significantly grow to 1.3 million. In 2016, Turkey and Germany together hosted 17 per cent of the world's total estimated number of refugees and asylum seekers (25.9 million).

Fragile economic growth puts pressure on social spending

For the first time since the 2008 global financial crisis, positive economic growth was observed in 2017 in all UNECE countries. This created a more auspicious context in which to tackle structural challenges while advancing the ICPD PoA and the 2030 Agenda for Sustainable Development. However, over the previous five years the region experienced a difficult and uneven recovery from the global financial crisis, which added significant pressure on social spending. In a number of countries, in particular in the south of Europe, the crisis has left a legacy of persistent unemployment and increased rates of people at risk of poverty and social exclusion.

The decline of oil prices that started in 2014 tipped the region of Eastern Europe and the Caucasus into a recession, which was accompanied by exchange rate instability and rising inflation. Growth has returned, but past gains in improving living standards and reducing poverty have been hampered. It is only in the United States that the economy has continued to grow uninterrupted since 2011 and has been relatively job-rich.

The region's overall employment rate has recovered slightly since the financial crisis. The largest employment rate gains were recorded among older employees, particularly women in the age groups 55–59 and 60–64. This was in part a result of the rise in the statutory retirement age in a number of UNECE countries. In 2014, income inequality as measured by the Gini coefficient remained lowest in Western European countries without EU membership (27) and Central Asian countries (28), and highest in countries of

Eastern Europe and the Caucasus (36) and South-Eastern Europe (41). In the same year, the income share of the poorest 20 per cent of the population in the UNECE region remained at 7 per cent.

1.2. The interrelationships between ageing, low fertility and migration

- Rising life expectancy, low fertility as well as increasing migration affect the extent and pace of population ageing. By 2023, the region's population aged 65 years and older will outnumber children (0–14 years) for the first time.
- Many men and women in the UNECE region remain unable to realize their fertility aspirations.
- Among the 49 UNECE countries with below-replacement fertility, higher fertility levels were observed in countries where holistic family policies support parents to reconcile work and family life.
- Several countries in the eastern part of the region are experiencing negative population growth rates exacerbated by out-migration of working-age populations, while important net migrant inflows of working-age populations are witnessed by countries in the western part of the region.
- Unemployment, poverty and the insufficient social protection faced by rural populations is leading to the depopulation of rural areas in some of the countries in the eastern part of the region.

The *2013 Chair's summary* acknowledged the policy implications of low fertility, population ageing and complex international and internal migration patterns affecting most UNECE countries. It stressed that in both low- and high-fertility countries policies should support the right of individuals to decide freely and responsibly on the number and spacing of their children and to have the information and means to do so. It particularly called on member States to develop evidence-based,

holistic, family-friendly and gender-sensitive policies across relevant sectors—including health, education, employment and migration. The *2013 Chair's summary* also highlighted that in many countries young people are migrating from rural to urban areas, and recommended the formulation of innovative policies and measures that are responsive to their evolving nature.

The current working-age population faces specific challenges deserving policy attention. Women's increased participation in the labour force, economic uncertainty and constraints in combining parenthood with professional careers are among the factors contributing to the inability of couples to realize their fertility aspirations. Presently in many countries, policies are being implemented to support men and women to achieve their desired fertility, through either direct support for family planning (29 countries) that protects their reproductive health over the life course and/or measures

to improve the balance between work and family life (49 countries).¹⁷

Overall, the data show that among the UNECE countries with below-replacement fertility, higher fertility rates were observed in countries where holistic family policies support men and women to reconcile work and family life. Supporting women and men to achieve their desired fertility in the higher-fertility settings is equally important. The interrelationships between ageing, low fertility and migration, both internal and international, play out differently across countries in the UNECE region. As pointed out earlier, several countries in the eastern part of the region, particularly in Eastern Europe and the Caucasus and among the 13 new EU Member States, are experiencing negative population growth rates. During the period 2010–2015, such declines exceeded 1 per cent annually in three countries, while 10 are projected to witness their populations decline by 15 per cent or more by 2050.

Box 1. Supporting couples to realize their fertility aspirations: Belarus

The Government of Belarus, concerned about declining fertility rates and shrinking population numbers, started a Demographic Security Programme in 2002 with a focus on relieving the financial burden of starting or expanding families. Despite some success, the government recognized that a more comprehensive approach was required. In 2016, in collaboration with UNFPA and UNICEF, and with funding from the Russian Federation, it conducted a Generations and Gender Survey to better understand the factors behind the gap between desired and actual fertility and the continuing trend towards smaller families. While two out of three young people today say they want to have two children, the reality is that two-child families account for only about a quarter of families with children in the country. Based on the survey results, the government is set to consider a wider range of policy measures and a more effective mix of family-friendly policies to address demographic security, based on evidence indicating that financial incentives alone will not suffice to support individual desires for more children. These include addressing work–life balance, gender equality at the household level, women's reproductive health, expanded public childcare services, and financial and housing support.

The high adult mortality rates, coupled with low fertility, in these subregions remain important factors behind the phenomenon.

However, it is exacerbated by significant out-migration of working-age populations, which consequently affects productivity as well as

¹⁷ United Nations Department of Economic and Social Affairs (2016) *World Population Policies*

Database. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

the sustainability of ageing and family support systems, despite the remittances sent by migrant workers. Over recent years, many of these countries were exploring policies not only to address low fertility levels but also to curb emigration, encourage the return of migrants and attract investment by the diaspora, as evidenced by the UN DESA World Population Policies Data.¹⁸ However, mixed results suggest that additional evidence-based analyses are required on the interactions among these dynamics, in addition to cooperation among countries in sharing good practices.

Countries in the western part of the region experience important net migrant inflows of working-age populations. If employed and integrated, migrants represent an asset for economies and societies. Moreover, they are likely to form families in destination countries, bringing cultural and ethnic diversity and compensating for the smaller cohort size of the native population compared to their parents' generation. Conversely, discrimination, social exclusion and inadequate access to health and social protection schemes increase migrants' vulnerability and can pose serious challenges to societies.

Box 2. Every Age Counts: Germany's demographic strategy

Germany's demographic strategy *Every Age Counts*,¹⁹ first developed in 2012 and subsequently revised in 2015 under the heading 'Greater prosperity and better quality of life for all generations', takes a broad approach to addressing demographic change. It builds on four main pillars:

- strengthening the potential for economic growth, to build on the material well-being already achieved and to be able to pass it on to future generations;
- maintaining and promoting social cohesion—within families, between generations, between the healthy and the sick, wealthy and poor, persons with and without disabilities, and among people from different cultural backgrounds;
- promoting equivalent living conditions and a high quality of life in rural and urban areas differently affected by demographic change; and
- ensuring the long-term effectiveness of government, the dependability of the social insurance systems and an attractive and modern public service through stable finances.

A central part of the strategy is a process of multi-stakeholder dialogue with representatives from every level of government, the private sector, social partners, the research community and civil society. They currently work in 10 thematic working groups to formulate concrete policy solutions under the strategy's thematic areas. Progress is regularly discussed and shared with the public at the biennial demography summits organized by the federal government.

Recent measures, including a Demography Check and a Youth Check, require that all proposed new laws and regulations are checked with regard to their demographic implications and impact. This practice ensures the integration of a population perspective into policy planning and contributes to sensitizing policymakers on the needs of youth and future generations.

According to the UN DESA World Population Policies Database,²⁰ several countries in the eastern part of the region adopted specific policies or strategies between 2010 and 2015 to reduce rural-to-urban migration, yet the

increased risk of unemployment and poverty, and the insufficient access to public services faced by rural populations is leading to the depopulation of some of these eastern

¹⁸ Ibid.

¹⁹ Case study based on German Federal Ministry of the Interior (2012) *Every Age Counts: Every Age Counts. The Federal Government's demographic*

strategy. German Federal Ministry of the Interior, Berlin.

²⁰ Ibid.

countries.²¹ As a result, both the use of productive land and the quality of infrastructure and services in these areas are likely to be impacted, including the quality of education. The implementation of integrated and holistic sustainable agricultural and rural development policies is, therefore, necessary to create employment opportunities, reduce poverty, guarantee productivity and attract investments in these areas. For those who decide to migrate from rural to urban areas, ensuring inclusive, safe and sustainable cities is necessary to support their right to move internally as a way to improve their lives.

1.3. Adolescents and youth: Strengthening the foundations of sustainable development

- In 2015, most countries in the UNECE region had achieved participation rates of 90 per cent or higher in organized learning one year before the official primary school entry age. No major access differences were observed between girls and boys across subregions.
- Youth unemployment declined from 20 to 18 per cent between 2010 and 2015, yet remains unacceptably high. The proportion of youth not in education, employment or training decreased in most countries and subregions and presently accounts for 14 per cent in the UNECE region. Alarming, in South-Eastern Europe and in Central Asia, twice as many girls and young women are not in education, employment or training compared to boys and young men.
- Overweight and obesity are among the fastest-growing health issues for children and adolescents. Physical inactivity rates among children and adolescents are also increasing rapidly. Alcohol use decreased among adolescent girls and boys between 2010 and 2014, but continues to represent a public health concern.

- In 2014 and 2015 the proportion of younger parliamentarians (aged under 40) amounted to just 15 per cent in the UNECE region.

Adolescents and youth are key agents of development and social change with high expectations for self-direction, freedom and opportunity. In its recommendation that member States invest in building the human capital of individuals throughout the life course, the *2013 Chair's summary* singled out the need to build the capacities of adolescents and youth and to develop their full potential.

Fulfilling their rights and investing in their capabilities across multiple sectors such as education, skills development, employment and health, including SRH and comprehensive sexuality education, enables them to enjoy high standards of well-being and to make active and productive contributions to society. By contrast, unequal investments in their capabilities perpetuate cycles of exclusion and limit their ability to thrive in society.

Undeniably, one of the best strategies for reaping the opportunities of the unfolding ageing process is to invest in the capabilities of all adolescents and youth. Central Asian countries in particular, with their younger age structures, have the opportunity to reap the potential benefits of the demographic dividend by making strategic investments in the human capital of youth.

A. Varying progress towards safe, quality education and skills development

The *2013 Chair's summary* emphasized the right to quality education at all levels in safe and participatory environments free from discrimination, violence, mobbing and bullying. Nowadays, children's educational

²¹ UNDG Europe and Central Asia (2017) *Building More Inclusive, Sustainable and Prosperous Societies in Europe and Central Asia. From Vision to*

Achievement of the Sustainable Development Goals. Call for Action from the Regional UN System. UNDG Europe and Central Asia, Istanbul, p.3.

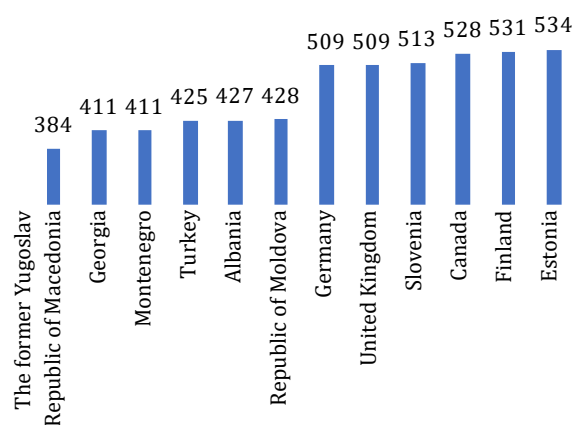
opportunities are moulded long before the start of primary school, and early childhood education and care are proven to be among the most critical and cost-effective investments to improve learning outcomes.²² Beyond the benefits for children themselves, high-quality, affordable and universal early childhood education and care can have transformative effects for societies. They can contribute to gender equality by allowing women and men to reconcile family and work life, and they can break early cycles of inequality and disadvantage. Targeting low-income households is essential to ensure that the potential benefits of early childhood education and care are shared by all, as income earners are urged to return to work and lack the financial means to afford such services; otherwise there is a risk that such cycles are perpetuated.²³

In 2015, most countries in the UNECE region had achieved participation rates of 90 per cent or higher in organized learning one year before the official primary school entry age (SDG Indicator 4.2.2). In only a handful of South-East European and Central Asian countries these remained below 50 per cent. Overall, no major access differences are observed between girls and boys across subregions.

Levels of pre-primary, primary and lower-secondary school completion vary across and within countries in the region, and so do learning outcomes, highlighting the complexity of guaranteeing universal access to quality education. Even in countries where full access is a reality, learning is not guaranteed, hence the need to ensure that all children not only complete these three educational cycles but that they do so achieving adequate

learning outcomes. As highlighted in a recent OECD report (2017), in many contexts access to quality early childhood education and to schools with highly qualified teachers is still a privilege reserved for a selected few.²⁴

Figure 7. **Highest and lowest average scores of 15-year-old students on the PISA science literacy scale, 2015**



Source: OECD. PISA Data Explorer.

The 2015 average scores of 15-year-old students on the Programme for International Student Assessment (PISA) science literacy scale serve to compare educational outcomes across the region (Figure 7). They represent an indicative measure of the quality of education systems and evidence significant differences in investments into students' capabilities. The lowest average scores were observed in countries of South-East Europe and Eastern Europe and the Caucasus, while the six top performers belong to four different subregions.

Further analyses on unequal access to quality education by socio-economic status, place of residence and migrant status are presented in Chapter 3. In addition, quality education also

²² UNICEF (2018) *Progress for Every Child in the SDG Era*. UNICEF, New York, p.54.

²³ UNICEF (2008) *The child care transition, Innocenti Report Card 8*. UNICEF Innocenti Research Centre, Florence, p.28.

²⁴ OECD (2017) *Educational Opportunity for All: Overcoming Inequality throughout the Life Course*. OECD Publishing, Paris, p.9.

includes access to comprehensive sexuality education, which is not yet a reality for many of the region’s students—a subject discussed in Chapter 2.

Access to information and communication technologies such as the Internet and mobile phones has empowered and moulded the expectations of adolescents and youth, bolstering their activism and participation and providing them with a vehicle to learn about, participate in and mobilize around political and social issues.²⁵

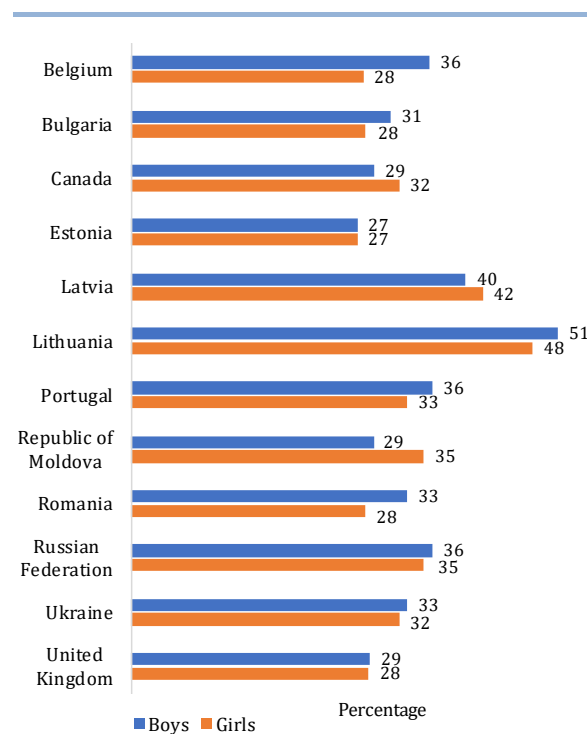
Affordable and effective broadband connectivity is a vital enabler of economic growth, social inclusion and environmental protection. While the use of the Internet has expanded widely, disproportionately poor, less educated and often female populations in remote rural areas still remain offline.²⁶ In 2015, at least two in every three individuals had used the Internet from any location over the last three months (SDG Indicator 17.8.1) in most of the region’s countries. In a number of countries in Central Asia and Eastern Europe and the Caucasus, however, this proportion remained below 50 per cent.

Similarly, technological change constantly reconfigures labour markets, penalizing individuals with low levels of educational attainment and skills.²⁷ The extent to which adolescents and youth can benefit from the digital revolution will enable them to adapt to such changes. In 2015, less than one in every four young persons and adults could find, download, install and configure software (SDG Indicator 4.4.1) in a few South-East European, Eastern European and the Caucasus and Central Asian countries with available data. Levels of use were generally higher among

²⁵ United Nations (2016) *World Youth Report: Youth Civic Engagement*. United Nations Department for Economic and Social Affairs, New York, p.67.

some of the 13 new EU Member States and most countries in the western part of the region. In countries where sex-disaggregated data are available, women remained, on average, less skilled in this regard than men.

Figure 8. Proportion of adolescents aged 15 who have been bullied at least once or twice at school in the previous couple of months, selected countries, 2014



Source: WHO. Health Behaviour in School-Aged Children Data Portal.

Lastly, safe school environments are a prerequisite for adolescents and youth to achieve their full potential. Bullying and other forms of discrimination in formal education contexts have adverse consequences for their physical and mental health and well-being. In 2014, bullying affected at least 30 per cent of adolescents aged 15 in a number of UNECE

²⁶ ITU and UNESCO (2016) *The State of Broadband: Broadband Catalyzing Sustainable Development*. ITU and UNESCO, Geneva and Paris, p.8.

²⁷ OECD (2017) *Educational Opportunity for All: Overcoming Inequality throughout the Life Course*. OECD Publishing, Paris, p.9.

countries (Figure 8). Boys were more likely than girls to experience bullying in most countries, although gender differentials were generally minor.

As Internet use continues to grow among adolescents and youth, there is an urgent need to ensure that the digital space is safe for everyone, particularly for women and girls. In the EU, 20 per cent of women aged 18–29 have been subjected to cyberbullying—i.e. they

have received unwanted, offensive, sexually explicit emails or SMS messages or faced inappropriate, offensive advances on social networking sites—since the age of 15.²⁸ Adolescents subjected to cyberbullying report increased depressive effects, anxiety, loneliness, suicidal behaviour and somatic symptoms, while perpetrators are more likely to report increased substance use, aggression and delinquent behaviours.²⁹

Box 3. Addressing bullying in schools: Finland

Finland has pioneered the KiVa programme to address bullying in schools.³⁰ With funding from the Ministry of Education, KiVa was rolled out in 2009 and has since reached over 90 per cent of comprehensive schools in the country. Through the programme teachers, students and parents receive professionally prepared materials which include concrete activities to be carried out. KiVa also places an emphasis on bystanders or witnesses of bullying by providing ways to enhance empathy and self-efficacy and to support victimized peers. A large-scale evaluation of the programme implementation in Grades 4 through 6 has shown that it reduces both self- and peer-reported bullying and victimization significantly. A remarkable 98 per cent of victims involved in discussions with the schools' KiVa teams felt that their situation improved. The programme has been rolled out in various other countries, such as the Netherlands, Estonia and Italy.

B. Mild recovery in youth unemployment, yet weak labour market transitions persist

The *2013 Chair's summary* emphasized the right to decent work for young people through effective policies and programmes that generate secure and non-discriminatory employment that provides a decent wage and opportunities for career development. Present generations of young people entering the labour market are better educated and

have higher career aspirations. Yet the youth employment crisis remains one of the region's most salient development challenges. The adverse effects of the global financial crisis and continuous jobless growth threaten to leave behind a generation of young people, entailing implications for the life course, such as long spells of unemployment, low-quality jobs, inadequate access to social protection and an increased risk of old-age poverty.³¹

²⁸ European Union Agency for Fundamental Rights (FRA) (2014) *Violence Against Women: an EU-wide Survey - Main Results*. FRA, Vienna. This share drops to 11 per cent if the 12 months before the survey are considered as the reference period.

²⁹ Nixon, C.L. (2014) "Current perspectives: the impact of cyberbullying on adolescent health", *Adolescent Health, Medicine and Therapeutics*, vol. 5, pp.143–158.

³⁰ Case study based on KiVa International. Available at: <http://www.kivaprogram.net/>; and UNESCO (2018) *The KiVa anti-bullying programme*

in Finland. UNESCO, Paris. Available at: <http://www.unesco.org/new/en/education/themes/strengthening-education-systems/quality-%20%20%20framework/promising-practices/anti-bullying-programme-in-finland>.

³¹ UNDG Europe and Central Asia (2017) *Building More Inclusive, Sustainable and Prosperous Societies in Europe and Central Asia. From Vision to Achievement of the Sustainable Development Goals. Call for Action from the Regional UN System*. UNDG, Istanbul.

As ILO (2017) and the Council of Europe (2017) indicate in their recent reports, today's young workers seek reputable employers that promote diversity and encourage work–life balance and mobility. However, many struggle to find quality jobs affording stability, satisfaction and the means to live above the poverty line.³² The transition from school to a stable and satisfactory job—a process contingent on individual capabilities and the jobs available in the labour market—remains problematic for many of the region's adolescents and youth, even for those with good qualifications. For instance, it takes young workers in some countries of the eastern part of the region³³ an average of 17.9 months to complete this transition.³⁴

In the EU, the flexible working arrangements that characterize today's labour markets respond to the private sector's needs to adjust their workforce in response to changes in economic conditions.³⁵ Temporary (fixed-term) contracts are mostly held by young people and persons with low educational attainment, while own-account employment is more prominent at older ages, although it is acknowledged that this latter form of employment allows young people to expand their choices and find a better work–life balance.³⁶ For example, individuals aged 30–39 and 50–59 are, respectively, 66 per cent and 84 per cent less likely to hold a temporary contract than individuals aged 20–29.³⁷

A few sectors in the economy have seen relevant growth in the participation of young

workers, including: financial services; trade, hotels and restaurants; transport and storage; information and communications; and health services, including care work and social work activities. The continuation of these trends depends on the evolution of technological change.³⁸ Trends in the share of young workers in financial services, however, are mixed, increasing and decreasing in the eastern and western parts of the region, respectively.³⁹

Box 4. Youth Guarantee in the European Union

The **Youth Guarantee** is a commitment by all EU Member States to ensure that all young people under the age of 25 years receive a good-quality offer of employment, continued education, apprenticeship and traineeship within a period of four months of becoming unemployed or leaving formal education. All EU Member States committed to the implementation of the Youth Guarantee through a European Council Recommendation (22 April 2013).

The labour force participation rate of youth aged 15–24 remained stable at around 45 per cent between 2010 and 2016 in the UNECE region (Table 1). Men were more likely to engage in the labour force than women (47 per cent vs. 40 per cent), although the gender gap narrowed slightly during this period. The gender gap continued to exceed the regional average by three-fold in South-Eastern Europe and by two-fold in Central Asia.

³² ILO and Bureau for Employer's Activities (2017) *Women in Business and Management. Gaining Momentum in Eastern Europe and Central Asia*. ILO, Geneva and Council of Europe (2017) *State of Democracy, Human Rights and the Rule of Law. Populism – How strong are Europe's checks and balances?* Council of Europe, Strasbourg.

³³ Armenia, Kyrgyzstan, Montenegro, the Republic of Moldova, the Russian Federation, Serbia and the former Yugoslav Republic of Macedonia.

³⁴ ILO (2017) *Global Employment Trends for Youth 2017*. ILO, Geneva.

³⁵ European Commission (2017) *Labour Markets and Wage Developments in Europe. Annual Review 2017*, European Commission, Brussels.

³⁶ Ibid.

³⁷ Ibid.

³⁸ ILO (2017) *Global Employment Trends for Youth 2017*. ILO, Geneva.

³⁹ Ibid.

Table 1. Labour force participation rate, youth aged 15–24, total and by sex, 2010–2016

Subregion	2010				2016			
	Total %	Men %	Women %	Gap %p	Total %	Men %	Women %	Gap %p
South-Eastern Europe	37	49	25	24	40	52	29	23
Eastern Europe and the Caucasus	41	45	36	9	36	40	32	8
Central Asia	46	54	38	16	46	55	38	17
EU13 new countries	32	37	28	9	32	37	27	10
EU15 countries	45	48	43	6	43	45	41	4
Western Europe non-EU	64	64	63	1	63	63	64	-1
North America and Israel	52	54	51	3	52	53	51	2
UNECE	45	49	41	8	44	47	40	7

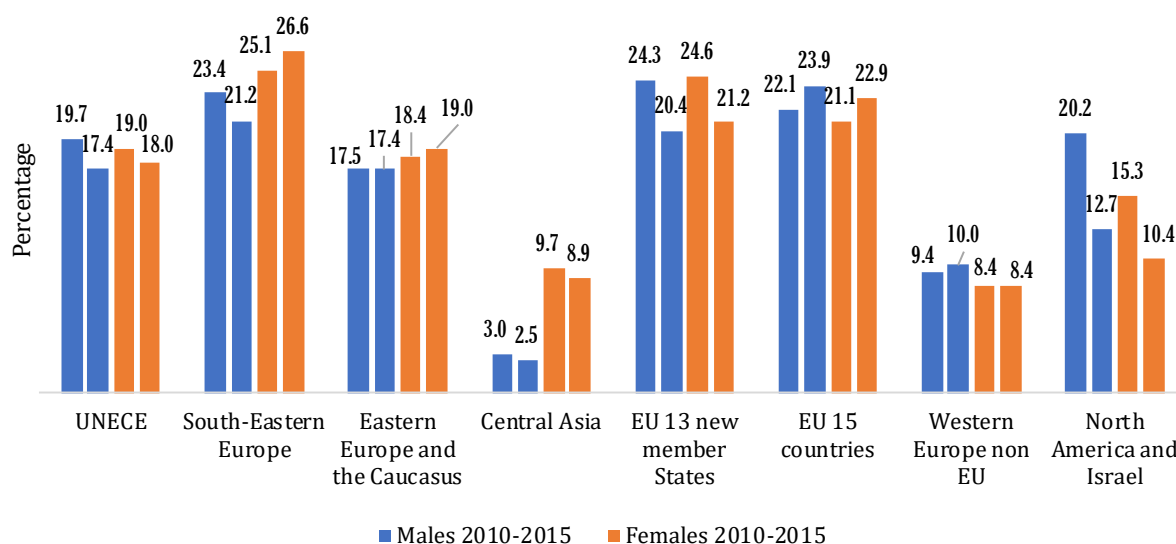
Source: ILO. ILOSTAT: Population and Labour Force Indicators

Considering the region’s ageing context, increasing youth labour force participation, particularly for women, and promoting rapid transitions from school to quality jobs become key interventions to support the sustainability of pension and health-care systems.

Unemployment disproportionately affects young people, and when occurring for long periods of time, it can hamper their skills

development as well as their job and income prospects. The rate of youth unemployment (among those aged 15–24 years) declined from 20 to 18 per cent in the region between 2010 and 2015, yet it remains unacceptably high. During this period, a greater reduction was observed among male youth (from 20 to 17 per cent) than among females (from 19 to 18 per cent) (Figure 9).

Figure 9. Unemployment rate by sex, youth aged 15–24, 2010–2015



Source: UNECE Statistical Database.

In the eastern subregions, young women were more likely to be unemployed than men, while the opposite relationship is observed in the western part of the region.

Labour force participation is substantially higher among youth aged 25–29, evidencing in part later transitions from education to labour markets due to expanded access to tertiary

education (Table 2). In both 2010 and 2016, more than 8 in every 10 youth aged 25–29 were engaged in the labour force in the UNECE region. During this period, the gender gap in labour force participation narrowed slightly, yet it was double that observed among the 15–24 age group, remaining even larger in eastern subregions.

Table 2. Labour force participation rate, youth aged 25–29, total and by sex, 2010–2016

Subregion	2010				2016			
	Total %	Men %	Women %	Gap %p	Total %	Men %	Women %	Gap %p
South-Eastern Europe	65	89	41	48	70	90	50	40
Eastern Europe and the Caucasus	84	91	77	15	85	93	77	16
Kazakhstan and Kyrgyzstan	89	95	82	13	87	94	79	16
EU13 new countries	82	90	73	16	82	90	73	17
EU15 countries	83	88	77	11	82	87	78	9
Western Europe non-EU	86	89	83	7	88	90	86	4
North America and Israel	82	88	76	12	82	87	76	11
UNECE	82	89	74	15	82	89	75	14

Source: ILO. ILOSTAT: Population and Labour Force Indicators.

Labour force participation rates, however, do not fully cover the unmet demand for employment, which can be sizeable in some contexts. In the EU, for instance, some 8.8 million people were available to work but did not look for a job in 2016 and, therefore, were not counted as part of the labour force. Due to family and study-related responsibilities, many women and young people are likely to be part of such *potential labour force*.⁴⁰

In the western part of the region, youth unemployment rates are expected to decrease in the coming years, continuing the recovery trend which started in 2013, mostly due to improvements in countries with high unemployment such as France, Italy and Spain.⁴¹ In the eastern part of the region, the future outlook is mixed. Although youth unemployment is expected to decrease in

Eastern Europe due mainly to the Russian Federation’s economic and labour market recovery, the reverse trend is likely to occur in South-Eastern Europe due to increasing youth unemployment in Turkey.⁴²

Adolescents and youth not in employment, education or training (NEET) are unable to fulfil their potential, jeopardizing their long-term career and earning prospects. Between 2010 and 2015, the share of NEET adolescents and youth aged 15–24 (SDG Indicator 8.6.1) moderately decreased in most countries and subregions (Figure 10). In 2015, youth NEET rates remained lowest (at 5 per cent) in Iceland, the Netherlands and Norway. Turkey, in turn, achieved significant declines in the NEET rates between 2010 and 2015 (from 32 to 24 per cent) but was still one of the countries with the highest NEET rates in the

⁴⁰ ILO (2018) *World Employment Social Outlook. Trends 2018*. ILO, Geneva.

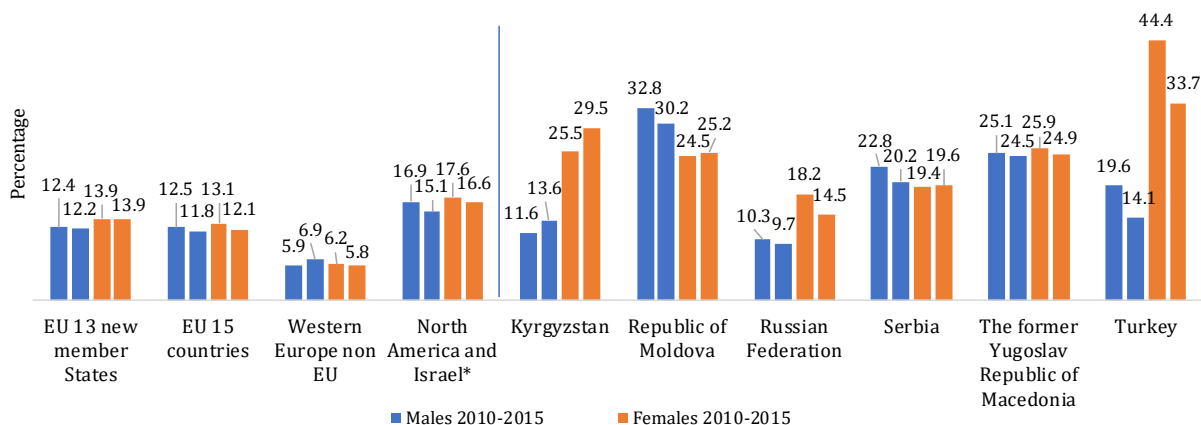
⁴¹ ILO (2017) *Global Employment Trends for Youth 2017*. ILO, Geneva.

⁴² Ibid.

region. The NEET rate among Turkish female adolescents and youth remained considerably higher than among their male counterparts, a

pattern that was observed to varying degrees across countries and subregions.

Figure 10. Proportion of adolescents and youth aged 15–24 not in employment, education or training by sex, 2010–2015



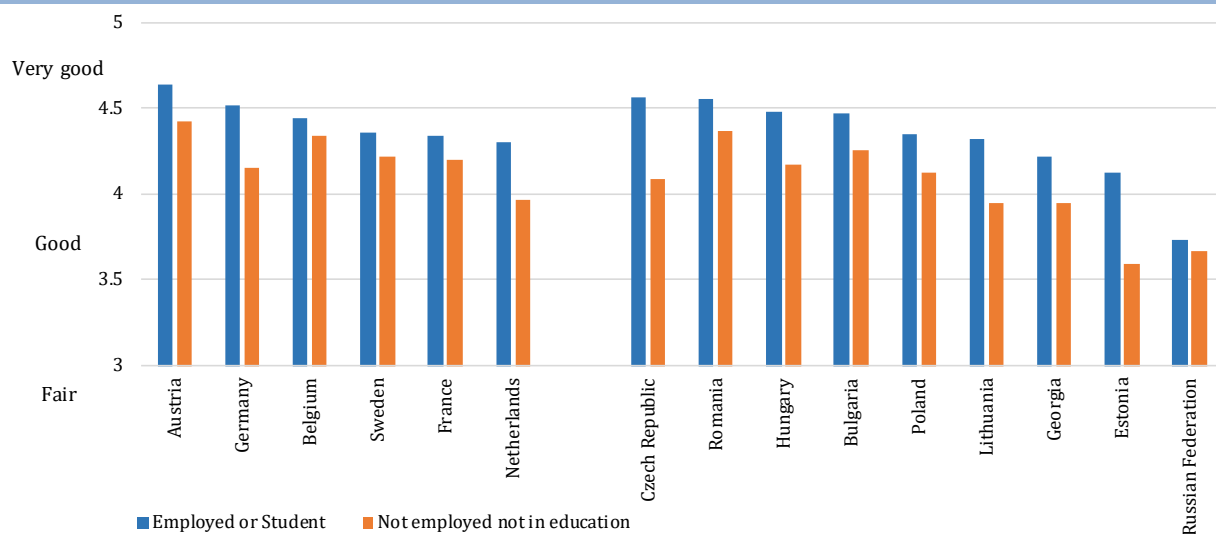
Source: ILO. UN Global SDG Database.

*In the aggregate for North America and Israel, US data refer to 2012 instead of 2015.

NEET status can be associated with a range of health and well-being issues. For instance, the Generations and Gender survey data show that NEET young adults have a lower level of life

satisfaction, though, overall, men and women aged 18–29 tend to be very satisfied with their life (Figure 11).

Figure 11. Life satisfaction among men and women aged 18–29 by activity status



Source: Generations and Gender Survey, wave 1.

Lastly, the lack of quality employment opportunities in domestic labour markets pushes workers to consider moving abroad to develop their careers and improve their living conditions. The region presents wide variations in this trend, with around 80 per cent of youth in Albania willing to move permanently to another country, around 45 per cent in Romania, around 30 per cent in Slovakia, around 15 per cent in both the United States and Canada, and less than 10 per cent in Israel and Luxembourg.⁴³

C. Promoting healthy lifestyles among young people

The *2013 Chair's summary* recommended the promotion of healthy lifestyles among adolescents and youth to improve the lives of future generations of older persons. Health at later ages is shaped by accumulated experience and adopted lifestyles throughout the life course, highlighting the need to instil healthy behaviours during childhood and adolescence.

Eating a balanced and varied diet and establishing healthy eating habits stimulate growth and intellectual development throughout the life course and reduce the likelihood of ill-health and premature death attributed to non-communicable diseases (NCDs).⁴⁴ Conversely, an unbalanced diet based on energy-rich, nutrient-poor foods results in overweight, obesity and higher risk of NCDs.

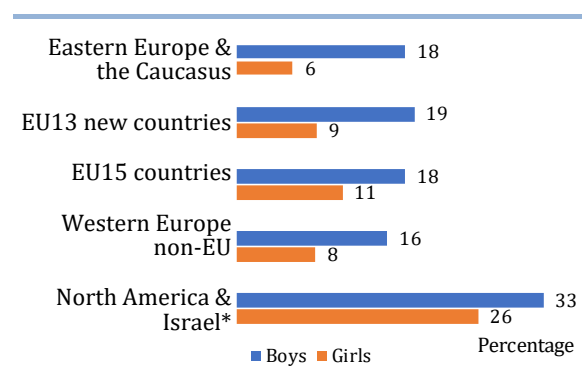
Overweight and obesity are among the fastest-growing health issues for children and adolescents, notably affecting those from low socio-economic backgrounds, causing health

⁴³ ILO (2016). *World employment and social outlook: Trends for youth 2016*. ILO, Geneva, p.4, Figure 4.

⁴⁴ WHO (2016) *Adolescents' Dietary Habits. Fact Sheet, 15 March 2016*. WHO Regional Office for Europe, Copenhagen, p.1.

problems in later stages of life and burdening health systems and economies.⁴⁵ Overweight and obesity are more common among boys than girls in most countries. Their prevalence among both sexes remains considerably higher in North America and Israel, where one in three boys and one in four girls are overweight or obese (Figure 12).

Figure 12. **Proportion of adolescents aged 15 overweight or obese by sex, 2014**



Source: WHO. Health Behaviour in School-Aged Children Data Portal.

* In the aggregate for North America and Israel, US data refer to 2010 instead of 2014.

Physical inactivity rates among children and adolescents in Europe are increasing rapidly, contributing to the energy imbalance that results in weight gain.⁴⁶ Only one in every three European adolescents aged 13 to 15 are active enough to meet the current WHO guidelines, with most countries evidencing that boys are more active than girls and that activity decreases with age in both sexes.⁴⁷

According to WHO (2016), these alarming trends are driven by more time spent in academic settings, coupled with increased academic demands, increased engagement in

⁴⁵ WHO (2014) *Investing in Children: the European Child and Adolescent Health Strategy 2015–2020*. WHO Regional Office for Europe, Copenhagen, p.9.

⁴⁶ WHO (2016) *Physical Activity Strategy for the WHO European Region 2016–2025*. WHO Regional Office for Europe, Copenhagen, p.6.

⁴⁷ *Ibid.*, p.2.

sedentary recreational activities, such as screen-based activities, and decreased walking

and cycling to and from school in urban contexts.⁴⁸

Box 5. Promoting adolescent healthy habits: Armenia

Armenia has been paying increased attention to the health habits of its population, conducting surveys and research with support from development partners to better understand the behaviour of its population.⁴⁹ In 2005, the country conducted a pilot Health Behaviour in School-aged Children (HBSC) survey, which informed the development of its child and adolescent health development strategy. A subsequent survey conducted in 2013-2014 revealed several issues for young Armenians' physical and mental health, including: unhealthy diets and insufficient levels of physical activity; a worrying increase in the prevalence of smoking at age 15–17; and a very high frequency of physical fights among boys.

The Armenian National Youth Policy seeks to encourage healthy lifestyles among young people, including through an annual programme led by the Ministry of Sport and Youth Affairs to prevent risk behaviours for HIV and other STIs. Healthy lifestyles and health education, including reproductive health, are already incorporated into the National Curriculum of General Education, which has already been rolled out in secondary educational institutions (grades 8–9 of schools) and is in the process of being rolled out in grades 10–11. This entails a 56-hour programme taught in grades 8–11 by physical education or biology teachers. Armenia is now an example in the region of how to produce sound, evidence-based policies to address and improve the health lifestyles of its adolescent population.

