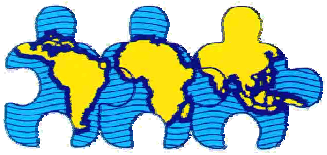
REPORT OF

THE CONSULTATIVE MEETING OF EXPERTS ON CAPACITY DEVELOPMENT

TAICANG, CHINA, 10-15 MAY 2007

Partners in Population and Development
A South-South Initiative



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Abbreviations and Acronyms

AIDS	Acquired Immune-Deficiency Syndrome
ARSH	Adolescent Reproductive and Sexual Health
CAFS	Centre for African Family Studies
CTC	China Center for Reproductive Health and Family Care
CH	Child Health
FP	Family Planning
FLE	Family Life Education
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
ICPD	International Conference on Population and Development
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MOU	Memorandum of Understanding
PPD	Partners in Population and Development
QoC	Quality of Care
RH	Reproductive Health
RTI	Reproductive Tract Infections
STI	Sexually Transmitted Infections
SOPs	Standard Operating Procedures
TOT	Training of Trainers
TSD	Technical Support Division
UNAIDS	United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
WHO	World Health Organization

I. INTRODUCTION

The International Conference on Population and Development held in 1994 in Cairo marked a watershed in the history of population movement. The Conference adopted an innovative, forward-looking, and far-reaching Program of Action to address issues of population, gender and reproductive health. It called for a new way of thinking on population issues and its relationship with development, and recommended an integrated approach to the resolution of the three interrelated issues of population, gender and reproductive health. Since its adoption, the Program of Action is being implemented in all earnestness by developing countries of all regions. More recently, in 2001, the General Assembly adopted the Millennium Declaration to end poverty and extreme hunger in the world. In order to help achieve this overarching objective, it has adopted eight goals, called the Millennium Development Goals (MDGs), that address eradicating extreme poverty, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, ensuring environmental sustainability and developing a global partnership. The Millennium Declaration called for a mainstreaming of these goals in the development frameworks of countries, as well as in development cooperation initiatives. The General Assembly has urged the international community to give the highest priority to the achievement of these goals.

A large number of studies, on national, regional and global level, has, however, documented the absence of uniform progress among developing countries in achieving these goals. Research has shown that the countries can be divided into three clusters. One group of countries will achieve the goals well in time by 2015, or even sooner; a second group will be most likely to reach the greater part of the goals by the target date; and a third group of countries, mainly in sub-Saharan Africa, will probably be unlikely to achieve the goals by 2015. Till now progress by and large can be discerned in the attainment of goals related to primary schooling, reducing infant and child mortality, and to a lesser extent in improving maternal health, promoting gender equality and empowering women, and reversing HIV/AIDS pandemic and environmental sustainability. Absolute poverty persists in the poorest of the PPD and many other developing countries, affecting the prospects of realizing the goals. Furthermore, adverse patterns in population dynamics and demographic factors are a concern in many of those countries. The same studies have also shown that unless the Cairo Program of Action is fully implemented, it will be very difficult to achieve the MDGs. Several reviews of how countries are implementing the ICPD and MDGs have indicated that one of the most critical constraints of effective implementation is the lack of analytical capacity in the poorest of the developing countries to undertake programmatic activities in the new perspective of ICPD and MDGs.

The Partners in Population and Development (PPD), an intergovernmental alliance of 21 developing countries, was created to promote and improve transfer of knowledge, experience and skills in population and reproductive health through South-South collaboration. In line with this vision, the PPD has undertaken over the last several years a number of substantive studies, supported a number of capacity development activities, organized several policy dialogues on ICPD and MDGs, and has promoted exchange of information and experience among its member countries. The PPD is committed to finding common solutions for similar problems they face in the implementation of MDGs and ICPD goals. Capacity building for MDGs and ICPD issues need to be pursued with a coordinated approach to enhance institutional capabilities on the one hand and to augment abilities and skills on the other. A coherent approach to assessing the individual capacity needs of Partner Countries, along with an appraisal of capabilities and potentials of Partner Institutions would seem necessary to effectively address the capacity issues of PPD member and other countries to handle MDGs and ICPD goals. It is widely recognized that training and research capabilities are the main determinants of analytical capacities needed to address the new policy and programmatic demands of MDGs and ICPD issues. Accordingly, the PPD and the China Center for Reproductive Health and Care (CTC) organized, with financial support from UNFPA, a Consultative Meeting of Experts in training and research on issues of population, gender and reproductive health (Taicang, China, 10-13 May 2007). The main objectives of this meeting were:

- To assess training and research needs in population, gender and reproductive health in Africa, Asia and the Arab region;
- To map out the various training programs that are currently being implemented by Partner Institutions to help build analytical capacities of developing countries in the same areas;
- To assess the training gaps in population, gender and reproductive health areas and to suggest modalities to address those gaps;
- To identify research needs and propose a strategy to address them; and
- To assess capabilities of Partner Institutions in facilitating cooperation among developing countries themselves through South-South Cooperation.

To help achieve these objectives, the PPD had commissioned five background documents in the form of four regional overviews, one each on priority issues and strategies needed to meet MDGs and ICPD goals for Anglophone Africa, for Francophone Africa, for Arab region and for Asia, as well as one technical paper synthesizing the findings of an inquiry sponsored by the PPD to assess the capabilities of Partner Institutions in teaching and research, and in undertaking South-South Cooperation.

The participants at the Meeting included training experts of the seventeen Partner Institutions of twelve PPD member countries that had participated in the **conduct** of the PPD Inquiry of institutional

capabilities, representatives of UNFPA, Government of China, PPD consultants and others. Given that the issues of population, gender and reproductive health are almost always interrelated and multi-sectoral in nature, the 17 selected Partner Institutions represented a wide spectrum of disciplines including, demography and population studies, health and medical sciences, public health, social sciences, as well as administrative and management disciplines.

The structure of the Experts Meeting was a classical one with an opening session to set the stage for the discussion of specific population and reproductive health issues within the context of a broader policy framework, followed by technical sessions to assess the training and research needs of PPD member countries, as well as to map out the capabilities and potentials of PPD Partner Institutions with a view to identifying gaps in training and research in support of MDGs and ICPD issues. There were breakout sessions to work out solutions to training and research gaps in population, gender and reproductive health, as well as sessions on how to promote capacity development among and by themselves through South-South Cooperation; also, plenary sessions to present and discuss the recommendations and outputs of the breakout / working group sessions, and to discuss the institutional implications of the recommendations, followed by identifying a Way Forward to follow up on the recommendations; and a closing session to express commitment at policy level.

II. SETTING THE STAGE

The Expert Meeting was inaugurated by a welcome speech from Mr. Jianhua Cai, President of China Training Center for Reproductive Health and Family Care. In his remarks, Mr. Cai expressed his pleasure in welcoming all the participants and underscored that the meeting was aimed at addressing training needs, existing institutional capacities and gaps in PPD member states with a view to develop a comprehensive strategy to respond to those needs and bridge gaps. He then went on to explain the twin objectives of the China Training Center: first, to explore an integrated approach to population issues for the Chinese government and policy makers, and second to seek an effective way of promoting economic prosperity for all developing countries and of realizing MDGs. The range of issues on which the Center is expected to provide advice includes upgrading population quality, in terms of health and education, improving population structure, ensuring population security, and expanding family planning service network to a broader public service network in the filed of reproductive health or for health promotion. He also mentioned that the Center is committed to promoting South-South Cooperation, which is the cornerstone of China's foreign policy.