Lastly, the use of alcohol among adolescents continues to represent a major public health concern in the region. Risky drinking during adolescence, including early and frequent drinking and drunkenness, is associated with poor academic performance, violence, motor vehicle accidents, unintentional injuries, use of other substances and unprotected sexual intercourse.⁵⁰ In addition, early initiation of alcohol use (before age 14) is associated with increased risk of alcohol dependence and abuse at later ages.⁵¹

In the UNECE region, alcohol use fell among all adolescent age groups during the period

2010–2014, with consumption decreasing slightly more among boys than girls.⁵² However, in 2014, adolescent boys aged 15 remained more likely to drink alcohol at least once a week, including beer, wine, spirits, alcopops or any other drink that contained alcohol, than their female counterparts (Figure 13). Regular alcohol consumption among both sexes was most widespread in the 13 new EU Member States and the EU15 countries. In 2014 the heavy episodic drinking rate was the highest in the world, with one fifth of adolescents aged 15 in the UNECE region reporting having had five or more drinks on one occasion during the previous 30 days.⁵³

⁴⁸ Ibid., p.13.

⁴⁹ Case study based on WHO (2016) *Health Behaviour in School-aged Children (HBSC) survey data informing policy: country examples*. WHO Regional Office for Europe, Copenhagen; and Ministry for Education and Science of Armenia (2010) *National Curriculum for General Education*. Ministry for Education and Science of Armenia, Yerevan. Available at:

http://www.ibe.unesco.org/curricula/armenia/ai_fw_2010_eng.pdf.

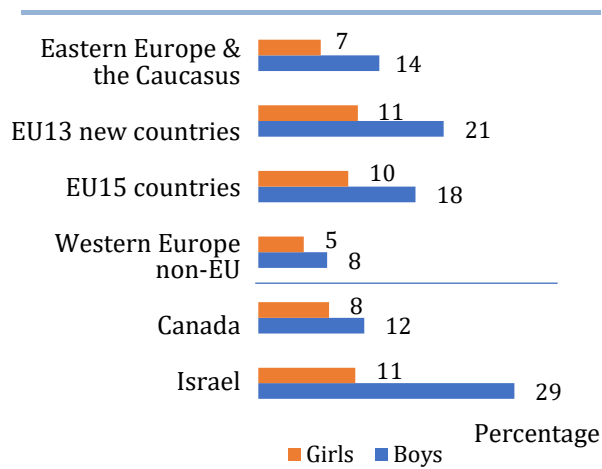
⁵⁰ Ibid., p.2; and WHO (2014) *Global Status Report on Alcohol and Health 2014*. WHO, Geneva, pp.7–8.

⁵¹ WHO (2014) *Global Status Report on Alcohol and Health 2014*. WHO, Geneva, p.7.

⁵² WHO (2016) *Alcohol Use in Adolescents. Fact Sheet, 15 March 2016*. WHO Regional Office for Europe, Copenhagen, p.1.

⁵³ Ibid., p.1.

Figure 13. **Proportion of adolescents aged 15 who drink alcohol at least once a week, by sex, 2014**



Source: WHO. Health Behaviour in School-Aged Children Data Portal.

The public media and comprehensive sexuality education programmes remain effective platforms to promote healthy lifestyles among children, adolescents and youth, including healthy eating, nutrition and physical exercise, as well as skills to prevent the abuse of alcohol, tobacco other substances.

D. Shortcomings in civic engagement

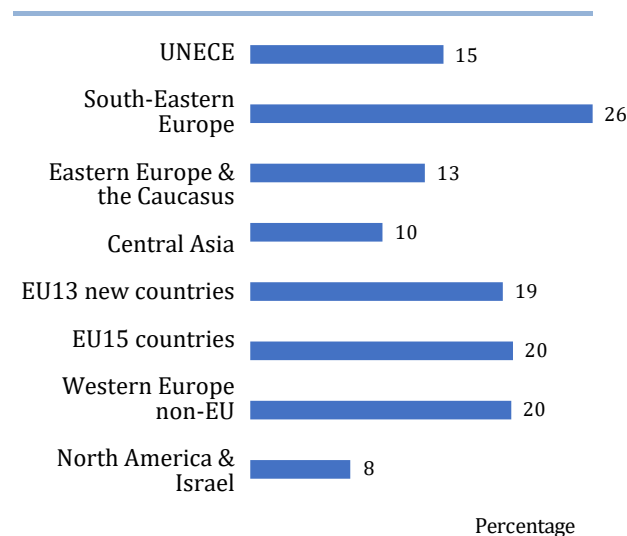
The 2013 Chair's summary emphasized the need to allow adolescents and youth to meaningfully participate in all stages of the formulation, implementation and evaluation of policies and programmes. Making assumptions about their needs, desires, frustrations and opportunities is likely to result in poor policy responses.⁵⁴

The involvement of adolescents and youth in political life can take place either by directly participating in political life as elected members of governing bodies or by engaging

⁵⁴ Council of Europe (2017) *State of Democracy, Human Rights and the Rule of Law. Populism – How strong are Europe's checks and balances?* Council of Europe, Strasbourg, p.116.

in specific formal structures established for their participation. In 2014 and 2015 the proportion of younger parliamentarians (aged under 40) amounted to 15 per cent, remaining lowest in North America and Israel and Central Asia and highest in South-Eastern Europe (Figure 14).

Figure 14. **Proportion of parliamentarians aged under 40, 2014–2015**



Source: Inter-Parliamentary Union. Youth participation in national parliaments 2016.

As a Council of Europe (2017) report points out, consultations with adolescents and youth in the region show that politicians pay insufficient attention to their views, causing formal structures once established for their meaningful participation to function ineffectively and in a tokenistic manner, resulting in disillusionment.⁵⁵

In 2015, almost two thirds of EU youth disagreed that more was being done to mainstream youth issues in policymaking and to include youth in democratic decision-

⁵⁵ Council of Europe (2017) *Challenges to Children's Rights Today: What do Children Think?* Council of Europe, Strasbourg, p.30.

making in comparison to five years ago.⁵⁶ Raising awareness among adolescents and youth on the existence and functioning of such platforms and ensuring that engagement opportunities are youth-friendly, meaningful and accessible are key to ensure that their views are heard.

Lastly, adolescent and youth involvement in volunteering and sporting activities remains an effective means of promoting their integration in communities, developing their life skills and creating environments in which they may be less likely to engage in adverse and risky behaviours.⁵⁷ Some comparative observations on the involvement of young persons aged 18–24 and older persons aged 65 years or older in undertaking monthly voluntary work with community and social services organizations is provided in Section 1.4.C below.

1.4. Older persons: realizing the potentials of longevity

- Older persons are increasingly being recognized as central assets to achieve sustainable and inclusive development, but their potential remains largely untapped.
- Since 2005 the average life expectancy at age 55 had increased by 19 months for women and by 21.5 months for men, reaching 28.7 and 24.6 years, respectively, in the region in 2015. Rates in Eastern Europe and the Caucasus and in Central Asia remained markedly below the region's average, in particular for men (18.6 years and 19.2 years, respectively, in 2015), partly due to NCDs, the rate of which remains highest in these two subregions, disproportionately impacting men.
- The labour force participation rate of persons aged 60–64 increased from 39 to 44 per cent between 2010 and 2016, while that of persons

aged 65 and older remained stable at 11 per cent. Women in both age groups remain less likely to engage in the labour force than men.

- Older workers are less impacted by unemployment than younger workers, but when faced by it, it generally takes them longer to secure a job, potentially discouraging them and forcing them to leave the labour force
- Between 2010 and 2015, participation in education and training among persons aged 55–74 increased from 4 to 5 per cent among women, and from 3 to 4 per cent among men, but remained low overall. In Western European countries without EU membership women and men in this age group were three times more likely to participate in education and training than the regional average.
- The proportion of younger (18–24) and older persons (65+) engaged in volunteering varies significantly across generations and subregions, ranging from 2 per cent for both younger and older persons in the 13 new EU Member States to 8 per cent among younger and 10 per cent among older persons in the EU15 countries.
- The region's societies increasingly rely on informal care when confronted with population ageing and growing needs for long-term care.
- Middle-aged women are likely to be the first responders to informal care needs, often bearing a triple burden as they care for the younger and older generations while remaining engaged in the labour force, with implications for their own health and well-being.
- Older generations, and older women in particular, play a key role in the provision of care to their children and grandchildren, as well as to their older relatives and relatives with disabilities.

⁵⁶ European Commission (2016) *Evaluation of the EU Youth Strategy and the Council Recommendation on the Mobility of Young Volunteers across the EU*. European Commission, Brussels, p.44.

⁵⁷ United Nations (2016) *World Youth Report 2016: Youth Civic Engagement*. United Nations, New York, p.13.

The 2013 Chair's summary highlighted the need to promote independent, active and healthy ageing at the place of residence. It emphasized that preventing discrimination against older persons, and securing their health care, income and social networks allows societies to benefit from their productivity and contributions as caregivers, volunteers and entrepreneurs.

As older persons are increasingly being recognized as a central asset to achieve sustainable and inclusive development, the region's countries must strive to reap the enormous potentials that longevity offers for economies and societies, most of which remain untapped.⁵⁸

Box 6. The Lisbon Ministerial Declaration 2017 sets policy goals on ageing in the UNECE region

The **Lisbon Ministerial Declaration on 'A Sustainable Society for All Ages: Realizing the Potential of Living Longer'** was adopted by UNECE member States at the Fourth UNECE Ministerial Conference on Ageing in 2017. The Lisbon Declaration outlines countries' determination to reach three priority policy goals by 2022, namely: recognizing the potential of older persons, encouraging longer working life and ability to work, and ensuring ageing with dignity.

These potentials may only be realized if older persons remain in good health, have opportunities to contribute to economies and are supported to pursue lifelong learning and volunteering, all of which empower them to stay actively engaged in the affairs of their communities. Promoting the rights and ensuring the full participation of older persons

contribute to building better societies for all ages.

A. Continuing advances towards healthier and more active and independent living

The 2013 Chair's summary acknowledged that in many of the region's countries people were living longer and healthier lives. Yet it also highlighted that persisting differences in life expectancy and adverse trends in mortality, especially among working-age men, remained of high concern in some countries in Eastern Europe and Central Asia.

Member States have achieved progress in the promotion of healthy, active and independent living among older persons. By 2015, average life expectancy at 55 reached 28.7 years for women and 24.6 years for men. While the burden of NCDs (SDG Indicator 3.4.1) declined in all subregions during the period 2000–2015, it remained highest in Eastern Europe and the Caucasus and Central Asia, where it continues to disproportionately impact men compared to women (Figure 15). Over the last 15 years, notable reductions in the male NCD burden were achieved by Kazakhstan (from 53 to 39 per cent) and the Russian Federation (from 51 to 42 per cent). The male NCD burden was also nearly halved in Ireland (from 22 to 12 per cent).

Among the three UNECE subregions with representative data available, healthy life expectancy⁵⁹ at age 55 is highest in Western European countries without EU membership (21.4 years for women vs. 21.1 years for men), followed by the EU15 countries (15.1 vs. 14.8 years) and the 13 new EU Member States (12.8 vs. 11.8 years), indicating that

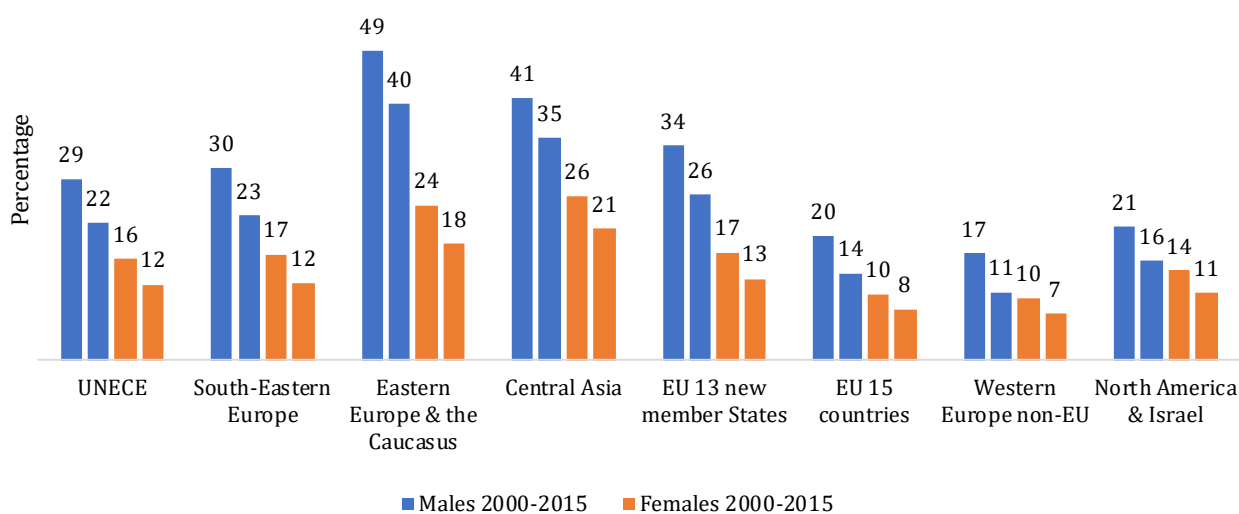
⁵⁸ UNECE (2017) *Synthesis Report on the implementation of the Madrid International Plan of Action on Ageing in the ECE region between 2012 and 2017*. UNECE, Geneva, p.69.

⁵⁹ Healthy life expectancy is a form of health expectancy that applies disability weights to health states to compute the equivalent number of years of life expected to be lived in full health.

increasing numbers of people are living in relatively good health beyond the age of 65. Gains in life expectancy reflect the benefits of investing in the education, health and social protection of individuals throughout the life course.

Further improvements require the promotion of healthy lifestyles and behavioural changes in dietary intake, smoking and alcohol consumption across generations, and the eradication of inequalities and disparities in access to services that may serve as risk factors.

Figure 15. **Proportion of deaths attributed to NCDs (cardiovascular diseases, cancers, diabetes or chronic respiratory diseases) among persons aged 30–70, 2000–2015**



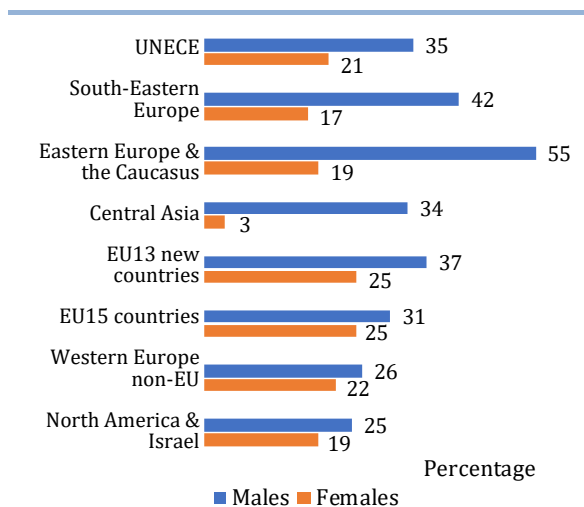
Source: WHO. UN Global SDG Database.

Box 7. WHO Action Plan for the Prevention and Control of Non-Communicable Diseases 2016–2025

The **Action Plan for the Prevention and Control of Non-Communicable Diseases in the WHO European Region 2016–2025** was adopted by member States at the 66th Session of the WHO Regional Committee for Europe in 2016. The Action Plan aims to avoid premature death and significantly reduce the disease burden of NCDs by taking integrated action, improving the quality of life and making healthy life expectancy more equitable within and between member States.

In 2015, one in every three men and one in every five women aged 15 or older in the UNECE region were tobacco users (SDG Indicator 3.a.1) (Figure 16). Smoking remained more common among men than women across all subregions, with male prevalence remaining higher in the eastern part of the region. In Eastern Europe and the Caucasus, more than half of men aged 15 or older reported smoking. Larger gender variations in the prevalence of smoking were observed in the eastern part of the region. In Central Asia, low levels of smoking among women (3 per cent) are likely to be explained by traditional societal norms.

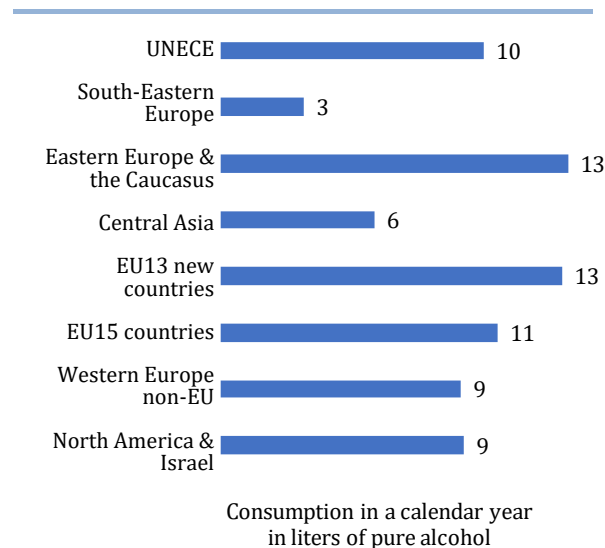
Figure 16. Age-standardized prevalence of current tobacco use among persons aged 15 or older, 2015



Source: WHO. UN Global SDG Database.

In 2016 the harmful use of alcohol (SDG Indicator 3.5.2), defined as the amount of per capita alcohol consumption among persons aged 15 years and older within a calendar year in litres of pure alcohol (beer, wine, spirits or other), was highest at 13 litres per capita in Eastern Europe and the Caucasus and the 13 new EU Member States, and lowest in South-Eastern Europe (3 litres per capita) (Figure 17).

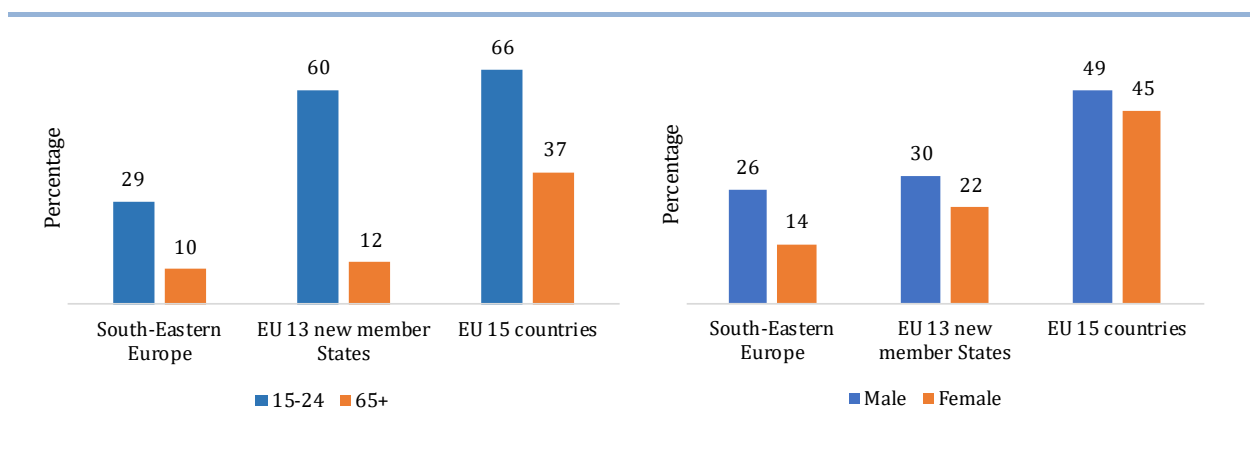
Figure 17. Harmful use of alcohol, persons aged 15 years and older, 2016



Source: WHO. UN Global SDG Database.

In 2016, men had a higher propensity to engage in sports or physical exercise than women in the three UNECE subregions with available data (Figure 18). Taking part in sports or physical exercise at least once a week remained most common in the EU15 countries, with Finland and the Netherlands in the lead: about 8 in 10 adults in Finland and 7 in 10 in the Netherlands.

Figure 18. Proportion of the population who take part in sports or physical exercise at least once a week, by sex and age group, 2016

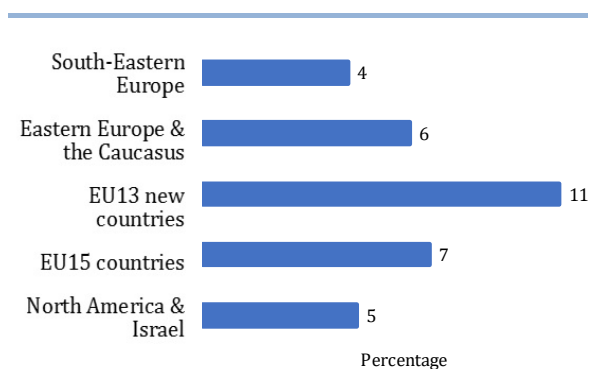


Source: Eurofound. European Quality of Life Survey.

More than a third of older persons were regularly engaged in sports or physical exercise in the EU15 countries (37 per cent), compared to only about 1 in 10 in the 13 new EU Member States and South-East Europe.

Between 2010 and 2015, at subregional level the proportion of the population in the UNECE region spending more than 10 per cent of household consumption or income on out-of-pocket health-care expenses was estimated at 6 per cent (Figure 19).

Figure 19. Proportion of the population spending more than 10 per cent of household consumption or income on out-of-pocket health-care expenses, 2010–2015



Source: WHO. Universal Health Coverage Data Portal.

The highest levels of catastrophic health spending were observed in the 13 new EU Member States (11 per cent). At the country level, about 29 per cent of Georgia’s population were spending more than 10 per cent of their household income/consumption on out-of-pocket health-care expenses, and this share ranged between 15 and 20 per cent in Albania, Armenia, Cyprus, Greece, the Republic of Moldova, Portugal and Switzerland.

Guaranteeing universal health coverage by expanding access to and improving the quality

of essential services is, therefore, essential for individuals across generations to remain healthy and active. As highlighted in a recent report by WHO and the International Bank for Reconstruction and Development (2017), progress towards universal health coverage is a continuous process that changes in response to shifting demographic, epidemiological and technological trends, as well as people’s expectations.⁶⁰

The goal of universal health coverage is to ensure that all generations in need of promotive, preventive, curative, rehabilitative or palliative health services receive them, and that the services received are of sufficient quality to achieve potential health gains. Although resource constraints might prevent some countries from providing all health services, all countries should be able to ensure coverage of essential health services.

B. Improvements in older persons’ economic participation

As the unfolding ageing process entails the shrinking of the region’s working-age population, the *2013 Chair’s summary* stressed the need to create employment opportunities for older persons. Over the past years, however, increases in healthy life expectancy have not been accompanied by significant growth in economic participation at older ages.

Between 2010 and 2016 the labour force participation rate of persons aged 60–64 increased from 39 to 44 per cent in the region, due in part to the rise in the statutory retirement age (Table 3). At the country level, the most significant increases were recorded in Denmark (from 42 to 56 per cent), Estonia (48 to 59 per cent), Germany (45 to 59 per cent), Latvia (33 to 54 per cent), Lithuania (37

⁶⁰ WHO and International Bank for Reconstruction and Development (2017) *Tracking universal health*

coverage: 2017 Global Monitoring Report. WHO and International Bank for Reconstruction and Development, Geneva, p.2.

to 54 per cent) and the Netherlands (39 to 58 per cent).

In contrast, the labour force participation rate among persons aged 65 or older remained

stable at 11 per cent during the period 2010–2016. Men in both age groups were more likely to participate in the labour force than their female counterparts, a trend that is evidenced across all subregions to varying degrees.

Table 3. Labour force participation rate, older persons aged 60–64 and 65+, total and by sex, 2010–2016

Subregion	60–64						65+					
	2010			2016			2010			2016		
	Total %	Men %	Women %	Total %	Men %	Women %	Total %	Men %	Women %	Total %	Men %	Women %
South-Eastern Europe	27	40	15	30	45	16	11	18	6	11	19	6
Eastern Europe and the Caucasus	32	40	27	31	37	26	13	16	11	12	15	11
Central Asia*	38	59	22	36	55	21	10	15	7	7	9	5
EU13 new countries	24	33	17	34	45	24	6	8	4	5	8	4
EU15 countries	35	43	27	46	52	40	5	7	3	6	8	4
West. Europe non- EU	58	66	49	64	70	58	13	18	10	12	17	9
North America and Israel	55	60	50	56	62	50	17	21	13	19	24	15
UNECE	39	47	32	44	52	37	11	14	8	11	15	9

Source: ILO. ILOSTAT: Population and Labour Force Indicators

* Average for Central Asia is based on data for Kazakhstan and Kyrgyzstan only.

Although the equalization of pension ages has occurred in some contexts, women’s longer life expectancy and structural gender inequalities in labour markets and in the division of domestic and care work result in women’s lower pension contributions, casting doubt over the appropriateness of their future pensions.

Older workers are less impacted by unemployment than younger workers, but when faced by it, it generally takes them longer to secure a job, potentially discouraging them and forcing them to leave the labour force.⁶¹

This highlights the need to engage older workers in lifelong learning and training activities.

When engaged in the labour force, older persons can lead satisfying professional lives, economically support their families and contribute to the productivity of economies and the sustainability of social security systems with their experience and expertise. Therefore, expanding decent work opportunities for young and old generations alike and combating ageism in the workforce and workplace remain vital active ageing

⁶¹ Heywood, J.S., and S.W. Siebert (2009) *Understanding the Labour Market for Older*

Workers: A survey. IZA Discussion Paper No. 4033. Institute for the Study of Labor (IZA), Bonn, p.3.

strategies. Similarly, improving the working conditions of older persons across sectors, by addressing work-related physical and mental

health issues and poor work–life balance, is necessary to ensure their continuity in the labour market.⁶²

Box 8. Fostering older persons' economic participation: Norway

Many countries in the region are gradually adjusting regulations to extend working lives in line with growing longevity and, ultimately, to sustain social protection systems. Countries are delaying retirement age and introducing incentives for remaining in work longer, skills development schemes, and incentives for employers for hiring older persons.

As a result of such policies, employment rates among older persons (aged 55–64) in Norway have increased from around 65–66 per cent in 2000–2005 to 69 per cent around 2010 and 72 per cent in 2015–2016. Average economic activity above the age of 50 has increased from 9.5 man-years beyond the age of 50 in 2001, when the initiative first began, to about 11.5 man-years beyond the age of 50 in 2015. This positive trend is sustained by knowledge-based information about senior resources, age-specific working adjustments and benefits, and life course-oriented human resource policies and management.⁶³

The Norwegian pension system has gradually been reformed since 2011 with an aim to make it more economically and intergenerationally sustainable. Previously, it provided weak work incentives, particularly for people above the age of 62, due to early retirement schemes in both the public and private sectors. Flexible retirement between 62 and 75 years of age based on actuarial neutrality was introduced for new pensioners from 2011, and the annual pension will increase, the longer people defer retirement. Ultimately, pension reform in Norway has contributed to lower future growth in pension expenditures and a more sustainable system.

C. Slight progress in lifelong learning and volunteering

The *2013 Chair's summary* highlighted the need to invest in building human capital throughout the life course of individuals, and acknowledged the transformative power of education and learning to achieve sustainable societies. It also recognized the role played by older persons as volunteers.

An increasingly ageing workforce and a rapidly evolving economy point to the need to maintain and update the skills of older workers as per emerging requirements; otherwise they remain likely to retire before the mandatory retirement age due to their inability to find a job. Investing in the skills of older workers also expands their capacity to shift sectors and occupations when the composition of jobs in the labour market is altered by structural changes.⁶⁴

⁶² ILO (2018) *World Employment Social Outlook Trends 2018*. ILO, Geneva, p.48.

⁶³ Case study based on Royal Norwegian Ministry of Labour and Social Affairs (2016) *UNECE National Report on Ageing 2016 – Norway. Follow-up to the Regional Implementation Strategy (RIS) of the Madrid International Action Plan on Ageing (MIPAA)*. Royal Norwegian Ministry of Labour and Social Affairs, Oslo. Available at

https://www.unece.org/fileadmin/DAM/pau/age/country_rpts/2017/NOR_report.pdf; and UNECE (2017) *Synthesis Report On the implementation of the Madrid International Plan of Action on Ageing in the ECE Region between 2012 and 2017*. UNECE, Geneva.

⁶⁴ ILO (2018) *World Employment Social Outlook Trends 2018*. ILO, Geneva, p.48.

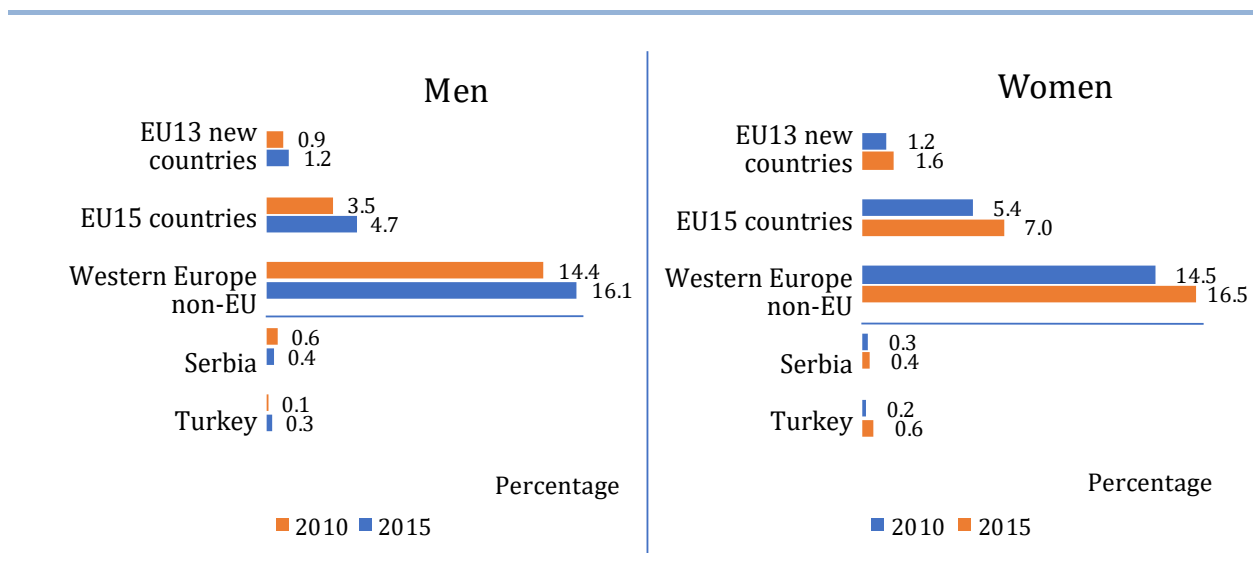
In contrast to younger workers, employers may feel disinclined to invest in older workers' capabilities, since they are expected to remain employed for a shorter period of time, which may explain older workers' generally low participation in formal education and on-the-job training. This in turn hampers older workers' employability prospects, their likelihood of changing occupation or sector of activity, and the innovation processes needed to ensure productivity growth.⁶⁵

The proportion of persons aged 55–74 participating in education or training varied significantly across countries and subregions, with women's exceeding that of men in most contexts (Figure 20). Women and men aged 55–74 in Western European countries without EU membership are three times more likely to

participate in education and training than the regional average. During the period 2010–2015, engagement in education or training among women aged 55–74 remained markedly high in Denmark (29 per cent), Iceland (from 16 to 18 per cent), Sweden (from 20 to 25 per cent) and Switzerland (from 18 to 20 per cent). In the EU13 and most countries in the eastern part of the region older persons' participation rate in education and training increased slightly but remained in low single digits or even below 1 per cent.

Overall low levels of education and training reveal an unrealized potential in maintaining and updating skills throughout working life and call for a greater emphasis on the promotion of and access to lifelong learning.

Figure 20. Proportion of persons aged 55–74 participating in education or training by sex, 2010–2015



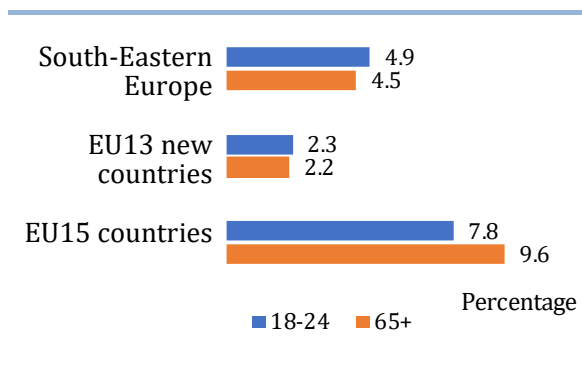
Source: UNECE. MIPAA+15.

Volunteering contributions of young and old generations alike, in formal and informal contexts, improve their well-being and strengthen human capital and social cohesion. In 2016, the proportion of young persons aged 18–24 and older persons aged 65 years or over

who engaged monthly in voluntary work with community and social services organizations ranged from about 1 in every 10 persons in the EU15 to only 1 person in 50 in the 13 new EU Member States (Figure 21).

⁶⁵ Ibid., p.3.

Figure 21. **Proportion of persons who undertake regular volunteering with community and social services organizations, 18–24 years and 65 years and older, 2016**



Source: Eurofound. European Quality of Life Survey.

D. Intergenerational involvement in long-term and informal care

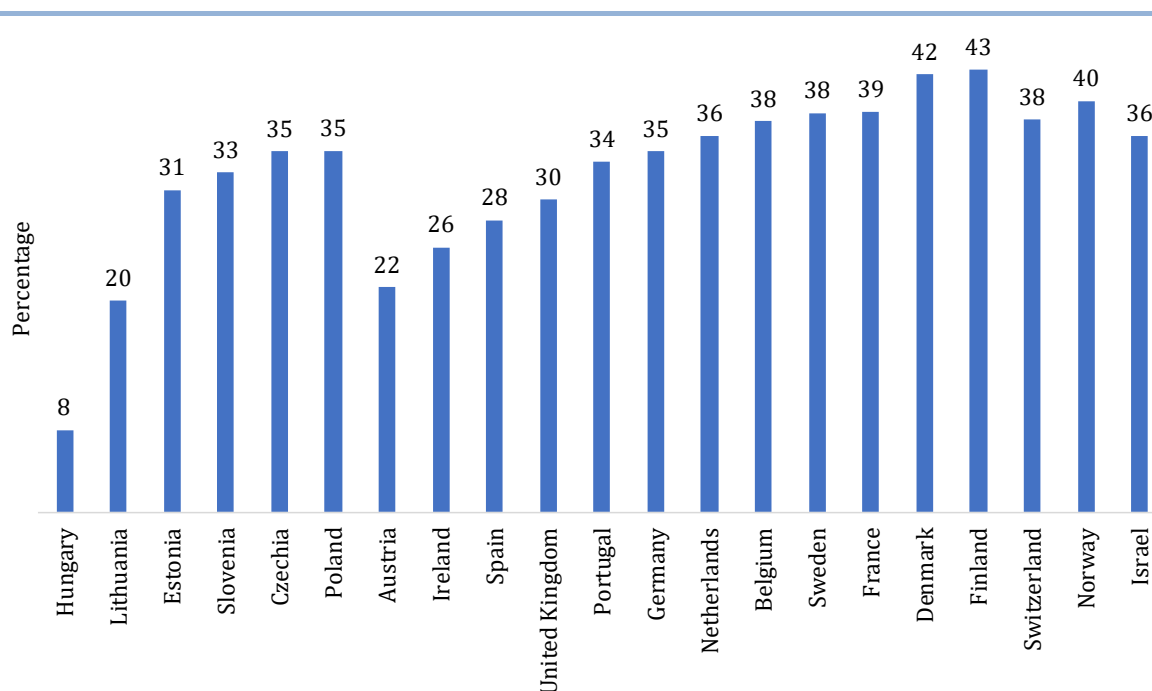
The *2013 Chair's summary* noted that population ageing in the UNECE region has implications for intergenerational equity; it

stressed the need to support communities and families to ensure that older persons receive the long-term care they need.

The region's societies increasingly rely on informal care when confronted with population ageing and growing needs for long-term care. In 2014 around one in every three persons aged 18 and older was involved in informal care in most EU countries and Western European countries without EU membership (Figure 22). In all these countries, most informal care providers reported contributing between 1 and 10 hours a week to informal care tasks.

Middle-aged women are likely to be the first responders to informal care needs, often bearing a triple burden as they care for the younger and older generations while remaining engaged in the labour force, with implications for their own health and well-being. Evidence from EU countries shows that informal caregiving is most prevalent among

Figure 22. **Proportion of persons aged 18 and older involved in informal care, 2014**



Source: European Social Survey Database.

women, 50–59 years old, the non-employed—especially those doing housework—and religious persons, and that caregivers, especially female and intensive caregivers, report lower mental well-being than non-

caregivers.⁶⁶ In addition, in this subregion middle-aged women remain one of the primary target groups of employment policies aiming to promote their increased participation in the labour force.⁶⁷

Box 9. Ensuring long-term care for older persons: France

In late 2015, France passed a ground-breaking law to respond to the specific needs of older age in terms of housing, transport, and social and civic life.⁶⁸ The Law on the Adaptation of Society to Ageing seeks to: prevent the loss of autonomy, reducing disability and extending good health, and reducing isolation among older persons; adapt society to ageing, developing responses that are better adapted to older persons and supportive of their autonomy, such as by integrating ageing issues into local housing programmes and urban transport planning; and provide personalized support to individuals through home-based care.

The law presents a positive approach to ageing, recognizes the challenges of this period of life, and seeks to present solutions and adaptations in a holistic fashion. It requires coordination across multiple sectors, reflecting the complexity of the issue it seeks to address. Despite the challenges faced in implementing the law, as reflected in an evaluation conducted in 2017, the shift from a dependency-centred to a human rights approach is significant and reflects positive progress in the long-term care of older people.

Older generations, and older women in particular, play a key role in the provision of care to their children and grandchildren, as well as to their older relatives and relatives with disabilities. In 2012, a higher proportion of women aged 55 or older provided care to older relatives or relatives with disabilities at least once a week compared to men within the same age group (15 per cent vs. 12 per cent) (Figure 23). This pattern was also observed in the provision of care to children or grandchildren, with overall care levels remaining higher (33 per cent vs. 30 per cent). While women's involvement in informal care exceeds that of men across subregions and care groups, larger gender gaps were

generally observed in the eastern part of the region.

The long-term viability of such inter-generational support systems is debatable, particularly in the context of decreases in family size and increased women's participation in the labour force and into older ages. As the absolute and relative number of older persons continues to grow across the region's countries, the configuration of long-term care services becomes highly relevant in national policymaking processes. Policies which holistically address the needs of older persons in terms of housing, transport, and

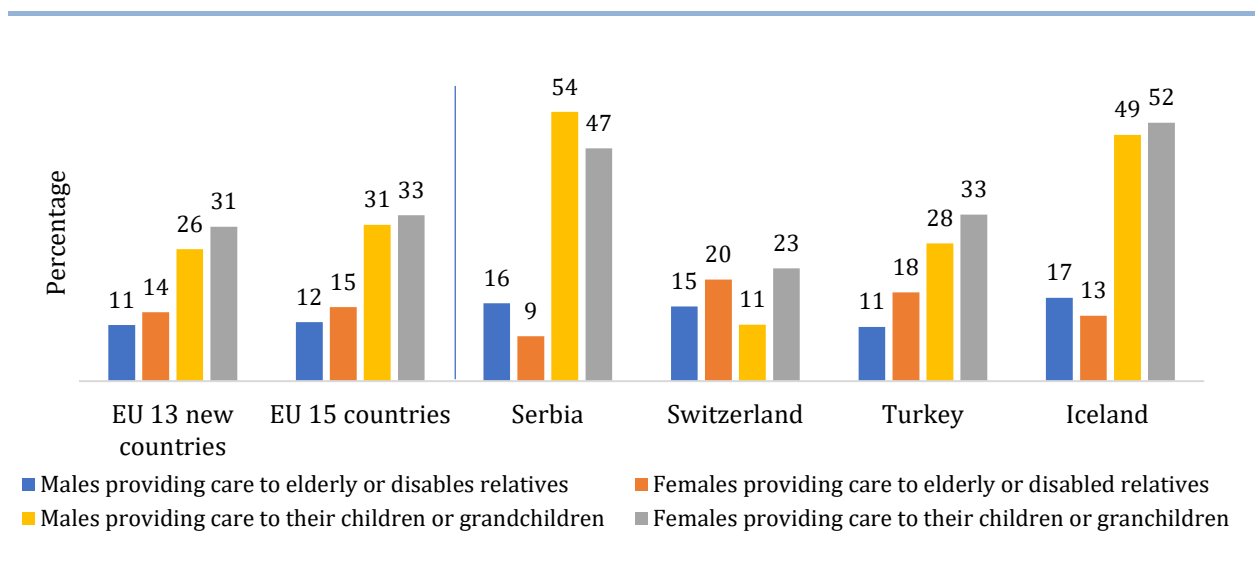
⁶⁶ Verbakel, E. et al. (2017) "Informal care in Europe: findings from the European Social Survey (2014) special module on the social determinants of health", *European Journal of Public Health*, vol. 27, supp. 1, pp.90–95.

⁶⁷ Ibid.

⁶⁸ Case study based on European Social Policy Network (ESPN) (2016) *France anticipates ageing*

society through new piece of legislation. ESPN Flash Report 2016/2018. ESPN, Brussels; and Ministry of Solidarity and Health of France (2017) *Report on the French Ageing Policy – 15 Years since the Second UN World Ageing Plan (Madrid International Plan of Action on Ageing – MIPAA) Madrid 2002.* Ministry of Solidarity and Health of France, Paris.

Figure 23. **Proportion of persons aged 55 or older providing care to their older or disabled relatives, and to their children or grandchildren, at least once a week, by sex, 2012**



Source: Eurofound. European Quality of Life Survey.

social and civic life, among others, remain key, as do policies facilitating the reconciliation of employment and care work in all life phases.

1.5. Promoting renewable energy and sustainable consumption patterns

- UNECE countries achieved significant reductions in CO₂ emissions between 2000 and 2014, yet these continue to impact livelihoods and ecosystems within and beyond the region.

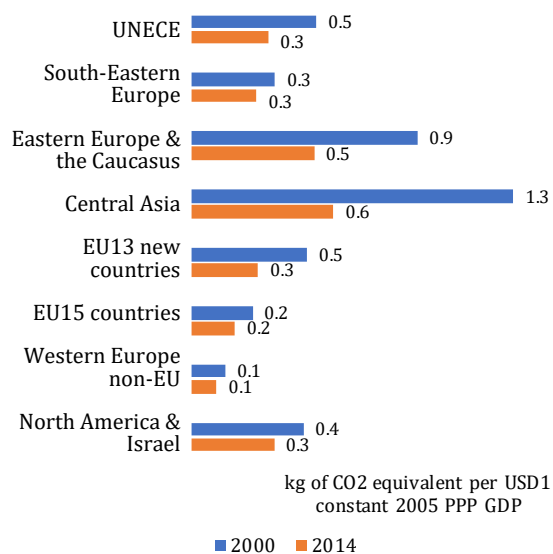
The 2013 Chair's summary acknowledged the impact of climate change and noted that the UNECE region has the highest levels of consumption and CO₂ emissions globally, which has implications beyond the region. It called for further emphasis on innovations aimed at energy efficiency and on progressive adaptation policies related to climate change.

The UNECE region has made significant progress in the reduction of CO₂ emissions per unit of value added (SDG Indicator 9.4.1),

which remain sensitive to the structure of the productive sector, the carbon intensity of the energy mix used, the energy efficiency of production technologies, and the economic value of outputs produced. Between 2010 and 2014, these decreased from 0.5 to 0.3kg of CO₂ equivalent per USD1 constant 2005 PPP GDP (Figure 24). Notable reductions in CO₂ emissions per unit of value added were achieved by Central Asia and Eastern Europe and the Caucasus during this period, although in 2014 levels remained highest in these two regions. Uzbekistan reduced CO₂ emissions from 1.9 to 0.6kg of CO₂ equivalent per USD1 constant 2005 PPP GDP, while in Azerbaijan they declined from 0.8 to 0.2kg.

When analysing the linkages between population dynamics and environmental sustainability, it is important to focus on the population's consumption profiles. Consumption patterns are one of the major contributors to sustainable environmental development, including climate change, natural resource degradation, biodiversity loss, and environmental impacts caused by

Figure 24. CO₂ emissions per unit of value added, 2000–2014



Source: International Energy Agency and UNIDO. UN Global SDG Database.

emissions and waste.⁶⁹ Nonetheless, all population members do not contribute equally to CO₂ emissions, nor are they equally impacted by climate change and human activity on the environment. Poor and marginalized populations too often endure most of the impacts of climate change and environmental degradation, despite contributing the least to CO₂ emissions.

While environmentally sound technologies have the potential to temporarily alleviate natural resource constraints and environmental impacts, reductions in CO₂ emissions remain highly dependent on the nature of consumption and economic growth. Therefore, a shift in consumption behaviours from present and future generations, young and old, as well as the development of innovative technologies that reduce

⁶⁹ UNDG Europe and Central Asia (2017) *Building More Inclusive, Sustainable and Prosperous Societies in Europe and Central Asia. From Vision to Achievement of the Sustainable Development Goals. Call for Action from the Regional UN System*. UNDG, Istanbul, p.3.

consumption without declines in well-being, is required to achieve sustainable development.

Box 10. Promoting renewable energy policies in the UNECE region

Most of the 56 UNECE countries have set goals to expand renewable energy and have introduced a wide range of promotion schemes and measures in the electricity (49 countries) and heat sectors (41 countries) to achieve these goals.⁷⁰ The most widely adopted policy instruments in the electricity sector are feed-in tariffs or feed-in premiums, tax reductions and investment incentives. These policy instruments have been implemented by most UNECE member States.

In addition, the *Status and Perspectives for Renewable Energy Development in the UNECE Region* report (2017) highlights the good practice of *Hard Talks*: a specific multi-stakeholder policy dialogue event organized by the UNECE in cooperation with host countries, local counterparts and other partners. *Hard Talks* are adapted to the specifications and requirements of each host country. They serve to investigate barriers that hinder the full unfolding of the potential of renewable energy in the host country, facilitate exchange and point out prioritized solutions to improve the investment climate for renewable energy and to foster discussion on what the UNECE can provide with similar initiatives. *Hard Talks* mobilize international experience to address domestic issues and have, thus far, been successful in identifying local constraints in Ukraine, Georgia and Azerbaijan, and sharing examples of good practice in renewable energy development.

The landmark Paris Agreement (2016) charts the way for UNECE countries to advance on this front. Evidence already points to the

⁷⁰ Case study based on UNECE and German Energy Agency (DENA) (2017) *Status and perspectives for renewable energy development in the UNECE region*. DENA, Berlin.

emergence of models for low-emission development that return a high quality of life, particularly in northern European countries, which have lower emissions per capita than their wealth might otherwise predict. Investing in human capital remains a primary strategy to promote environmental sustainability, as education can influence consumption behaviours by raising awareness on energy-efficient, less consumptive lifestyles.

1.6. Recommendations: Population dynamics and sustainable development

A. The interrelationships between ageing, low fertility and international migration

- Ensure that policy frameworks reflect increases in longevity and the new balance of generations, by fostering active **ageing** and independent living among **older persons**, including their capacity to support the younger generations and society at large, and by investing in the capabilities of **adolescents and youth** across multiple sectors such as education, skills development, employment and health.
- Strengthen rights-based and people-centred policies aimed at removing the health, economic, financial and social barriers that prevent men and women from realizing their **fertility** aspirations, and enabling them to reconcile their education and career aspirations with their fertility desires.
- Promote international cooperation efforts to ensure orderly, regular and safe processes of **international migration**, recognizing the roles and responsibilities of countries of origin, transit and destination, and involving local authorities; promote the integration and reintegration of migrants and ensure the portability of acquired professional credentials and benefits from work abroad; address the root causes of international

migration by improving employment and living conditions in origin countries to reduce out-migration of schooled, ambitious and risk-taking young adults; and facilitate the flow and productive investment of remittances.

- Implement integrated and holistic sustainable **agricultural and rural development** policies based on more effective institutional arrangements and partnerships between central and local governments, civil society, the private sector and smallholders, among others; improve access to and ensure the quality of public infrastructure and services in rural areas; facilitate linkages between urban and rural areas in recognition of their economic, social and environmental interdependence; and promote **inclusive, safe and sustainable cities**.

B. Adolescents and youth: Strengthening the foundations of sustainable development

- Promote inclusive and equitable access to **quality education and learning** throughout the life course; expand access to quality early childhood education, as a means to promote gender equality and break cycles of inequality and disadvantage; ensure that every child, regardless of circumstance, completes lower secondary education and achieves adequate learning outcomes; ensure gender parity in school across all levels, as well as in tertiary education; ensure access to age-appropriate, rights-based, evidence-based and scientifically accurate comprehensive sexuality education in school and non-school settings; enable the reintegration of pregnant girls and young mothers into education at all levels; and expand access to tertiary education and vocational education and training opportunities.
- Equip young people with the skills to meet the demands of labour markets; develop

labour protection policies and programmes that support smooth transitions from education to employment and that promote **employment** opportunities for young people which are safe, secure, non-discriminatory, provide a fair wage and improve their career prospects; and improve employment opportunities and living conditions in domestic economies to reduce out-migration of highly qualified young adults.

- Promote **healthy lifestyles** throughout the life course, including healthy diets, physical exercise and skills to prevent the abuse of alcohol, tobacco and other substances, to reduce the prevalence of obesity and the burden of NCDs in the region; and use intersectoral approaches, involving the health, sports and education sectors to promote **physical activity** among students in schools and in out-of-school settings.
- Guarantee the **meaningful and inclusive participation of adolescents and youth** in all stages of decision-making—i.e. during the formulation, development, implementation and evaluation of laws, public policies, programmes and budgets; ensure sufficient investment in accessible youth-friendly platforms; and involve young people when developing strategies for youth participation to ensure that policies are informed by diverse youth perspectives and needs.
- Enhance **civic engagement and volunteering** across generations to strengthen human capital and social cohesion.

C. Older persons: Realizing the potentials of longevity

- Reduce the **burden of NCDs** by promoting healthy lifestyles and behavioural changes in dietary intake, alcohol consumption and smoking from childhood and adolescence,

and by eradicating inequalities that may lead to such unhealthy habits.

- Encourage **physical activity** for all adults as part of daily life, including during transport, leisure time, at the workplace and through the health-care system; and promote physical activity among older persons to ensure that the functional ability of ageing populations is maintained as long as possible.
- Encourage longer working lives and the ability to work by limiting early retirement options, and by introducing tax credits for older workers who continue working after the standard retirement age; provide incentives for employers to retain older workers; eradicate all forms of discrimination in **employment** against older persons; and address older persons' work-related physical and mental health issues and poor work-life balance to ensure their continuity in labour markets.
- Enhance access to **lifelong education and training** opportunities within and beyond the workplace, to ensure that adult and older workers maintain and update their knowledge and skills to adapt to changing labour markets or to seek improved employment opportunities.
- Facilitate individualized and home-based **long-term care** for older persons; provide support for informal caregivers by extending non-contributory allowances and strengthening intergenerational solidarity systems; and ensure that older persons, particularly those living alone, have adequate access to housing, transport, recreation and the amenities of communal life.
- Ensure the inclusion and equitable **participation** of older persons in the design and implementation of policies, programmes and plans that affect their lives.

D. Promoting renewable energy and sustainable consumption patterns

- Promote **sustainable production and consumption patterns** by: promoting energy efficiency innovations and climate change adaptation policies within and beyond the region; undertaking research

and technical cooperation, including the mutually agreed sharing of technologies; developing innovative technologies that reduce consumption without decreasing well-being; and raising awareness on environmental sustainability and energy-efficient, less consumptive lifestyles in formal and informal education contexts.

Chapter 2. Families, sexual and reproductive health over the life course

The *2013 Chair's summary* called on UNECE member States to guarantee universal access to SRH care by taking a human rights-based approach, including by supporting SRH services that protect general health and well-being, allow for well-informed decisions and are respectful of individual choices.

Universal access to SRH over the life course is central to improving everyone's quality of life and achieving the 2030 Agenda for Sustainable Development. Sexual and reproductive health and rights (SRHR) are directly linked and targeted in SDG 3 on good health and well-being and in SDG 5 on gender equality. Similarly, social and economic inequalities explain differences in SRH behaviours and outcomes (SDG 10), and poor SRH can be a significant barrier for individuals to poverty reduction (SDG 1), education (SDG 4) and employment (SDG 8). In addition, the educational sector (SDG 4) remains a crucial platform to promote SRH through the delivery of comprehensive sexuality education programmes.

While the region's countries have accomplished progress in the protection, respect and fulfilment of SRHR, persisting and new challenges continue to prevent many women, men and couples of different ages and backgrounds from enjoying the right to the highest attainable standard of SRH over their life course (Section 2.1). Achieving the SDG targets on SRH and eliminating inequalities in access to SRH care require the universal provision of an essential, integrated package of services and information (Section 2.2).

The heterogeneity of family formation patterns in the UNECE region outlined in Chapter 1 demands tailored responses from social protection systems that target

vulnerable family members. This chapter discusses family support by placing the focus on children and older persons (Section 2.3), while Chapter 3 ('Inequalities, social inclusion and rights') addresses family support to women and couples in the context of balancing family and life, as well as the need to ensure the social protection of poor people, including older women and single mothers, and persons with disabilities.

2.1. Sexual and reproductive health over the life course

- Inequalities in access to quality SRH care between and within the region's countries persist, despite aggregate regional progress on SRH outcomes.
- Certain population groups, such as minorities, older people, adolescents and youth, and people with disabilities, continue to face diverse obstacles to obtain SRH services and information, with those most deprived remaining worse off.
- Over the past five years, a number of countries have made significant progress in regulations for the provision of SRH services and comprehensive sexuality education, although the implementation of these policies continues to face challenges, while others have introduced legal and policy provisions seeking to roll back existing SRH protections.

Aggregate regional progress on SRH outcomes during the past five years conceals inequalities in access to quality care between and within the region's countries. Women and men have distinct, evolving SRH needs throughout the life course, yet many continue to face diverse obstacles to obtain SRH services and information. The poorest, as well as those

living in rural areas, with lower educational attainment and belonging to minority groups tend to be worse off.

As highlighted in a recent report by the Council of Europe and its Commissioner for Human Rights (2017), effective action from policymakers is needed to remove major barriers—including access barriers—to ensure SRH information, education and services for all population groups and at all ages, in a context of increasing opposition to SRHR among some politicians and civil society groups.⁷¹

The report stresses that some countries have recently introduced legal and policy provisions seeking to roll back existing SRH protections, compromising the achievement of long-standing commitments to gender equality and women's rights.⁷² Conversely, as described in Section 2.2, other countries have made significant progress to introduce regulations for the provision of SRH services and comprehensive sexuality education over the past five years, although the implementation of these new policies continues to face challenges.

The report emphasizes that, despite notable progress, many **women** in the region continue to experience denials and restrictions of their SRHR, resulting from legislative and policy frameworks and practices that undermine their SRH, autonomy, dignity, integrity and decision-making, and that reflect ongoing harmful gender stereotypes and inequalities.⁷³ Commitments to advancing gender equality thus remain central to protecting and fulfilling women's SRHR.⁷⁴

⁷¹ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women's Sexual and Reproductive Health and Rights in Europe*. Council of Europe and Commissioner for Human Rights, Strasbourg.

⁷² Ibid.

Box 11. WHO Action Plan for Sexual and Reproductive Health

The **WHO Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind** was adopted by Member States at the 66th Session of the WHO Regional Committee for Europe in 2016. This landmark regional Action Plan, the first of its kind, links the SRH goals of the ICPD PoA and the SDGs, and envisions “a region in which all people, regardless of sex, age, gender, sexual orientation, gender identity, socioeconomic condition, ethnicity, cultural background and legal status, are enabled and supported in achieving their full potential for SRH and well-being a region where their human rights related to SRH are respected, protected and fulfilled; and a region in which countries, individually and jointly, work towards reducing inequities in SRHR”. Member States are expected to report progress on the implementation of the Action Plan at the 69th Session of the Regional Committee in 2019.

Men need access to the full spectrum of SRH services and information. They account for half of the population of reproductive age, yet SRHR is too often considered a women's issue. Often men are disinclined to seek care in health facilities that are mainly designed to meet the needs of pregnant women and their infants, leaving them underserved and hindering their support to women's SRH.⁷⁵

Engaging men and boys through social and cultural institutions, in schools and through media and awareness-raising can contribute to supporting women's rights and their access to SRH services, and to fostering healthier, more equitable gender attitudes, including zero

⁷³ Ibid.

⁷⁴ The Lancet (2018) *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission*. The Lancet Commissions, London.

⁷⁵ Ibid.

tolerance towards gender-based violence (GBV).

Early in the life course, **adolescents and youth** have the right to access quality SRH care, including affordable, confidential and youth-friendly SRH services, a wide range of contraceptive options and comprehensive sexuality education, yet they continue to face age-based and financial barriers, as well as third-party consent requirements, among other restrictions. According to the UN DESA World Population Policies Database, in 2015, five UNECE countries had policies in place which required minors to obtain parental consent to access contraceptive services (Belarus, the Czech Republic, Ireland, the Republic of Moldova and Slovakia).⁷⁶

As is the case with adolescents and youth, **older persons** face heightened levels of harmful stereotypes, assumptions and stigma in relation to their sexuality and sexual rights. Data illustrate that sizeable numbers of adults remain sexually active well into advanced old age, contrasting with predominant socio-cultural attitudes.⁷⁷ However, some national health systems still do not fully cater to the specific SRH needs of older persons.⁷⁸

The sexuality of older men and women is influenced by physiological changes that take place as part of the ageing process, as well as by a number of psychosocial and socio-environmental factors.⁷⁹ As populations across the region continue to age, the SRH needs of older persons require priority attention from both policymakers and researchers.

Minority groups such as **migrants** need information and services in their own language and in places that are accessible to them. Regardless of their legal status, they need a safe, non-judgemental place to receive services where they do not fear being reported to the authorities. These efforts should be complemented through sharing of information, coordination and cooperation among governments of sending, transit and receiving countries.

Persons with disabilities continue to face barriers in accessing and receiving SRH education, information and services, arising from prejudice and stigma, physical and attitudinal inaccessibility to services, exclusion from decision-making, and a lack of knowledge and awareness.

Meeting the SRH needs of all persons, therefore, requires the removal of access barriers, commitments to advancing gender equality and the strengthening of health systems for the universal provision of an essential package of SRH services and information from birth to old age that responds to changing sexual needs without financial overburden. Integrating this package of SRH services at the primary health-care level remains central for success.

Comprehensive SRH services and information and access to reproductive health commodities should be an integral part of national health plans and budgets, and must be made universally available, physically accessible, affordable, acceptable, appropriate and of high quality, particularly to those most deprived.

⁷⁶ United Nations Department of Economic and Social Affairs (2016) *World Population Policies Database*. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

⁷⁷ WHO (2015) *World Report on ageing and health*. WHO, Geneva, p.56.

⁷⁸ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women's Sexual and Reproductive Health and Rights in Europe*. Council of Europe and Commissioner for Human Rights, Strasbourg, p.43.

⁷⁹ WHO (2015) *World Report on ageing and health*. WHO, Geneva, p.56.

Box 12. Addressing UPR recommendations on SRHR: Azerbaijan and Romania

In 2015, **Azerbaijan's** National Ombudsperson's Office partnered with UNFPA Azerbaijan to assess the country's progress in implementing the latest CEDAW and Universal Periodic Review (UPR) recommendations on SRHR. Primarily focused on women and girls' SRHR, the country assessment analysed available data in six key areas: reproductive health information and services, abortion, maternal health, violence against women, comprehensive sexuality education and HIV/AIDS.

The findings from this assessment were presented in a report to government counterparts and to civil society organizations.⁸⁰ As a result, the Ministries of Health, Education and Labour and the Ombudsman agreed to update their performance monitoring tool. The assessment findings ensured the inclusion of SRHR issues such as human trafficking, domestic violence and women's participation in the 2016 UPR midterm report.⁸¹ SRHR issues were also successfully incorporated into the State Programme on Demography and Population Development and to develop the National Action Plan on Gender-Based Violence with a view to ensuring the effective implementation of the 2010 law on domestic violence prevention.

During the 15th session of the UPR in 2013, **Romania** accepted three recommendations related to maternal health and SRHR: adopt a national strategy on SRHR; provide comprehensive and age-appropriate sexuality education, including to prevent unwanted pregnancies; and strengthen prenatal and postnatal services, implementing additional programmes on maternal breastfeeding and hygiene for development and survival in early childhood.

During the 29th UPR session in early 2018, Romania reported that it had adopted a National Health Strategy in 2014, together with an Action Plan for its implementation in 2014–2020.⁸² In the area of family planning and contraception, Romania aims to integrate family planning as part of the basic package of services, including free distribution of contraceptives and awareness-raising campaigns. Its school syllabus includes an optional course on 'health education', but, according to the Ministry of Education, only 6 per cent of students participated in such classes in 2014–2015.⁸³ While noting the efforts made by the government, NGOs and young people have highlighted key issues, such as the need to develop teacher training courses on education for SRH and to create opportunities in formal education settings for specialized NGOs to promote SRH.⁸⁴ Raising awareness among youth about access to contraceptives is important, since many young people do not know about the existence of family planning services and that some services are free.

⁸⁰ UNFPA, UNOHCHR and the Commissioner for Human Rights of the Republic of Azerbaijan (2014) *Assessment of the implementation status of treaty body recommendations on sexual and reproductive health and rights in the Republic of Azerbaijan*. UNFPA, Baku.

⁸¹ UNOHCHR and the Republic of Azerbaijan (2013) *Mid-Term Report of the Government of the Republic of Azerbaijan on implementation of recommendations indicated in the report (A/HRC/24/13) of the Working Group of the UN Human Rights Council on Universal Periodic Review*. UNOHCHR, Geneva.

⁸² UNHRC, Working Group on the Universal Periodic Review (2017) *Compilation on Romania*. A/HRC/WG.6/29/ROU/2. United Nations, Geneva, para. 107, 109.

⁸³ *Ibid.*

⁸⁴ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Romania. Report of the Office of the United Nations High Commissioner for Human Rights*. A/HRC/WG.6/29/ROU/1. United Nations, Geneva, para. 35.

2.2. Towards an essential, integrated package of sexual and reproductive health services and information

- Recent aggregate trends in SRH outcome indicators confirm that UNECE countries have made some progress in enhancing access to quality SRH care, although progress has been uneven.
- Sexuality education has been implemented in many UNECE countries, yet it can only be considered comprehensive in a few contexts. With some exceptions, teachers remain insufficiently trained.
- Between 2010 and 2015, the demand for family planning satisfied by modern contraceptive methods increased slightly from 76 to 77 per cent, although it remained significantly lower in South-Eastern Europe, increasing from 52 to 55 per cent over the same period.
- During the same period, the unmet need for family planning increased slightly from 8 to 9 per cent in the UNECE region.
- In 2014 around two thirds of adolescents aged 15 used a condom at last intercourse—a figure that varies significantly across countries and by sex. The adolescent birth rate remained high in the eastern part of the region and the United States of America. It was estimated at 20 births per 1,000 women aged 15–19 between 2013 and 2015 in the UNECE region.
- Aggregate decreasing trends in abortion confirm an expansion in access to contraceptive methods and knowledge, including comprehensive sexuality education, and progress towards achieving gender equality. Since 2013, various UNECE countries have made steps to revise restrictions in existing abortion laws and to remove barriers to access to safe abortion services.
- Maternal mortality declined from 15 to 14 deaths per 100,000 live births between 2010 and 2015, and neonatal mortality decreased from 5 to 4 deaths per 1,000 live births, although considerable subregional differences prevail. While antenatal care and skilled attendance at birth are almost universal, these rates evidence gaps in the quality of such services, as well as in emergency obstetric care and perinatal and post-partum care.
- In 2017, over 120,000 new HIV infections occurred in the eastern part of the region, representing an increase of 30 per cent since 2010. Sexual transmission is rapidly becoming the predominant factor. Less than half of persons living with HIV in Eastern Europe and the Caucasus and Central Asia received antiretroviral therapy in 2016.
- The risk of primary and secondary infertility increases with STI infections and postponements in childbearing. It was estimated that secondary infertility affected 18 per cent of child-seeking women aged 20–44 in the central and eastern parts of the region in 2010 (13.9 million women), while over 2 per cent were affected by primary infertility (1.8 million women).
- Cervical cancer is the second most common cause of cancer death among women in the eastern part of the region, where an estimated 38,000 new cases and 18,000 deaths occur every year. Breast cancer is a common cause of disease for women in all subregions except Central Asia, with incidence and mortality rates above the global average.

Accelerating regional and national progress on SRHR to achieve the ICPD PoA and the SDGs demands firm commitment to the provision of an essential, integrated package of SRH services and information, available to all persons regardless of their age, marital status, socio-economic status, race or ethnicity, sexual orientation or gender identity.

The various package components are echoed in the objectives of the *WHO Action Plan for*

*Sexual and Reproductive Health*⁸⁵ and reflected in a recent report by the Guttmacher-Lancet Commission.⁸⁶ While it is acknowledged that some package components are more commonly provided than others, the list below does not reflect a priority order:

- Evidence-based comprehensive sexuality education
- Counselling and services for a range of modern contraceptive methods
- Safe abortion services and treatment of complications of unsafe abortion
- Maternal health care, including emergency obstetric and newborn care
- Prevention, diagnosis and treatment of HIV and STIs
- Prevention, diagnosis and treatment of infertility
- Prevention, diagnosis and treatment of reproductive cancers
- Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (discussed in Section 3.1.D. 'Gender-based violence and harmful practices').

A costing analysis shows that meeting all needs for these services would be affordable for most countries, irrespective of their starting point.⁸⁷ In this regard, the strengthening of primary health-care systems for their integrated delivery—with adequate referrals for more specialized needs—should be afforded high priority, as it remains predominantly specialized in some of the region's countries.⁸⁸

⁸⁵ WHO (2016) *Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*. WHO Regional Office for Europe, Copenhagen.

⁸⁶ The Lancet (2018) *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission*. The Lancet Commissions, London.

⁸⁷ Ibid.

Moreover, commitments beyond the health sector are required. Legislative and policy frameworks that support gender equality, as well as changes in societal values towards women, are central to the successful implementation of this holistic package and realizing SRHR for all, as discussed in Chapter 3.⁸⁹ The following sections discuss trends in SRH outcome indicators and policy responses to enhance access to quality SRH care, to illustrate the extent to which the various package components remain available in UNECE countries.

A. Comprehensive sexuality education remains widely unrealized

The *2013 Chair's summary* highlighted that gender-sensitive and life skills-based comprehensive sexuality education that meets international quality standards empowers adolescents and youth to make responsible and autonomous decisions about their sexuality and SRH, to promote values of tolerance, mutual respect and non-violence in relationships, and to plan their lives. It also stressed the need for comprehensive sexuality education to be fully integrated into undergraduate and in-service training of professionals such as teachers, school psychologists and social workers. The recently revised *UNESCO Technical Guidance on Sexuality Education (2018)* further reiterates these principles, emphasizing that comprehensive sexuality education addresses the cognitive, emotional, physical and social aspects of sexuality, aiming to equip children

⁸⁸ WHO (2016) *Action Plan for Sexual and Reproductive Health. Towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind*. WHO Regional Office for Europe, Copenhagen.

⁸⁹ The Lancet (2018) *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher-Lancet Commission*. The Lancet Commissions, London.

and young people with knowledge, skills, attitudes and values.⁹⁰

Comprehensive sexuality education, however, is not yet being widely implemented across the region. A recent study by the Federal Centre for Health and Education (BZgA) and the International Planned Parenthood Federation (IPPF) (2018) reviewed sexuality education programmes in 25 countries representative of the UNECE region, and confirmed the existence of a legal basis—i.e. laws, policies or strategic frameworks—requiring or supporting it in 21 of them, laying the ground for its sustainable implementation and confirming that sexuality education has become the norm in most countries across the region.⁹¹

However, only 10 of these programmes can be considered comprehensive, as defined by various criteria such as age and development-adapted teaching, competence-building on social and gender values and norms, the development of protective and caring behavioural skills, and the breadth of topics addressed. In some contexts, this may be partly explained by the lack of dedicated and comprehensive curricula or guidelines, and scientifically and medically inaccurate information that reinforces discriminatory gender assumptions, roles and norms.

Among the 21 countries where sexuality education programmes are in place in schools, it is a mandatory teaching subject in only 11 of them, partly mandatory in 6 and optional in 4. In most countries sexuality education is offered to primary and secondary students but integrated into other teaching subjects, which does not guarantee the provision of comprehensive and holistic education and

information on sexuality, reproduction and relationships.

In formal education contexts, the success of sexuality education is highly dependent on its full integration into the training curricula of teachers and other relevant school personnel. However, the knowledge and competence of teachers remains one of the most important challenges for the region's countries. Many countries have not established adequate training programmes, continuing education or support mechanisms and resources for teachers. Only in a handful of countries covered by the study (notably Finland and Estonia) are most teachers sufficiently trained; in the others most teachers had either not been trained or participated in a brief one-day course.

The same BZgA–IPPF report highlights that in countries where sexuality education programmes are well developed, contraceptive use among young people tends to be high and teenage birth rates tend to remain very low, with the opposite relationship observed in countries where programmes remain underdeveloped or non-existent.

Parenting programmes that contribute to raising awareness among parents and guardians on adolescent and young people's SRH, as well as on the need for sexuality and health education, represent a good complement to sexuality education programmes. Lastly, it is crucial to link comprehensive sexuality education programmes with youth-friendly SRH services where young people can access information and modern contraceptives free of charge.

⁹⁰ UNESCO, UNAIDS, UNFPA, UNICEF, UNWOMEN, WHO (2018): *Technical Guidance on Sexuality Education*. UNESCO, Paris.

⁹¹ BZgA and IPPF (2018) *Sexuality Education in Europe and Central Asia: State of the Art and Recent*

Developments. Federal Centre for Health Education (BZgA) and IPPF European Network, Cologne and Brussels.

Box 13. of comprehensive sexuality education and SRH services for adolescents and youth: Kyrgyzstan and the Netherlands

The Parliament of **Kyrgyzstan**⁹² passed a reproductive health law in 2015, providing a legal framework for the delivery of SRHR services. Before the law came into effect, only about one in five school children received SRH information from teachers, and only about one in seven received it from parents. The law requires schools to offer comprehensive sexuality education, addressing not only biology but also life skills and responsible behaviours, introducing age-appropriate information over time throughout a young person's education. Although there are persisting challenges to full implementation of the law, there is now a legal framework that supports protection of the health and reproductive rights of adolescents and young people in Kyrgyzstan.

Teen pregnancy and abortion rates in the **Netherlands**⁹³ have long been the lowest in the world and continue to decrease. The adolescent birth rate stands at 4.5 per 1,000 births, while the abortion rate among teenagers is low and decreasing (3,181 abortions in 2014). Adolescent use of at least one modern contraceptive method during first-time sex stands at 92 per cent for boys and 94 per cent for girls. There is a long-standing tradition of providing adolescents and youth with a full range of information, contraception and services for them to be able to make informed decisions about their SRH. All schools in the country are legally obliged to provide sexuality education in their curriculum.

NGOs and the government are both concerned about the barriers for girls in challenging family situations, with lower educational attainment, and girl asylum seekers in accessing the best-fit contraceptive method. To address these challenges, maintain the positive trends and better align with WHO commitments and the SDGs, the Ministry of Health launched a new National Plan on STIs, HIV and sexual health in 2018. The plan presents an integral approach that is centred around a positive approach to sexuality. Comprehensive sexuality education is an overarching principle of the plan, as are surveillance and monitoring to inform policymaking. Other key priorities concern STIs, HIV/AIDS, unwanted pregnancies and sexual violence, particularly among vulnerable groups.

B. Lasting barriers in access to modern contraceptive methods

The *2013 Chair's summary* emphasized that highest priority needed to be given to preventing unintended pregnancies by, *inter alia*, removing all barriers to access to contraceptives, including restrictions based

on age or marital status or the prohibition of certain contraceptive methods.

In most countries of the UNECE region access to modern contraception remains limited by availability, choice, costs, including the lack of subsidization or reimbursement, poor-quality information and misconceptions, as well as

⁹² Case study based on UNFPA (2015) *UNFPA Annual Report 2015: For People, Planet and Prosperity*. UNFPA, New York.

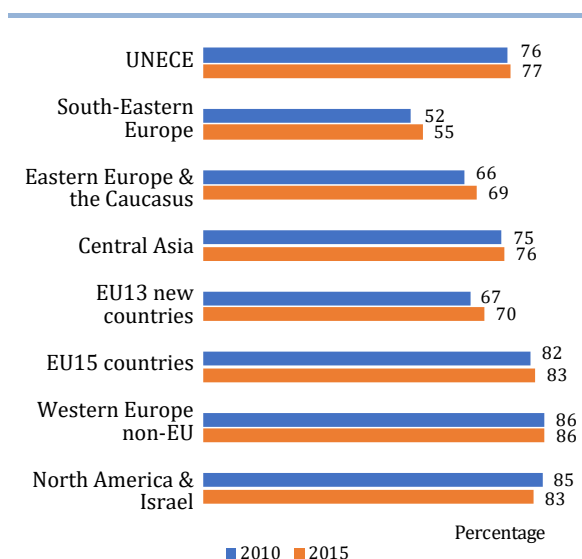
⁹³ Case study based on Rutgers and Soa Aids Nederland (2017) *Main conclusions, Sex under the age of 25*. Rutgers, Utrecht, p.2.; RIVM (2018) *National Action Plan on STIs, HIV and Sexual Health: 2017–2022*. RIVM, Netherlands, p.26; Hehenkamp,

L., and C. Wijzen (2016) *Landelijke abortusregistratie 2014*. Rutgers, Utrecht; and Rutgers and the Government of the Netherlands (2017) *Factsheet on Teenage Pregnancy for the High-Level Political Forum 2017 Roundtable Discussion on Preventing Teenage Pregnancies*, Rutgers and the Government of the Netherlands, Utrecht and The Hague, p.2.

discriminatory policy barriers such as requirement for third-party authorization.⁹⁴

Between 2010 and 2015, the proportion of married or in-union women of reproductive age (15–49 years) who had their demand for family planning satisfied with modern methods (SDG Indicator 3.7.1) increased slightly from 76 to 77 per cent (Figure 25), yet this share remained disproportionately low in South-Eastern Europe (55 per cent).

Figure 25. Demand for family planning satisfied by modern methods, married or in-union women aged 15–49 years, 2010–2015



Source: UN Population Division. Estimates and Projections of Family Planning Indicators 2018.

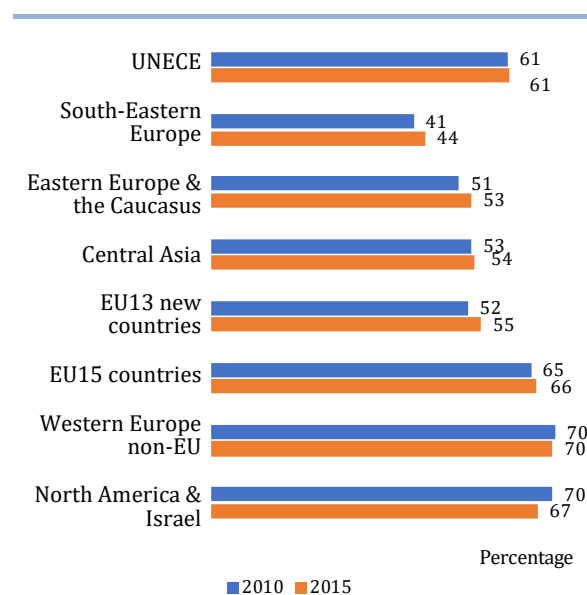
While 60 per cent of women in Turkey had their demand for family planning satisfied with modern methods in 2015, this proportion remained much lower in Albania (27 per cent), Bosnia and Herzegovina (26 per cent), the former Yugoslav Republic of Macedonia (28 per cent), Montenegro (36 per cent) and Serbia (33 per cent). In contrast, 90 per cent of women in Denmark, 91 per cent in France and

⁹⁴ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women’s Sexual and*

93 per cent in the United Kingdom had their demand for family planning satisfied with modern methods in 2015.

Barriers to knowledge and access to modern methods remain in the UNECE region, reflected in a large share of women using traditional contraceptive methods, which decreased only slightly from 28 to 27 per cent in South-Eastern Europe. Between 2010 and 2015, larger reductions in the use of traditional contraceptive methods were achieved by countries in Eastern Europe and the Caucasus (from 17 to 14 per cent) and the 13 new EU Member States (from 15 to 12 per cent).

Figure 26. Contraceptive prevalence, modern methods, married or in-union women aged 15–49 years, 2010–2015



Source: UN Population Division. Estimates and Projections of Family Planning Indicators 2018.