Given these aims, the CTC, Mr. Cai pointed out, is designed to develop a service-oriented platform delivering training and education on reproductive health and family care, as well as to facilitate cooperation and communication on population and development with both developing and developed

countries. Mr. Cai then briefly described some of the activities of the Center and noted that in 2007 the Center was going to undertake three international workshops, one each on MCH for Health Practitioners and Service Providers, on Sexual and Reproductive Health and Human Rights, and on Reproductive Health Institutional Development. In conclusion, Mr. Cai wished the Meeting a complete success.

In his address to the Expert Meeting, the Executive Director of PPD, Mr. Harry Jooseery, welcomed the participants and described the many steps the PPD had taken over the last several months in organizing the meeting, including the design and conduct of the Inquiry among Partner Institutions, its analysis and preparation of a technical paper based on it, the preparation of four regional overviews, discussions with UNFPA, and logistics preparation for the meeting by CTC and PPD. He thanked everybody who was involved in that process. He also thanked CTC President Mr. Cai and the Executive Director of UNFPA Dr. Thoraya Obaid, as well as Dr. Fernandez-Castilla, the UNFPA TSD Director, for their support and advice. He also welcomed Mr. Rabbi Royan of UNFPA to the meeting.

Mr. Jooseery emphasized the importance of capacity development in the current development context and pointed out that the PPD perspective on capacity development refers to the building of abilities, skills, attitudes, and values, the imparting of knowledge to enable the effective performance of functions, problem solving and achievement of objective in a sustainable manner. He drew attention to that fact that the PPD has embarked on the development of a new Capacity Development Framework that will respond to the needs of its member countries. He referred to the assessment exercise conducted by PPD consultant Mr. S.L.N.Rao and remarked that the analysis would help in developing effective capacity building programs. He then went on to describe the five essential elements of the PPD capacity development program: I) comprehensive enough to be a "one-stop shopping"; ii) customized to the specific needs of its member countries; iii) competence-based; iv) assessment-based; and v) conceptualized for the attainment of ICPD and MDGs in the context of development agenda imposed by globalization. He underscored that capacity building should form the essential basis for South-South Cooperation and that there was a lot of experience and know-how in countries of the South, which need to be redefined, refined, reconstructed and re-channeled to meet emerging needs. He pointed to PPD's ongoing and current effort at formulating strategic framework for capacity building, and in that regard thanked Mr. Jyoti Singh, Mr. Rao, Mr. Seetharam, and Mr.Wilopo, who are all involved in that process.

Mr. Jooseery expressed his indebtedness to the authors of the regional overviews, Prof. Mari Bhat, Ms. Joy Mukaire, Prof. Abdelghany and Mr. El Hadji Dioum. He also expressed his gratitude to the

representatives of the seventeen Partner Institutions participating in the Meeting from Bangladesh, China, Egypt, India, Indonesia, Kenya, Mexico, Morocco, Senegal, Thailand, Tunisia, and Uganda. He paid a special tribute to UNFPA, whose financial and technical support to the Meeting was extremely critical. He placed on record his appreciation for the tremendous assistance and support received from the Government of People's Republic of China and most particularly that of H.E. Mr.Zhang Weiqing, the Minister of National Population and Family Planning Commission of China and the Chair of PPD in initiating PPD's Capacity Development Program. He also expressed his gratefulness to the Mayor of Taicang and its Municipal Council for their support and assistance.

Mr. Jooseery noted that China has committed to provide financial and technical assistance to PPD for the organization of two training programs per year till 2010 for participants from member countries. He expressed the wish that by the end of the Meeting, there could be an agreement on the priority themes in population, gender and reproductive health, on which training programs could be organized by PPD, CTC and Partner Institutions. He concluded by expressing his conviction that the meeting would come up with concrete proposals to move forward with meaningful results. He ended with the dictum, "If we give someone a fish, he eats for the day; teach someone to catch fish, he feeds himself for a lifetime."

Mr. Rabbi Royan, representing the UNFPA at the Meeting, began his remarks by congratulating PPD for organizing the Consultative Meeting to discuss the very important subject of capacity development. He noted that special credit was due to the National Population and Family Planning Commission for hosting the Meeting and to CTC for the excellent logistic and secretariat support. He pointed out the importance of capacity development in national development efforts and in international development cooperation. He also emphasized how capacity constraints shackle countries in taking advantage of resources and opportunities to maximize economic and social development. Finally he observed that capacity development remains important as developing countries strive to achieve the MDGs by 2015, especially because capacity constraints in many countries serve as a brake on sustainable development and sustained economic growth.

Mr. Royan pointed out that there was one big difference between the past and the current notion of capacity development in that, while previously it was primarily seen as knowledge transfer from the North to the South, it now refers to key conditions for sustainable development centered on national leadership and ownership of the development process by countries of the South. He underlined that it was in this particular context that PPD has an important role in ensuring that countries of the South have the required and requisite capacity to implement the ICPD Program of Action in order to achieve the MDGs. He went on to say that PPD, by promoting the exchange of experience and lessons

learned, could help countries of the South to share and benefit from good development practices and avoid development pitfalls.

Mr. Royan highlighted that UNFPA, as a multilateral agency, is committed to national capacity development as a priority, and to South-South Cooperation as a modality for laying the solid foundations for long-term economic and social development of poor countries, and for the realization of ICPD goals and the MDGs. He underscored the urgent need for regional training institutions in population and development to play an even bigger role to support and promote the development of new capacities in this area, besides upgrading existing skills. He cautioned that to meet both newly emerging demands and to replace trained individuals lost through retirement attrition, new and creative ways of training strategies are required. Mr. Royan concluded that important work remained to be done and that the Meeting should make attempts to find ways and make recommendations on how gaps between training needs and supply could be bridged and on what would be required to strengthen national and regional capacity in population, gender and reproductive health so that countries are better positioned to achieve ICPD goals and MDGs.

In his Opening Statement to the Expert Meeting, Mr. Hu Hongtao, the Deputy Director-General of the National Population and Family Planning Commission of China, welcomed everyone on behalf of Dr. Zhao Baige, the Vice-Minister of National Population and Family Planning Commission of China. He also thanked PPD for selecting the CTC as the venue and host of the Expert Meeting.

He emphasized that South-South Cooperation is a very important approach for realizing the ICPD goals and MDGs, and that China has always been an active promoter and advocate for South-South collaboration in population and development. Since becoming a member of PPD in 1997, China has trained around one thousand (1000) program mangers and service providers of reproductive health and family planning from developing countries. He highlighted the role that China has played for South-South, including the three recent international workshops conducted by CTC for ministers and other senior officials, the establishment of the China PPD Program office in 2006, China's hosting of the PPD Board meetings thrice in the past, China's donations of contraceptives and medical supplies to some African countries, and China's repeated call at international gatherings to the international community to provide greater support to South-South Cooperation.

Recognizing capacity development as the fundamental component of development and a key element in attaining ICPD goals and MDGs, Mr. Hu Hongtao noted that China had signed several MoUs with PPD mainly for capacity building during 2006-2010. As per one MOU, China would be supporting the training of 300 senior program managers and service providers from developing countries,

especially from African countries, providing a total amount of USD three million for capacity development to six reproductive health centers of six PPD member countries and trying to mobilize over USD one million for donation of contraceptives and reproductive health commodities to the PPD member countries.

Mr. Hu Hongtao then outlined the demographic and economic revolution of China during the last few decades. He pointed out that on the population front China has achieved a remarkable demographic transition to low levels of fertility, and population growth, as well as high levels of life expectancy. The economic growth in the country during the last twenty years has been even more spectacular. It has been growing at 9.6 percent annually and has experienced a several-fold increase in gross national product. He drew the attention of the Meeting to the three peaks that China would embrace in the first half of the 21st century: a peak of total population, a peak of working-age population and a peak of old-age population. He also noted the implications of demographic trends, among others, of employment challenge, social instability due to higher than normal sex ratio at birth, and effect of migration on distribution of public resources, etc. Given these and other challenges, he remarked that China was willing to continue the policy dialogue and the experience sharing and commodity exchanges with other developing countries, as it strives to address the population issue in the country in a comprehensive way.