Overall, no major changes in the use of modern contraceptive methods were observed among married or in-union women aged 15–49. In both 2010 and 2015, 61 per cent of women

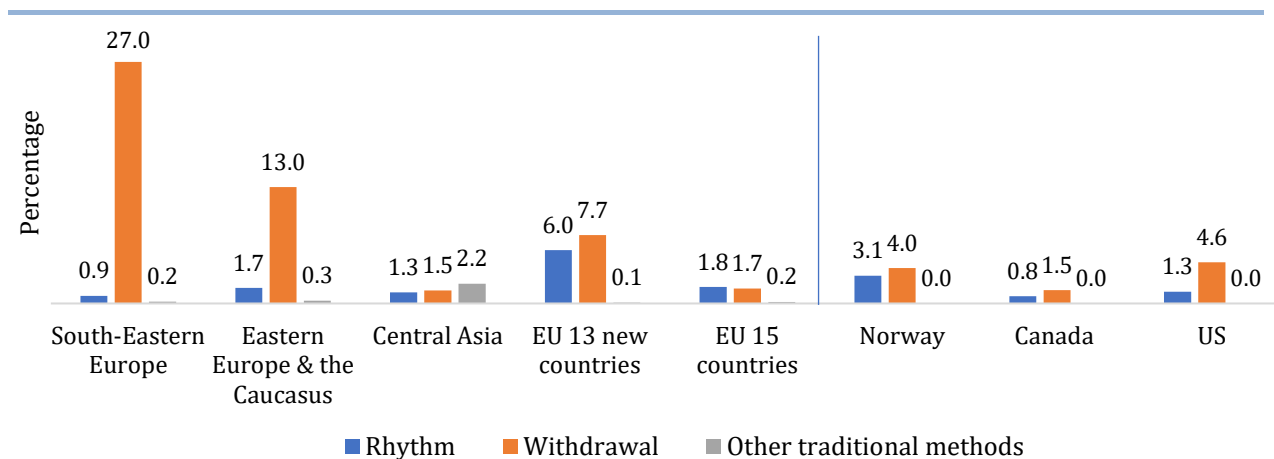
Reproductive Health and Rights in Europe. Council of Europe and Commissioner for Human Rights, Strasbourg.

were using modern contraceptive methods across the UNECE region (Figure 26).

Although small improvements or setbacks have occurred at the subregional level during this period, the use of modern contraception was least common in the eastern part of the

region, where many women continue to rely on traditional methods—withdrawal in particular—including during their adolescence, placing them at higher risk of unintended pregnancy, STIs and abortion (Figure 27).⁹⁵

Figure 27. **Contraceptive prevalence, traditional methods by method type, married or in-union women aged 15–49 years, 2015**



Source: UN Population Division. Trends in Contraceptive Use Worldwide 2015.

Research in Armenia, Azerbaijan, Bulgaria, Bosnia and Herzegovina, Kazakhstan, the former Yugoslav Republic of Macedonia and Serbia identified seven cross-country factors influencing contraceptive behaviour, demand and access:

- Lack of commitment by policymakers, including lack of implementation measures and inadequate funding
- Misinformation and distrust towards modern (hormonal) methods of contraception
- Barriers limiting young people’s access to family planning methods, in particular the lack of confidential and youth-friendly services

- Misinformation practices by service providers, which often confirm myths
- Limitations in the range of modern contraceptive methods available on the market
- Lack of affordability for specific population groups
- Expectations with regards to sex and sexuality and gender power dynamics, confirming that women’s empowerment is still a perceived threat to traditional cultures and patriarchal values.⁹⁶

In 2015 the contraceptive pill, the intrauterine device (IUD) and the male condom remained the most popular modern contraceptive methods in the UNECE region,

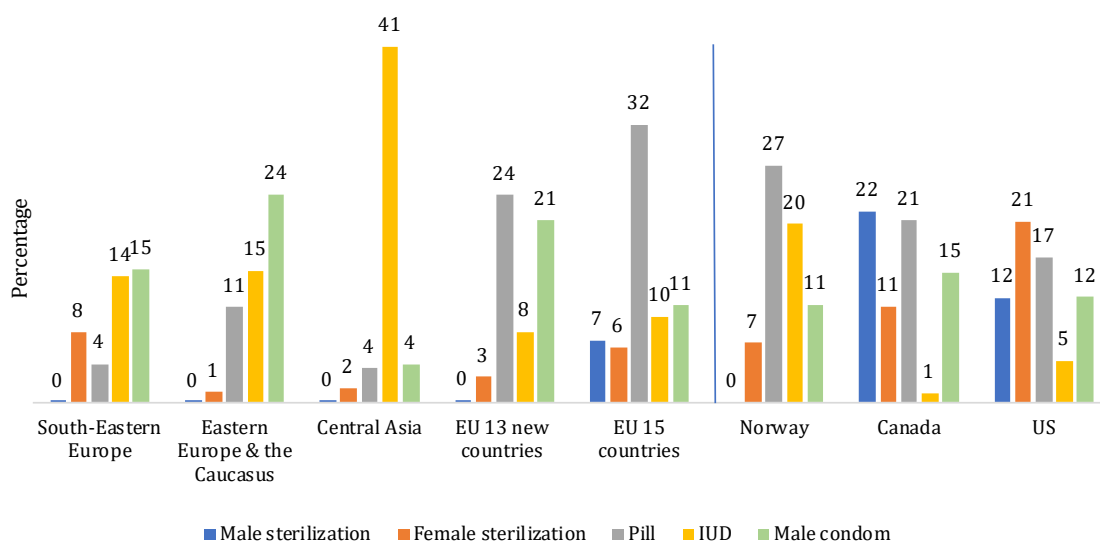
⁹⁵ IPPF (2016) *Access to Modern Contraceptive Choice in Eastern Europe and Central Asia*. IPPF European Network, Brussels.

⁹⁶ IPPF and UNFPA (2012) *Key Factors Influencing Contraceptive Use in Eastern Europe and Central Asia*. IPPF European Network and UNFPA EECARO, Brussels and Istanbul, p.2.

although differences in the mix of modern methods across subregions and countries prevailed (Figure 28). In Central Asia the IUD remained the most commonly used method (41 per cent), while the contraceptive pill was preferred in EU countries and Norway. The male condom remained most popular in Eastern Europe and the Caucasus (24 per

cent) and South-Eastern Europe (15 per cent). In Canada and the United States of America and Israel, female and male sterilization (21 and 12 per cent, respectively) remained more common than in other subregions. The use of injectables and implants remained very limited across the UNECE region.

Figure 28. Contraceptive prevalence, modern methods by method type, married or in-union women aged 15–49 years, 2015



Source: UN Population Division. Trends in Contraceptive Use Worldwide 2015.

Couples may choose different methods over the lifetime as preferences and circumstances change throughout their life course. Hence the availability and accessibility of a wide range of modern contraceptive methods, including

accurate information about them, is important for adolescents, youth, women and men to be able to make their own contraceptive choices.

Box 14. Allocating state budget resources for contraceptive procurement: Kyrgyzstan, Tajikistan and Turkmenistan

In recent years the eastern part of the region has demonstrated a pattern of decline in the Family Planning Effort Index, which measures the types and levels of effort of national family planning programmes worldwide in four components: policies, services, evaluation and access to contraceptive methods. To reverse these trends, in partnership with Ministries of Health, Members of Parliament, Mandatory Health Insurance Funds, health-care providers and CSOs, UNFPA EECARO has undertaken advocacy efforts at regional and national levels to highlight the challenges faced by the most vulnerable women in accessing modern contraception, with the aim of increasing the allocation of funds from state budgets for contraceptive procurement. The examples below illustrate some of the successful results of these efforts:

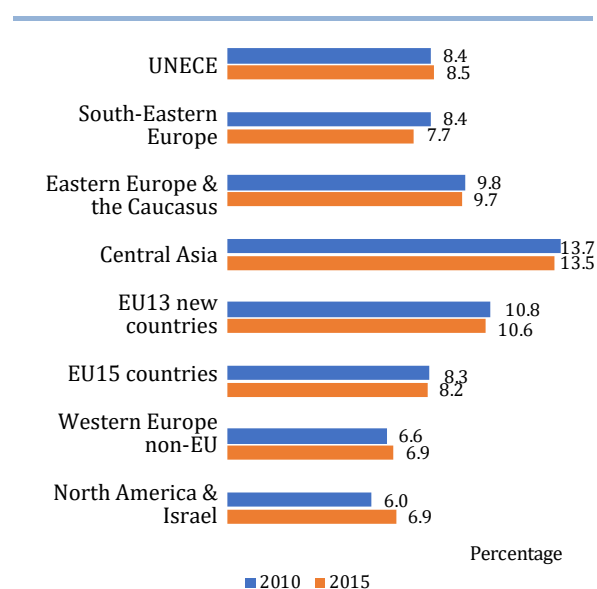
The Government of **Kyrgyzstan** delivered a Statement of Intent during the Global FP2020 Summit in London in 2017, which paved the way to accelerating progress in the area of family planning in the country. In 2018, for the first time since the nation’s independence, the Ministry of Health allocated funds to procure contraceptives. The five-year plan (2019–2023) currently under development aims to gradually increase the state budget for the procurement of contraceptives and cover the needs of at least 50 per cent of women with high medical and social risks of maternal mortality by 2023.

In early 2017, UNFPA and the governments of **Tajikistan** and Japan signed a project proposal to strengthen the national family planning services for the period 2017–2020 with a total budget of USD2.7 million, aimed at mobilizing supplementary resources for the procurement of contraceptives, outreaching family planning services and increasing the number of family planning choices. The Government of Tajikistan confirmed its 2018 budget contribution of USD50,000, which represented a 10 per cent annual increase, thus fulfilling its commitment to gradually increase state financing for contraceptive procurement. The actionable roadmap for contraceptive security developed by UNFPA and the support of the UNFPA Supplies Global Programme were key to sustaining those commitments, which started at 4 per cent of total contraceptive needs covered by the State in 2016.

A Memorandum of Understanding signed between the Government of **Turkmenistan** and UNFPA to cover the family planning needs of the most vulnerable women was signed in January 2014. The agreement, which included the roadmap for a gradual shift towards 100 per cent contraceptive procurement from the state budget, was fully implemented in 2017. The government was able to benefit from UNFPA’s global purchasing power and quality-assured commodities.

During the period 2010–2015, the unmet need for family planning increased slightly from 8 to 9 per cent in the UNECE region (Figure 29). In 2015 the highest levels were observed in Central Asia (13 per cent), followed by the 13 new EU Member States (11 per cent) and Eastern Europe and the Caucasus (10 per cent). While on average only 8 per cent of women in South-Eastern European countries had an unmet need for family planning in 2015, this subregional estimate is skewed by the large population weight of Turkey, where an unmet need of 6 per cent was witnessed. In 2015, the unmet need for family planning remained particularly high in Montenegro (24 per cent), the former Yugoslav Republic of Macedonia (18 per cent) and Bosnia and Herzegovina (17 per cent). In the four eastern subregions, more investments are required in both the supply and demand sides of modern contraception.

Figure 29. **Unmet need for family planning (any method), married or in-union women aged 15–49 years, 2010–2015**



Source: UN Population Division. Estimates and Projections of Family Planning Indicators 2018.

The trends mentioned above call for ensuring universal access to a wide range of effective, evidence-based, acceptable and affordable modern contraceptive methods, with special attention to adolescents and youth. Adolescent contraceptive use, alongside adolescent birth rates, reflects the extent to which this population group is reached by comprehensive sexuality programmes and SRH information and services to prevent both unwanted pregnancies and the transmission of STIs.

In 2014, around two thirds of adolescents aged 15 used a condom at last intercourse in the UNECE region (Figure 30), a share that varies considerably across subregions and countries and by sex. A higher proportion of adolescent boys than girls reported using a condom at last intercourse in all subregions.

Box 15. IPPF European Network: Providing SRH services and creating enabling environments for improved access to and quality SRH

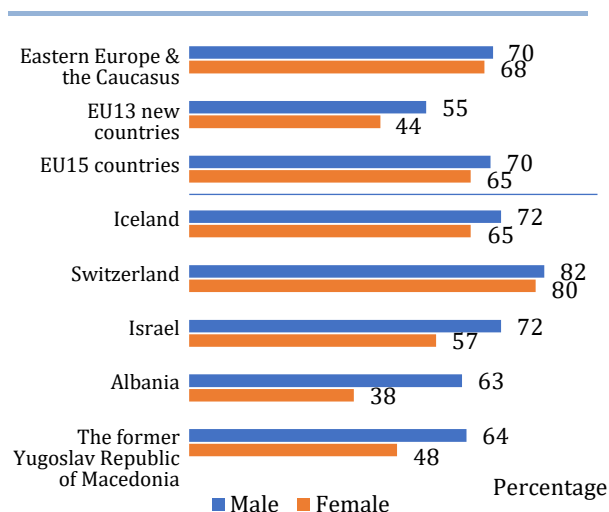
International Planned Parenthood Federation European Network (IPPF EN) contributed to the implementation of all the *2013 Chair's summary* themes. It provided SRH care services, and contributed to creating enabling environments for improved access to and quality of health-care services by training providers and advocating for policy changes to reduce inequalities and inequities for the most underserved people and communities, particularly young people.

Between 2013 and 2017, IPPF EN member organizations supported governments to bring about 196 successful policy initiatives/legislative changes in support of SRHR and gender equality. These include: broader eligibility criteria to access medically assisted reproduction (Portugal, Sweden, Lithuania); budget allocation for subsidized/free contraceptives for vulnerable groups and young people (Kazakhstan, France); legislation combating forced and early marriage (Kyrgyzstan); and legislative changes improving the quality (Georgia) and accessibility (France, Albania) of abortion services.

IPPF EN also contributed greatly to the introduction and provision of sexuality and relationship education across the region. Together with UNFPA EECA, it documented the obstacles that young people belonging to key populations are facing in accessing HIV and SRH services. Collaboration with these young people resulted in a practical tool 'Health, Rights and Well-Being' and country-level actions to empower them to claim their rights and help prevent discrimination and stigma.

Challenges remain in the region, such as the rise of new HIV infections in Eastern Europe and Central Asia, especially in key populations. The situation is exacerbated by widespread homophobia, but also no or slow progress in contraceptive choices. Of particular concern are rights violations arising from the increasing number of health-care professionals and pharmacists fully prepared to force women into pregnancy—for example, by restricting access to retroactive contraception, on the grounds of their personal and private beliefs. Attacks on abortion rights and on civil society in many countries deliberately aim to prevent people, especially women and girls, from realizing their SRHR.

Figure 30. Condom use at last intercourse among adolescents aged 15, by sex

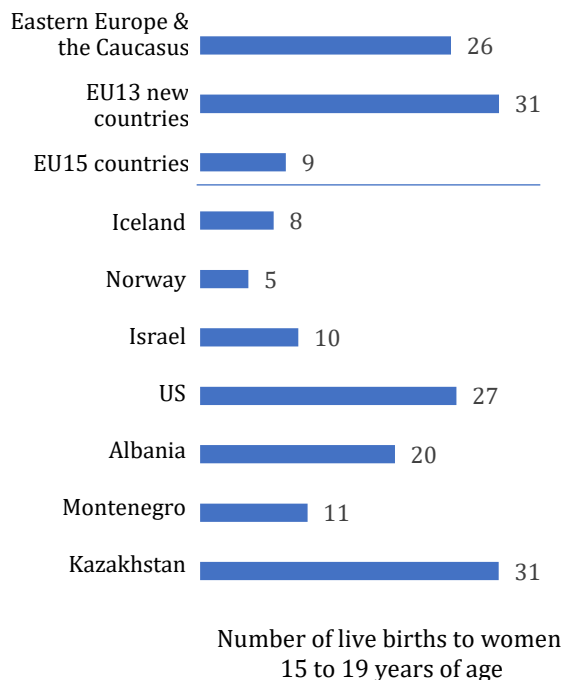


Source: WHO. Health Behaviour in School-Aged Children Data Portal.

Between 2013 and 2015 the adolescent birth rate (SDG Indicator 3.7.2) was estimated at 20 births per 1,000 women aged 15–19 in the UNECE region, remaining highest in Central Asia and the 13 new EU Member States (31 births per 1,000 women aged 15–19), followed by Eastern Europe and the Caucasus and North America and Israel (26 births per 1,000 women aged 15–19) (Figure 31).

While trends since 2000 evidence declines at the aggregate level, some countries have witnessed increases or minor reductions in adolescent birth rates between 2000 and 2013–2015. This is the case of Azerbaijan (from 38 to 54 births per 1,000 women aged 15–19), Kyrgyzstan (from 35 to 65), Bulgaria (from 46 to 41) and Romania (from 39 to 35).

Figure 31. Adolescent birth rate, 2013–2015



Source: WHO. UN Global SDG Database.

C. Declining prevalence of induced abortions

The *2013 Chair's summary* called for the removal of all barriers preventing women and girls from accessing safe abortion services. It also emphasized the need to integrate emergency obstetric care and the management of complications arising from unsafe abortions, including revising restrictions within existing abortion laws, into policies and practices to safeguard the lives of women and adolescent girls.

A recent issue paper by the Council of Europe and its Commissioner for Human Rights (2017) states that although abortion is legal in most of the region's countries on request or on broad socio-economic grounds, women may still be confronted with procedural obstacles such as third-party authorization requirements or with medical professionals' refusal to provide care on grounds of conscience, which can limit or deny their

timely access to safe abortion care.⁹⁷ In these cases, women are likely to incur considerable financial and practical costs, as they must travel to other health facilities, within the country or abroad, to find practitioners willing to provide abortion care.

The report stresses that in the few countries where legislation remains highly restrictive and abortion is only allowed under exceptional circumstances, women who do not qualify are likely to seek an illegal and clandestine abortion, increasingly by obtaining and taking an abortion pill. Alternatively, they may travel to another country to access safe abortion services, although they may still face difficulties in doing so.

The prevalence of induced abortions among women aged 15 or older declined from 256 to 216 abortions per 1,000 live births between 2010 and 2014. Decreases were also observed among women under the age of 20, although these women remained four times more likely to resort to an abortion than the general population (875 abortions per 1,000 live births) (Table 4). When teenage pregnancy occurs, abortion is a much more common outcome in the western part of the region, with slight increases observed between 2010 and 2014 among the EU15 countries and Western European countries without EU membership.

Table 4. **Induced abortions per 1,000 live births, women aged 15 or older and women aged under 20 years, 2010–2014**

Subregion	Women aged 15+		Women aged under 20	
	2010	2014	2010	2014
South-Eastern Europe	84	64	205	204
Eastern Europe and the Caucasus	477	360	224	214
Central Asia	126	105	106	80
EU13 new countries	222	189	550	298
EU15 countries	214	211	1271	1302
Western Europe non-EU	184	167	1728	1854
North America and Israel	137	202	687	610
UNECE	256	216	927	875

Source: WHO. European Health Information Gateway: Health for All explorer.

According to the UN DESA World Population Policies Database, unsafe abortions represented a major concern for 13 of the 29 UNECE countries with data available in 2015, with 10 of the countries being in the eastern part of the region.⁹⁸

Despite remaining among the highest in the world, abortion rates in the eastern part of the

region are declining with the increased availability of modern contraceptives, but the family planning demand satisfied by these still remains relatively low in some countries. In most countries with high abortion rates, a large percentage of women who are trying to delay or prevent pregnancy are not using a

⁹⁷ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women's Sexual and Reproductive Health and Rights in Europe*. Council of Europe and Commissioner for Human Rights, Strasbourg.

⁹⁸ United Nations Department of Economic and Social Affairs (2016) *World Population Policies Database*. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

reliable method of contraception.⁹⁹ In some countries, this relationship is particularly evident when analysing adolescent fertility rates,¹⁰⁰ highlighting adolescents' inadequate access to comprehensive sexuality education and SRH services.

While variations in abortion rates across countries reflect the prevailing legislative and socio-cultural environments, aggregate decreasing trends confirm an expansion in access to modern contraceptive methods and

knowledge, including comprehensive sexuality education, and progress towards achieving gender equality.

Since 2013, various UNECE countries have made steps to revise restrictions in existing abortion laws and to remove barriers to access to safe abortion services. However, more can be done to remove barriers denying women timely access to safe abortion care where it is legal.

Box 16. Legal and policy developments on abortion: Cyprus, Estonia, France, Ireland, Kyrgyzstan and Luxembourg

France gradually introduced changes to increase access to safe abortion services between 2013 and 2016. Regulations¹⁰¹ have been rolled out to cover 100 per cent of the costs of abortion. The country reduced the mandatory waiting period prior to abortion on request from seven to two days.¹⁰² Finally, the law was revised to allow midwives to provide medical abortions (in early pregnancy), which could previously only be performed by doctors.¹⁰³

Kyrgyzstan reaffirmed reproductive rights by law in 2015. The law differentiates between protections for mothers, fetuses and newborns and requires the woman's written consent for any medical interventions during pregnancy. It affirms that abortion is legal for any reason through week 12 of a pregnancy for 'social reasons', through week 22 (with Medical Board approval based on established standards), and for medical necessity at any time.¹⁰⁴

⁹⁹ IPPF (2016) *Access to Modern Contraceptive Choice in Eastern Europe and Central Asia*. IPPF European Network, Brussels, p.2.

¹⁰⁰ *Ibid.*, Figure 2.

¹⁰¹ Government of France (2002) Decree no. 2002-39. *Décret n°2002-39 relatif à la délivrance aux mineures des médicaments ayant pour but la contraception d'urgence*. 9 January 2002.

Government of France, Paris. Available at: <http://legifrance.gouv.fr/eli/decret/2002/1/9/MESP0123909D/jo/texte>.

¹⁰² Clavel, Geoffrey (2015) "Avortement: le délai de réflexion d'une semaine supprimé par les députés", *Huffington Post*, 9 April 2015. Last updated: 5 October 2015. Available at:

https://www.huffingtonpost.fr/2015/04/09/avortement-delai-de-reflexion-semaine-supprime-deputes_n_7031024.html, referring to Public Health Code, Legislative part, Second part, Book II, Title I, Chapter II, Arts. L2212-4 to L2212-5.

Available at: <https://www.legifrance.gouv.fr/affichCodeArticle.do?sessionId=D48E0D2DC2882315FE6D381967D>

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¹⁰³ See *Article L2212-1 et seq. LOI n° 2016-41 du 26 janvier 2016 de modernisation de notre système de santé* (1) [Fr.], amending Public Health Code, Legislative part, Second part, Book II, Title I, Chapters I-IV, Articles L2212-1 to L2213-2; and Title II, Chapter II, Articles L2222-1 to L2223-2.

¹⁰⁴ ЗАКОН КЫРГЫЗСКОЙ РЕСПУБЛИКИ от 4 июля 2015 года № 148 О репродуктивных правах граждан и гарантиях их реализации [Law of July 4, 2015 No. 148 On reproductive rights of citizens and guarantees for their implementation]. Available at:

<http://cbd.minjust.gov.kg/act/view/ru-ru/111191>; see also Library of Congress, Global Legal Monitor, "Kyrgyzstan: Reproductive Rights Now Specified by Law", 17 November 2015. Available at: <http://www.loc.gov/law/foreign-news/article/kyrgyzstan-reproductive-rights-now-specified-by-law/>.

In 2014, **Luxembourg** removed abortion from the penal code and removed the requirement that women be ‘in distress’ before accessing abortion on request, with a time limit of 12 weeks of pregnancy. The country also removed the requirement for a mandatory psychological consultation. Minors are still required to receive mandatory counselling.¹⁰⁵

In 2018, **Cyprus** passed legislation permitting abortion on request up to 12 weeks of gestation, and up to 19 weeks in cases of rape.¹⁰⁶ Also in 2018, citizens in **Ireland** voted in a nationwide referendum to repeal the eighth amendment to the constitution, which recognizes the equal right to life of pregnant women and unborn children. Provisions may now be made by law for the regulation of termination of pregnancy. The government has published draft legislation that would allow abortion on a woman’s request in the first 12 weeks of pregnancy, and thereafter where there is a serious risk to a woman’s health or there is fatal foetal impairment.¹⁰⁷

Estonia amended the Act on the Termination of Pregnancy and on Sterilization¹⁰⁸ in 2015, removing the substituted decision-making for minors and persons with disabilities, so that third-person approval is no longer required for them to access abortion.¹⁰⁹

In other countries, laws have changed to introduce mandatory waiting periods^{110, 111} and counselling,¹¹² to require parental consent for minors seeking an abortion¹¹³ or to increase fines for women who

¹⁰⁵ *Voluntary Interruption of Pregnancy, Law of 17 December 2014 (modifying articles 348–353-1 of the Penal Code)*. Available at: <http://eli.legilux.public.lu/eli/etat/leg/loi/2014/12/17/n2> (Fr.). See also <http://www.wort.lu/en/politics/decriminalisation-parliament-votes-for-abortion-law-reform-547defd90c88b46a8ce434aa>.

¹⁰⁶ Cyprus Mail, “Parliament decriminalises abortion (Updated)”, 20 March 2018. Available at: <https://cyprus-mail.com/2018/03/30/parliament-decriminalises-abortion/?hilite=%27abortion%27>.

¹⁰⁷ Independent, “Irish abortion referendum result: Yes defeats pro-life campaign with double number of votes, official count reveals”, 26 May 2018. Available at: <https://www.independent.co.uk/news/world/europe/irish-abortion-referendum-result-official-yes-votes-count-latest-repeal-a8370851.html>.

¹⁰⁸ Raseduse katkestamise ja steriliseerimise seadus, Vastu võetud 25.11.1998, RT I 1998, 107, 1766 [*Pregnancy Abatement and Sterilization Act of 25 November 1998*]. Available at: <https://www.riigiteataja.ee/akt/120022015011>, as amended by Raseduse katkestamise ja steriliseerimise seaduse muutmise seadus, Vastu võetud 29.01.2015 [*Pregnancy Abatement and Sterilization Act Amendment Act of 29 January 2015*], Dec. No. 584. Available at: <https://www.riigiteataja.ee/akt/120022015004>.

¹⁰⁹ *Pregnancy Abatement and Sterilization Act Amendment Act of January 29, 2015, Decision No 584* [Estonia]. Available at: <https://www.riigiteataja.ee/akt/120022015004>; and Library of Congress, <http://www.loc.gov/law/foreign-news/article/estonia-access-to-abortions-simplified-for-minors/>.

¹¹⁰ See *Law on Health Care as amended by Act No. 2646/2014*, art. 139(2)(b) (2000) (Geor.)

¹¹¹ *Amendment to the Law on “Human Reproductive Health and Reproductive Rights” of Dec. 2002* (2015). Available at: <http://parliament.am/drafts.php?sel=showdraft&DraftID=38184>. See also Astra Network, “Restrictions in the law on abortion in Armenia”. Available at: <http://www.astra.org.pl/repronews/449-restrictions-in-the-law-on-abortion-in-armenia.html>.

¹¹² *Pregnancy Termination Bill*, art. 21 (2013) (Macedonia). The waiting period is waived under certain circumstances, such as where the pregnancy poses a risk to the woman’s health. An English translation of the law available at: <http://srhr.org/abortion-policies/documents/countries/01-MACEDONIA-LAW-ON-TERMINATION-OF-PREGNANCY-2013.pdf>.

¹¹³ *Ley 2/2010 Orgánica de Salud Sexual y Reproductiva y de la Interrupción Voluntaria del Embarazo* [*Organic Law 2/2010 on Sexual and Reproductive Health and the Voluntary Interruption of Pregnancy*] art. 13(4º), Boletín Oficial del Estado, 4 March 2010. Available at: <http://www.boe.es/buscar/act.php?id=BOE-A-2010-3514>, as modified by *Ley Orgánica 11/2015 de 21 de septiembre*. Art. 1, Ref. BOE-A-2015-10141.

obtain illegal abortions,¹¹⁴ even though these changes are not in line with WHO recommendations.¹¹⁵ Laws have also changed in terms of indications for which women may obtain abortions¹¹⁶ and banning advertising of abortion.¹¹⁷ In many cases, while abortion is legal on most grounds, countries in the region also have legal provisions for medical staff to conscientiously object to performing abortions. It is possible to accommodate conscientious objection while ensuring access to services if there is clarity about who can object and to which components of care, and if there is ready access to abortion by mandatory referral or direct access to an abortion service.¹¹⁸ However, in some cases, countries fail to ensure that these refusals of care do not jeopardize women's access to abortion care.^{119, 120}

D. Gains in maternal and newborn care have not been shared by all

The 2013 Chair's summary called for the elimination of preventable maternal mortality and morbidity by ensuring that all women have access to quality prenatal care and that all births are attended by skilled health personnel. It also stressed the need to establish mechanisms that foster providers' compliance with human rights and ethical and professional standards.

Maternal mortality (SDG Indicator 3.1.1) declined from 15 to 14 deaths per 100,000 live births between 2010 and 2015, remaining

highest in Central Asia (33 deaths per 100,000 live births) and Eastern Europe and the Caucasus (24 deaths per 100,000 live births) (Figure 32). In contrast, maternal mortality has stabilized at very low levels in the western part of the region. During the period 2010–2015, maternal mortality significantly declined in Kazakhstan (from 20 to 12 deaths per 100,000 live births), the Republic of Moldova (from 34 to 23) and Turkey (from 23 to 16 deaths per 100,000 live births).

¹¹⁴ The Local, "Anger as Italy Fines Women up to 10k for Secret Abortions", 24 February 2016. Available at: <https://www.thelocal.it/20160224/anger-as-italian-women-to-be-fined-up-to-10k-for-secret-abortions>.

¹¹⁵ World Health Organization (2012) *Safe abortion: technical and policy guidance for health systems*. WHO, Geneva.

¹¹⁶ *Bylaw of the Council of Ministers of the Republic of Belarus #23 of 11 January 2013* (2013) (Belarus). See also Отменено большинство социальных показаний для аборттов на позднем сроке Читать полностью ["The Majority of Social Indications for Late-Term Abortion Were Abolished"], Tut, 14 January 2013. Available at: <http://news.tut.by/health/330313.html>.

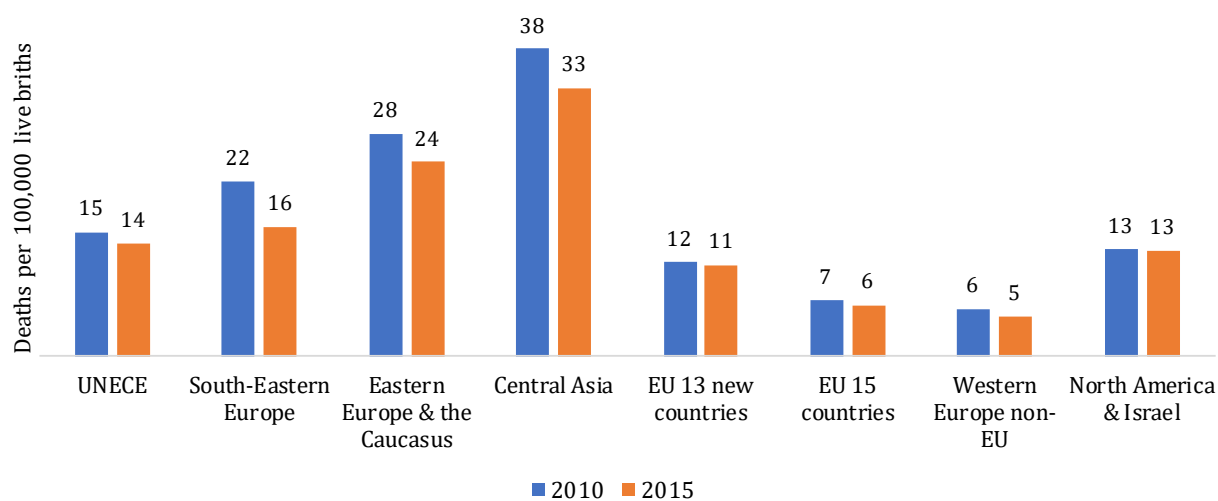
¹¹⁷ *Federal Law #317-FZ*, art. 7, pt. 9 (2013) (Russ.)

¹¹⁸ Chavkin, W., L. Swerdlov and J. Fifield (2017) "Regulation of Conscientious Objection to Abortion: An International Comparative Multiple-Case Study", *Health and Human Rights Journal*, Vol. 19, No. 1.

¹¹⁹ Center for Reproductive Rights (CfRR) (2018) *Addressing Medical Professionals' Refusals to Provide Abortion Care on Grounds of Conscience or Religion: European Human Rights Jurisprudence on State Obligations to Guarantee Women's Access to Legal Reproductive Health Care*. CfRR, Geneva, p.5.

¹²⁰ European Committee of Social Rights, *Confederazione Generale Italiana del Lavoro (CGIL) v. Italy*, Complaint No. 91/2013.

Figure 32. Maternal mortality ratio, 2010–2015



Source: WHO. UN Global SDG Database.

Such decreases reflect improvements in access to quality antenatal care and skilled attendance at birth, including emergency obstetric care. In the eastern part of the region, the proportion of pregnant women receiving pregnancy consultations in 2014 remained lowest in Tajikistan (71 per cent), Kazakhstan (75 per cent) and Romania (78 per cent) (source: UNICEF). However, coverage was practically universal in Armenia, Belarus, Croatia, Georgia, Hungary, Latvia, the Republic of Moldova, the Russian Federation and Ukraine.

During the period 2013–2014, the proportion of births attended by skilled health personnel (SDG Indicator 3.1.2) was virtually universal (over 97 per cent) across all UNECE countries except Tajikistan (90 per cent).

Nonetheless, such improvements have not been equally shared by all. Failures to ensure adequate standards of health care and respect for women’s rights in childbirth, including coercive and discriminatory practices in maternal health care, have recently been observed in some contexts, with such

infringements remaining particularly acute for poor women, Roma women, undocumented migrant women and women with disabilities.¹²¹

In the case of undocumented migrants, harmful restrictions and obstacles continue to limit their access to health care in Europe. This has particular consequences for maternal health among these populations, given that in most countries women are unable to legally access ordinary prenatal care, and women even face limitations to seeking medical attention during labour—issues that are aggravated by financial barriers and exclusions in health insurance schemes.

According to a study by the Platform for International Cooperation on Undocumented Migrants (2016), undocumented migrant women who are pregnant can access some form of maternity care, from delivery only to a full complement of reproductive services, in 21 EU Member States. Free HIV screening is available for them in only 15 countries, with treatment provided in 10 countries. However,

¹²¹ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women’s Sexual and*

Reproductive Health and Rights in Europe. Council of Europe and Commissioner for Human Rights, Strasbourg, p.41–44.

only 10 EU Member States provide some access to primary care, limiting undocumented migrant women's access to information, and in the case of pregnancy, to contraception and family planning counselling.¹²²

All in all, the absence of firewalls separating the provision of basic health-care services from immigration control, administrative and language barriers, and social exclusion often dissuade undocumented migrant women from seeking medical assistance during pregnancy.

Box 17. Strengthening maternal mortality surveillance: Kazakhstan and Ukraine

An important aspect of addressing maternal mortality is to strengthen data collection and surveillance systems which help identify the root causes and challenges that need targeted solutions.¹²³ **Kazakhstan** has made positive progress in this respect since 2011, by conducting 'confidential enquiries' into maternal deaths. According to WHO, "such confidential enquiries are designed to improve maternal health and health care by collecting data, identifying any shortfalls in the care provided and devising recommendations to improve future care".¹²⁴ By collecting information via interviews with family members and health workers, reviews of CRVS data, household surveys, and health centre and burial records, the approach seeks to identify and investigate the cause of all deaths of women of reproductive age. The information helps classify cases and assess the accuracy of maternal mortality data; most importantly, it can be used to revise and strengthen clinical guidelines and inform activities to end preventable maternal deaths.

In Kazakhstan, the Central Confidential Audit Commission (CCAC) audited officially reported maternal deaths for 2009–2010 to determine their causes. In 2014, the audit was expanded to cover deaths in women of reproductive age that were not officially assigned to maternal causes. Over 150 pregnancy-related deaths that had occurred between 2011 and 2013 were revised.

Ukraine's use of confidential enquiries into maternal deaths is a positive example of the use of data to address development challenges. The decreasing trend in maternal mortality in Ukraine is unstable, partly due to the difficulty in identifying the causes of maternal deaths. Women's deaths in childbirth are mostly due to failures of the health system; therefore, it is important to collect information on these deaths to improve health care. This approach, supported by the WHO and adopted by many countries in the region, is effective in identifying the causes behind maternal deaths, moving beyond a punitive approach to mistakes and flaws in the health-care system towards a learning model that helps improve service delivery.¹²⁵

¹²² Platform for International Cooperation on Undocumented Migrants (PICUM) (2016) *The Sexual and Reproductive Health Rights of Undocumented Migrants, Narrowing the Gap between their Rights and the Reality in the EU*. PICUM, Brussels.

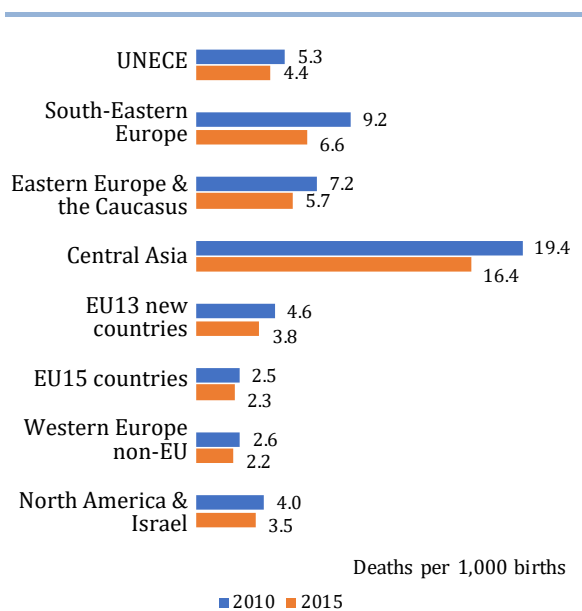
¹²³ WHO (2017) *World Health Statistics (2017): Monitoring health for the SDGs*. WHO, Geneva.

¹²⁴ Ibid.

¹²⁵ Based on WHO Regional Office for Europe (2017) *Press Release: WHO supports implementation of confidential enquiries into maternal deaths in Ukraine*, 9 October. WHO Regional Office for Europe, Copenhagen. Available at: <http://www.euro.who.int/en/health-topics/Life-stages/maternal-and-newborn-health/news/news/2017/10/who-supports-implementation-of-confidential-enquiries-into-maternal-deaths-in-ukraine>.

Neonatal survival reflects the extent to which women and infants have continued, quality access to SRH care before and during pregnancy, delivery and the post-partum period. Between 2010 and 2015, neonatal mortality (SDG Indicator 3.2.2) decreased from 5 to 4 deaths per 1,000 live births. Although declines were observed across all regions, neonatal mortality in Central Asia in 2015 remained four times higher than the regional average (16 deaths per 1,000 live births).

Figure 33. Neonatal mortality rate, 2010–2015



Source: UN Inter-Agency Group for Child Mortality Estimation. UN Global SDG Database.

Although antenatal care and skilled attendance at birth are almost universal, both the maternal and neonatal mortality rates evidence gaps in the quality of such services, as well as in emergency obstetric care and perinatal and post-partum care, which deserve policy attention.

¹²⁶ ECDC and WHO (2017) *HIV/AIDS Surveillance in Europe 2017*. ECDC and WHO Regional Office for Europe, Solna and Geneva, p.ix.

E. Concerning HIV epidemic growth in the eastern part of the region

The *2013 Chair's summary* acknowledged that STIs, including HIV, remained a major concern in the UNECE region, particularly in Eastern Europe and Central Asia, and highlighted that their prevention and treatment needed to be an important part of health system responses. To this end, it called on governments to assume full ownership over the long term of their response to STIs, rather than relying on donor funding.

In Europe, the Caucasus and Central Asia, sexual transmission of HIV continued to increase, accounting in aggregate for 71 per cent of all new HIV diagnoses in 2016 (47 per cent heterosexual and 24 per cent sex between men).¹²⁶ The HIV epidemic in the region continued to grow at an alarming rate in the eastern part of the region, calling for increased prevention, testing and treatment efforts, as well as fighting stigma and discrimination against people living with HIV (PLHIV) and key at-risk population groups (people who inject drugs, men who have sex with men, and sex workers).

A recent UNAIDS report (2018) highlighted that against the global trend, over 120,000 new HIV infections occurred in 2017 in the eastern part of the region, representing an increase of 30 per cent since 2010, and reflecting insufficient political commitment and domestic investment in national AIDS responses.¹²⁷ The report highlights that, in 2017, HIV transmission among people who inject drugs and their sexual partners accounted for the majority of HIV infections in the region (39 per cent), followed by clients of sex workers and other sexual partners of key populations, and men who have sex with men (28 per cent), yet national HIV surveillance

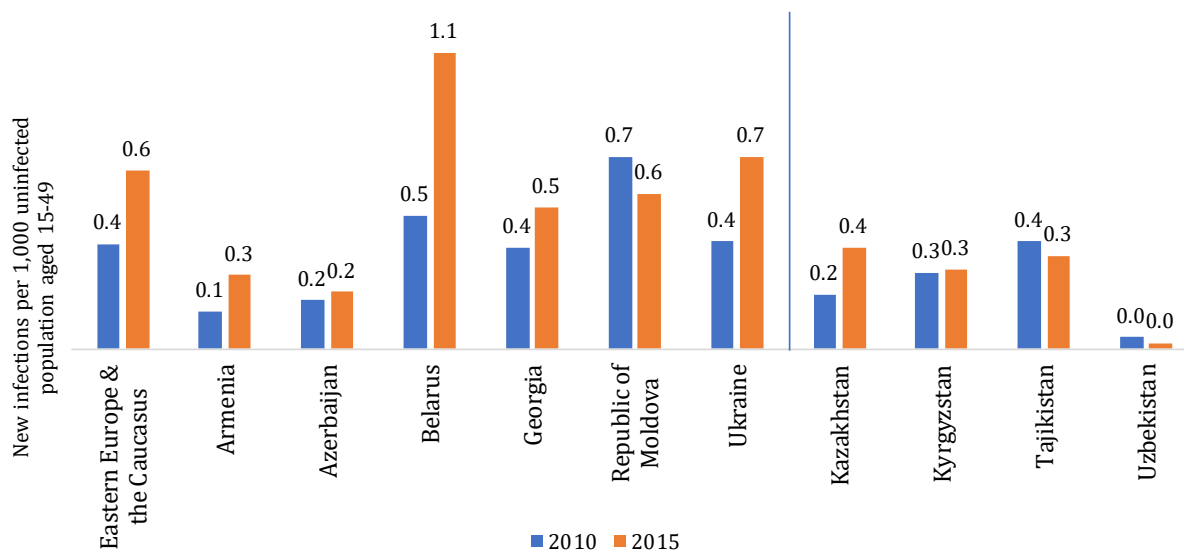
¹²⁷ UNAIDS (2018) *Global Aids Update: Miles to Go*. UNAIDS, Geneva, pp.70, 240–243.

shows that HIV infections are growing among the general population, particularly urban residents and labour migrants.

An analysis of HIV incidence—i.e. the number of new HIV infections per 1,000 uninfected

population aged 15–49 (SDG Indicator 3.3.1)—shows that it grew from 0.4 to 0.6 in Eastern Europe and the Caucasus and from 0.1 to 0.2 in Central Asia between 2010 and 2015, although some countries achieved declines in incidence (Figure 34).

Figure 34. HIV incidence, 2010–2015



Source: UNAIDS. UN Global SDG Database.

In 2016, however, only around half of PLHIV were reached by antiretroviral therapy in Eastern Europe and the Caucasus (51 per cent) and Central Asia (60 per cent). In addition, it is estimated that 6.6 million people in the eastern part of the region need treatment for chronic hepatitis C.¹²⁸ They face an increased risk of death and morbidity if co-infected with HIV. However, major gaps in epidemiological data remain: reported hepatitis C prevalence ranged from 1.5 to 7.5 per cent for the general population, 23 to 70–95 per cent for people who inject drugs, and 18 to 80 per cent for PLHIV.¹²⁹

Six countries in the eastern part of the region have data available for 2012–2016 on the

percentage of women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission. In Lithuania, 71 per cent of young people have accurate knowledge on HIV, compared to 39 per cent of young people in Armenia. HIV knowledge levels are lower among youth in Kyrgyzstan, Ukraine (23 per cent) and Bulgaria (19 per cent), and lowest in Tajikistan (3 per cent). These levels, coupled with those related to condom use and increases in the sexual transmission of HIV, call for specific prevention efforts targeting this population group, and for investments in data collection on HIV prevention knowledge.

¹²⁸ Maistat et al. (2017) “Hepatitis C in Eastern Europe and Central Asia: a survey of epidemiology, treatment access and civil society activity in eleven

countries”, *Hepatology, Medicine and Policy*. Vol. 2, No. 9.

¹²⁹ Ibid.

In 2016, three countries in the eastern part of the region were validated by the WHO Global Initiative to Eliminate Mother-to-child Transmission of HIV and Syphilis, which focuses on a harmonized approach to improving health outcomes for mothers and children: Belarus (HIV and syphilis), Armenia (HIV only) and the Republic of Moldova (HIV only).

As for the western part of the region, the UNAIDS *Miles to Go: Closing gaps, breaking barriers, righting injustices* report (2018) highlighted that high levels of coverage of HIV services over the last two decades have resulted in steady progress towards ending the AIDS epidemic.¹³⁰ The report emphasized that under 80,000 new HIV infections occurred in 2017, most of which were reported by men who have sex with men (57 per cent), and clients of sex workers and other partners of key populations (24 per cent). The report also highlighted that 76 per cent of PLHIV were accessing antiretroviral therapy in 2016.

Although all UNECE countries have HIV prevention measures in place, additional efforts need to be directed at ensuring earlier diagnosis. For instance, around 30 per cent of PLHIV in the eastern part of the region have not been tested for HIV and do not know their status. New strategies are required to expand the reach of HIV testing, including self-testing services and testing provided by lay providers.¹³¹ This would not only contribute to

halting the spread of the epidemic but also allow individuals to start treatment sooner, increasing their chances of living longer and healthier lives.

Stigma and discrimination towards PLHIV and key at-risk populations remain high. These are expressed in the form of government laws and regulations, access to health care, and employment limitations, among others. Many countries in the UNECE region report that stigma and discrimination within key at-risk populations represent a barrier to increasing the uptake of HIV services.¹³² New, conservative legislation in some countries is placing additional restrictions on same-sex relationships, sex work and drug use, which could further prevent key populations from accessing HIV services and hence contribute to the expansion of the HIV epidemic. However, some progress has been made, such as in Lithuania, where restrictions on PLHIV entering the country, travelling and staying were lifted in 2015.¹³³

Sex workers remain particularly marginalized and at risk of social exclusion due to social marginalization and the criminalization of sex work. In addition, they face increased risks of acquiring HIV due to discrimination, their work environment,¹³⁴ violence, alcohol and drug use.¹³⁵ It is estimated that decriminalization of sex work could avert between 33 and 46 per cent of HIV infections

¹³⁰ UNAIDS (2018) *Global Aids Update: Miles to Go*. UNAIDS, Geneva, pp.248–251.

¹³¹ ECDC and WHO (2017) *HIV/AIDS Surveillance in Europe 2017*. ECDC and WHO Regional Office for Europe, Solna and Geneva.

¹³² ECDC (2017) *Evidence brief: Impact of stigma and discrimination on access to HIV services in Europe. Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia*. ECDC, Stockholm, p.2.

¹³³ UNAIDS (2015) *Press Statement: Lithuania confirms no restrictions on entry, stay and residence for people living with HIV*, 17 September. UNAIDS,

Geneva. Available at:

http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2015/september/20150917_Lithuania.

¹³⁴ Shannon, K. et al. (2015) “Global epidemiology of HIV among female sex workers: influence of structural determinants”, *The Lancet*, vol. 385, issue 9962, pp.55–71.

¹³⁵ WHO, UNFPA, UNAIDS, Global Network of Sex Work Projects, World Bank (2013) *Implementing comprehensive HIV/STI programmes with sex workers: practical approaches from collaborative interventions*. WHO, Geneva.

globally in the next decade.¹³⁶ According to WHO (2012), “countries should work toward the decriminalization of sex work and the elimination of the unjust application of non-criminal laws and regulations against sex workers”.¹³⁷

Anti-discrimination and other rights-respecting laws to protect against discrimination and violence, and other violations of rights faced by sex workers need

to be established. Sex workers should be able to access health services based on the principles of avoidance of stigma, non-discrimination and the right to health. Finally, violence against sex workers must be prevented and addressed in partnership with sex workers and sex worker-led organizations. It is estimated that eliminating sexual violence against sex workers could lead to a 20 per cent reduction in new HIV infections.¹³⁸

Box 18. AFEW Network delivering HIV services in Eastern Europe and the Caucasus and Central Asia

AFEW Network comprises member organizations and over 160 local partners in Eastern Europe and the Caucasus and Central Asia. The network and its partners remain committed to support those living with or affected by HIV, tuberculosis, viral hepatitis and other public health concerns, without judgement or stigma. It is making progress in addressing key human rights and contributing to universal health coverage in the subregions by increasing equitable access to essential HIV, hepatitis C and tuberculosis prevention, treatment and care services for marginalized communities and groups in society. It also helps build the skills of key populations by giving them a powerful voice to demand rights and access to services. The network also promotes innovative leadership and approaches, and the sharing of evidence-based best practices and technical, clinical and medical knowledge and expertise to support civil society and governments.

In **Tajikistan** AFEW Network went through administrative and agreement processes with the local government to start the first community-based HIV testing facility. It shares its experience with other NGOs, and there are now seven points that offer community-based counselling and testing.

In **Kazakhstan** AFEW Network developed a mobile application (POZ.INFO) to help PLHIV adhere to treatment. The app will be developed further and will offer other services to improve the quality of life of PLHIV.

In the **Russian Federation** AFEW Network is supporting an NGO that reaches out to people who inject drugs and offers clean needles and syringes. It provides care for minor medical problems such as sores or small injuries and refers people for HIV testing and to medical specialists.

¹³⁶ Shannon, K. et al. (2015) “Global epidemiology of HIV among female sex workers: influence of structural determinants”, *The Lancet*, vol. 385, issue 9962, pp.55–71.

¹³⁷ WHO (2012) *Prevention and Treatment of HIV and Other Sexually Transmitted Infections For Sex Workers in Low- and Middle-Income Countries*. WHO, Geneva.

¹³⁸ WHO website, accessed 20 June 2018.

Box 19. Preventing STI transmission among the population aged 50 or older: Canada

The *2013 Chair's summary* called for effective policies and programmes related to SRH services that better respond to the needs of an ageing population. While the inception of clear, robust SRH programmes aimed at those 65 and older are not yet visible on the surface, there is evidence to suggest that conversations on the prevention of sexually transmitted and blood-borne infections (STBBIs) among this age group have begun at certain national levels.

The Public Health Agency of Canada,¹³⁹ for example, published a report in 2015 addressing the notion of rising rates of STBBIs (including HIV and hepatitis C) in the over-50 population and unpacking the social, structural and economic determinants that impact STBBI prevention among older adults. Additionally, in the United States, the Institute for Healthcare Policy and Innovation at the University of Michigan took a poll of adults aged 65–80 and concluded that, while sex is important for many older adults, it is not often discussed (83 per cent of respondents had not spoken with their health-care provider about their sexual health in the past two years). These initiatives highlight the growing understanding of the realities pertaining to the sexual health of the ageing population and the need to promote open, respectful and inclusive dialogue on the matter.

Lastly, according to WHO data, syphilis infections decreased from 14 to 11 cases per 100,000 population between 2010 and 2012–2013 in the UNECE region, remaining highest in Eastern Europe and the Caucasus (27 cases per 100,000 population). The prevention, surveillance and treatment efforts of this and other STIs receive insufficient attention and need to be strengthened.

F. Broadening access to infertility care

Infertility is associated with adverse health and socio-economic outcomes such as psychological distress, intimate partner violence, risky sexual behaviours, stigma and exclusion, marital instability and economic hardship, with women often withstanding most discrimination.¹⁴⁰

The *2013 Chair's summary* called for investments in STI prevention to reduce secondary infertility, which can be prevented by providing access to safe delivery and safe abortion care, to modern contraception to prevent unintended pregnancies, and by preventing, detecting and treating infections, including STIs. Obesity, smoking and alcohol and drug abuse, which remain more prevalent among men, can also lead to infertility.

The risk of primary and secondary infertility among women and men increases with STI infections and postponements in childbearing. Although little or no systematic information is available on the prevalence of infertility, secondary infertility was estimated to affect 18 per cent of child-seeking women aged 20–44 in the central and eastern parts of the region in 2010 (13.9 million women), while over 2 per cent were affected by primary infertility (1.8 million women).¹⁴¹ In the case of men, a recent

¹³⁹ Canada Public Health Agency (PHAC) (2015) *Questions & Answers: Prevention of Sexually Transmitted and Blood Borne Infections Among Older Adults*. PHAC, Ottawa.

¹⁴⁰ The Lancet (2018) *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission*. The Lancet Commissions, London.

¹⁴¹ Mascarenhas, M.N. et al. (2012) “National, regional, and global trends in infertility: a systematic analysis of 277 health surveys”, *PLOS Medicine*, vol. 9, issue 12.

study showed that sperm counts of European and North American men declined by 50–60 per cent between 1973 and 2011.¹⁴²

These factors explain the increased demand for information about infertility and the treatment options available and infertility care, including assisted reproductive technologies. Despite progressing fast, however, these technologies remain largely only available to wealthy people.¹⁴³

User data show that in the United States of America, infertility services have been used by 17 per cent of all women aged 25–44, and by 41 per cent of women with fertility problems.¹⁴⁴ Prag and Mills (2017) recently conducted an in-depth review of the use of and legislation on assisted reproductive technologies in Europe. They highlighted that while Europe remains the largest market for such technologies globally, their use varies significantly due to country differences in legislation, costs, reimbursement modalities and the norms surrounding childbearing and conception.¹⁴⁵

No clear subregional patterns in the use of assisted reproductive technologies can be distinguished from their findings. In 2010 the highest numbers of assisted reproduction cycles are initiated in Denmark, Belgium, Iceland, Sweden and Slovenia, with the Czech Republic, Estonia and Serbia also populating the upper half of the distribution. In contrast, it was less widespread in countries such as Germany, Austria, Ireland, Ukraine and Albania, which display similar levels of use.

¹⁴² Levine, H. et al. (2017) “Temporal trends in sperm count: a systematic review and meta-regression analysis”, *Human Reproduction Update*, vol. 23, issue 6, pp.646–659.

¹⁴³ The Lancet (2018) *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission*. The Lancet Commissions, London.

¹⁴⁴ Ibid.

The study highlights that as the cost of treatment remains the most important barrier to accessing assisted reproductive technologies, their use is highest in countries where treatments are fully covered by national health plans. In addition, European couples are often required to be married or in a stable union to access treatment, while single and lesbian women remain unable to initiate it in many contexts.

G. Addressing the burden of cervical and breast cancer

Cervical cancer is caused by persistent infection with one or more of the 15 carcinogenic (or ‘high-risk’) subtypes of the human papillomavirus (HPV), a very common STI which is usually acquired early in life. While almost 90 per cent of HPV infections are cleared naturally by the immune system, those that persist can lead to the development of precancerous lesions that can in turn progress to cervical cancer over a period of about 10 years if untreated.¹⁴⁶

There are no treatments for HPV infections, but the precancerous lesions can be removed using simple and effective outpatient procedures. However, these lesions do not cause any clinical symptoms and can only be identified by cervical screening.

Cervical cancer is the second most common cause of cancer death among women in the eastern part of the region, where the number of new cervical cancer cases and deaths is up to 10 times higher than in the western part of

¹⁴⁵ Prag, P., and M.C. Mills (2017) “Assisted Reproductive Technology in Europe: Usage and Regulation in the Context of Cross-Border Reproductive Care”, in Kreyenfeld, M., and D. Konietzka (eds) *Childlessness in Europe: Contexts, Causes, and Consequences*. Springer Open, Cham.

¹⁴⁶ UNFPA (2015) *Preventing Cervical Cancer in Eastern Europe and Central Asia. Issue Brief 5*. UNFPA EECARO, Istanbul.

the region.¹⁴⁷ It is estimated that every year more than 38,000 new cases and 18,000 deaths from cervical cancer occur in the eastern part of the region.¹⁴⁸ Cervical cancer primarily affects younger women, with most cases occurring between the ages of 35 and 45, a time when women are working, caring for their families or doing both, hence removing them from their families and disrupting economies.¹⁴⁹

Yet a large share of cervical cancer incidence and mortality is preventable. Its burden remains unacceptably high, even though its causes and progression are well known and despite the availability of effective HPV vaccines and the existence of cost-effective screening and treatment options for early precancerous lesions.¹⁵⁰ In eastern countries, where the burden of disease is shifting towards chronic NCDs, this calls for the strengthening of cervical cancer prevention programmes by increasing HPV vaccination coverage among girls aged 9–13 and the

provision of cervical screening (Pap tests) for all population groups.

To this end, programmes need to shift from opportunistic to organized screening to ensure that their benefits are equitably delivered across all social strata, provide free cervical screening as well as free treatment of precancerous lesions and cervical cancer, and collect the quality assurance data for effective programme operation, including by strengthening screening registries.¹⁵¹

Breast cancer is the most common cancer affecting women worldwide.¹⁵² In Europe, breast cancer is a common cause of disease for women in all subregions with the exception of Central Asia,¹⁵³ and incidence and mortality rates—66.5 and 12.9 per 100,000 women, respectively—remain higher than the global average.¹⁵⁴

Box 20. Strengthening the capacity of service providers to improve the prevention and response to cervical cancer

In Eastern Europe and Central Asia, the limited success of comprehensive cervical cancer prevention programmes can be attributed to unresolved capacity gaps at systems level, aggravated by inadequate provider skills, as evidenced by an assessment conducted in 2014 by UNFPA EECARO, in partnership with the International Cervical Cancer Prevention Association (ICCPA). To bridge these gaps, UNFPA, in partnership with the International Federation of Cervical Pathology and Colposcopy (IFCPC) and the International Agency for Research on Cancer (IARC) created a dedicated *Certified Online Training Course for service providers in Colposcopy and Cervical Cancer Prevention*. The 12-month programme, available in English and Russian, incorporated two different but complementary parts: an online course, and a clinical component supervised by accredited colposcopy master trainers. Finally, students complete a clinical examination, and successful trainees receive a certificate from IFCPC-IARC.

¹⁴⁷ Ibid.

¹⁴⁸ Ibid.

¹⁴⁹ Ibid.

¹⁵⁰ The Lancet (2018) *Accelerate Progress—Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission*. The Lancet Commissions, London.

¹⁵¹ Ibid.

¹⁵² Altobelli, E. et al. (2017) “Breast Cancer Screening Programmes across the WHO European Region: Differences among Countries Based on National Income Level”, *International Journal of*

Environmental Research and Public Health, vol. 14, supp. 4, p.452.

¹⁵³ WHO (2015) *Beyond the Mortality Advantage: Investigating Women’s Health in Europe*. WHO Regional Office for Europe, Copenhagen.

¹⁵⁴ Altobelli, E. et al. (2017) “Breast Cancer Screening Programmes across the WHO European Region: Differences among Countries Based on National Income Level”, *International Journal of Environmental Research and Public Health*, vol. 14, supp. 4, p.452.

The first training programme began in January 2017, with 150 participants from 17 Eastern Europe and Central Asia countries and territories. Twenty-two trainees who managed to successfully complete both theoretical and clinical components of the course sat their first Objective Structured Clinical Examination (OSCE) in colposcopy and case management of cervical cancer.¹⁵⁵ In addition, 20 master/clinical trainers from 13 countries attended two rounds of a training of trainers seminar and are currently skilled to support and coordinate the national capacity-building efforts linking international training with the implementation process of national SRH action plans. New initiatives under way in these countries include development of the National Cervical Screening Registry in Georgia, clinical guidelines for cervical cancer prevention in the former Yugoslav Republic of Macedonia, and procurement of colposcopy equipment by the Government of Uzbekistan for primary health facilities and to increase access to cervical cancer screening.

The incidence of breast cancer is higher in the western part of the region, mostly due to women's longer life expectancy and higher levels of cancer detection. Indeed, in these countries screening programmes are well organized, free of charge, and use high-quality data sources and methodologies to estimate incidence and mortality rates.¹⁵⁶

Both cervical and breast cancer screening and treatment outcomes can be improved if programmes factor in a range of social determinants, including educational attainment, socio-economic status, neighbourhood composition, immigrant status and urban environment, among others.¹⁵⁷

2.3. Orienting family support policies to reach those in need

- Over recent decades, UNECE countries have witnessed, to various extents, a transition away from traditional family formation—consisting of married couples with children—towards cohabitation, single-parent families and reconstituted families, among others.

The *2013 Chair's summary* called for appropriate public policy responses, responsive legal frameworks, and support,

including financial support, to respond to the diverse family formation patterns observed in the UNECE region. It recommended a life-course approach as individuals move in and out of families and partnerships and as they experience various family transitions, to ensure the protection of family members, including children who remain at an increased risk of vulnerability.

The evolution of family and household structures in the UNECE region reflects the social changes under way across the life course, and evidence the need to adapt family policies, as well as those related to health, long-term care and housing, among others, to current realities.

The continuation of current trends in low fertility and ageing projects a region where fewer children will be born—with those more likely to be born out of wedlock and experience family dissolution—and with more older persons, increasingly living alone. Informal support networks are likely to come under pressure as a reduction in the number of children will lead to fewer future informal carers for older persons, and a greater reliance on professional care. In this regard, divorced, separated and remarried parents are more

¹⁵⁵ UNFPA (2014) *Programme Document: UNFPA Regional Cervical Cancer Prevention Initiative in Eastern Europe And Central Asia 2014 – 2017*. UNFPA EECARO, Istanbul.

¹⁵⁶ Ibid.

¹⁵⁷ WHO (2015) *Beyond the Mortality Advantage: Investigating Women's Health in Europe*. WHO Regional Office for Europe, Copenhagen.

likely to be at a disadvantage, as they have greater difficulties sustaining long-lasting relationships with their children, leading to less informal care capacity within their family networks.¹⁵⁸

Family support policies need to be oriented to address these changing realities and ensure the delivery of universal, integrated and locally based services which guarantee equality of opportunity, irrespective of family type, with more intensive delivery for at-risk populations.¹⁵⁹ Integrating service delivery in childcare centres, schools or clinics generates economies of scale, promotes innovation in working practices and ensures an adequate and efficient delivery of benefits, while clients avoid repeat visits, reducing their time, money and emotional burdens. In addition, the provision of conditional benefits can empower vulnerable families to break disadvantage and dependency cycles simultaneously across generations.

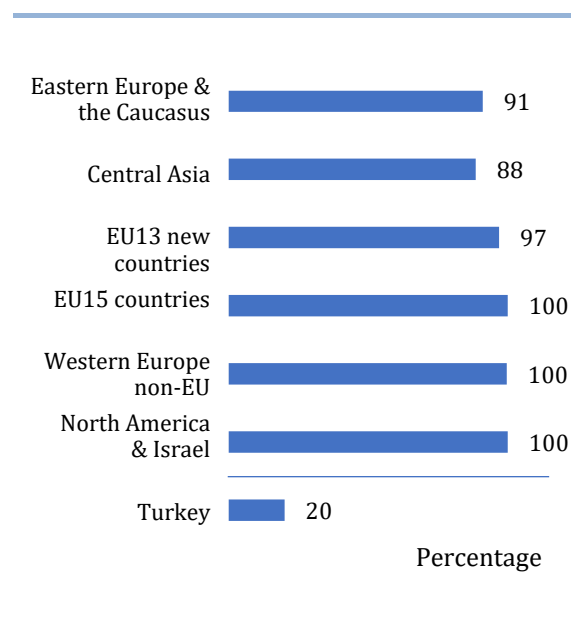
As discussed in Chapter 1, human capital investments in early ages yield greater returns to societies, hence the need to ensure universal access to early childhood education and care, and to sustain public spending on education throughout the remaining years of childhood and adolescence. Guaranteeing the social protection of children during these stages is equally important, particularly for those most vulnerable.

In 2016 the proportion of children covered by social protection floors and systems (SDG Indicator 1.3.1.b) remained universal (100 per cent) among most of the region's countries except Kyrgyzstan (18 per cent), Armenia (21 per cent), Canada (40 per cent), Bulgaria (49 per cent), Cyprus (60 per cent), Slovenia (79 per cent) and Portugal (93 per cent) (source: ILO).

¹⁵⁸ OECD (2011) *The Future of Families to 2030. A Synthesis Report*. OECD International Futures Programme, Paris, p.8.

Similarly, the increased risk and feminization of poverty at older ages call for the provision of adequate income support to older persons. In 2016 most subregions were close to or had achieved universal pension coverage (93 per cent) among persons above retirement age (SDG Indicator 1.3.1.c). However, this share remained as low as 21 per cent in Montenegro and 20 per cent in Turkey in 2016 (Figure 35). The remaining subregions had achieved or were close to achieving universality.

Figure 35. **Proportion of the population above retirement age receiving a pension, 2016**



Source: ILO. UN Global SDG Database.

As the region's ageing process advances, labour forces decrease and pressures on pension systems mount, the provision of tax incentives for employers to retain older workers remains one of the most effective strategies for older persons to support consumption over a longer lifespan, and to guarantee the overall sustainability of family support systems.

¹⁵⁹ OECD (2011) *Doing Better for families*. OECD Publishing, Paris, p.12.

2.4. Recommendations: Families and sexual and reproductive health over the life course

A. Sexual and reproductive health over the life course

- Design and implement policies that address existing **inequities** in access to SRH information, education and services, addressing the distinct needs of women, adolescents and youth, older persons, men and boys, migrants, persons with disabilities, and other marginalized people, over their **life course**.
- Increase efforts to improve the SRHR of **women and girls**, including by combating gender stereotypes and negative social norms and attitudes and by promoting gender equality; prioritize the SRHR of **older people** by ensuring their access to age-specific SRH services; engage **men and boys** in meeting their SRHR and to encourage them to take an active part in advancing gender equality, SRHR of women and girls and preventing GBV; take effective measures to meet the SRHR needs of **migrants, persons with disabilities, key at-risk and vulnerable populations and other marginalized groups**.
- Prioritize the SRHR of **adolescents and youth** in all their diversity, by ensuring their equitable access to comprehensive sexuality education and youth-friendly SRH and HIV services, including modern contraception; and remove all legal and policy barriers that hinder their access, such as financial barriers and parental or spousal consent laws.

B. Towards an essential, integrated package of sexual and reproductive health information and services

- Support universal access to quality SRH care by: reviewing legal frameworks and policies that pose access barriers to SRH information,

education and services, including third-party authorization and financial barriers, and those that restrict access on the basis of age, marital status, sexual orientation and gender identity; fostering commitments to advancing gender equality; strengthening health systems for the **universal provision of an essential package of SRH services** and information across the entire life span that responds to changing SRH needs without financial overburden; and integrating this essential service package at the primary health-care level.

- Mainstream mandatory, age-appropriate, rights-based, evidence-based and scientifically accurate **comprehensive sexuality education** curricula across primary and secondary education and in non-school settings; guarantee that such curricula are based on a holistic approach to SRHR and addresses a wide range of issues, including gender equality, the prevention of early pregnancy, STIs and sexual violence, among others; and introduce a system of continuing, specialized competency training in comprehensive sexuality education for teachers, educators and health professionals, including peer education and life-skills education methodologies.
- Ensure universal access to a wide range of effective, evidence-based, acceptable and affordable **modern contraceptive methods** irrespective of gender, age, income, place of residence and marital and vulnerability status, within the context of universal comprehensive SRH services; address myths and misconceptions about modern contraceptive methods; use transformative approaches that empower women and involve men; ensure that maternity and abortion services offer comprehensive modern contraceptive information and commodities; and earmark domestic resources to ensure reproductive health commodity security, and contraceptive security in particular.

- Ensure access to safe, quality **abortion** services to the full extent of national laws, and provide quality post-abortion care.
- Ensure that all women, including those who are vulnerable, disadvantaged and hard to reach, have access to quality, evidence-based **antenatal care, skilled attendance at birth, emergency obstetric care, and perinatal and post-partum care** that respects their perspectives; establish confidential enquiries into all cases of maternal death at the national level and analyse severe maternal morbidity cases at the national and health-facility level; establish perinatal death audits and perinatal registers; and build the capacity of health-care providers to detect and address intimate partner violence against pregnant women.
- Strengthen national surveillance of the incidence and prevalence of **HIV and STIs**, including key at-risk and vulnerable populations; ensure universal access to quality and affordable STI and HIV care, including information, education, counselling, diagnosis and treatment services, with a particular focus on key at-risk and vulnerable populations and young persons; fully integrate STI and HIV services into existing SRH services; provide universal access to antiretroviral therapy, with the aim of eliminating mother-to-child transmission of HIV, follow-up of HIV-exposed infants, improving the life expectancy and quality of life of persons living with AIDS; address the contraceptive needs of PLHIV; expand hepatitis C epidemiological surveillance and an appropriate response, including ensuring the availability of direct-acting antivirals, especially for people who inject drugs and PLHIV; eliminate laws and regulations that discriminate against PLHIV in employment, health care and travel, and combat stigma against them; and decriminalize same-sex practices and lift propaganda bans and NGO restrictions to further strengthen prevention efforts.
- Ensure the health and rights of **sex workers**, through decriminalization of consensual sex work, ensuring access to health services without stigma and discrimination, preventing and eliminating violence against them, and ensuring safe working conditions.
- Prevent **infertility** by reducing risk factors such as obesity, unsafe abortions and sexually transmitted and post-partum infections; and expand access to quality counselling, diagnosis and fertility treatments, including psychosocial support services for persons affected by infertility.
- Strengthen national **cervical and breast cancer** screening programmes by targeting vulnerable, high-risk population groups, ensuring strong linkages with free referral services for diagnosis and treatment, expanding HPV vaccination coverage among adolescent girls, and investing in the collection of quality data for effective programme operation.

C. Orienting family support policies to reach those in need

- Develop **family support policies**, as well as those related to health, long-term care and housing, that factor in the changing nature of family and household composition and prioritize the delivery of universal, integrated and locally based services which guarantee equality of opportunity, irrespective of family type, with more intensive delivery for at-risk populations, such as children and older persons.

Chapter 3. Inequalities, social inclusion and rights

The *2013 Chair's summary* highlighted that equality and non-discrimination are necessary preconditions for all individuals to enjoy their human rights and realize their potential. It called on member States to achieve gender equality and guarantee the social inclusion of marginalized population groups, which continue to suffer multiple and intersecting forms of inequality, disempowerment and discrimination.

Despite the proliferation of legislative and public policy frameworks aimed at protecting human rights, women, vulnerable individuals and specific population groups continue to face persistent inequalities in income and opportunity, as well as discrimination, abuse and neglect. Their inability to exercise their human rights has significant societal costs, ranging from health, well-being and productivity losses, to social and political instability. Achieving the 2030 Agenda for Sustainable Development, therefore, requires sound policies that reduce such inequalities, within and across countries, by fostering the economic and social inclusion of those most left behind (SDG 10).

As evidenced in most goals and targets of the 2030 Agenda for Sustainable Development, and particularly in SDG 5, realizing gender equality is pivotal for achieving fairer and prosperous societies. Yet progress is far too slow, and much remains to be done. Poverty is at the centre of individual and household vulnerability, resulting in and perpetuating exclusion and inequality cycles. Vulnerability is often the result of the interaction between individual characteristics and environmental factors such as group membership. The social inclusion of marginalized and vulnerable population groups, such as international migrants, refugees, ethnic minorities, persons with disabilities, and persons of diverse sexual

orientation and gender identity, among others, requires enhancing their individual choices and opportunities, investing in their capabilities, enabling them to access resources and respecting their rights.

Societies with effective, sustainable policies that protect human rights, oppose stigma and discrimination, and establish concrete measures to support the poorest and most vulnerable are likely to have improved development outcomes.

3.1. Gender equality and women's empowerment

- Despite moderate progress, women remain less likely to participate in employment and continue to be paid less than men for equal work. In the UNECE region, women's labour force participation increased from 64 to 65 per cent between 2010 and 2016, and the gender gap narrowed from 14 to 13 per cent over the same period. Trends in the unadjusted gender gap in median earnings decreased from 15 to 14 per cent.
- Women continue to be underrepresented in leadership positions at all levels of public life. Although the share of seats in national parliaments held by women increased from 20 per cent in 2010 to 24 per cent in 2017 in the UNECE region, the proportion of managerial positions held by women remained largely unchanged at around a third in Eastern Europe between 2010 and 2015 and decreased from 36 to 32 per cent in the Caucasus, the EU and Western European countries without EU membership.
- Achieving a successful and more gender-balanced reconciliation between family and work responsibilities in all life phases remains a challenge for men and women in the UNECE region. Women continue to bear a heavier workload in family and household chores,

besides working outside the home, and they often change their employment status to reconcile family and work life.

- Gender-based violence remains a pervasive challenge to the region's societies. The Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention) came into force in 2014 and has been signed by 45 UNECE member States, 32 of which have ratified it.
- The prevalence of gender-biased sex selection and child and forced marriages remain of concern in some societies in the eastern part of the region.
- UNECE countries have made some progress in developing legal and policy frameworks to strengthen prevention mechanisms and provide effective assistance to survivors of GBV and access to special programmes for perpetrators, strengthening the judicial system and implementing information campaigns, among others.

The *2013 Chair's summary* emphasized that the achievement of gender equality, women's rights and women's empowerment can make a significant contribution to poverty reduction, inclusive growth, democratic governance, and peace and justice. It called for the creation of employment opportunities for women, while placing a special emphasis on ensuring that they, alongside men, find the desired work-life balance to realize their fertility aspirations. Lastly, the *2013 Chair's summary* stressed the need to ensure zero tolerance for GBV and address harmful gender norms and practices, such as gender-biased sex selection.

Although achieving gender equality is positively linked to creating prosperous societies, trends during the past five years indicate that considerable gender inequalities

prevail in the economic, social and political spheres. Comprehensive legislative and policy responses are, therefore, required to transform gender norms, guarantee equality of opportunity between women and men, and ensure women can fully exercise their rights, including their sexual and reproductive rights.

A. Minor gains in women's economic participation

Women's equal educational attainment and increasing labour force participation rates have not yet resulted in equal labour market outcomes in the region.¹⁶⁰ While the gender gap in labour force participation is narrowing in parts of the region, women continue to be paid less than men for equal work and are overrepresented in lower-level sectors, underrepresented in positions of power and decision-making and bearing most unpaid care and household work. Moreover, if women decide to bear children or care for older relatives, they are likely to be penalized in terms of pension contributions.

While the gender gap in labour force participation is narrowing, gender norms rooted in cultural and social traditions remain an instrumental factor behind women's engagement in the labour market.¹⁶¹ Between 2010 and 2016, the gender gap in labour force participation among persons aged 15–64 in the UNECE region narrowed slightly from 14 to 13 per cent (Table 5). Around two in every three women aged 15–64 are engaged in the labour force, in contrast to more than three in every four men within the same age group. Gender gaps generally remain larger in the eastern part of the region, where women are less likely to engage in the labour force. Between 2010 and 2016, the most notable increases in female labour force participation

¹⁶⁰ ILO and Bureau for Employer's Activities (2017) *Women in Business and Management. Gaining Momentum in Eastern Europe and Central Asia*. ILO, Geneva.

¹⁶¹ ILO (2017) *Global Employment Trends for Youth: Paths to a Better Working Future*. ILO, Geneva.

were observed in Hungary (from 56 to 64 per cent), Malta (from 43 to 56 per cent) and Serbia (from 51 to 58 per cent).

Table 5. Labour force participation rate by sex (percentage), persons aged 15–64, 2010–2016

Subregion/country	2010			2016		
	Men	Women	Gap	Men	Women	Gap
EU13 new Member States	73	59	14	76	63	13
EU15 countries	79	66	13	79	69	11
Western Europe non-EU	85	76	9	85	78	7
North America	80	69	11	79	68	11
Selected countries						
Kyrgyzstan	80	56	24	79	52	27
Republic of Moldova	49	44	4	49	46	3
Russian Federation	78	68	10	80	69	11
Serbia	67	51	17	73	58	15
The former Yugoslav Republic of Macedonia	78	50	27	78	51	27
Turkey	75	30	45	78	36	41

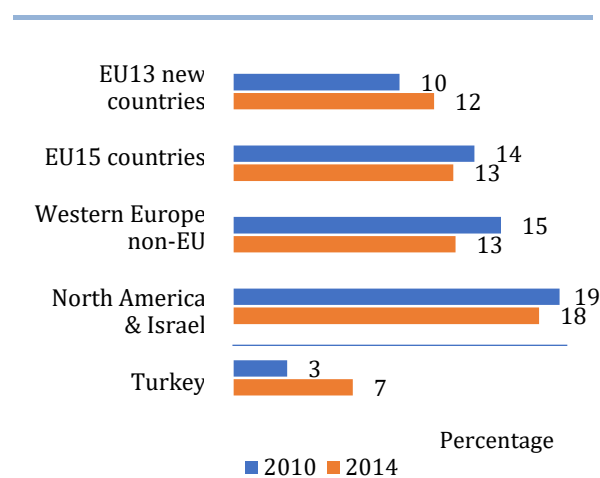
Source: ILO. ILOSTAT: Population and Labour Force Indicators.