Mr. Hu Hongtao underscored that, in the current context, a brand new paradigm for capacity development has emerged with cooperation among developing countries, necessitating continuous efforts to be made for the capacity development of policy-makers, program managers, and service providers as well as strengthening institutional development. He expressed his agreement with the five essential elements of capacity development that Mr. Jooseery had put forward in his statement to the Meeting. Mr. Hu Hongtao also expressed his conviction that the outcome of the Consultative Meeting would help to better understand the training needs in developing countries, and to develop a comprehensive strategy for the institutional capacity development of PPD member countries.

III. ASSESSING REGIONAL NEEDS IN TRAINING AND RESEARCH

Chairman: Mr. Harry Jooseery
Rapporteur: Mr. K.S. Seetharam

Mr. Harry Jooseery, Chairperson, in his introductory remarks reiterated the points that he had made in the opening session in that the Capacity Development programs must reflect the needs of member countries, while at the same time take into account the commonalities that exist among some countries and regions to facilitate the clustering of countries in developing and implementing specific interventions. He also drew attention to the need for Capacity Development programs to be in line with the new and emerging contexts of globalization and meet the requirements of achieving MDGs and ICPD goals.

He indicated that the four regional assessments, dealing respectively with Anglophone Africa, Francophone Africa, Arabic speaking countries of the Middle East, and Asia, will provide the necessary background for discussion in both the plenary and working group sessions to (i) take stock of the situation with regard to existing capacities and (ii) identify training and research gaps and suggest ways to address them.

Mr. Jyoti Singh, in his introductory overview, highlighted the role played by the United Nations, in particular the UNFPA, in supporting training and capacity development in developing countries. In this regard, he noted that South-South Cooperation as an effective and efficient modality received full recognition and support during the ICPD that led to the formation of PPD. Continued commitment to South-South Cooperation has revealed the wealth of expertise and experience that exist in the countries of the South, which can be shared among the countries in a cost-effective manner. Mr. Singh urged the participants to focus on the needs for technical support in the Partner Institutions to review and revise their curricula including training of trainers, exchange of expertise and experience, and more efficient networking among Partner Institutions.

Drawing on the experience of five countries, namely Gambia, Kenya, Nigeria, Uganda and Zimbabwe, Ms. Mukaire, argued that fertility and population growth continue to remain very high, contributing to the persistence of high levels of poverty and extremely low standards of living. She also brought out the differences that exist among the countries with regard to the use of reproductive health services and its underlying factors such as supply vs. demand and low level of health and social services.

Ms. Mukaire noted the absence of policies and that training programs were not cost effective and failed to meet service delivery needs. She also highlighted gaps in research, evidence- and performance- based planning, data and indicators, as well as in monitoring and evaluation. She recommended a number of management, training and advocacy strategies to improve policy development, planning, implementation and monitoring and evaluation of programs to accelerate the achievement of MDGs and ICPD goals. In conclusion, she suggested a comprehensive set of training courses and strategies as well as research priorities, and identified the needs for institutional capacity development.

Mr. Dioum, reviewing the situation in three countries of Francophone Africa, Benin, Mali and Senegal, observed that progress was being made in training a cadre of professionals. He noted, however, that population issues are loosing ground in the formulation of national policies and strategies due in part to the absence of trained population specialists and their effective involvement in the process. He also drew attention to significant gaps in research and recommended that high level advocacy is needed to support and strengthen research and related capabilities. He remarked that models such as RAPID, REDUCE and ALLOCATE are useful for advocacy, scenario analysis, and planning and that training should focus on the application of these models. Mr. Dioum also provided a set of training courses and research agenda to be pursued.

Prof. Abdelghany reviewed the progress in achieving MDGs in Arab countries based on the experience of five countries namely Egypt, Jordan, Morocco, Tunisia and Yemen. He identified the high rate of population growth including the growth of population at young adult ages, gender inequality and availability and affordability of reproductive health services as important issues. He also noted that lack of good quality data is a constraint to monitor progress in achieving the MDGs and ICPD goals and in conducting evidence-based research and developing policies, strategies, plans and programs.

Prof. Abdelghany underscored the need for training in data collection and processing using modern tools and methodologies and operations research, in strengthening the integration of Reproductive Health and Family Planning services, in managing multi-sectoral programs and interventions, and in communicating research findings to policy makers and senior planners.

Prof. Mari Bhat, in his report (presented in his absence by Dr. S. L. N. Rao) on the progress in achieving the MDGs in five countries of Asia, namely Bangladesh, China, India, Indonesia, Pakistan and Thailand, noted that, while significant progress was being made by all countries, they varied in terms of their ability to meet the goals and targets by 2015. He underscored that significant progress

had been made in training and that the region had a number of well established training and research institutions, which organize and conduct national as well as regional training programs of varying duration, cover a wide range of topics and use a number of different strategies. But he also pointed out that training in policy-related and applied fields had been weak and had received little attention.

Prof. Bhat's paper noted that while research had provided a clear picture of the changes that are taking place in population trends, it had not been sufficient to explain why they varied in different contexts and why some of the policies and programs worked while others did not. He emphasized the need for capacity development in conducting operations research.

Prof. Bhat recommended in his paper the organization of Training of Trainers (TOT), development of training modules, and cooperation among the different institutions through sharing of expertise and materials in strengthening the training programs. He further recommended that a journal be started to disseminate exclusively findings from operations research.

Discussion during the session revealed the following issues and general agreement among the Partner Institutions:
Teaching and research on population and development issues receive less emphasis and support from the countries as well as development partners. There is, therefore, a need to continue and enhance support for training of population specialists. In this regard, it is very important to review and revise the curriculum to reflect linkages with issues of poverty and make the training programs relevant to policy and strategy development and planning in various sectors and to address emerging issues. There is also a need to enhance support for relevant policy and operations research to better understand the linkages and to enhance policy and program effectiveness.

It is necessary to learn from the past training programs organized through South-South Cooperation programs as some of these programs have proved to be effective in developing management and leadership skills.

Population specialists need to communicate with policy makers and planners, particularly in the context of PRSPs, SWAPs, Sector Reforms, etc., to ensure that issues of population, reproductive health and gender are brought into the mainstream of these discussions. Special training programs need to be organized to develop these skills among population and health specialists.

Networking among the institutions both within individual countries and among the member countries could help build capacity of Partner Institutions in organizing and conducting training and research programs and, hence, should receive support.

Information and lessons learned from new methods of training e.g. distance learning, e-learning, etc. should be exchanged among the institutions, and efforts should be made to facilitate the transfer of related skills through exchange of staff among the institutions.

Inadequate resource was cited as a major hindrance for conducting training and research in a number of the institutions. Resource mobilization in support of these institutions was, therefore, accorded a high priority.

PPD was requested to play a major role in addressing these issues, in particular to strengthen the networking among the institutions, facilitating exchange of staff, information and materials and in supporting efforts to mobilize resources for strengthening training and research in Partner Institutions.