Between 2010 and 2014, trends in the unadjusted gender gap in median earnings of full-time employees were mixed across countries and subregions, since it increased in Turkey and the 13 new EU Member States, and decreased in the EU15 countries, Western European countries without EU membership, and North America and Israel (Figure 36).

During this period, notable reductions in the unadjusted gender gap in median earnings were achieved by Hungary (from 6 to 4 per cent) and Belgium (from 7 to 3 per cent), while the gender gap remained largest, and unchanged, in Estonia (28 per cent). The gender wage gap constitutes a major setback for women’s economic opportunities. Women, primarily due to unpaid care responsibilities, are more likely to choose sectors that offer more flexibility to adjust working hours and re-enter the labour market than men, and sectors that do not require large or continual investments in skills or where skills do not depreciate significantly as a result of career interruptions. Wages in these lower-level, female-dominated sectors, such as health,

education and social services, tend to be lower than those dominated by men. In addition, women remain highly underrepresented in leadership positions in both the public and private sectors, further influencing the existing wage gap.

Figure 36. Unadjusted gender gap in median earnings of full-time employees, 2010–2014



Source: OECD Family Database.

Unpaid care work is both an important aspect of economic activity and an indispensable factor contributing to the well-being of individuals, families and societies. As the region’s societies age, middle-aged women tend to be the first responders to informal care needs of older persons, while looking after one or more dependent children and combining paid employment. The combination of these three roles can have detrimental effects on their health and well-being, but also on their careers and accumulated savings and pension entitlements.

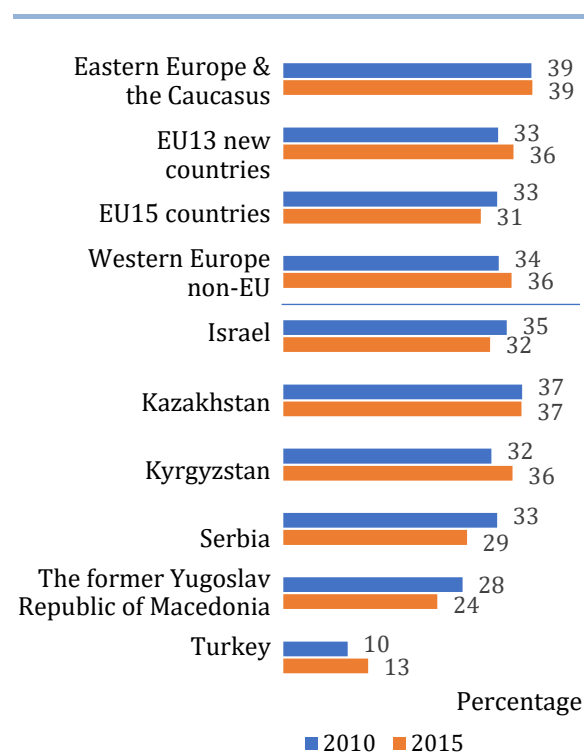
Research on the factors behind the gender pay gap in the EU show that two thirds of the gender pay gap cannot be attributed to the differences in average characteristics of working men and women—such as age, education, occupation, industry affiliation, part-time or temporary employment, job tenure, firm size or employment in the private versus the public sector—and that an important part of the unexplained gender pay gap is likely to be caused by women taking career breaks following childbirth.¹⁶²

Governments and the private sector can play a key role in reversing these trends. The former can enact policies that support affordable access to quality childcare to enable a greater proportion of women to enter or re-enter the workplace, in addition to ensuring both paid maternity and paternity leave and equal pay for equal work. The latter can capitalize on technological advancements and promote flexible working arrangements that enable workers to balance professional and family responsibilities, as well as accommodate the needs of pregnant and breastfeeding women.

Between 2010 and 2015, the proportion of women in managerial positions (SDG Indicator 5.5.2) remained lowest in the FYR of

Macedonia, Serbia and Turkey, where it increased from 13 to 15 per cent, and remained largely unchanged in the four subregions with representative data available (Figure 37). In contrast, this share increased in Latvia, from 42 to 44 per cent, and the Republic of Moldova, from 36 to 48 per cent, the two countries which were closest to achieving parity.

Figure 37. **Proportion of women in managerial positions, 2010–2015**



Source: ILO. UN Global SDG Database.

The way in which societies and policymakers address issues concerning care has important implications for the achievement of gender equality. In this regard, expanding the capabilities and choices of women and men across generations remains central, as detailed in Section 3.1.B below.

¹⁶² European Commission (2018) *Report on equality between women and men in the EU*. European Commission, Brussels, p.18–19.

B. Shortfalls in achieving work–life balance across generations

Achieving a successful and more gender-balanced reconciliation between family and work responsibilities in all life phases remains a challenge for men and women in the UNECE region. Overall, women continue to bear a heavier workload in family and household chores, besides working outside the home, and they often change their employment status, either by discontinuing it or by taking part-time jobs, to reconcile family and work life.

According to the UN DESA World Population Policies Database,¹⁶³ in 2015 most UNECE countries had adopted specific policy measures to improve work–life balance for childbearing and child-rearing, such as maternity and paternity leave, publicly subsidized childcare and flexible or part-time work hours for parents. Yet disparities in these entitlements continue to condition parents' work–life balance and influence their professional careers and childbearing decisions.

Research by the International Network on Leave Policies and Research (2017) covering 33 countries in the UNECE region found that leave entitlements around childbirth are focused on mothers and that only a few countries have introduced gender-sensitive leave entitlements that favour the involvement of fathers.¹⁶⁴ Twenty-eight Western and Central European and North American countries have a statutory and designated maternity leave entitlement with paid leave, mostly at a high earnings-related level. Only five countries allow mothers to transfer part of their maternity leave to fathers. While 22 out of these 33 Western and Central European and North American

countries have a statutory and designated paternity leave entitlement, in 14 of them it does not exceed two weeks.

While quality and affordable early childhood education and care enable parents to balance their careers and parenthood and improve children's learning outcomes, enrolment levels remain generally low in the subregions with available data. Between 2010 and 2014 the proportion of children aged 0–2 enrolled in formal childcare and pre-school increased from 9 to 13 per cent in the 13 new EU Member States, from 35 to 37 per cent in the EU15 countries and from 42 to 45 per cent in Western European countries without EU membership (OECD).

As the region's societies age, further work–life reconciliation needs emerge. Middle-aged workers, and women in particular, increasingly become first responders to the care needs of older generations, besides caring for their children and remaining engaged in the labour force. In turn, older workers and retirees play a key role in the provision of care to younger generations, as evidenced in Section 1.4.D.

Many UNECE countries remain far from achieving full equality in the sharing of domestic and care responsibilities between women and men. In all UNECE countries with data available for 2013–2015, women spent a higher proportion of time conducting unpaid domestic and care work than men (SDG Indicator 5.4.1), although levels of involvement and the gender distribution of such tasks vary to a certain degree (Figure 38).

Inequalities in the gender division of unpaid work are also captured by the Generations and Gender Survey's housework and childcare

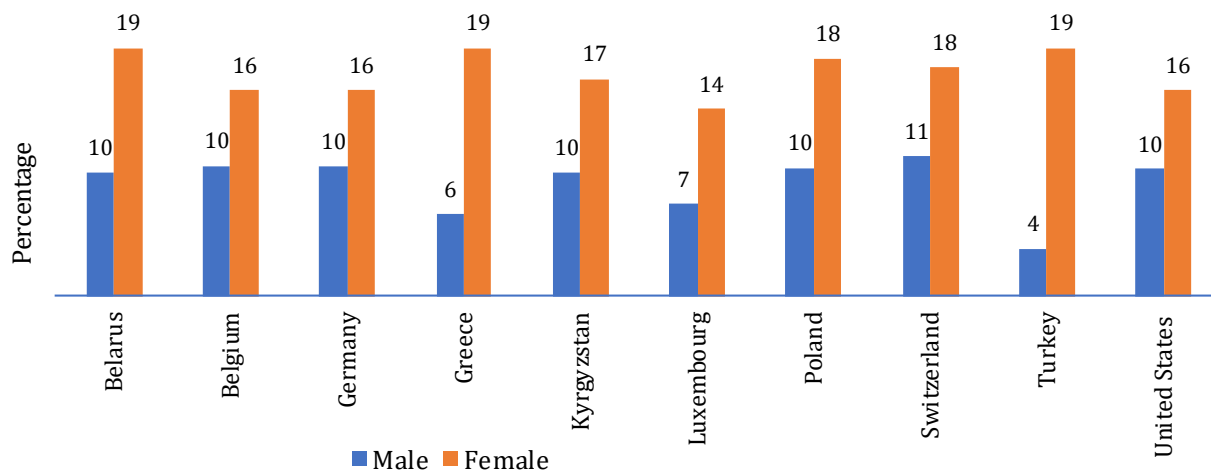
¹⁶³ United Nations Department of Economic and Social Affairs (2016) *World Population Policies Database*. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

¹⁶⁴ Blum, S. et al. (2017) *International Review of Leave Policies and Research 2017*. International Leave Network, pp.8–15. Available at: http://www.leavenetwork.org/lp_and_r_reports/.

indices of gender inequality. Findings reveal relatively high levels of inequality among most

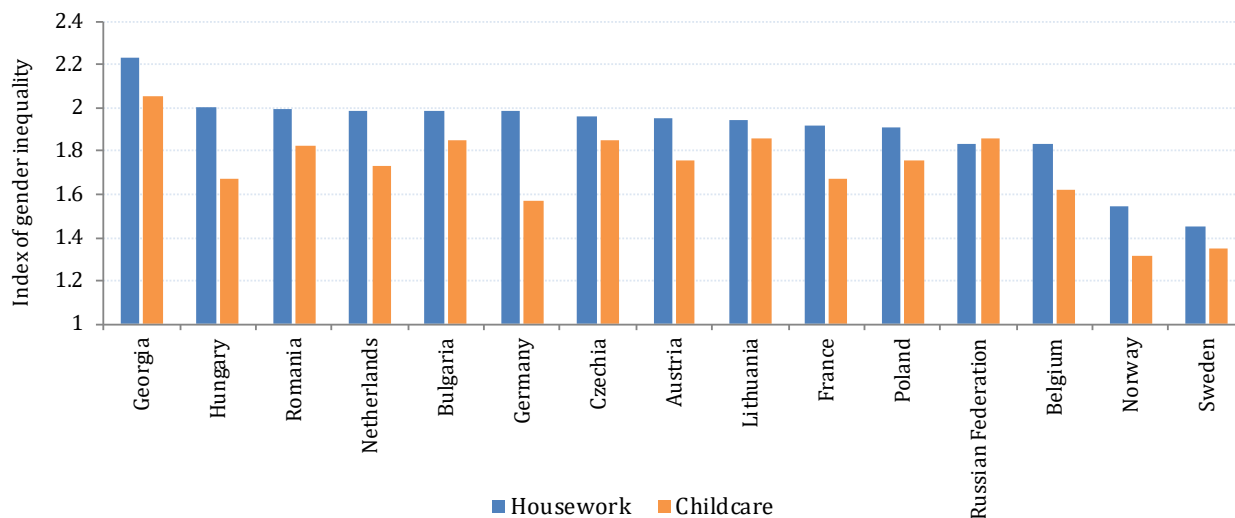
countries, and a more unequal gender distribution in housework than childcare.

Figure 38. **Proportion of time spent on unpaid domestic and care work, selected countries, 2013–2015**



Source: UN Statistics Division and UN Women. UN Global SDG Database.

Figure 39. **Housework and childcare indices of inequality**



Source: Generations and Gender Survey, wave 1

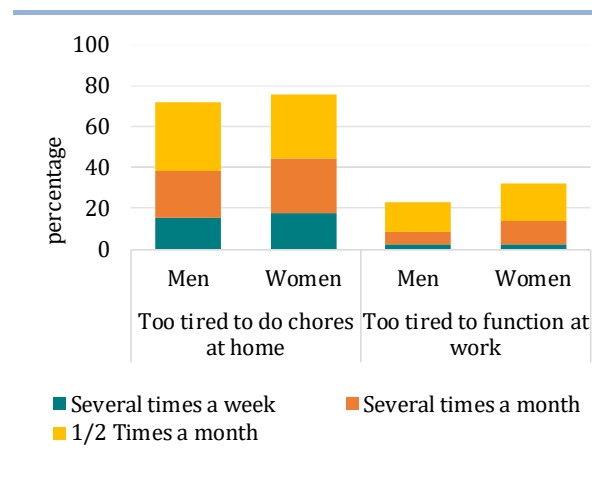
The gender gap in unpaid care work has significant implications for women’s ability to actively take part in the labour market, move to male-dominated employment sectors, attain

career goals and quality employment opportunities and accumulate higher pension entitlements. These imbalances also have repercussions on the ability of couples—and

particularly women—to conduct household chores and perform at work, as evidenced in Belarus, where women bear a larger share of housework and childcare than men (Figure 40).

Supporting women and men across generations in achieving a more gender-balanced reconciliation between family and work responsibilities requires a holistic approach, including the compensation of lost income during full-time care for children and older persons, the promotion of flexible working arrangements for employees with care responsibilities, the provision of quality and affordable early childhood education and care, the provision of non-transferrable paternity leave, and increased options for older persons who both receive care and provide care to young family members.

Figure 40. **Work–family balance among the working population in Belarus who live together with a partner**



Source: Generations and Gender Survey 2020, wave 1

Box 21. Working with men and boys to change gender stereotypes: Georgia and Ukraine

According to the Institute of Social Studies and Analysis (2014), only 18 per cent of men in **Georgia** performed everyday duties for their children under 6, such as preparing meals, changing clothes or diapers, bathing them, taking them to school or kindergarten, and entertaining or reading to them.¹⁶⁵

Georgia joined the MenCare Global Campaign in 2016, supported by UNFPA, the NGO We Care, Promundo, the Government of Sweden, the Georgian Football Federation and FC Locomotive. The campaign aims to raise awareness of the stereotypes related to masculinity, and the importance of sharing household responsibilities and supporting women’s SRHR. Various activities used in the campaign include: a day-long module of ‘Men Talking to Men’ interactive training sessions; public book reading sessions for children by famous male personalities, called ‘Daddy, Read me a Book!’; the ‘Father’s Football Cup’, encouraging fathers to coach both boys and girls in football; photo projects by famous photographers, entitled ‘Fathers of Tbilisi’; ‘Men for Equality’, featuring popular personalities challenging gender stereotypes; and ‘Lullaby for Lilly’, a children’s book about a family where the mother and father share the household duties and childrearing responsibilities equally.

Currently, in partnership with the Gender Equality Council of the Parliament of Georgia and the Human Rights Education and Monitoring Centre, a local NGO, UNFPA advocacy efforts focus on improving provisions for paternal and parental leave in Georgia by analysing successful models in other countries, generating recommendations for policy change and providing costing analysis.¹⁶⁶ In 2018, the MenCare

¹⁶⁵ UNFPA and Institute of Social Studies and Analysis (2014) *Men and Gender Relations in Georgia*. UNFPA, Tbilisi.

¹⁶⁶ UNFPA (2017) *Georgia Country Office Annual Report*. UNFPA, Tbilisi.

Georgia Campaign was included in Georgia's official programme at the Frankfurt Book Fair—as the Guest of Honour¹⁶⁷—and won the Emerging Europe Awards.¹⁶⁸

Using visuals, videos and advice material to target young couples, the '4 Hands Happiness' programme aimed to promote gender equality in **Ukraine** by fostering responsible fatherhood and the equal distribution of household chores.¹⁶⁹ A number of highly successful public events were organized, namely: 'Festival for happy families' to mark International Women's Day and Family Day in 2017, 'Daddy, Read to Me!' and 'Daddy, Dance and Kids'. The programme reached over 4 million people through social media and outdoor campaigns.

In addition, UNFPA established an official partnership with the football club Shakhtar Donetsk to promote gender equality, responsible fatherhood and non-violent communication in the family. Lastly, in close cooperation with the Ministry of Education and Science, as well as the Institute of Education Content Modernization, UNFPA conducted three 3-day training modules on the development of anti-discriminatory educational content in 2017 for textbook authors and representatives of publishing houses.

C. Increased women's political participation, yet far from parity

Women have the same right as men to participate in democratic governance and ensuring it is central to achieving inclusive and effective governance. Between 2010 and 2017 the proportion of seats held by women in national parliaments (SDG Indicator 5.5.1) increased from 20 to 24 per cent, yet no UNECE country has achieved full parity (Figure 41).

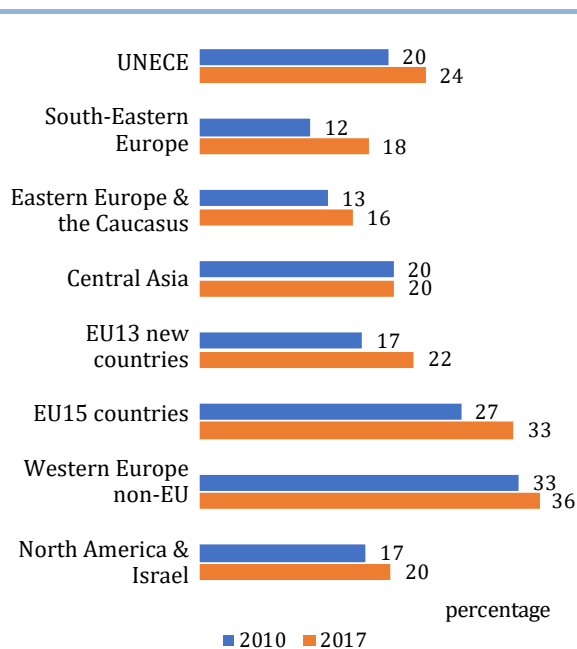
Progress was observed across all subregions except Central Asia, where this share remained unchanged (20 per cent). Between 2010 and 2017, remarkable increases were observed in Slovenia (from 15 to 37 per cent), while Finland (42 per cent), Iceland (48 per cent) and Sweden (44 per cent) remained closest to achieving parity in 2017. Achieving it requires the effective removal of discriminatory laws and practices, and addressing gender attitudes and stereotypes.

¹⁶⁷ Georgia (2018) Made by Characters – Press kit for the press conference at the Architekturmuseum Frankfurt, 8 May. Available at: <https://www.buchmesse.de/files/media/pdf/press-georgia-guest-of-honour-frankfurt-book-fair.pdf>.

¹⁶⁸ "Emerging Europe Recognises Its Champions at London Awards Ceremony", Emerging-Europe.com, 27 June 2018. Available at: www.emerging-europe.com/in-brief/emerging-europe-recognises-its-champions-at-london-awards-ceremony/; and "Winners", Emerging Europe Awards 2018. Available at: www.awards.emerging-europe.com/winners/.

¹⁶⁹ ZAGS official website: <http://zags.org.ua/>.

Figure 41. Proportion of seats in national parliaments held by women, 2010–2017



Source: UN Women and Inter-Parliamentary Union. UN Global SDG Database.

D. The inescapable challenge of eliminating gender-based violence

GBV and discrimination continue to plague the region’s societies, impacting a large proportion of women and girls, taking several forms—including physical, sexual, psychological and economic violence—and occurring in different contexts within the private and public spheres.

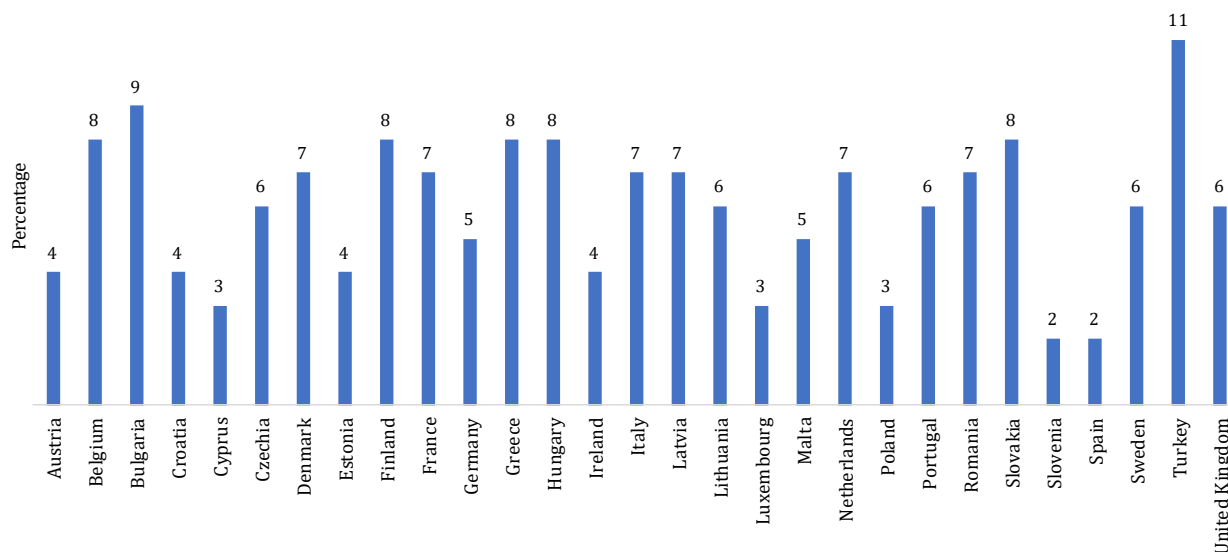
The proportion of ever-partnered women and girls aged 15–49 subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months (SDG Indicator 5.2.1) remains unacceptably high among UNECE countries with available data for 2012–2014 (Figure 42), making this form of violence against women and girls one of the most prevalent forms of human rights violations.

Box 22. Convention on Preventing and Combating Violence Against Women and Domestic Violence

The **Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention)** opened the door to creating a legal framework at the pan-European level to protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence. The Convention has a strong focus on prevention, requiring Parties to train professionals in close contact with survivors, regularly run awareness-raising campaigns, take steps to include issues such as gender equality and non-violent conflict resolution in interpersonal relationships in teaching material, set up treatment programmes for perpetrators of domestic violence and for sex offenders, and involve the media and the private sector in eradicating gender stereotypes and promoting mutual respect, among other measures.

One of the Convention’s many achievements is the definition and criminalization of the various forms of violence against women as well as domestic violence, mandating Parties to introduce a number of new offences where they do not exist. It also established a specific monitoring mechanism (‘GREVIO’) to ensure effective implementation of its provisions by the Parties. It entered into force on 1 August 2014 following 10 ratifications, including the 8 required by Council of Europe member States. Currently, 45 UNECE member States are signatories to the Convention, 32 of which have ratified it.

Figure 42. Proportion of ever-partnered women and girls aged 15–49 subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, 2012–2014



Source: UN Women, UNICEF, UN Statistics Division, WHO and UNFPA. UN Global SDG Database.

National-level studies indicate that some countries in the eastern part of the region have some of the world’s highest rates of intimate partner violence. For example, 58.3 per cent of women in Tajikistan and 41.9 per cent in Turkey reported that they had experienced some form of physical and/or sexual violence by a partner.¹⁷⁰

Intimate-partner violence is deeply rooted in gender inequality and violates women and girls’ right to physical and emotional integrity. Besides severely impacting their physical and mental health and well-being, intimate partner violence is also associated with an increased risk of STI infection, higher rates of induced abortion and poor birth outcomes, including low birth weight and pre-term births, and entails short- and long-term costs for health systems and economies.¹⁷¹

Cultural acceptance of violence—especially in the family but also in society as a whole—remains high. Patriarchal attitudes and stereotypes of the perceived role of women in society are common across the region, and such attitudes, beliefs and behaviours are entrenched in deeply rooted social norms. Furthermore, a re-emerging conservatism regarding stereotyped gender norms and roles of women and men has been observed in the eastern part of the region and has contributed to the reinforcement of strict gender roles.¹⁷² Although most individuals in all UNECE countries with available data believe that it is never justifiable for a man to beat his wife, significant subregional differences prevail (Figure 43).

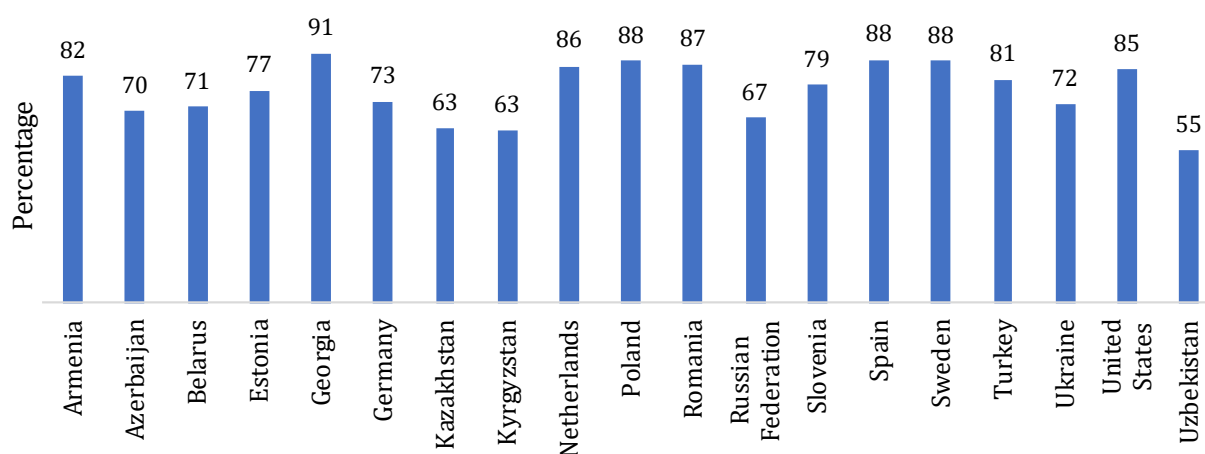
¹⁷⁰ UNFPA (2016) *Combating Violence Against Women and Girls in Eastern Europe and Central Asia. Issue Brief 6*. UNFPA EECARO, Istanbul.

¹⁷¹ United Nations (2014) *Framework of Actions for the Follow-up to the Programme of Action of the*

ICPD Beyond 2014 Report of the Secretary-General A/69/62. United Nations, New York.

¹⁷² UNFPA (2016) *Combating Violence Against Women and Girls in Eastern Europe and Central Asia. Issue Brief 6*. UNFPA EECARO, Istanbul.

Figure 43. Proportion of individuals who believe that it is never justifiable for a man to beat his wife, 2010–2014



Source: World Values Survey Database, wave 6.

Besides redressing deeply rooted negative gender attitudes, values and stereotypes, the elimination of GBV requires strengthening legislative and policy frameworks to prevent, investigate and punish acts of GBV within and outside the family, and providing support to survivors, including counselling and health, psychosocial and legal services.

According to UNICEF (2014), despite legal advances in many European and Central Asian countries, further efforts are required to translate legislations from *de jure* into *de facto* measures that will measurably and sustainably impact the prevention and elimination of GBV.¹⁷³ The report highlights that in CEDAW concluding observations for

many European and Central Asian countries, ensuring the awareness of, agreement with and willingness to implement existing laws remains a major challenge among professionals in the law enforcement field, as does their lack of training.

The report also stresses that interministerial collaboration tools such as regulations, protocols, guidelines instructions, directives and standards for the comprehensive, timely and coordinated response to and protection of survivors are largely absent, and that in the eastern part of the region, the lack of shelter for women subjected to violence remains a major concern, which contributes to underreporting of cases of violence.

¹⁷³ UNICEF (2014) *Preventing and eliminating violence against women and girls in the Europe and*

Central Asia region. Note by UNICEF to the ECE Beijing+20 Regional Review Meeting. UNICEF, Geneva.

Box 23. Addressing domestic violence recommendations from international treaty bodies

During the third cycle of the UPR, countries in the region reported on the accepted recommendations of the second cycle related to domestic violence.

Legal and policy developments on preventing and combating domestic violence

Finland,¹⁷⁴ Germany,¹⁷⁵ Ukraine,¹⁷⁶ Luxembourg,¹⁷⁷ Montenegro,¹⁷⁸ Romania¹⁷⁹ and Serbia¹⁸⁰ developed laws, strategies and action plans to combat domestic violence, many of which thereby incorporate the Istanbul Convention into national law. The Netherlands¹⁸¹ and the Russian Federation¹⁸² have indicated that they will do so in the near future. Policies include the development of protection and services for survivors of GBV and continuing training for experts in this field to enable them to offer appropriate support services, such as in Romania and Serbia. Turkmenistan¹⁸³ is analysing national legislation with a view to the possible adoption of a law criminalizing violence and to conduct research on the prevalence, causes and consequences of all forms of violence against women, including domestic violence. France¹⁸⁴ is implementing a proactive criminal policy to combat violence against women. The designation in each prosecutor's office of a contact judge for domestic violence ensures careful treatment of reports of people at risk of domestic violence.

¹⁷⁴ UNHRC, Working Group on the Universal Periodic Review (2017) *A report on the implementation of the recommendations by the Government of Finland- Annex. A/HRC/WG.6/27/FIN/1*. United Nations, Geneva, para.9.

¹⁷⁵ UNHRC, Working Group on the Universal Periodic Review (2018) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Germany. A/HRC/WG.6/30/DEU/1*. United Nations, Geneva, para.48.

¹⁷⁶ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Ukraine. A/HRC/WG.6/28/UKR/1*. United Nations, Geneva, para.110.

¹⁷⁷ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Luxembourg. A/HRC/WG.6/29/LUX/1*. United Nations, Geneva, para.48.

¹⁷⁸ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Montenegro. A/HRC/WG.6/29/MNE/1*. United Nations, Geneva, para.52–53.

¹⁷⁹ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Romania - Report of the Office of the United Nations High Commissioner for Human Rights. A/HRC/WG.6/29/ROU/3*. United Nations, Geneva, para. 89.

¹⁸⁰ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Serbia. A/HRC/WG.6/29/SRB/1*. United Nations, Geneva, para.149.

¹⁸¹ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Netherlands. A/HRC/WG.6/27/NLD/1*. United Nations, Geneva, para.37.

¹⁸² UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Russian Federation. A/HRC/WG.6/30/RUS/1*. Geneva, United Nations, para.81

¹⁸³ UNHRC, Working Group on the Universal Periodic Review (2017). *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Turkmenistan. A/HRC/WG.6/30/TKM/1*. United Nations, Geneva, para.189.

¹⁸⁴ UNHRC, Working Group on the Universal Periodic Review (2017). *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - France. A/HRC/WG.6/29/FRA/1*. United Nations, Geneva, para.100.

Implementation

In various countries over recent years, support services have been set up for survivors of domestic violence, where they can obtain *inter alia* social, psychological and legal support. Finland and Montenegro reported on the implementation of these services in their UPR. Training programmes for the police and representatives of the judiciary are being offered in Canada¹⁸⁵ and Montenegro, and in Switzerland¹⁸⁶ for both survivors and perpetrators. Poland reported that awareness-raising about domestic violence among the general public is being implemented and that the skills of the services responsible for tackling domestic violence are being improved.¹⁸⁷ Azerbaijan¹⁸⁸ set up a special database with information from various government agencies and rehabilitation centres for survivors of domestic violence.

Implementation challenges

Human Rights Committees, NGOs and other stakeholders, while often appreciating the legislative and policy changes made, remain concerned about domestic violence being widespread in the region. They observed the problem of underreporting¹⁸⁹ and the lack of adequate data on domestic violence.¹⁹⁰ In other cases, they reported challenges in the support system, such as the availability of shelters for survivors¹⁹¹ and challenges in the justice system.¹⁹² They also shared their concern that in some countries, domestic violence is not criminalized.¹⁹³

¹⁸⁵ UNHRC, Working Group on the Universal Periodic Review (2018). *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Canada, Annex. A/HRC/WG.6/30/CAN/1*. United Nations, Geneva, para.24.

¹⁸⁶ UNHRC, Working Group on the Universal Periodic Review (2017). *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Switzerland. A/HRC/WG.6/28/CHE/1*. United Nations, Geneva, para.17.

¹⁸⁷ UNHRC, Working Group on the Universal Periodic Review (2017). *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Poland. A/HRC/WG.6/27/POL/1*. United Nations, Geneva, para.116.

¹⁸⁸ UNHRC, Working Group on the Universal Periodic Review (2018) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 - Azerbaijan. A/HRC/WG.6/30/AZE/1*. United Nations, Geneva, para. 167.

¹⁸⁹ UNHRC, Working Group on the Universal Periodic Review (2018) *Compilation on Germany. A/HRC/WG.6/30/DEU/2*. United Nations, Geneva, para.59; UNHRC, Working Group on the Universal Periodic Review (2018) *Summary of stakeholders' submissions on Germany. A/HRC/WG.6/30/DEU/3*. United Nations, Geneva, para.82; and UNHRC, Working Group on the Universal Periodic Review (2018) *Compilation on Switzerland. A/HRC/WG.6/28/CHE/2*. United Nations, Geneva, para.44.

¹⁹⁰ UNHRC, Working Group on the Universal Periodic Review (2018) *Compilation on Turkmenistan. A/HRC/WG.6/30/TKM/2*. United Nations, Geneva, para.66.

¹⁹¹ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Finland. A/HRC/WG.6/27/FIN/3*. United Nations, Geneva, para. 25; and UNHRC, Working Group on the Universal Periodic Review (2018) *Compilation on Germany. A/HRC/WG.6/30/DEU/2*. United Nations, Geneva, para. 83.

¹⁹² UNHRC, Working Group on the Universal Periodic Review (2017) *Compilation on Montenegro and Summary of stakeholders' submissions on Montenegro. A/HRC/WG.6/29/MNE/2-3*. United Nations, Geneva, para.61–54; and UNHRC, Working Group on the Universal Periodic Review (2017) *Compilation on Switzerland. A/HRC/WG.6/28/CHE/2*. United Nations, Geneva, para. 44.

¹⁹³ UNHRC, Working Group on the Universal Periodic Review (2018) *Compilation on Russian Federation and Summary of stakeholders' submissions on Russian Federation. A/HRC/WG.6/30/RUS/2-3*. United Nations, Geneva, para.66–58; and UNHRC, Working Group on the Universal Periodic Review (2018) *Compilation on Uzbekistan and Summary of stakeholders' submissions on Uzbekistan. A/HRC/WG.6/30/UZB/2-3*. United Nations Geneva, para.74–63.

Box 24. Establishment of a national inter-agency database for gender-based violence: Azerbaijan

In 2016, the Government of Azerbaijan, in partnership with UNFPA Azerbaijan, developed an inter-agency online GBV database to improve institutional response capacity, internal accountability and performance monitoring.¹⁹⁴ The State Committee for Family, Women and Children's Affairs (SCFWCA) acts as the administrator of the database, while other government agencies and NGOs act as the users. Training was organized for 43 database users from relevant ministries, executive offices and NGOs to ensure that they correctly input information on all reports of GBV received.¹⁹⁵ According to the SCFWCA, almost 1,200 new cases have been recorded since operationalization.

Box 25. Criminalizing all non-consensual sexual acts: Austria

Austrian criminal legislation gives effect to most provisions of the Istanbul Convention. Several of these existed well before the Convention came into existence, but Austria was one of the first parties to adapt its criminal law to include the criminalization of all non-consensual sexual acts. A provision on "violation of sexual integrity" was introduced with effect from January 2016, covering instances of sexual intercourse or equivalent conduct "against the will of a person", "under coercive circumstances" or "following an act of intimidation".¹⁹⁶ Since the amendments to the law came into effect, charges for "butt grabbing" (Po-Grapsch-Paragraf) increased by about more than one third, from 242 cases reported in 2015 to 329 between January and October 2016.

Box 26. Building robust, multisectoral responses to gender-based violence

In Eastern Europe and Central Asia, the UNFPA Regional Office, in partnership with the Eastern European Institute for Reproductive Health, introduced the multi-country Programme on Coordinated Multisectoral Response to GBV. As a result, the UN Essential Services Standards for services for women and girls who are subjected to GBV has been institutionalized in a number of countries.

In **Belarus**, with support from UNFPA, the Ministries of Interior, Health and Labour and Social Protection developed policy guidelines to set up a coordinated multisectoral response to GBV at both national and subnational levels. To adjust the content to the practical context and needs, the policy guidelines were piloted at subnational levels.

¹⁹⁴ UNFPA (2017) "UNFPA on Azerbaijan's population growth, healthcare, labour force, youth issues".

Available at:

<http://azerbaijan.unfpa.org/en/news/unfpa-azerbaijans-population-growth-healthcare-labor-force-youth-issues>.

¹⁹⁵ USAID Project Report for UNFPA implemented GBV project in Azerbaijan (2016–2018).

¹⁹⁶ Based on: Group of Experts on Action against Violence against Women and Domestic Violence (GREVIO) (2017)

Baseline Evaluation Report. Council of Europe, Strasbourg, and European Commission (2017) *Report on equality between women and men in the EU*. European Commission, Brussels.

In light of the State Programme '**Kazakhstan** without Violence in the Family', the local government of South Kazakhstan, with support from UNFPA, adapted international principles and guidelines for the provision of services to survivors of GBV to the local context and tested them. Based on this experience, Standard Operating Procedures for the police, health professionals, psychologists and social workers were developed. The Ministries of Health, Labour and Social Protection and Internal Affairs also developed their institutional strategies on how to implement Standard Operating Procedures on the provision of services to survivors of domestic violence.

The new Domestic Violence Law adopted in 2017 in **Kyrgyzstan** includes measures to improve protections for survivors of domestic abuse and to strengthen police and judicial responses. To put into practice and enforce these new measures, in November 2017 the Ministry of Internal Affairs, with sustained technical support from UNFPA over two years, adopted sectoral policy documents that integrated all the relevant international principles and procedures on responding to and preventing GBV. Specific tools for health professionals on how to register health outcomes of domestic violence and how to report them to the police are also part of the regulatory package.

Two key national strategic documents on domestic violence were developed for the health and social sectors in the **Republic of Moldova** with the technical support of UNFPA. These documents ensure that the services provided to GBV survivors will be human rights-centred and in line with international principles and procedures. The process continued with the validation of the strategic frameworks by the government through the Ministry of Health, Labour and Social Protection, and piloting them in five districts of the country. UNFPA developed a monitoring tool to assess the implementation framework and improve standards to meet women and girls' needs. The process of developing these key documents was facilitated by the government's adoption in February 2018 of the National Strategy on prevention and combating violence against women and domestic violence for 2018–2023. The Strategy is aligned with the Istanbul Convention, which sets the standards for preventing GBV, protecting survivors of violence and punishing perpetrators.

The local government in Eastern **Ukraine** recognized a comprehensive and coordinated response to GBV as being critical to tackling the phenomenon. The process of setting up specialized services for survivors accompanied the development of subnational policy recommendations based on the Global Essential Services Package and regional Standard Operating Procedures. Policy guidelines on how to develop and implement a multisectoral response to GBV, as well as recommendations for the psychosocial sector, with a focus on intervention/service provision and referral, were adopted in three administrative districts of Ukraine.