IV. MAPPING OF CAPACITIES AND EXPERIENCES OF PARTNER INSTITUTIONS IN TRAINING AND RESEARCH

Chairman: Dr. Siswanto Wilopo

Rapporteur: Dr. Alloys Illinigumugabo

Dr. Swiswanto Wilopo, the chair, made a few introductory remarks about the purpose of the session, and emphasized that given the large number of presentations, 18 in all, the presenters should be brief. The session was launched by an overview on the findings and issues of discussion from an Inquiry of Partner Institutions specially conducted by the PPD for the Expert Meeting. Mr S.L.N. Rao, the author of the background paper, pointed out that the inquiry was centered on assessing the capacities and experiences of the institutions with respect to MDGs and ICPD. He emphasized the need for implementing the ICPD Plan of Action to achieve the MDGs. Citing a previous study conducted by the PPD, he observed that that study had noted inadequate capacity in integrating population, gender and reproductive health issues in national policy, planning and budgeting processes as a major hindrance in rapidly achieving the MDGs and ICPD goals. The study had thus recommended new training courses and South-South Cooperation as a solution.

It was against this background that the current study was carried out from 17 training institutions of 12 PPD member states. While he regretted that the time allowed for presentation was too short to do any justice to the report, he referred the participants to consult the paper itself for detailed findings.

The study showed that a number of training courses on a large number of topics in population and reproductive health had been in operation in the Partner Institutions. However, gender-training programs were few and not comprehensive enough. He also revealed that existing training programs did not cover MDG issues, or development reforms in the context of SWAPs and PRSPs. Similarly, on-going research programs did not cover either MDG-related or policy-related issues, nor gender issues.

Almost all training institutions were promoting networking and partnership, though there was room for improvement. The speaker recommended to PPD to encourage this trend. Staff capacity issues came out as the main constraint facing training programs in many institutions. Mr. Rao requested the participants to discuss further on the following issues:

- Need for an integrated perspective in training course on population, gender and reproductive health, and whether separate courses are required on policy and programmatic issues or a single one.

    - Need for mainstreaming population, gender and reproductive health in PRSPs, SWAPs and other development frameworks. Identifying the t kinds of training activities that would be required.

- Need to pursue a more rigorous capacity development program through South-South Cooperation. How should PPD advocate giving priority and commitment to South-South initiatives at national and international levels?

- Need for PPD, UNFPA and others to respond to staff constraints for South-South initiatives through TOT, twining arrangements and sabbatical leaves in renowned institutions in the North, and supporting the presence of international expertise at Partner Institutions.

After this introductory presentation, the participants were introduced to training and research programs being implemented by the seventeen training institutions that were represented in the meeting. The presentations gave an overview of population and reproductive health training programs from 12 countries, namely Bangladesh, China, Egypt, India, Indonesia, Kenya, Mexico, Morocco, Senegal, Thailand, Tunisia, and Uganda. The presenters highlighted on-going training programs, research and technical assistance activities, as well as partnerships involved in their implementation. Annex C provides the power point presentations used by all the presenters of the session.

After a series of institution-based presentations, participants exchanged views on emerging issues and the way forward The participants expressed thanks to the speakers and highlighted the commonalities between the various training programs presented. The following recommendations emerged from the discussions:

- PPD to spearhead the creation of an institutional network/partnership of training institutions in population and reproductive health from member countries. In order to operationalize this, they proposed establishing a coordination mechanism in PPD, and developing a catalogue of existing training and research services and disseminating it through electronic media.
- PPD to promote advocacy for resource mobilization for South-South technical assistance.
- PPD to build capacity for training institution in impact training evaluation and evidence-based training development.
- PPD to review capacity development strategies and match them with the trend toward Swaps.

V. ADDRESSING PRIORITY ISSUES IN TRAINING, RESEARCH AND SOUTH-SOUTH COOPERATION THROUGH THE WORK OF THE WORKING GROUPS

A. Briefing on the work of the Working Groups

Chairman: **Dr. Jotham Musigunzi**
Rapporteur: **Dr. Siswanto Wilopo**

After making some introductory remarks, Dr Musigunzi invited Mr. Rao to brief the Meeting about the work program for the Working Groups. Mr. Rao pointed out that the Meeting had listened on the previous day to four regional presentations on the needs for training and research in Africa, Asia and Arab regions, as well as to institutional experiences and capacities from Partner Institutions and that the time had come to identify the critical gaps in population, gender and reproductive health and on how such gaps could be met. He suggested that the Meeting should constitute six working groups, three on substantive topics and another three on crosscutting topics:

1. Training in Reproductive Health
2. Training on Gender Concerns
3. Training on Population and Poverty
4. Training on Strategies and Options
5. Research in Population, Gender and Reproductive Health
6. Capacity Development Through South-South Cooperation

He pointed out that to set in motion the process of discussion in the working groups, the PPD had prepared a list of issues that the working groups could consider in their deliberations. While distributing the Issues Note, he emphasized that PPD was expecting a set of recommendations on the six topics and particularly a matrix of suggested training activities (courses) by duration and substantive focus in population, gender and reproductive health. He stated that a preliminary start had already been made on this in the form of suggestions in the four regional overview papers and that the working groups could further expand or elaborate on them. He declared that PPD would, with the help of subject experts, develop full-fledged modules on a limited number of thematic topics out of the suggested matrix of training courses coming out of working group's recommendations.

He then described the mechanics and functioning of working group formations, and the procedures of how the draft outputs of the working groups would be processed the next day in the Plenary session for their finalization and eventual presentation on the final day of the Meeting. He informed that the three working groups on substantive topics would meet simultaneously in the morning and the other

three on crosscutting topics would meet simultaneously in the afternoon. The list of issues for discussion for each working group, consolidated into one document is contained in the Annex. **Which one?**

B. Discussion of Draft Outputs of the Working Groups.

Chairman: Dr. Jotham Musigunzi
Rapporteur: Mr. S.L.N. Rao

Dr. Musigunzi invited Mr. Rao to first brief the participants of the Meeting on the planned work for the day before giving the floor to the various rapporteurs of the working groups to present reports. Dr. Rao made a few suggestions on how the outputs and recommendations coming out of the working groups would be dealt with by the Meeting. First, the Meeting would, he said, receive the rapporteurs' presentations and following each presentation, the participants would make comments and suggestions to improve the outputs, and that rapporteurs would revise their respective reports and submit to the PPD Secretariat the revised reports; second, at the end of presentations of all working groups that afternoon, participants would be invited to analyze the regional implications of the recommendations for each subregion taking into account all the working groups recommendations; third, at the Plenary next day, the Meeting would go over the implications of the recommendations for each represented institution by examining, for instance, what the specific institution planned to do in order to take into account the identified training gaps in its current or planned courses; and fourth, after the discussion of institutional implications, the Meeting would examine the global implications of the recommendations.

The Chairman then invited the rapporteurs of the working groups to make the presentations. On the whole, the outputs of the various working groups were well received by the Plenary. There were suggestions for improving the matrix of courses for a few areas, and in some cases more general recommendations were made that could be applicable to all areas.
The following is a summary of the discussions on the outputs of the six working groups, taken by the Plenary, one at a time:

1. Reproductive Health

The working group had identified as gaps: historical perspectives on the evolution of reproductive health concept, a number of specific issues at policy, programme, and management levels, and advocacy as well as providing support and role for PPD. It also included, a framework of courses by thematic focus, type of training, and duration and target audience in reproductive health. During the

discussion that ensued, many participants thanked the group for a job well done and made a few minor suggestions on a couple of issues like duration and target. A suggestion was made to add IEC. There was a general recommendation that PPD, through a small grant project, could provide for an exchange of scholars and experts.

2. Gender Concerns

Since there were not many courses on gender in Partner Institutions, the group identified many issues related to legal and human rights perspectives, role and responsibilities, access and control of resources, decision-making, and interlinkages with other MDGs for inclusion in training. Within that framework, the working group had identified seven clusters of issues and had proposed action, strategy and target audience. The working group also had provided a matrix by thematic focus, type of training, duration and target group. During the discussions, there were a number of comments made on the specific areas in the proposals including the addition of sexuality education, issues of adolescent and youth in gender, and gender concerns in training. There was a general recommendation that a pilot syllabus aimed at integrating reproductive health, gender and poverty should be tried out.

3. Population and Poverty

The group had identified as gaps a number of issues and termed them as considerations for the matrix, six focus areas, and matrices of courses and recommendations. The group was congratulated on a good piece of work, as it was the most advanced in terms of a module. There was a suggestion that a thematic area of population displacement and poverty be added to the matrix.

4. Training Strategies and Options

The group had identified a number of gaps to be addressed categorized into contents of training, training methods and materials, training of trainers, and management of training programmes. For each gap, it identified a strategy to overcome it and also the nature of support action by the Partner Institutions themselves, by PPD and by international organizations. During the discussion, a number of additional suggestions were made, including preparing a catalogue of courses; undertaking needs assessment for training and review of curricula, as well as adding education on HIV/AIDS, and elements of skills competencies and core competencies to the contents of training. There was some general discussion on performance-based approach vis- a- vis competency-based approach. It was also recommended that the issue of resources for training at both national and international levels deserved urgent attention, as also the need for a team of lecturers for the training of policy makers, planners and programme managers.

5. Research in Population, Gender and Reproductive Health

The working group had identified a number of issues on conducting research in population, gender and reproductive health, starting with needs assessment, possible research topics in population and poverty and in reproductive health, and a model for research on gender and poverty. The group also highlighted issues and considerations in finding support for research. Furthermore it suggested issues for evaluation research on training and research. However, many participants found the format of presentation difficult to follow. A number of participants raised a range of issues including suggested topics for research such as violence against women, evidence-based research, population aging, menopausal issues, neo-natal mortality issues, adolescent reproductive health issues and access to services, and unmet access to reproductive health care. Proposals on research strategies included evaluation of technical assistance projects, capacity building for research methodologies, requisite research to mount new training programmes, research on training evaluation, and resource mobilization for research agenda and projects, and on how to improve programmes to achieve MDGs, indicators development to monitor programmes. There were general recommendations that PPD should produce a database of research projects in PPD countries, support training on the writing of project proposals and protocols, and help facilitate resource mobilization for research.

6. South-South Cooperation

The group considered the four issues assigned earlier and consolidated them into three, and then identified issues within the clusters that have to be resolved and made detailed recommendations. The group had the clearest presentation of what needs to be done and how to do it. During the discussion, there were very few questions raised on the report. There was a recommendation that PPD should try to link the Partner Institutions by offering fellowships to participants from other countries.

The chairman requested the Group Rapporteurs to revise their respective individual group reports and to submit them to the Secretariat for finalization and distribution. He then invited the participants to trace the regional implications.

C. Regional Implications

At the end of the discussions on the work of the working groups, the Chairman invited comments on the regional implications of the working groups' recommendations. A summary of the points made are presented below:

a. Asia

1. Sub-regional collaboration among Partner Institutions in South Asia is possible, but needs a framework for cooperation. PPD was requested to help facilitate such cooperation, including issuance of invitations.
2. Partner Institutions indicated a desire to get together in Dhaka. Since the NIHFW is a WHO cooperating institution, it can collaborate with institutions from other regions as well.
3. PPD should facilitate and strengthen communication among Partner Institutions.
4. PPD should conduct income-generating activities to raise funds in support of research, training, and materials development.

b. Africa

1. While CAFS has built capacities in Africa, it was costly and short-term consultants were very expensive. Given that at the national level there were no facilities, technical capacities were limited, and consultants were expensive, the process of capacity building in Africa was a major issue. Resource shortage was the biggest problem in Africa.
2. There was no collaboration among Partner Institutions within Africa once again because of no availability of funds.
3. CAFS was willing to help other countries to develop models and modules for advocacy, implementation of emergency obstetric care, adolescent reproductive health, abortion care, and conduct of short-term training courses.
4. CAFS was trying to reduce cost by transferring training capabilities to institutions at country level.

VI. RECOMMENDATIONS AND THE WAY FORWARD

Chairman: Mr. Jyoti Singh

Rapporteur: Mr. K.S. Seetharam

Mr. Jyoti Singh, the Chairman, in his introductory remarks, noted the significant progress that was made during the plenary and working group sessions. He suggested the circulation of the revised reports of the working groups to the Plenary (Item E in the Annex). He also noted that it was time to take a closer look at the role that the Partner Institutions could play in future towards capacity development and what support PPD and other international organization like UNFPA could provide towards this goal. He then requested Mr. Rao to summarize the major outcomes of the Meeting so as to provide a framework for further discussion.

Mr. Rao, in his overview, highlighted the following four common themes that merged out of the six working groups dealing with training needs in the areas of population and poverty, reproductive health and gender, as well as the cross-cutting issues of training strategies, research and South-South cooperation:

(i) Needs assessment of training and research gaps

(ii) Joint programmes and collaboration among the institutions

(iii) New and non-traditional methods of data collection, analysis and research

(iv) Resource mobilization for training, research and information exchange

Mr. Rao informed the participants about the Capacity Development needs assessment of member countries that PPD was currently undertaking which covered organizational as well as priority areas in reproductive health, population and gender. He also stated that the findings from this assessment would authenticate as well as supplement the needs and priorities identified during the Expert Meeting.

Mr. Rao further pointed out that the possibility for collaboration among the institutions exists in several common areas of training and research as programmes in the Partner Institutions are complementary and cover a wide and comprehensive array of topics. Such collaboration, he noted, would be extremely valuable to build capacities of the institutions as well as to further strengthen South-South exchanges of information, expertise and knowledge.

In view of the need expressed to strengthen the capacity of the institutions to address new and non-traditional methods of data collection and analysis, Mr. Rao suggested the convening of a workshop on the topic among the Partner Institutions.

He also alluded to the role that Partner Institutions, PPD and member countries could play in augmenting resources for training, research and related capacity development activities on population and poverty, reproductive health and gender.

Mr. Rao suggested that a limited number of training modules on population and poverty and gender be developed initially to enable their integration into the training curricula of Partner Institutions. In this regard, he requested the Partner Institutions to share with the Secretariat and among themselves the details of course curricula that are being offered in various training institutions. In closing, Mr. Rao raised the following issues and requested the Partner Institutions to share their view on these:

i. Willingness to incorporate the training modules on reproductive health, population and poverty, and gender into the ongoing training programmes and courses offered by Partner Institutions,
ii. Role of Partner Institutions in collaborative or joint programmes,
iii. Willingness to share/exchange expertise, resources and materials.
iv. Their own needs for building capacity in the areas of training and research.

A. Institutional Implications

In their response, the Partner Institutions were in agreement with the following:

- To review and revise their training curricula and incorporate new dimensions of population, reproductive health, poverty and gender into the ongoing training programmes and courses as appropriate,
- To open up their training programmes for participants from other countries by making information about the courses available more widely, and some expressing the possibility of providing partial and/or full support for such participation through the award of fellowships for training,
- To work collaboratively among the institutions, within and among the countries, in organizing training courses, and in facilitating the organization and conduct of research, by pooling their resources when feasible,
- To share their expertise and resources among the institutions.

The responses from the Partner Institutions also highlighted the following:

PPD should share the revised modules, when they become available, with the Partner Institutions to help organize and conduct the Training of Trainers (TOT) from the institutions, as well as to facilitate the incorporation of new contents related to population and poverty and gender into their curricula.

Some of the Institutions expressed that they would be able to increase the number of fellowships or would seek funding from their own countries and/or from other sources to award fellowships to others in the future. The need to learn from each other about the experiences with new training methodologies was considered very important.

Partner Institutions also highlighted the role PPD should play in coordinating and exchanging information and expertise among the institutions and in seeking additional resources to develop and implement a well-coordinated capacity development programme.