Box 27. Private sector engagement to improve women's working environment and raising awareness on domestic violence: Turkey

The Business Against Domestic Violence project was launched in 2013, led by Sabancı University Corporate Governance Forum, in close cooperation with the Turkish Industrialists' and Businessmen's Association (TUSIAD), UNFPA and Sabancı Foundation, to introduce response mechanisms in the workplace to address domestic violence. The project aims to collaborate with CSOs and responsible state partners to raise awareness about women's rights in business and equip companies to be able to play an active role in practising gender equality by creating enabling working environments.

The project first focused on identifying the root causes of domestic violence through a survey at 20 companies in Turkey to determine the extent to which white-collar working women in the country remained subject to domestic violence, to measure the awareness of employees concerning domestic violence, and identify whether businesses had support policies in place. The survey results showed that

working women had little awareness about intimate partner violence and did not want to share their situation with their employers in anticipation of negative consequences for their employment and career. They also showed that most companies do not have any policies related to domestic violence, and employees do not consider their companies when they seek help.

In 2016, companies such as Aygaz, Yeşim Tekstil and Aras Kargo developed policies to promote gender equality and combat domestic violence, and Garanti Bank established a hotline for its employees. In December 2016, a workshop was held for companies to launch their policies and share their experiences. In 2017, 14 new companies from Istanbul, Bursa, İzmir and Antalya developed company policies and internal awareness campaigns, a trend that is expected to continue in 2018.

E. Harmful practices remain of concern in some eastern societies

The prevalence of harmful practices such as gender-biased sex selection, early and forced marriages and female genital mutilation remain a concern in some countries in the eastern part of the region. Along with GBV, these practices result in deeply negative social and health impacts on women and girls, and deprive them of the agency to chart their own course in life.¹⁹⁷

Early and forced marriage is a human rights violation which persists in the eastern part of the region despite legal prohibitions. It hinders girls' rights to education, life and physical integrity, as the early childbearing that often accompanies it is more likely to result in complications during pregnancy or childbirth. During the period 2010–2016, the percentage of women aged 20–24 who were first married or in union before age 18 (SDG Indicator 5.3.1) was estimated at 11 per cent among 14 countries in the eastern part of the region (Figure 44).¹⁹⁸

According to the UN DESA World Population Policies Database, 4 of these 14 countries had not raised and/or enforced measures on the minimum age at marriage in 2015 (Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Kazakhstan and Ukraine).¹⁹⁹

Box 28. EU Resolution 'Towards an EU external strategy against child, early and forced marriages'

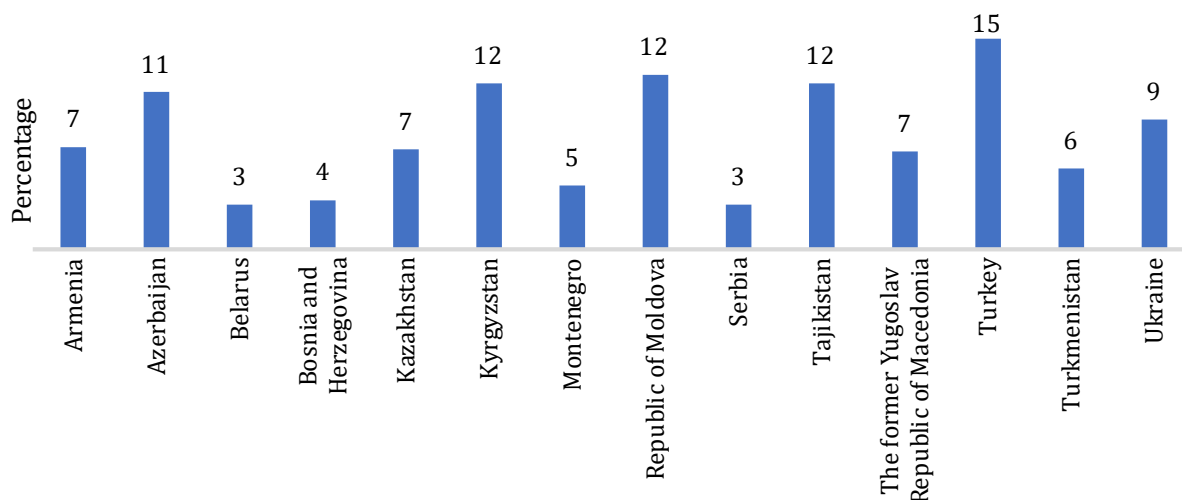
In July 2018, the European Parliament adopted the resolution 'Towards an EU external strategy against child, early and forced marriages', which calls on the EU, in the context of its foreign and development cooperation policies, to offer a strategic pact to its partners requiring that: all EU partner countries prohibit child, early and forced marriages, eliminate existing loopholes and enforce legislation in line with existing international human rights standards; this prohibition is respected and enforced in practice at all levels; the resources needed to achieve this objective are mobilized; the level of public development aid allocated to government authorities is made dependent on the recipient country's commitment to comply with human rights requirements, including the fight against child, early and forced marriages; the European Commission and its Member States support the SheDecides movement and pledge additional funding to international aid for SRH services; and the European Commission initiates a wide-ranging awareness-raising campaign and dedicates a European year to the fight against child, early and forced marriages.

¹⁹⁷ UNICEF (2018) *Progress for Every Child in the SDG Era*. UNICEF, New York.

¹⁹⁸ UNICEF (2018) *Child Marriage: Latest Trends and Future Prospects*. UNICEF, New York.

¹⁹⁹ United Nations Department of Economic and Social Affairs (2016) *World Population Policies Database*. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

Figure 44. **Proportion of women aged 20–24 who were first married or in union before age 18, 2010–2016**



Source: UNICEF. UN Global SDG Database.

A small number of countries in the region—including Azerbaijan, Armenia, Georgia, Albania and Montenegro—report skewed sex ratios at birth due to a strong preference for sons. Three factors emerge as key contributors to gender-biased sex selection: the existence of entrenched social and family norms favouring male children, the emergence of modern reproductive technologies, and the effect of low fertility on reproductive strategies among couples.²⁰⁰

This practice has far-reaching negative consequences, as it endangers the health and rights of women and girls, perpetuates a culture of gender inequality and jeopardizes sustainable development and stability. In addition, it carries demographic implications

such as the creation of age-structure imbalances.

²⁰⁰ UNFPA (2015) *Preventing gender-biased sex selection in Eastern Europe and Central Asia. Issue Brief 4*. UNFPA EECARO, Istanbul.

²⁰¹ Gupta et al. (2018) *Exploring Harmful Practices of Early/Child Marriage and FGM/C in Georgia*

Lastly, a recent qualitative study by the National Center for Disease Control and Public Health of Georgia and Promundo (2017) revealed that most older women of Avar ethnicity in Kakheti had either undergone female genital mutilation or heard of it.²⁰¹

While they acknowledged that their granddaughters were not presently circumcised, a focus group discussion with key informants indicated that female genital mutilation remains a crucial part of the Avar ethnic identity and might be practised clandestinely. Respondents noted that female genital mutilation continued to be seen as a ritual, much like baptism, where one’s Muslim religious identity is closely associated with the practice.

Results from a Qualitative Research. Georgia National Center for Disease Control and Public Health, Promundo US, UNFPA and UNICEF, Tbilisi and Washington, DC.

Box 29. Addressing gender-biased sex selection with advocacy and cutting-edge evidence

Sex ratios at birth (SRB) normally range from 102 to 106 boys per 100 girls, yet in **Armenia** they remained as high as 120 boys per 100 girls in the early 2000s and stabilized at 114 in the early 2010s.²⁰² The Global Programme to Prevent Son Preference and the Undervaluing of Girls was officially launched in 2016 to address son preference and combat gender-biased sex selection in Armenia, Georgia and Azerbaijan. Funded by the EU and implemented by UNFPA, the programme conducted several capacity-building events targeting government officials, national research institutions and medical personnel. Advocacy efforts included a partnership with World Vision Armenia via multiple area development programmes located in almost all regions of the country.

In 2015 the Government of Armenia, with support from UNFPA and local organizations, had developed and approved a programme to prevent gender-biased sex selection for 2015–2017, to be continued in a new programme for 2018–2022 to be finalized soon. As a result of the wide-scale work conducted by the government and international and local development partners over past years, the SRB dropped from 114 boys per 100 girls in 2010 to 110 boys per 100 girls in 2017.²⁰³ Between 2011 and 2016, the proportion of families voicing a desire for a boy declined from 45 to 13 per cent, and that of families reporting an equal preference for a boy or a girl increased from 47 to 82 per cent.²⁰⁴

Azerbaijan has the second highest SRB in the world, with evidence showing a steady increase between 1990 and 2017, from 105–106 males to 114 males for every 100 females.²⁰⁵ The Government of Azerbaijan, in close partnership with UNFPA, conducted a qualitative and quantitative analysis of the factors that led to skewed SRB, revealing that preferential treatment of male children, combined with rising levels of infertility, and the advent of modern technologies enabling sex determination played a central role in skewing SRB over recent decades.²⁰⁶ Provisions for addressing the issue were included in the draft State Programme on Population Development and Demography (currently pending endorsement). And the government, with the support of UNFPA, invited international experts to assist with drafting a National Action Plan. UNFPA efforts also focus on supporting young men and future fathers to promote the value of the girl child, through a project funded by the Embassy of the Netherlands.

²⁰² NSS Armenia:

www.armstat.am/file/article/sv_12_10a_520.pdf.

²⁰³ NSS Armenia: www.armstat.am/file/article/sv_12_17a_6200.pdf.

²⁰⁴ Monitoring Report, ICHD 2017.

²⁰⁵ UNFPA (2014) *Mechanisms behind the Skewed Sex Ratio at Birth in Azerbaijan: Qualitative and Quantitative Analyses*. UNFPA, Baku, p.29–30.

²⁰⁶ *Ibid.*

3.2. Poverty and socio-economic inequalities

- The region's at-risk-of-poverty rate declined from 29 to 24 per cent between 2010 and 2016, yet children, single-mothers and older women are still more likely to face poverty and experience greater inequalities.
- In 2014, income inequality as measured by the Gini coefficient remained lowest in Western European countries without EU membership (27) and Central Asian countries (28), and highest in Eastern European and the Caucasus (36) and South-Eastern Europe (41). The income share of the poorest 20 per cent of the population in the UNECE region remained at 7 per cent.
- Gender differentials in the risk of poverty or social exclusion remain small between young and middle-aged men and women, but they increase at older ages, reflecting the cumulative impacts of lifetime inequalities disadvantaging women, particularly in the field of economic participation.
- Alongside universal and equitable access to quality services, social protection systems that adopt a life-course approach remain central to mitigating the impacts of poverty and breaking inequality cycles.

The *2013 Chair's summary* highlighted increased educational levels as an important tool in fighting unemployment and poverty. Poverty is, indeed, the epitome of the failure to invest in individual capabilities. It is the result of and perpetuates cycles of exclusion and inequality, limiting individuals' ability to achieve their full potential.

Its representations include the lack of access to quality education and health care, including SRH care, exposure to violence and discrimination, and lack of political participation, affecting different population groups in different ways. Eradicating poverty and breaking cycles of inequality require

ensuring universal and equitable access to quality services, and extending social protection to all citizens, particularly the most vulnerable.

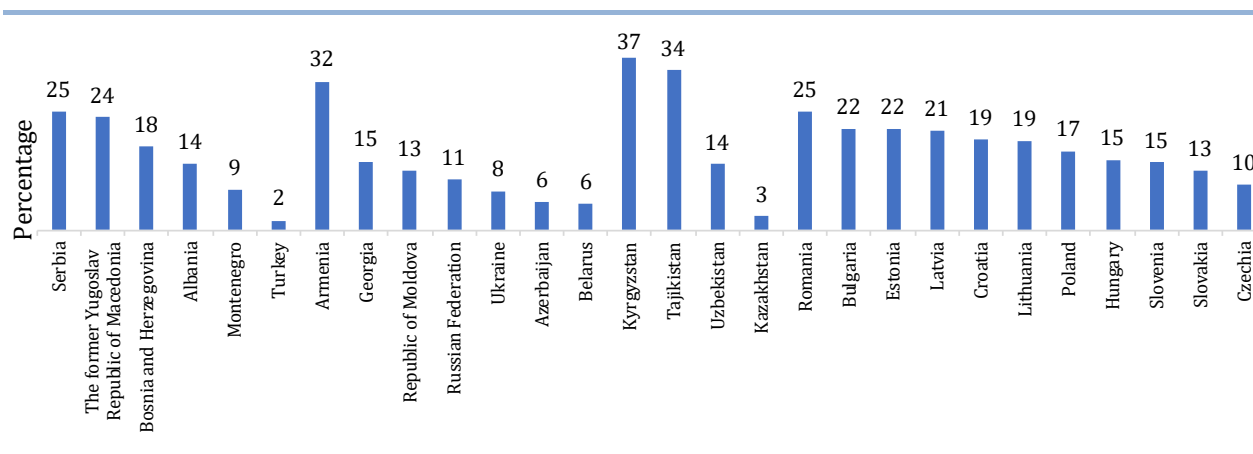
A. Poverty declines mask women's, children's and single parents' vulnerability

Poverty eradication (SDG1) is a prerequisite for all individuals to fully exercise their human rights and for societies to achieve sustainable development. For individuals experiencing it, poverty can be a long-lasting or a temporary condition, with many living narrowly above or below the threshold.

The proportion of the population living below the national poverty line (SDG Indicator 1.2.1) is available for countries in the eastern part of the region for the period 2012–2013 (Figure 45). It remained highest in Kyrgyzstan (37 per cent), Tajikistan (34 per cent) and Armenia (32 per cent), and lowest in Azerbaijan (6 per cent), Belarus (6 per cent), Kazakhstan (3 per cent) and Turkey (2 per cent).

Monetary poverty measures, however, do not fully reflect the diversity in the living conditions across the region's countries, evidencing the need to complement them with estimates of material deprivation. The at-risk-of-poverty rate decreased slightly from 24 to 23 per cent during 2010–2016 in EU and Western European non-EU member States. Aggregate trends, however, mask a higher impact on women and children (Figure 46). During this period, the share of women at risk of poverty or social inclusion increased the most in Greece (from 29 to 37 per cent), Cyprus (from 26 to 29 per cent) and Estonia (from 22 to 27 per cent). In contrast, Latvia achieved remarkable decreases in the proportion of women and persons under 16 at risk of poverty or social inclusion between 2010 and 2016, from 39 to 31 per cent and from 42 to 24 per cent, respectively.

Figure 45. Proportion of the population living below the national poverty line, 2012–2013



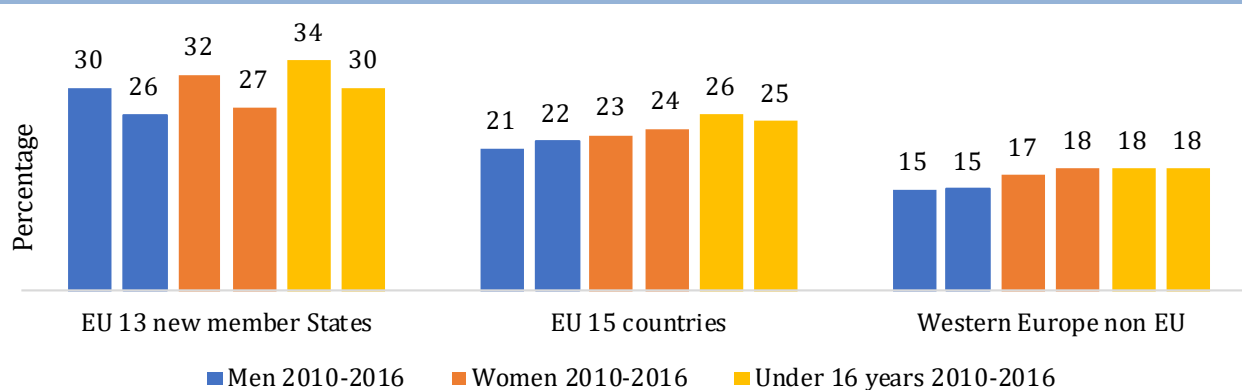
Source: World Bank. UN Global SDG Database.

Gender differentials in the risk of poverty or social exclusion remain small between young and middle-aged men and women, but they increase at older ages. This reflects the cumulative impacts of lifetime inequalities, particularly in the field of economic participation. Underemployment and earlier retirement in comparison to men, increased participation in low-paid, part-time and precarious employment, career breaks to bear

and raise children, and the burden of unpaid domestic and care work are factors that limit women’s economic independence and lead to reduced pension entitlements after retirement.²⁰⁷

As sole income earners, single parents also face a higher risk of poverty or social exclusion, even if employed. In various UNECE

Figure 46. Proportion of the population at risk of poverty or social exclusion, men, women and persons under 16 years, 2010–2016

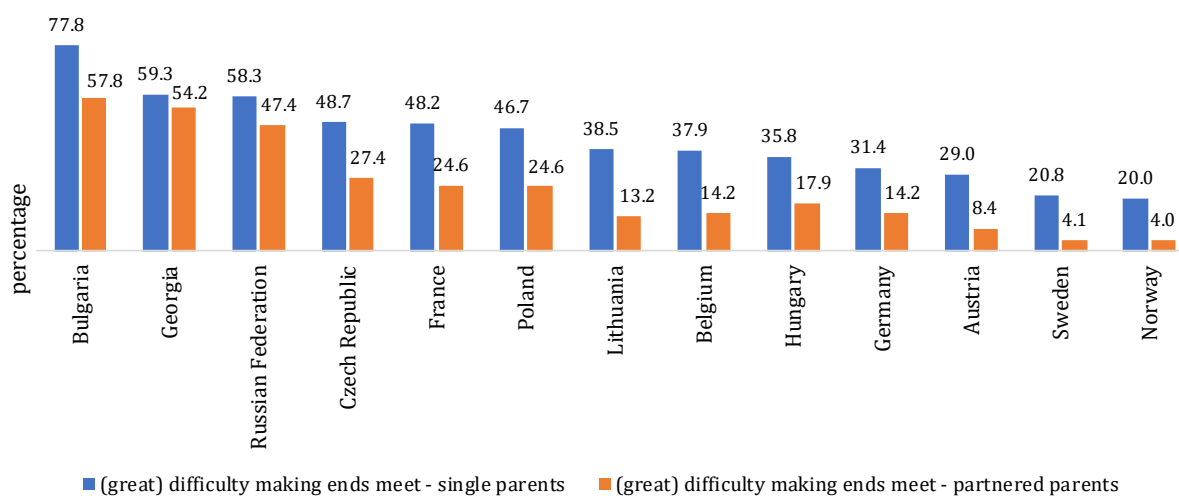


Source: Eurostat. European Union Statistics on Income and Living Conditions

²⁰⁷ EIGE (2017) *Poverty and gender over the life cycle: Review of the implementation of the Beijing*

Platform for Action. European Institute for Gender Equality, Vilnius.

Figure 47. **Difficulty in making ends meet among single and partnered parents with children younger than 14 living in the household**



Source: Generations and Gender Survey, wave 1

countries, they remain at least twice as likely to face great difficulties in making ends meet than partnered parents (Figure 47).

Among single parents, single mothers remain significantly impacted. The European Institute for Gender Equality (EIGE) estimated that single mothers headed 85 per cent of single-parent households in the EU in 2014, and that they remained exposed to a higher risk of poverty or social exclusion than single fathers (48 per cent vs. 32 per cent).²⁰⁸

For approximately one in every three single mothers and fathers in the EU, their personal income from work was not enough to lift them above the national poverty line in 2016. In entering the job market, single mothers are at a disadvantage, engaging in flexible but lower-paid, insecure jobs to reconcile family and work life. Younger single mothers and single mothers with young children are the two groups of single parents participating the least in the job market.²⁰⁹

Children who are living in residential care institutions due to the inability of their families to care for them have a higher risk of experiencing poverty or social exclusion—an issue of relevance in the eastern part of the region. According to UNICEF, in 2014 the rate of children in residential care (per 100,000 population aged 0–17) was highest in the Czech Republic (1,218), followed by Kazakhstan (1,074), the Russian Federation (960) and Kyrgyzstan (950), while the lowest levels were observed in three South-East European countries—the former Yugoslav Republic of Macedonia (161), Albania (147) and Serbia (124)—as well as Georgia (141). The well-being of children in residential care can be improved by giving them the opportunity to be heard, particularly in the decision to leave residential care institutions, supporting them to retain family links where possible, and engaging them in the running of residential care institutions.²¹⁰

²⁰⁸ EIGE (2016) *Poverty, gender and lone parents in the EU Review of the implementation of the Beijing Platform for Action*. European Institute for Gender Equality, Vilnius.

²⁰⁹ Ibid.

²¹⁰ Council of Europe (2017) *Challenges to Children's Rights Today: What do Children Think?* Council of Europe, Strasbourg.

Lastly, realizing the right of persons with disabilities to live independently and be included in the community requires meaningful and sustainable deinstitutionalization. According to a recent report by the EU Agency for Fundamental Rights (2017), while most EU Member States have adopted deinstitutionalization strategies, some of them lack the adequate funding, clear time-frames and benchmarks, and the involvement of disabled persons' organizations required to make them effective.²¹¹ Moreover, few EU Member States have expressly committed to cease building new institutions or to stopping new admissions into existing institutions.

B. Breaking inequality cycles with universal and equitable access to quality services

Achieving equal opportunity and equitable outcomes is the basis for individual well-being and sustainable development. Inequalities in access to quality education, health, decent work and other sectors continue to trap many in poverty, limiting their contributions to society.

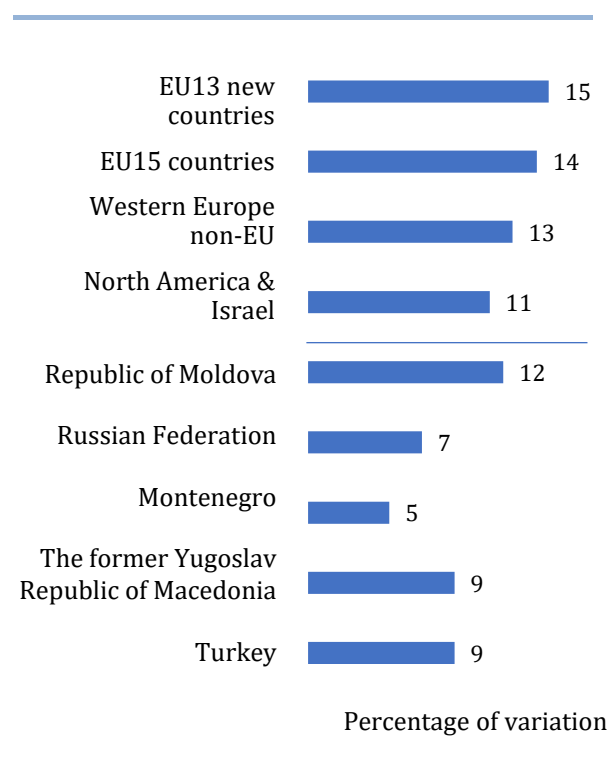
Ensuring universal and equitable access to quality services is thus one of the most effective means of breaking cycles of inequality. In this regard, the contribution of education systems in empowering individuals and developing their skills cannot be overstated, particularly during early childhood, adolescence and youth.

Since data on educational performance are available for most of the region's countries, the education sector can be used as an example to illustrate equality of opportunity in access to quality education by socio-economic factors such as household wealth and place of

residence to determine the equity and inclusiveness of national education systems.

The PISA science literacy test is used to measure the extent to which differences in individual students' results in the test can be attributed to their socio-economic status (Figure 48). Regionally, 12 per cent of the variation in individual student results in the test can be attributed to the students' socio-economic status. This percentage is as high as 15 per cent among the 13 new EU Member States and as low as 7 per cent in the Republic of Moldova, the Russian Federation and Ukraine. It is in this latter subregion where the benefits of schooling are most equitably shared among students from different socio-economic backgrounds, as measured by student performance.

Figure 48. **Variation in the PISA science performance explained by students' socio-economic status, 2015**



Source: OECD. PISA Data Explorer.

²¹¹ European Union Agency for Fundamental Rights (FRA) (2018) *From institutions to community*

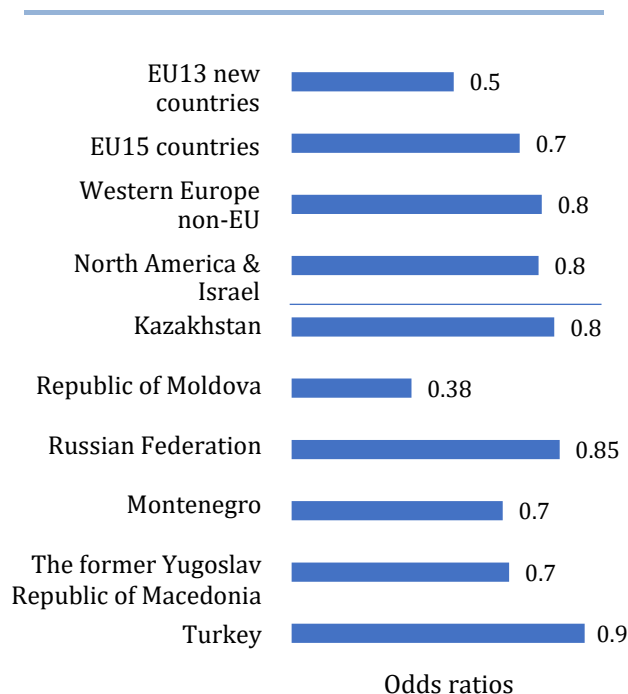
living - Part I: commitments and structures. FRA, Vienna, p.5.

Socio-economic status also shapes students' career expectations. On average, disadvantaged students in the UNECE region are least likely to expect a career in science relative to advantaged students, after accounting for performance based on the PISA 2015 questionnaire (odds ratio: 0.8) (Figure 49). In the 13 new EU Member States, disadvantaged students are half as likely to expect a career in science (odds ratio: 0.5).

UNESCO data on the rural-to-urban parity index for achievement in mathematics by the end of lower secondary education (SDG Indicator 4.5.1) for the period 2011–2012 showed stark differences in educational outcomes by place of residence, particularly in the eastern part of the region (Figure 50). Only in Denmark (1.02) and Italy (1.02) do rural students achieve better average mathematics outcomes than urban students.

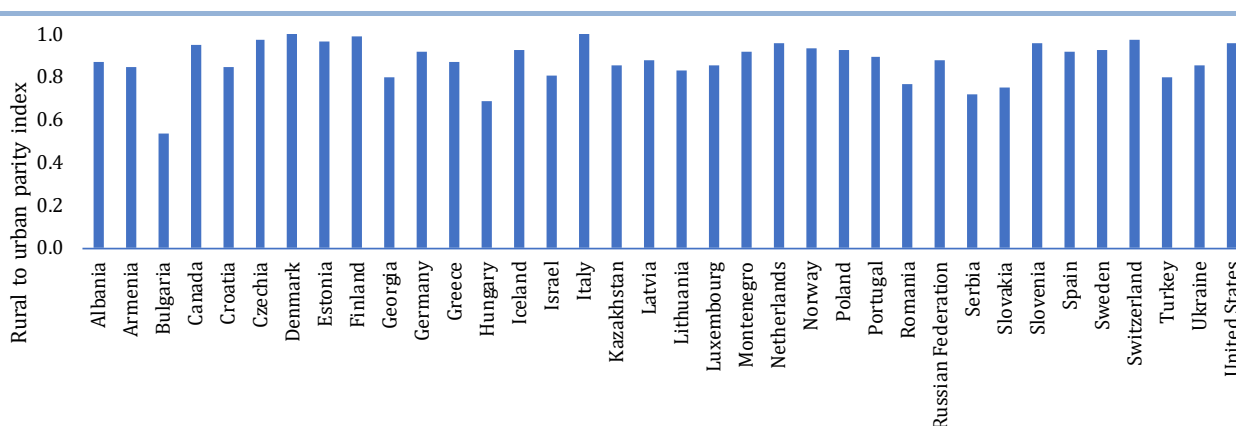
These results show that much remains to be done in the UNECE region to ensure equitable access to quality education. Targeting low performers from disadvantaged backgrounds as well as disadvantaged schools remain vital strategies to end segmentation by household

Figure 49. Disadvantaged students' likelihood of expecting a career in science (relative to advantaged students), after accounting for performance based on the PISA questionnaire, 2015



Source: OECD. PISA Data Explorer.

Figure 50. Rural-to-urban parity index for achievement in mathematics by the end of lower secondary education, 2011–2012



Source: UNESCO. UN Global SDG Database.

wealth or place of residence.²¹² If the root causes of income and social inequality remain unaddressed through education and skills formation over the life course, the cost of redistributive policies such as taxes and transfers is likely to be much higher.

More equality benefits not only poor people but societies as a whole. Countries with more in-country equality perform better on most social development indicators than countries with more inequality. Greater equality, therefore, makes the most difference among the poorest people, but also has positive effects for the middle class and the wealthiest people.²¹³

This holds true in the case of addressing inequalities in child well-being in the education sector and other domains which lead to an overall improvement of child well-being outcomes. Research in EU and OECD countries shows that children in countries that have managed to reduce inequalities in child well-being are healthier, more educated and satisfied with life, and less impacted by poverty than children living in countries with higher levels of inequality in child well-being.²¹⁴ Therefore, reducing inequalities across multiple sectors throughout the life course contributes to the well-being of present and future generations, ensuring equity and sustainability.

C. Extending social protection to those who are most vulnerable

The extension of social protection to all citizens—through a combination of social insurance and social assistance schemes—is contingent on domestic fiscal capacities, and indeed overall budget allocation varies

significantly across the region. However, targeting disadvantaged groups such as the poorest people and those who have lost their jobs is essential to guarantee their income security and avoid their households being pushed into—or further into—poverty.

Only five countries in Eastern Europe and the Caucasus have data available on the proportion of the poorest quintile of the population covered by social assistance programmes (SDG Indicator 1.3.1.e) during the period 2013–2014 (source: ILO). Coverage was highest in the Russian Federation (76 per cent), followed by Belarus (63 per cent) and Ukraine (58 per cent), and lowest in Armenia (40 per cent) and the Republic of Moldova (30 per cent). In contrast, most countries in the region have data available on the proportion of unemployed persons receiving unemployment benefits (SDG Indicator 1.3.1.a). During the period 2013–2016, the share of unemployed persons receiving unemployment benefits was as low as 8 per cent in Turkey and 9 per cent in Central Asia (Figure 51). Conversely, around two thirds of those unemployed in Western European countries without EU membership (62 per cent) and Eastern Europe and the Caucasus (65 per cent) were covered by unemployment insurance schemes.

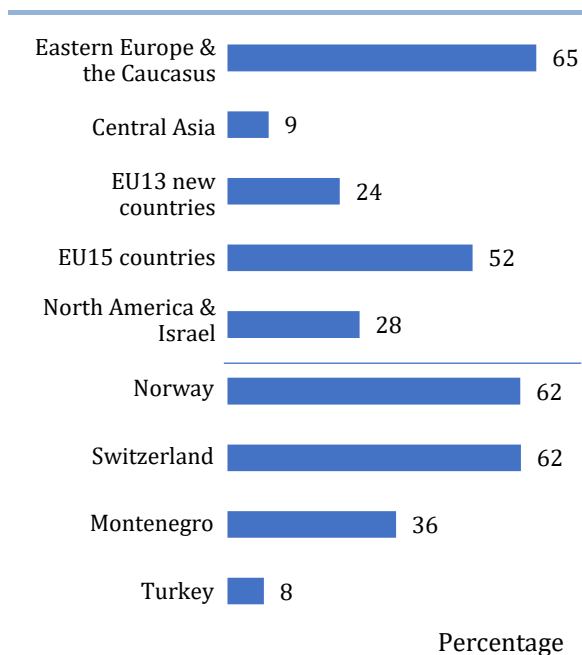
Along with universal and equitable access to quality services, social protection systems that adopt a life-course approach and target vulnerable individuals remain central to mitigating the impacts of poverty and generating more equal development.

²¹² OECD (2017) *Educational Opportunity for All: Overcoming Inequality throughout the Life Course*. OECD Publishing, Paris.

²¹³ UNICEF (2008) *The child care transition, Innocenti Report Card 8*. UNICEF Innocenti Research Centre, Florence.

²¹⁴ UNICEF (2016) *Fairness for Children: A league table of inequality in child well-being in rich countries, Innocenti Report Card 13*. UNICEF Innocenti Research Centre, Florence.

Figure 51. **Proportion of unemployed persons receiving unemployment benefits, 2013–2016**



Source: ILO. UN Global SDG Database.

3.3. Social inclusion of marginalized and vulnerable groups

- In 2015, the proportion of foreign nationals residing in UNECE countries amounted to 11 per cent, with a range from 23 per cent in Western European countries without EU membership to 3 per cent in the 13 new EU Member States.
- Policy efforts that support the integration of migrants are more common in EU15 countries. UNECE countries hosted over 17 per cent of the world’s estimated total of 25.9 million refugees and asylum seekers in 2016.
- In a number of countries, minority groups, including ethnic minorities such as the Roma, and persons with disabilities, continue to face persistent exclusion, material deprivation and inferior educational and health outcomes.

- Persons of diverse sexual orientation and gender identity continue to face stigma, discrimination and violence.

The *2013 Chair’s summary* called for equality before the law and non-discrimination for all persons in the exercise of their social, cultural, economic, civil and political rights. It emphasized the need to promulgate or enforce laws that punish any kind of discrimination, violence or hate crimes and take active steps to protect all persons, and marginalized groups in particular, from discrimination, stigma and violence.

The region still has much progress to achieve when it comes to ensuring social inclusion. A number of specific population groups continue to be at a disadvantage in accessing social services, enjoying the protection and exercise of their human rights and achieving their full potential in society. International migrants, refugees, ethnic minorities, persons with disabilities and persons of diverse sexual orientation and gender identity, among others, continue to endure multiple, overlapping forms of inequality and discrimination. Efforts combating these continue to be hampered by prevailing stigma and prejudice, affecting especially lesbian, gay, bisexual, transgender and intersex (LGBTI) people and PLHIV in most contexts (Figure 52).

National human rights institutions play a key role in addressing discrimination in all its forms, and in promoting and protecting the civil, political, economic, social and cultural rights of most vulnerable groups. They are an important link between government and civil society, since they contribute to bridging the protection gap between the rights of individuals and the responsibilities of the State. By 2016 most UNECE countries had established independent national human rights institutions in compliance with the Paris

Figure 52. Proportion of persons not willing to have homosexuals, persons living with HIV and people of a different race as neighbours, 2010–2014



Source: World Values Survey Database, wave 6.

Principles²¹⁵ (SDG Indicator 16.a.1), with the exception of Austria, Bulgaria, Cyprus, the former Yugoslav Republic of Macedonia, Kazakhstan, Kyrgyzstan, Montenegro, Republic of Moldova, Romania, Slovakia, Slovenia, Switzerland and Tajikistan.

In 2015, the proportion of foreign nationals residing in UNECE countries amounted to 11 per cent, with a range from 23 per cent in Western European countries without EU membership to 3 per cent in the 13 new EU Member States. While the diversity of international migration patterns impacts countries of origin, transit and destination in different ways, persistent anti-migrant sentiments and discriminatory practices against **international migrants** are widely observed.

Addressing deeply rooted social norms, as well as promoting equitable and inclusive legislative and policy practices in the education, health, employment, social security and housing sectors, among others, are necessary measures to combat discrimination against international migrants and expand their opportunities.

Data from the education sector can again be used as a proxy to determine whether the benefits of investing in the capabilities of adolescents and youth are being equitably shared by immigrant and non-immigrant students. In 32 out of 38 UNECE countries, the difference in PISA 2015 science performance between immigrant and non-immigrant 15-year-old students, after accounting for economic, social and cultural status and language spoken at home, favours the latter. In 23 of these UNECE countries, such values

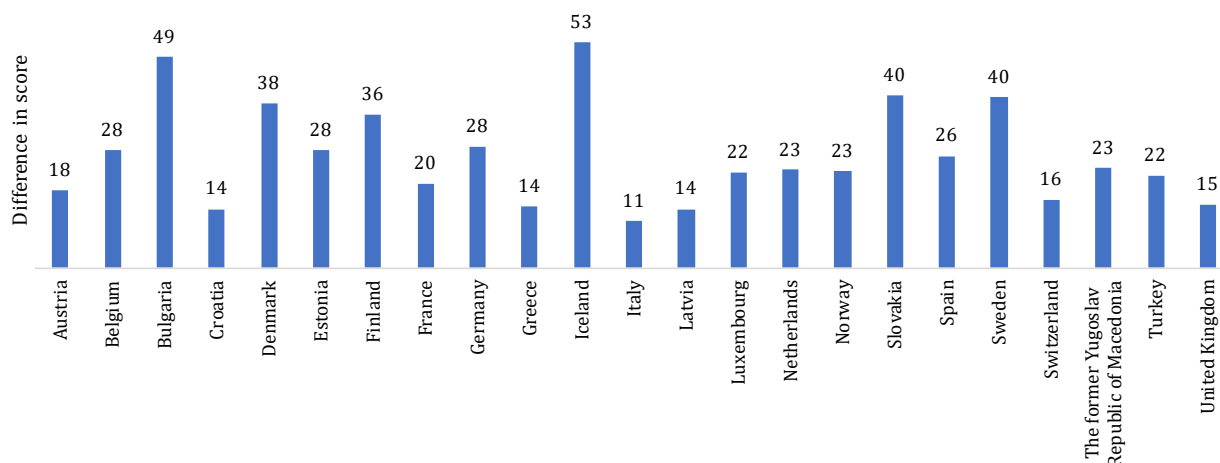
²¹⁵ The Principles relating to the Status of National Institutions (the Paris Principles) were adopted by the General Assembly in 1993 (resolution 48/134) based on the rules of procedure of the Global Alliance of National Human Rights Institutions (GANHRI, formerly the International Coordinating Committee of National Institutions

for the Promotion and Protection of Human Rights—ICC). Compliance with the Paris Principles vest national human rights institutions with a broad mandate, competence and power to investigate and report on the national human rights situation, and publicize human rights through information and education.

remain statistically significant, and call for additional efforts ensuring the inclusiveness

and equity of national education systems (Figure 53).

Figure 53. Countries with a statistically significant PISA science performance difference favouring non-immigrant students, 2015



Source: OECD. PISA Data Explorer.

Moreover, protecting and fulfilling the human rights of migrants in an increasingly connected region requires international cooperation, which may be directed at ensuring the portability of acquired professional credentials and benefits from work abroad, fostering their integration and reintegration, and combating trafficking and exploitation.

Policy efforts to support the integration of migrants vary considerably across countries. According to the UN DESA World Population Policies Database, comprehensive policies aimed at integrating migrants into host societies were most common in 2015 in EU countries and North America and Israel, and least common in South-Eastern Europe and Central Asia.²¹⁶ These included language skills and training, the possibility to transfer professional credentials, and measures to protect migrants against discrimination.