B. UNFPA Implications

In his intervention, Mr. Rabbi Royan, UNFPA representative, noted that the recommendations emanating from the discussion are feasible and that the areas for training were in line with needs and priorities. He also indicated that capacity development through South-South Cooperation was one of the elements of UNFPA's Strategic Planning and was well in line with UNFPA's thrust of

strengthening regional and national institutions. He commented that there was a close synergy between PPD's initiative on capacity development and that of UNFPA.

C. PPD Implications

In his closing comments, Mr. Jyoti Singh stated that the report of this Meeting, including the six working group reports would be finalized soon under the direction of Mr S. L. N. Rao and distributed to all the participants. He went on to highlight the planned PPD follow up actions:

1. PPD is convening in June 2007 a meeting in Dhaka with selected experts/authors of modules, including those who submitted the regional papers to this consultative meeting, to review the drafts of course modules on several specific topics. These would include:

   a. Population, Reproductive Health, and Poverty Alleviation
   b. Gender, Reproductive Health and Rights
   c. Reproductive Health: Definition and Conceptual Framework.
   d. Population, ICPD goals and MDGs: A Historical and Institutional Perspective

He was hopeful that the June meeting would be in a position to finalize these drafts, which would then be circulated among the institutions interested in introducing courses or modifying and adapting existing courses. These courses might be introduced in the academic year 2008-2009 or earlier in some cases.

2. Given that the participants at the Expert Meeting had agreed to participate in a network of training institutions on population, reproductive health and development themes, PPD should try to make such a network operational as soon as possible. This would require assigning a staff member at PPD Dhaka (and perhaps also at PPD Kampala) with specific responsibilities in this regard. A list serve operation would enable the participating institutions to post course curricula and materials on the website, advertise courses and fellowships and post such other information as may be of interest to other institutions;

3. PPD would discuss with UNFPA the possibility of developing courses for training of trainers, providing financial support for posting of experts and resource persons interested in launching courses, support for a fellowship programme and production and dissemination of training materials and documents. UNFPA had a major technical and financial role to play in all of these areas, and the time was propitious as it was launching soon its own strategic plan for capacity development, as well as its inter country programme for 2008-2011. It was encouraging to note here that the strategic plan

that PPD was formulating on capacity development was in sync with UNFPA's strategic plan on capacity development, with much potential for synergy.

4. Within existing resources, many of the institutions might be in a position to invite selected experts, develop training materials and provide fellowships. The new network should promote South-South initiatives in this regard; and

5. The training to be undertaken by CTC and other institutions in cooperation with PPD under its Memorandum of Understanding with China should utilize the course modules and materials being developed under this project.

In closing, Mr. Singh expressed the hope for UNFPA's continued support to PPD's Capacity Development initiative through its support for the regional and national institutions that are Partner Institutions of PPD. He also expressed the hope that PPD would facilitate bi-lateral and tri-lateral meetings to support the Partner Institutions in building their capacities, including upgrading the infrastructure of some of the institutions. He also felt the need to involve other organizations such as WHO and UNAIDS in this effort.

VII. EXPRESSING POLICY COMMITMENT: CLOSING REMARKS

The substantive component of the Expert Meeting came to a close with the end of discussions on the implications of the recommendations at regional, institutional and global levels. The closing ceremony included short speeches by the President of CTC, Mr. Cai, the Director-General of the National Population and Family Planning Commission, Dr. Hao Linna, and Mr. Harry Jooseery, the Executive Director of PPD.

In his vote of thanks, Mr. Cai thanked everybody attending the Meeting and expressed special thanks to Mr. Jooseery, Dr. Rao, Mr. Royan, Mr. Singh, Dr. Musigunzi, Dr. Wilopo and Mr. Hongtao. He also thanked Dr. Hao Linna for having come from Beijing for the closing ceremony. He expressed the hope that like him, all the participants also believed that the Expert Meeting was a highly productive one. He assured the audience that CTC was willing to work closely in the future as well on follow-ups on capacity development in South-South Cooperation. He wished everybody a wonderful journey back home.

In her official closing statement, Dr. Hao Linna warmly congratulated everybody for the success of the Meeting. She also expressed her gratitude to PPD Secretariat and CTC for their excellent logistic support for the Meeting. She acknowledged that the outcome of the Meeting had laid a very good

foundation for capacity development. Reviewing the demographic situation, she remarked that PPD countries continued to face major challenges in population. Making family planning information widely available and improving reproductive health in developing countries would increase opportunities for education and career development for women in those countries. She appreciated the critical role of the seventeen PPD institutions in capacity development and expressed her conviction that with active and full participation of those institutions, good progress on capacity development could be made. In the same vein, she paid tribute to China's training institutions, which have trained a total of over one thousand programme managers and service providers from other developing countries. She mentioned that China would offer three hundred fellowships in family planning and reproductive health during the coming years. She promised to promote networking and cooperation among the Partner training institutions. In closing, she thanked CTC and PPD for organizing this Meeting and UNFPA for their consistent and valuable support to South-South Cooperation. Finally, she conveyed the greetings of Vice Minster Dr. Zhao Baige to all the participants and others and wished everyone a safe and pleasant journey back home.

Mr. Jooseery was the last speaker, and in his remarks, he summarized the various steps PPD had taken to prepare for this meeting. He expressed his firm belief that the discussions of the Meeting dealing with implications of the recommendations at regional, intuitional and global levels would help PPD to move strategically during the next four years. He particularly emphasized four points, which are (a) institutionalization of new training courses within the training programs of Partner Institutions, and fostering ownership of the initiative; (b) the development of new capacity development framework that would address the emerging areas tailored to the specific regional needs in reproductive health and population and development; (c) the need for networking; and (d) the issue of capacity development program sustainability. He then underscored the need for a mechanism to link all the Partner Institutions.

Given the emergence of a new direction in promoting capacity building, Mr. Jooseery felt convinced that there would be additional opportunities to sustain progammes. A close collaboration with donors and collaborators would be essential for shared but different responsibilities. He appealed to UNFPA to substantially fund PPD to enable it to implement its capacity development plan, which was in concordance with UNFPA's own strategy on capacity development. He expressed his great appreciation to China, which is taking the lead on capacity development, especially among the PPD member countries. He stated that resources should not only flow to PPD, but to all concerned including Partner Institutions, and if that would happen, then everyone would succeed. Mr. Jooseery characterized the PPD motto, in short, as "Business with a Difference."

He wished everyone a safe journey back home. With that, the Consultative Meeting of Experts on Capacity Development was declared closed.

VIII. CONCLUSION

The universal pursuit of MDGs and ICPD goals and the record of mixed progress in achieving them has brought to the fore the issue of capacity development of analytical capacities in developing countries. The PPD, as an alliance of 21 developing countries, is committed to building capacity through South-South Cooperation. With the financial assistance of UNFPA and in collaboration with China Training Center in Reproductive Health and Family Care (CTC), PPD had organized this International Consultative Meeting of Experts on Capacity Development at Taicang, China, with the main objective of assessing the training gaps and on how to address them. Having identified the gaps, it was important to determine what role South-South cooperation could play in overcoming the shortfalls.

The deliberations during the 4-day Meeting have succeeded in elaborating those training gaps and the likely role that Partner Institutions could adopt to reduce the lack through South-South Cooperation. The substantive topics identified for training in the areas of population, gender and reproductive health and suggested training modalities to address them is a major step forward in enhancing the analytical capacities of developing countries. The willingness of Partner Institutions to review their own course curricula and to incorporate actions to address the identified gaps, as appropriate, in current or planned courses is an excellent welcome development, demonstrating institutional ownership. PPD's efforts to help develop a limited number of modules to mainstream population, gender and reproductive health would complement the institutional responses noted above and would help raise the capacities of developing countries. This augurs well for the implementation of MDGs and ICPD goals aimed at eradication of extreme poverty and promising a brighter picture for future generations.

Annex A:

Working Groups Reports with Recommended Matrices

Annex B.

STATEMENTS MADE AT OPENING CEREMONY

Welcome Address By:

Mr. Jianhua Cai

President, China Training Center of Reproductive

Health and Family Care

Your Excellency Mr. Harry Jooseery, Executive Director of PPD
Your Excellency Mr. Hu Hongtao, Deputy Director-General, Department of International Cooperation, National Population and Family Planning Commission of China
Distinguished Guests,
Ladies and Gentlemen, Good morning.

It is my great pleasure to welcome you all to China Training Center of Reproductive Health and Family Care on the occasion of this Consultative Meeting of Experts on Capacity Development under the sponsorship of UNFPA and NPFPC. This meeting co-organized by PPD and CTC, aims at addressing the training needs, existing institutional capacities and the gaps in PPD member states, so as to develop a comprehensive strategy to respond to these needs and bridge the gaps.

Here, I would like to take the opportunity to give you a brief idea on CTC. As a young institution established in October 2005, CTC is created mainly for two purposes.

Firstly, over the past three decades, China has undergone a historic population transition from high fertility, high mortality and low natural growth to low fertility, low mortality and low natural growth. The total fertility rate has been reduced from 5.8 in early 1970s to below the replacement level. Hence, how to explore an integrated approach to population issue is a great challenge for the government and policy-makers. Issues that need to be taken into consideration include upgrading population quality in terms of health and education, improving population structure, ensuring population security, and expanding the family planning service network to a broader public service network in the field of reproductive health or even for health promotion.

Secondly, as the largest developing country in the world, China highly appreciates the solidarity and cooperation with other developing countries. South-South Cooperation has always been the

cornerstone of China's foreign policy, and we firmly believe that South-South Cooperation is the driving force for development effectiveness among the developing countries. Since the inception of reform and opening-up program, China has scored great achievements in economic development. GDP per capita has been raised from RMB 379 in late 1970s to RMB 15,930 in 2006, almost over 40 times of what it was three decades ago. Rural poor population has been reduced from 250 million in 1978 to 26 million at present, and the poverty incidence has dropped sharply from 30.7% to 2.8%. In addition to achievements in self-development, China also seeks an effective way to promote common prosperity with other developing countries, and ultimately, aiming at the common realization of MDGs.

Under these circumstances, CTC is designed to develop a service-oriented platform delivering training and education on reproductive health and family care, as well as to facilitate the cooperation and communication on population and development with both developing and developed countries.

During the past 18 months, under the vigorous support of the Chinese government and in partnership with international organizations, CTC has experienced rapid development. We have organized a series of training programs for capacity building with international experience for reference. Last month, a reproductive health consultant, initiated and advocated by CTC, has been approved as a new occupation by the Ministry of Labor and Social Security, which is believed to be a significant progress in China's implementation of ICPD PoA. We have also constructed the metabase, which serves as an information platform for commodity security and RH in South-South Cooperation. Since establishing this, we have successfully organized three international workshops for senior officials in population and development, promoting information-exchange and experience- sharing in capacity building of program management and South-South Cooperation. This year, we are going to have three more international workshops, i.e., workshop on MCH for practitioners and service providers, workshop on SRH and human rights, and a workshop on RH institutional development. Moreover, having the PPD China Program Office in CTC is another advantage enabling us to better engage in South-South Cooperation. This afternoon, I will share with you more details on CTC as well as what we do.

Last but not least, please allow me to extend my sincere gratitude to Mr. Harry Jooseery and the PPD, for selecting CTC as the venue for this important event. I hope, in the coming few days, we will have the privilege and opportunity to communicate with all the experts and professors here, share your wisdom and vision, and seek future cooperation. I'm sure this will be a productive meeting. Also, we will do our best to ensure the complete success of this event.

Wish you all a nice stay in China.

Thank you.

Address By:

Mr. Harry S. Jooseery

Executive Director

Partners in Population and Development (PPD)

Mr. Hu Hongtao, Deputy Director General, Department of International Cooperation, National Population and Family Planning Commission (NPFPC) of China
Mr. Jianhua Cai, President, CTC
Mr. Rabbi Royan, Senior Technical Advisor, Population and Development,
UNFPA, New York
Consultants, Participants, Ladies and Gentlemen,

I am pleased to welcome you to this consultative meeting that is being organized here in this beautiful city of Taicang in collaboration with the UNFPA and the China Training Center. We have had a long preparation for this meeting with our lead consultants deeply involved in the enquiry process, preparing the instrument for a comprehensive collection of relevant information, the analysis of the data, the preparation of the regional papers by the four experts, the discussion with UNFPA, the sharing of feedback among consultants, experts and PPD staff, and the logistic preparations by PPD and CTC. I take this opportunity to thank all of you who have been involved in the whole process. I am very appreciative of all those who have expended precious time in completing the inquiry questionnaire, and also in preparation of the regional papers. Thank you also Messrs Jyoti Singh, S.L.N. Rao, K.S. Seetharam, and Siswanto Wilopo for your hard work and valuable contribution. I would like also to thank Mr. Cai, President of CTC, and his team for all the logistic arrangements for the holding of this meeting at Taicang. My special thanks go to Mr. Rogelio Fernandez-Castilla, TSD Director of UNFPA, for his unrelenting support and assistance to us. Unfortunately, he could not be with us today due to other commitments. I do welcome Mr. Rabbi Royan from UNFPA at this meeting, and we would request you to convey our best regards and greetings to Mr. Rogelio Fernandez-Castilla.

Ladies and gentlemen, we are all here to bring together our expertise and experience, synergize our efforts to create a discourse on the way forward for our strategic capacity development initiative. Capacity building has become the buzzword on many fronts internationally and indeed drawing the attention it deserves. This is in recognition of the importance of continued and constant sharing of

knowledge as a dynamic process to adapt and to grow to the fullest potential. For us, capacity building refers to the development of abilities, skills, attitudes and values, and the imparting of knowledge to enable the effective performance of functions, problem solving and achievement of objectives in a sustainable manner. Sustainability entails that we keep abreast of new development, equip ourselves with skills and resources that will enable us to survive, adapt and thrive in a fast changing world.

The emerging environment ushered by globalization imposes a readjustment of the human system that will enable us to survive, grow, diversify and become more competent. Capacity is most sustainable when it responds effectively to the needs of the people and is strategically based on a long- term vision. PPD has embarked on the development of a new Capacity Building Framework that will respond to the specific needs of its member states. We have utilized the McKinsey Capacity Framework to assess human resources, systems and organizational structure in relation to the development of aspirations, strategies and skills. You have all participated in the assessment exercise, and our consultant Dr. S.L.N. Rao has analyzed the data and has come up with very valuable information that will help all of us to understand capacity gaps and capacity development potentials, and develop effective capacity building programs.

We need to consider five essential elements:

We desire a program that is comprehensive enough so that it will offer some degree of "one-stop shopping". We would like to partner with institutions in order to reach a wide array of Reproductive Health issues that would contribute to the attainment of ICPD and MDGs.

- We need capacity building program to be customized to the specific needs of member states. Recognition of the commonalities among developing countries would help to cluster needs and develop program interventions as per regional specificity.
- Capacity building efforts need to be competence based. They should be offered by competent professionals; more so, when requested by "enlightened customers", who are committed to make a difference. We do not get trained for the sake of training only.
- We need to be assessment based. We should start with the assessment of the needs and assets to be able to steer the type of capacity building program we want.
- Capacity building program needs also to be contextualized. We need, as I said before, to develop programs that will galvanize efforts for the attainment of the ICPD and MDGs, and also will consider the context of the new population and development agenda imposed by globalization.