Trafficking and exploitation have detrimental effects on the physical and mental health of victims, including their SRH. Sex- and age-disaggregated data on the number of victims of human trafficking per 100,000 population (SDG Indicator 16.2.2) in 2014 show that women (aged 18 and over) and girls (aged under 18) face an increased risk of trafficking, since they vastly outnumber male victims within these same age groups (Table 6). Measures supporting **refugee** protection and integration remain important in the framework of current forced displacement flows affecting the UNECE region. Refugees typically must leave their homes with little notice and little time to prepare or choose their destination. Female refugees face an increased risk of GBV, rape, trafficking, unintended pregnancy, unsafe abortion, early and forced marriage and STIs in conflict and crisis settings, which calls for the adoption of

²¹⁶ United Nations Department of Economic and Social Affairs (2016) *World Population Policies*

Database. United Nations, New York. Available at: https://esa.un.org/PopPolicy/about_database.aspx.

Table 6. Countries with the highest number of detected or living victims of human trafficking per 100,000 population by age and sex, 2014

Women		Men	
Aged 18+	Aged under 18	Aged 18+	Aged under 18
United States 2,003	United States 510	Uzbekistan 770	Italy 110
Netherlands 1,055	Romania 280	United States 736	United Kingdom 80
Germany 485	Netherlands 218	United Kingdom 271	Netherlands 65
Bulgaria 433	United Kingdom 148	Romania 184	United States 55
Uzbekistan 380	Germany 50	Netherlands 160	Uzbekistan 24

Source: UNODC. UN Global SDG Database.

adequate and effective rehabilitation and response services in receiving countries.²¹⁷

In many UNECE countries refugees are not allowed to join the labour force until their legal status is resolved, a process that can last various years; once they do so they remain less likely to find jobs that match their qualifications or have access to documents

certifying their skills. Evidence from the 2008 EU Labour Force Survey shows that refugees take 6 years to achieve the labour force participation rates of migrants who moved for family reasons, and more than 15 years to catch up with migrants who moved for work or education.²¹⁸ The recent influx of refugees accentuates the need for strong integration programmes.

Box 30. Protecting women and girl refugees from GBV: Turkey

As Turkey continues to host the world's largest refugee population, Women and Girls Safe Spaces (WGSS) emerged in 2015 as a key strategy to protect and empower women and girls affected by the Syrian crisis. There are currently 39 WGSS, including 4 youth centres, in 17 provinces of Turkey, concentrated in the provinces with a high population of Syrians residing outside Temporary Accommodation Centres. In WGSS, GBV prevention activities, such as outreach, information and awareness sessions, individual and group consultations, GBV-specific case management and training programmes are undertaken. The inter-agency GBV case management guidelines aim to set the standards for quality and compassionate care for GBV survivors in humanitarian settings, with a particular focus on the provision of case management services.²¹⁹ As of 2018, 78 case workers are providing standardized six-step survivor-centred GBV case management services to GBV survivors through WGSS in Turkey.

²¹⁷ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women's Sexual and Reproductive Health and Rights in Europe*. Council of Europe and Commissioner for Human Rights, Strasbourg, p.43.

²¹⁸ World Bank (2017) *Economic Update: Migration and Mobility Europe and Central Asia*. World Bank, Washington, DC, p.40.

²¹⁹ UNFPA, UNICEF, UNOHCHR, USAID, IRC and IMC (2017) *Interagency gender-based violence case management guidelines*. UNFPA et al., New York.

Key refugee groups are reached through Red Umbrella Association, Positive Living Association and Social Policies, Gender Identity, and Sexual Orientation Studies Association (SPOD) implementing partners. Legal counsellors or protection workers provide legal information and counselling services, support referral to registration services, act as peer social support, and spread awareness about physical and sexual violence and other forms of persecution encountered. Psychologists provide psychological support surveys through individual meetings and group counselling. A website and information, education and communications materials have been developed that contain substantive information on HIV, gender, gender identity, sexual and gender-based violence, STIs etc. A joint hotline has been established to link services provided by all implementing partners.

Box 31. Supporting the integration of refugees: Sweden

Although the 2015 arrival of a large number of asylum seekers in Europe has created new challenges, Sweden has demonstrated a highly developed and sustainable policy for reception and introduction.²²⁰ Its migration and asylum policy seeks to ensure a sustainable process that safeguards the right of asylum and, within the framework of managed immigration, facilitates mobility across borders, promotes demand-driven labour migration, harnesses and takes account of the development impact of migration, and deepens European and international cooperation.

Sweden provides asylum seekers and refugees with access to an introduction programme managed by the Public Employment Service, so that the time spent waiting for asylum can be used to strengthen an individual's prospects of establishing themselves. The government wants newly arrived immigrants to quickly find a workplace that is relevant to their education and experience; thus the programme provides education, vocational training, language courses and meaningful occupation to prepare refugees for employment. The government has also implemented a fast-track process to match migrants to specific economic sectors where a shortage of labour has been identified.

Box 32. Supporting migrants and refugees to make informed and responsible decisions on SRH: Germany

The online portal zanzu.de, set up by the Federal Centre for Health Education in cooperation with the NGO Sensoa, provides simple explanations in 13 different languages on SRHR, including the human body, pregnancy and birth, contraception, HIV/AIDS, other STIs, sexuality and relationships. It contains detailed information on the respective rights and laws in Germany, as well as on existing support and counselling structures. The portal uses illustrations and integrated text-to-speech functions and special icons to be easily accessed by immigrants who have recently arrived in Germany and may not yet have the adequate language skills to obtain quality SRH information.²²¹

²²⁰ Based on: Sweden Ministry of Justice (2018) *Fact Sheet: Sweden's migration and asylum policy*. Sweden Ministry of Justice, Stockholm; and European Commission Advisory Committee on Equal Opportunities for Women and Men (2016) "Opinion on gender mainstreaming in refugees' reception and integration measures". Available at: <http://ec.europa.eu/transparency/regexpert/index.cfm?do=groupDetail.groupDetailDoc&id=30762&no=2>.

²²¹ WHO (2018) *Practices in Addressing the Health Needs of Refugees and Migrants*. WHO Regional Office for Europe, Copenhagen, p.12.

Box 33. Empowering migrants and refugees with access to quality SRH care and knowledge on GBV: Serbia

In 2018, UNFPA Serbia is supporting the Ministry of Health to strengthen emergency preparedness in SRH and GBV by developing the Minimum Initial Service Package for relevant actors, including health and non-health workers. The UNFPA Country Office has also worked to provide essential health services beyond primary medical care, including ensuring access to gynaecological services. This has been accomplished by donating mobile clinics for gynaecological examinations for migrant women and providing medical consumable materials and support for humanitarian workers and for the needs of women and children.

Together with the Danish Refugee Council and the NGO Atina, UNFPA Serbia is empowering refugee and migrant women and girls through workshops covering SRH, gender roles, stereotypes, forms of violence, human trafficking, honour killings and the importance of education, among other topics. The relevance of such workshops became immediately apparent in the first cases of women from refugee populations reporting violence they had witnessed.²²²

Ethnic minorities, such as the Roma, continue to face persistent exclusion, material deprivation, and inferior educational and health outcomes. The midterm review of the *EU Framework for National Roma Integration Strategies (2017)* took stock of progress towards Roma inclusion during the period 2011–2016 and noted that gains had occurred in education, particularly in the growing participation of Roma children in early childhood education and care, which is encouraging for their later development.²²³ The report, however, stated that school dropouts and the increased risk of poverty among Roma remain too high, despite the progress observed. It stressed that the growing share of young Roma who are not in education, employment or training is an alarming signal that translating results in education into employment and other areas requires more effective responses to discrimination.

In the field of health, the report highlighted that basic social security coverage remains a challenge, without significant improvement in the countries most concerned—Bulgaria and Romania—where around half of the Roma population are still without basic medical insurance. In contrast, Greece witnessed an improvement of over 30 percentage points.

The SRH outcomes of Roma women are worse than those of the general population. This is often the result of the ethnic segregation and racial harassment and abuse endured in SRH care settings, as well as the financial, practical, social and policy barriers they face in accessing SRH care.²²⁴ They are often discriminated against in accessing health services due to their perceived inability to pay medical bills or travelling lifestyle, a lack of health insurance or

²²² WHO (2018) *Practices in Addressing the Health Needs of Refugees and Migrants*. WHO Regional Office for Europe, Copenhagen, p.25.

²²³ European Commission (2017) *Mid-term review of the EU Framework for National Roma Integration Strategies*. European Commission, Brussels, pp.2, 10.

²²⁴ Council of Europe and Commissioner for Human Rights (2017) *Issue Paper: Women's Sexual and Reproductive Health and Rights in Europe*. Council of Europe and Commissioner for Human Rights, Strasbourg, p.43.

relevant identity documents.²²⁵ Roma girls face an increased risk of early or forced marriage and teenage pregnancy. While limited evidence is available, studies suggest that women belonging to ethnic minorities, such as the Roma, are at greater risk of experiencing all forms of intimate partner violence than the overall female population.²²⁶

2016 marked the 10th anniversary of the adoption of the Convention on the Rights of **Persons with Disabilities** (CRPD). The vast majority of countries in the UNECE region have ratified the CRPD—with the exceptions of Tajikistan, which has not signed the Convention, and the United States of America, Ireland, Belarus, Lithuania, Uzbekistan and

Kyrgyzstan, which have signed but not ratified it.²²⁷ The EU has also launched the European Disability Strategy 2010–2020, a framework for implementing the CRPD.

Globally, it is estimated that 15 per cent of the population experience some form of disability. In the EU, one person out of every seven reports a basic activity difficulty, and less than half of those with basic activity difficulties are employed.²²⁸ Eighty million people in the EU (a sixth of the population) have disabilities ranging from mild to severe. They are often prevented by their disability from taking part in society and the economy, and have a poverty rate 70 per cent higher than the EU average.²²⁹

Box 34. The Roma Health Mediators programme

In the former Yugoslav Republic of Macedonia, the Roma Health Mediators (RHMs) programme was officially launched in 2011 as part of the Strategic Framework for Improvement of the Health and Social Status of the Roma. The work of the RHMs is divided into three main areas: (1) health protection: referral to health facilities, support for access to the right to health protection, health education and promotion of preventive health services; (2) social protection: referral to social centres and mediation in the case of challenges to accessing the right to social protection; and (3) administrative procedures: support for issuing documents for personal identification.

The programme is now fully sponsored by the Ministry of Health with the active involvement of CSOs and international organizations in capacity-building and advocacy. In 2017, a total of 1,297 new families or 5,948 individuals were engaged by the mediators (2,583 male and 2,915 female). Although a downward trend has been observed more recently, in 2017 alone, 1,445 individuals (660 male and 785 female) successfully realized their right to health protection with the support of the mediators.

Serbia adopted in 2016 the National Strategy for Social Inclusion of Roma (2016–2025), which aims to combat poverty and discrimination affecting Roma citizens, and create the necessary conditions for them to exercise their human rights to employment, housing, education, health, social protection and participation. The Strategy builds on various successful initiatives, including the National RHM programme established by the Ministry of Health in 2008, and was supported by UNFPA until 2013 to

²²⁵ Ibid.

²²⁶ UNFPA (2016) *Combating Violence Against Women and Girls in Eastern Europe and Central Asia. Issue Brief 6*. UNFPA EECAO, Istanbul, p.4.

²²⁷ United Nations, Department of Field Support (2017) *CRPD and Optional Protocols Signatures and Ratifications*. United Nations, New York.

²²⁸ Eurostat (2011) *Disability Statistics: European Union Labour Force Survey*. Eurostat, Luxembourg.

Available at:

http://ec.europa.eu/eurostat/statistics-explained/index.php?title=Disability_statistics.

²²⁹ European Commission (2010) *European Disability Strategy 2010–2020: A Renewed Commitment to a Barrier-Free Europe*. European Commission, Brussels.

create a sustainable link between the Roma population and national institutions. Along with a special focus on training to address reproductive health, a third of the RHMs were trained to work with young Roma to effectively broaden the reach of SRH services. For instance, in the Sandzak region, in the most undeveloped municipalities, RHMs worked with 700 young people, of which 60 per cent were girls.²³⁰

In **Bulgaria**, the RHM programme began in 2003 as part of the pre-accession EU-funded PHARE programme. The National Network of Health Mediators, established in 2007, sets professional standards, develops strategic plans, holds an ethical code and defends the professional rights of its members. As of 2018, 230 RHMs are working across all 28 regions and over 120 municipalities of the country.²³¹ They have become the bridge between vulnerable communities and institutions, working on maternal and child health, reproductive health, immunization, health information, diseases, health screening, and campaigns and information dissemination.

Persons with disabilities are more likely to experience adverse socio-economic outcomes than persons without disabilities, such as less education, poorer health outcomes, lower levels of employment and higher poverty rates. Barriers to full social and economic inclusion of persons with disabilities include inaccessible physical environments and transportation, a lack of assistive devices and technologies, non-adapted means of communication, gaps in service delivery, and discriminatory prejudice and stigma in society.²³²

The 2030 Agenda for Sustainable Development clearly states that disability cannot be a reason for a lack of access to development programming and the realization of human rights. A key challenge in addressing the needs of persons with disabilities is the limited amount of data. There have been several international and regional efforts to

harmonize data collection on disabilities, including the Budapest

Initiative to measure Health Status. This task force was launched under the auspices of UNECE, in partnership with WHO and Eurostat, with the objective of developing a new common instrument to measure health status suitable for inclusion in interview surveys and to allow international comparisons and aggregations.

The task force published in 2012 a Survey Module for Measuring Health Status,²³³ including a set of questions on health status. Building on this work—and in coordination with another global effort to harmonize data collection on disabilities, the Washington Group on disability statistics—a limited set of questions to measure ‘functioning’ have been recommended by the UN Statistical Commission for use in the context of the 2020 population censuses.²³⁴

²³⁰ UNFPA (2015) *Annual Report of the Joint Project “Improving Human Security for Migrants & Vulnerable Communities in southwest Serbia” funded by Human Security Trust Fund - November 2012 - November 2014*. UNFPA, Belgrade.

²³¹ www.zdravenmediator.net.

²³² World Bank (2018) *Disability Inclusion*. World Bank, Washington, DC. Available at: <http://www.worldbank.org/en/topic/disability><http://www.worldbank.org/en/topic/disability>.

²³³ Meltzer, H. (2003) *General Measures of Health for use in Health Interview Surveys and Censuses: the UK experience*. Washington Group Meeting, Ottawa.

²³⁴ OECD (2013) *How’s Life? 2013: Measuring Wellbeing* OECD Publishing, Paris, p.29; and OECD (2017) *How’s Life? 2017: Measuring Wellbeing*. OECD Publishing, Paris, pp.6, 121.

The proportion of the population with severe disabilities receiving disability social protection benefits (SDG Indicator 1.3.1.d) is universal (100 per cent) among most UNECE countries, except Turkey (5 per cent), Cyprus (26 per cent), Malta (60 per cent), Canada (67 per cent), Germany (74 per cent), Kyrgyzstan (76 per cent), Spain (83 per cent), Israel (90 per cent) and Austria (93 per cent) (source: ILO).

Violence and discrimination based on **sexual orientation and gender identity** (SOGI) exist across the region. Several comprehensive reviews have shown that persons with a sexual orientation or gender identity that does not conform to—perceived—majority norms face disproportionate discrimination, marginalization, abuse and violence.²³⁵

Box 35. Addressing discrimination and violence on the basis of sexual orientation and gender identity

Legislative and policy changes

During the UPRs in 2017 and 2018, several member States from the region reported legislative and policy changes to combat discrimination and violence on the basis of SOGI. Discrimination based on SOGI was introduced in the Criminal Codes of Liechtenstein²³⁶ and Montenegro.²³⁷ Romania reported that its 2010 anti-discrimination law is defining discrimination in a very large sense, including discrimination based on sex and sexual orientation.²³⁸ Same-sex couples are now able to get married in Finland²³⁹ and Germany,²⁴⁰ while in Israel legislation was changed to enable same-sex couples to more easily obtain visas and to adopt children.²⁴¹ In Czechia, in 2016 the Constitutional Court cancelled the ban on adoption by registered same-sex partners.²⁴² Luxembourg reported that a national action plan is being developed for the promotion and protection of the rights of LGBTI persons in close consultation with civil society and other stakeholders.²⁴³ Serbia developed the Strategy for the Prevention of and Protection from Discrimination, which recognizes LGBTI persons as a vulnerable social group at risk of

²³⁵ UNHRC (2018) *Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity*. A/HRC/38/43. United Nations, Geneva.

²³⁶ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Liechtenstein*. A/HRC/WG.6/29/LIE/1. United Nations, Geneva, para.26.

²³⁷ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Montenegro*. A/HRC/WG.6/29/MNE/1. United Nations, Geneva, para.129.

²³⁸ UNHRC, Working Group on the Universal Periodic Review (2017) *Compilation on Romania*. A/HRC/WG.6/29/ROU/2. United Nations, Geneva, para.68.

²³⁹ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Finland*. A/HRC/WG.6/27/FIN/1. United Nations, Geneva, para.141.

²⁴⁰ UNHRC, Working Group on the Universal Periodic Review (2018) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Germany*. A/HRC/WG.6/30/DEU/1. United Nations, Geneva, para.54.

²⁴¹ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Israel*. A/HRC/WG.6/29/ISR/1. United Nations, Geneva, para.25(b).

²⁴² UNHRC, Working Group on the Universal Periodic Review (2018) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Czechia*. A/HRC/WG.6/28/CZE/1. United Nations, Geneva, para.51.

²⁴³ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Luxembourg*. A/HRC/WG.6/29/LUX/1. United Nations, Geneva, para.36.

discrimination.²⁴⁴ The Labour Code of Ukraine was amended to specifically prohibit discrimination based on SOGI in employment and occupation,²⁴⁵ and the Government of the Netherlands has teamed up with the national expertise and lobbying group Transgender Network Netherlands (TNN) to combat discrimination in the labour market, by building up networks for transgender individuals, increasing sensitivity among employers, and sharing best practices to promote the participation of transgender people.²⁴⁶

Violence and discrimination

Despite the positive legislative and policy changes in the region, Human Rights Committees, NGOs and other stakeholders expressed their concern about violence and discrimination against LGBTI persons. Hate speech and crimes and the lack of prosecution are serious concerns and need to be addressed,^{247, 248, 249, 250} and discrimination remains prominent in the labour market.^{251, 252, 253} Recommendations were made to promote understanding and respect for LGBTI persons, especially in schools.²⁵⁴

Evidence collected by the US Agency for International Development (USAID) and UNDP reflects both progress and persisting challenges in the eastern part of the region. For example, in Albania, although the government passed a National Action Plan on LGBTI inclusion (2016–2020), covering education, employment, health and housing, over 70 per cent of LGBTI persons report having been

psychologically abused or verbally harassed. In Serbia, there is a wide anti-discrimination legal framework, including on grounds of SOGI, and the Constitutional Court established that failing to recognize the sex change of a post-operative trans person violates their privacy and dignity; however, the protection of LGBTI people's rights is reportedly weak and inconsistent in practice.²⁵⁵

²⁴⁴ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Serbia*. A/HRC/WG.6/29/SRB/1. United Nations, Geneva, para.68.

²⁴⁵ UNHRC, Working Group on the Universal Periodic Review (2018) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Ukraine*. A/HRC/WG.6/28/UKR/1. United Nations, Geneva, para.93

²⁴⁶ UNHRC, Working Group on the Universal Periodic Review (2017) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21 – Netherlands*. A/HRC/WG.6/27/NLD/1. United Nations, Geneva, para. 38.

²⁴⁷ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Finland*. A/HRC/WG.6/27/FIN/3. United Nations, Geneva, para. 18.

²⁴⁸ UNHRC, Working Group on the Universal Periodic Review (2017) *Compilation on Montenegro*. A/HRC/WG.6/29/MNE/2. United Nations, Geneva, para.18.

²⁴⁹ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Poland*. A/HRC/WG.6/27/POL/3. United Nations, Geneva, para.17.

²⁵⁰ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Russian Federation*. A/HRC/WG.6/27/RUS/3. United Nations, Geneva, para.17.

²⁵¹ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Ukraine*. A/HRC/WG.6/28/UKR/3. United Nations, Geneva, para.57.

²⁵² UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Finland*. A/HRC/WG.6/27/FIN/3. United Nations, Geneva, para.15.

²⁵³ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Netherlands*. A/HRC/WG.6/27/NLD/3. United Nations, Geneva, para.3.

²⁵⁴ UNHRC, Working Group on the Universal Periodic Review (2017) *Summary of stakeholders' submissions on Luxembourg*. A/HRC/WG.6/29/LUX/3. United Nations, Geneva, para.31.

²⁵⁵ USAID and UNDP (2017) *Being LGBTI in Eastern Europe Progress, drawbacks, recommendations*. UNDP, Istanbul.

Discrimination also has its economic costs, with evidence emerging on the harmful effect that violations of the human rights of LGBTI people can have on a country's level of economic development. Exclusionary treatment of LGBTI people can result in lost labour time, lost productivity, under-investment in human capital, and the inefficient allocation of human resources through discrimination in education and hiring practices.²⁵⁶

3.4. Recommendations: Inequalities, social inclusion and rights

A. Gender equality and women's empowerment

- Eradicate all forms of discrimination in **employment** against women, by guaranteeing them the same access as men to formal and secure employment, with equal pay for equal work.
- Ensure women's full and effective participation as **political leaders and managers**, including by granting them equal access to leadership positions at all levels of public life.
- Support the successful reconciliation of work and family life by: implementing holistic family policies that aim to achieve the combined and mutually reinforcing objectives of child education, adult autonomy and gender equity; promoting access to high-quality early childhood education and care, including extended after-school care; guaranteeing universal and paid maternity and paternity leave, supporting fathers' involvement in childcare and avoiding long career breaks for women; promoting the provision of flexible working

arrangements for parents and carers complementing care services and financial support; and ensuring that public and private workplaces accommodate the needs of pregnant and breastfeeding women.

- Prevent **gender-based violence** and provide support to victims by: strengthening legislative and policy frameworks to prevent, investigate and punish acts of GBV within and outside the family, and to provide support to survivors, including counselling and health, psychosocial and legal services; strengthening health systems to prevent and respond to GBV from a rights-based, life-course perspective; including GBV, intimate partner violence and other forms of sexual violence and exploitation in the educational curricula of health-care professionals, teachers and social workers; redressing deeply rooted negative gender attitudes, values and stereotypes, including through public awareness campaigns, comprehensive sexuality education, and other measures which foster the participation of men and boys and the equal sharing of responsibilities; and eradicating harmful practices, such as gender-biased sex selection and early and forced marriages, including through the adoption and enforcement of laws that criminalize marriage below age 18.

B. Poverty and socio-economic inequalities

- Invest in the capabilities of all persons throughout the life course by ensuring universal and equitable access to quality services and social protection, as the most effective means to eradicate **poverty**, break **inequality** and exclusion cycles, and realize their full potential. Guaranteeing the social protection and income security of vulnerable individuals and groups, such as the poorest,

²⁵⁶ Badgett, L. et al. (2014) *The Relationship between LGBT Inclusion and Economic Development: An Analysis of Emerging Economies*.

USAID and The William Institute, Washington, DC; and Badgett, L. (2014) *The Economic Cost of Stigma and the Exclusion of LGBT People: A Case Study of India*. World Bank, Washington, DC.

unemployed persons, single mothers and older women, by extending non-contributory allowances and pension systems, deserves special attention.

- Prioritize the well-being of **children in residential care**, support their transitions to and from such centres and enable them to retain family links.

C. Social inclusion of marginalized groups

- Address the multiple and overlapping forms of **inequality and discrimination**, through firm commitments to equality and non-discrimination for all persons, without distinction of any kind, in the exercise of their social, cultural, economic, civil and political rights.
- Address **stigma, violence, hate speech against and negative stereotypes and prejudices** towards marginalized groups, by raising awareness and promoting tolerance among the general public, training state personnel that interact with these groups, developing school-based curricula on human rights and ensuring adequate legal responses.
- Promote and protect the human rights of **international migrants**, especially those of women, adolescents and youth, regardless of

their migration status; combat discrimination against international migrants by addressing deeply rooted social norms and discriminatory practices across sectors that prevent their full integration in societies and contribute to development; develop legal measures to penalize those who engage in human trafficking, including into forced prostitution; and provide protective measures and legal and health services to victims of trafficking.

- Strengthen the protections and social inclusion of **refugees**, through the provision of food, shelter, education, social and health services, including SRH services, in the short term, and by facilitating their local integration, voluntary return or settlement in a third country in the long term.
- Foster the social inclusion of **ethnic minorities and persons with disabilities** by improving their educational and health outcomes, expanding their economic participation and ensuring their income support.
- Decriminalize same-sex practices and combat the stigma, discrimination, and violence faced by persons of diverse **sexual orientation and gender identity**.

Chapter 4. The way forward: Addressing persisting and emerging population and development issues

The three preceding chapters have raised persisting and emerging population and development issues that deserve high policy priority. Some affect the entire UNECE region, while others significantly impact specific subregions, UNECE countries, or population groups within and across countries. In some contexts trends are already alarming, while in others emerging population issues can be anticipated and mitigated through forward-looking policy adaptations.

Holistically addressing these persisting and emerging issues in the areas of population dynamics and sustainable development (section 4.1), families and SRH over the life course (section 4.2), and inequalities, social inclusion and rights (section 4.3) at the national and local levels through a multi-stakeholder approach will contribute to the achievement of the goals and objectives of the ICPD PoA, the *2013 Chair's summary* recommendations and the SDGs (section 4.4).

4.1. Population dynamics and sustainable development

The linkages between the ICPD PoA, the *Chair's summary* and the 2030 Agenda for Sustainable Development evidenced throughout this report, as well as the current socio-demographic and economic context, call for the **integration of population dynamics into national and local sustainable development agendas**. Addressing the complex interrelationships between low fertility, internal and international migration and ageing, and their effects on population growth and age structures requires holistic, human rights-based policies that eradicate inequalities and embrace the contributions of all individuals and generations to sustainable development.

Investing in human capital development across the life course contributes to addressing the implications of population ageing and, where applicable, population shrinking, as well as to more inclusive and sustainable development. Ensuring universal access to early childhood education and care, improving the quality of education systems, guaranteeing smooth education-to-employment transitions as well as access to decent jobs, and promoting access to SRH information, education and services, remain prominent challenges affecting **younger generations** which deserve policy attention over the next five years. Ensuring decent employment opportunities can serve to address out-migration of qualified young professionals in sending countries particularly affected by brain drain. Investment in human capital can also serve to increase fertility levels, as it helps create conditions for people to have confidence in building a future in their own country and realize their fertility intentions.

Similarly, realizing the potentials of longevity demands efforts in the promotion of active ageing and independent living among **older persons**. Enabling older persons to remain engaged in the labour force and facilitating access to lifelong learning and training are measures that have the potential to ensure the sustainability of pension and social security systems in a context of shrinking labour forces. Reducing the burden of NCDs requires the promotion of physical activity, healthy lifestyles and behavioural changes in dietary intake, alcohol consumption and smoking, especially among men.

Societies will be increasingly confronted with growing needs for long-term care, putting pressure on intergenerational support systems. It is important for policymakers to

address the provision of support for informal caregivers, particularly women, as well as a shift to individualized and home-based care. Given the increased longevity of women, particular attention should be given to the integration of a gender perspective into relevant policy frameworks.

Declining population in rural areas and increasing urbanization require integrated and holistic sustainable agricultural and rural development policies, fostering of linkages between urban and rural areas, and the promotion of inclusive, safe and sustainable cities, with a view to ensuring the **quality of services and infrastructure in rural and urban areas alike**.

A collective shift towards individual well-being derived from **production and consumption patterns** that are more equitable and have less impact on the environment is necessary from young and old generations to achieve sustainable development. The extent to which innovative technologies that reduce consumption without declines in well-being are developed will determine the capacity of Member States to reconcile emissions targets with development aspirations. The landmark Paris Agreement (2016) charts the way to advance on this front.

Specific **data and research gaps** identified under this theme include: improving data quality and availability on adolescent health, including healthy habits among adolescents, physical activity across all age groups, and government performance and beneficiary satisfaction; and strengthening the research base on the role of sedentary behaviour as an independent risk factor for health and the relationship between physical activity and other health-related behaviours, such as diet or smoking tobacco.

In recent years UNECE countries have conducted population and housing censuses and strengthened birth and death registration

systems. Bosnia and Herzegovina, Canada, France, Georgia, Ireland, Republic of Moldova and Slovenia conducted population and housing censuses during the period 2013–2016 (SDG Indicator 17.19.2). In 2015, Tajikistan remained the only UNECE country that had not achieved at least 90 per cent birth registration, while all countries had achieved at least 75 per cent death registration (SDG Indicator 17.19.2). Lastly, in 2014 the proportion of children under 5 years of age whose births had been registered with a civil authority (SDG Indicator 16.19.1) had reached 100 per cent among all UNECE countries except Kyrgyzstan (98 per cent) and Serbia (99 per cent).

4.2. Families, sexual and reproductive health over the life course

Ensuring that all persons enjoy the right to the highest attainable standard of SRH over their life course requires a continuum of quality care from birth to old age that responds to the changing SRH needs of distinct populations. In this regard, the provision of an **essential, integrated package of SRH services and information** to all persons regardless of age, marital status, socio-economic status, race or ethnicity, sexual orientation or gender identity, and the removal of all barriers faced by individuals in accessing such a package remain key strategies to eradicate SRH inequalities. Integrating this package of SRH services at the primary health-care level remains central for success, alongside commitments to achieving gender equality.

Over the next five years, efforts need to be accelerated in the provision of **comprehensive sexuality education** by expanding access in primary and secondary education and in non-school settings, ensuring that curricula meet international quality standards, improving the capacity of teachers, educators and health professionals, and involving parents and guardians.

Many women and men continue to face constraints in accessing a **wide range of modern, affordable contraceptive methods**. This is of concern to adolescents and youth and vulnerable groups and can be tackled by addressing related myths and misconceptions, using transformative approaches and expanding the supply of modern contraceptives at SRH service delivery points.

In countries where **abortion** services are legal on request or on broad socio-economic grounds, barriers to safe abortion care, such as third-party authorization requirements or medical professionals' refusal to provide care on grounds of conscience, should be further removed. These limit or deny women's timely access to safe abortion care, forcing them to travel to other health facilities, within the country or abroad, incurring significant financial and practical costs.

While **maternal health** indicators show progress in most contexts, additional efforts are required to ensure universal access to quality antenatal care, skilled attendance at birth, emergency obstetric care, and perinatal and post-partum care. In addition, the lack of adequate standards of health care and respect for women's rights in childbirth that have been witnessed in some contexts, and that have particularly affected vulnerable women, call for the eradication of coercive and discriminatory practices in maternal health care.

The growth of the **HIV epidemic** in the eastern part of the region requires achieving universal access to quality and affordable STI and HIV care, including information, education, counselling, diagnosis and treatment services, particularly among key at-risk and vulnerable population groups and young persons. Intensifying national surveillance efforts to measure the incidence and prevalence of HIV and STIs is equally important.

STI infections and postponements in childbearing increase the risk of **primary and secondary infertility** among women and men; hence the demand for infertility information and services, including assisted reproductive technologies, is likely to continue growing over the coming years. In this regard, the strengthening of preventive measures that focus on reducing infertility risk factors such as obesity, alcohol and drug abuse, unsafe abortions, STIs and post-partum infections should remain high on the agenda.

Likewise, the burden of **cervical and breast cancer** in the UNECE region can be reduced by ensuring national screening programmes targeting at-risk population groups, intensifying HPV vaccination coverage among adolescent girls and strengthening screening registries.

The changing nature and **increasing diversity of family and household composition** in the UNECE region needs to be considered when developing family support policies, which should target those vulnerable in both traditional and emerging forms of families and households.

Specific **data and research gaps** identified under this theme include: improving data quality and availability on coverage of comprehensive sexuality education programmes, teenage pregnancies (10–14 years and 15–19 years), HIV knowledge among adolescents and youth, the SRH needs of older persons, primary and secondary infertility and new and emerging forms of families and households.

4.3. Inequalities, social inclusion and rights

Achieving **gender equality** demands strong commitments to eradicate all forms of discrimination affecting women in the economic, social and political spheres. Further

efforts need to be directed at guaranteeing women the same access as men to formal and secure employment and with equal pay for equal work. Further efforts need to be directed at ensuring women's full and effective participation and equal opportunities for leadership at all levels of decision-making in political, economic and public life, and removing barriers for men to equally participate in childcare and domestic work.

Eliminating **gender-based violence**, which remains a pervasive challenge to the region's societies, demands coordinated, rights-based, preventive and response measures from the health, education, social and legal sectors, and redressing deeply-rooted negative gender attitudes, values and stereotypes. **Harmful practices**, such as early and forced marriages and sex selection, remain a concern in some countries in the eastern part of the region.

Work-life reconciliation needs emerge throughout the productive life of all individuals, yet women continue to bear a larger share of care and household work, often changing their employment status as a result. Achieving a successful and more gender-balanced reconciliation between family and work responsibilities requires multisectoral policies, including compensation for lost income during full-time care for children and older persons, the promotion of flexible working arrangements for employees with care responsibilities, the provision of quality and affordable early childhood education and care, the provision of non-transferrable paternity leave, and increased options for older persons to both receive care and provide care to young family members.

Many individuals who are vulnerable as a result of their characteristics, context or group membership continue to be mired in **poverty**, trapped in **inequality** cycles, and lacking access to quality services and social protection. This is the case for the poorest people, those who are unemployed, children, single mothers

and older women, among others, and requires investing in the capabilities of all persons throughout the life course. Ensuring universal and equitable access to quality services, as well as guaranteeing the social protection and income security of those most vulnerable, is paramount to increase their freedom of choice and the means to shape their lives.

As the intensity and complexity of **international migration** flows deepens, member States will be required to bolster international cooperation efforts to ensure orderly, regular and safe international migration processes. Further policy efforts need to be directed at promoting the integration and reintegration of migrants and ensuring the portability of acquired professional credentials and benefits from work abroad. Similarly, strengthening the protections and social inclusion of refugees is of utmost importance in countries hosting **refugee** populations.

International migrants, refugees, ethnic minorities, persons with disabilities, persons of diverse sexual orientation and gender identity and sex workers, among others, continue to face **stigma, discrimination and violence**, originating in deeply rooted negative attitudes and values. Protecting and fulfilling their human rights require firm commitments to equality and non-discrimination for all persons, without distinction of any kind.

Social exclusion, material deprivation and inferior educational outcomes continue to impact **persons with disabilities and ethnic minorities, such as the Roma**, thus demanding additional investments in their capabilities and social protection.

Lastly, specific **data and research gaps** identified under this theme include: ensuring that census and survey data are adequately disaggregated by sex, age, income, place of residence, ethnicity, migrant status, and other

relevant dimensions that can serve to identify and understand inequalities affecting vulnerable and marginalized populations; conducting time-use surveys to improve the understanding of women and men's dynamics in reconciling caregiving and paid work; improving data availability and data quality on GBV, early and forced marriages, the development benefits of international migration, trafficking, social attitudes and values related to gender inequality and other forms of discrimination; and conducting qualitative research involving refugees, ethnic minorities, sex workers and persons of diverse sexual orientation and gender identity that informs policymaking discussions.

4.4. Governance and accountability

Findings have shown that over the past five years, UNECE countries have made a certain amount of progress in the implementation of the recommendations of the *2013 Chair's Summary*. This is evidenced by aggregate improvements in individual social and economic outcomes related to these three themes. Yet progress has been uneven across and within regions and countries. Multiple and overlapping forms of inequality and discrimination continue to impede individuals from realizing their full potential, even in the most advanced countries.

Preparing for and realizing the potentials of ageing populations in the region require a life-cycle approach. This approach is in line with the core message of the ICPD PoA: investing in individual capabilities, dignity and human rights without distinction, across multiple sectors and throughout the life course is the foundation of sustainable development. Findings have shown, however, that further efforts are required in the protection and promotion of human rights, including SRHR and gender equality.

As efforts in the UNECE region are accelerated to implement the 2030 Agenda for Sustainable Development, the vision of the ICPD PoA, and the guidance for its full implementation provided by the *2013 Chair's Summary*, remains essential for the achievement of sustainable development. The integrated nature and linkages between these agendas demand increased policy coherence at both national and local levels to maximize impact and available resources. Coordination and collaboration among and within governments, donors, the United Nations, CSOs, the private sector and intended beneficiaries is, therefore, essential.

Allocating domestic human and financial resources, strengthening the funding and capacity of CSOs and creating enabling environments remain key to deliver on commitments. The removal of barriers hindering access to services, including SRH services, deserves priority. Meaningfully engaging younger and older generations alike and capitalizing on their energy, innovation, experience and expertise can contribute to the realization of sustainable societies.

UNECE countries have implemented a wealth of good practices across diverse contexts, highlighting the potential of international cooperation and collaboration in mobilizing and transferring resources, knowledge and technologies, and devising common solutions to common issues.

Some population and development issues, however, have received only limited research, measurement and implementation. This is the case for healthy habits and physical activity, comprehensive sexuality education, the SRH of older persons and people with disabilities, primary and secondary infertility, GBV, child and forced marriages, trafficking, and social attitudes and values, among others.

In addition, the limited availability of disaggregated data for marginalized population groups remains one of the most prominent challenges. The *UNECE Monitoring Framework for the ICPD Programme of Action* presented in this report represents a first step in this direction, serving as an accountability mechanism for all relevant stakeholders to monitor progress against the goals and objectives of the ICPD PoA and the *2013 Chair's summary* recommendations.

Moving forward, UNECE and UNFPA will continue to facilitate the generation of timely, high-quality knowledge, support advocacy and policy dialogue processes, develop institutional capacities and foster partnerships and international coordination and cooperation.

The findings of the Regional Report on ICPD+25, alongside the deliberations of the

2018 UNECE Regional Conference, will inform the global review of the ICPD at the 52nd Session of the Commission on Population and Development in 2019, the 2019 UNECE Regional Forum on Sustainable Development, and the 2019 United Nations Economic and Social Council High-Level Political Forum on Sustainable Development. To better integrate the review and follow-up of the ICPD PoA and the 2030 Agenda on Sustainable Development, future review cycles of the ICPD PoA will be aligned with the SDG review cycle and take place every four instead of five years.

As the 25th anniversary of the ICPD PoA nears, fulfilling the potential of present and future generations in the UNECE region will require collective action to guarantee the freedom and equality of all persons in dignity and rights, including sexual and reproductive rights and gender equality.

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