Ladies and gentlemen, we contend that capacity building forms an essential base for South-South Cooperation. Countries of the South have got lots of expertise and know-how which need to be redefined, refined, reconstructed and re-channeled to meet emerging needs. We are questioning conventional wisdom for the promotion of competency and result oriented capacity development program. Mr. Jyoti Singh, Mr. Rao, Mr. Seetharam and Mr. Wilopo have been kind enough to support our initiative and to assist PPD in the development of the strategic framework for capacity building and I am very thankful to them. We are also thankful to Mr. Mari Bhat, Ms. Joy Mukaire, Prof. Abdelghany and Mr. El Hadji Dioum for having worked on regional papers on capacity building program. 17 Partner Institutions represented here from Bangladesh, China, Egypt, India, Indonesia, Kenya, Mexico, Morocco, Senegal, Thailand Tunisia and Uganda have participated in the Training and Research Capacity Needs Assessment, and I am thankful to all of them**.** This meeting would not have been possible without the financial and technical support and assistance from UNFPA, to which I am very grateful. Last but not least, I wish to place on record the tremendous assistance and support provided by the Government of the People's Republic of China, and most particularly the Hon. Zhang Weiqing, the Minister of National Population and Family Planning Commission of China and the Chair of PPD in initiating our Capacity Development program. PPD has signed a Memorandum of Understanding with China on Capacity Development, and this has been spearheaded by Hon. Zhang Weiqing, the Chair of PPD. China has committed to provide financial and technical assistance to PPD for the organization of 2 training programs every year for participants from our member states till 2010. We wish that by the end of this meeting we will be able to agree on the priority RH themes and training modules which will be developed. This will serve as a basis for the organization of a series of training programs to be organized by PPD, CTC and also Partner Institutions.

Ladies and gentlemen, we are today among experts in the field of capacity building and I am convinced that by the end of this 4-day meeting we will come up with concrete proposals that will enable us move forward with meaningful results, and turn dilemmas into opportunities because we believe, as the dictum says: "If we give someone a fish, he eats for a day, teach someone to catch fish, he feeds himself for a lifetime".

Ladies and gentlemen, thank you for your attention.

Address By: Mr. Rabbi Royan
Officer-in–Charge, Population and Development Branch
Technical Support Division, UNFPA, New York

Mr. Hu Hongtao, Deputy Director General Dept of International Cooperation, National Population and Family Planning Commission (NPFPC)
Mr. Harry Jooseery, Executive Director, Partners in Population and Development (PPD)
Mr. Cai Jianhua, President, China Training Centre (CTC)
Ladies and Gentlemen,

Let me on behalf of UNFPA congratulate Partners in Population and Development (PPD) for organizing this Consultative Meeting of Experts to discuss the very important subject of capacity development. Special credit is also due to the National Population and Family Planning Commission (NPFPC) for hosting the meeting in this beautiful city of Taicang. Thanks to China Training Centre for the excellent secretariat and logistic support. A warm welcome to all participants who have come here from countries far and near to provide their inputs and contribute to the discussions over the next few days.

The topic of capacity development continues to receive much attention in almost all global development discussions. It has been an issue that has been discussed for a very long time by governments of developing countries trying to achieve development results for their population; it has been a major issue of donors and multilateral agencies working to ensure that the countries of support had the capacity to take advantage of resources and opportunities available to maximize economic and social development. Capacity development remains important today as developing countries strive to achieve the Millennium Development Goals by 2015, especially because capacity constraints in many countries serve as a brake on sustainable development and sustained economic growth.

The one difference between the past and the current notion of capacity development is that while previously capacity development was seen primarily as knowledge transfer from North to South, there is currently an increasing understanding that the key conditions for sustainable development are national leadership and ownership of the development process by countries of the South. And here is where PPD has an important role to play in ensuring that South countries have the required and

requisite capacity to implement the ICPD Program of Action and achieve the Millennium Development Goals. PPD can also help to make it possible for South countries to share and benefit from good development practices and sometimes even highlight the development pitfalls to avoid, on the basis of the experiences of other South countries.

UNFPA, as a multi-lateral development agency, is committed to national capacity development as a priority, and South-south Cooperation as a modality for building the foundations for long-term economic and social development of poor countries, and for the realization of the ICPD Program of Action and the Millennium Development Goals. There is an urgent need for regional training institutions that are working in the area of population and development to play an even bigger role to support and promote the development of new capacity in this area, even while they upgrade existing skills. New areas of demand have also emerged. Cohorts of experts trained earlier in population studies are retiring in many countries, and the resulting shortages have to be met in new and creative ways of training.

Ladies and Gentlemen,

This meeting is a follow-up to the very critical work that has been initiated over the last few months on research and training needs assessment of PPD countries as well as the capacity of institutions in Partner countries to meet these needs. We have, therefore, very important work to do. Among other things we will have to attempt to find ways and make recommendations on how we can bridge the gap between training needs and supply, and what needs to be done to strengthen national and regional capacity development in population, reproductive health and gender, so that countries are better positioned to achieve the ICPD PoA and the MDGs.

Thank you.

Opening Address By:
Mr. Hu Hongtao
Deputy Director-General, Department of International Cooperation, National Population and Family Planning Commission of China

Distinguished Mr. Harry Jooseery, Executive Director of PPD

Distinguished Mr. Rabbi Royan, Technical Advisor of UNFPA

Distinguished Prof. Dr Nabiha Gueddana, Director General, National Office of Family and Population, Tunisia

Distinguished professors, resource persons, friends,

Ladies and Gentlemen,

Good morning!

In China's history, there was a great philosopher and educator, and his name was Confucius. Confucius says, "What a great joy to have friends from afar". Today in this beautiful spring season and beautiful Taicang City, we are very pleased and honored to have you, distinguished experts and friends from afar.

First of all, please allow me, on behalf of Dr. Zhao Baige, the Vice Minister of National Population and Family Planning Commission of China, to extend my heartfelt congratulations on the convening of the Consultative Meeting of Experts on Capacity Development and my warm welcome to all of you from afar. Also, I would like to thank PPD for selecting CTC, a home of PPD China Program Office as the venue for this important event.

South-South Cooperation is a very important approach for realizing the ICPD goals and MDGs. China has always been an active advocate and promoter for South-South Cooperation in population and development. Ever since 1997 when China became a member of PPD, China has trained about 1000 reproductive health and family planning program managers and service providers from developing countries, and even CTC alone has conducted three international workshops for ministers and other senior officials in the last two years; China has been the host country three times for the PPD annual board meetings; China has established PPD China Program Office in 2006; and China has donated contraceptives and medical equipment to various African countries; China always uses every opportunity to call on the international community to provide more support to South-South Cooperation, and greater assistance to PPD. We made such a call again during the 40th Session of the UN Commission on Population and Development held in New York last month. I really appreciate Indonesia for joining China in calling for greater support to PPD. I thank Dr Siswanto Wilopo for his valuable contribution in this regard. Though our voice may still not be strong enough, if we, however, continuously unite voices, we could make a difference.

Capacity development is widely recognized as the fundamental component of development and a key element in attaining ICPD goals and MDGs. Last November, China signed three MoUs with PPD mainly for capacity building. According to the MOUs, China, during the period of 2006-2010, will train a total of 300 senior program managers and service providers from developing countries, especially from African countries, will provide a total of over USD3 million for capacity building to six reproductive health service centers in six PPD member countries, and will try to mobilize over USD 1 million for donation of contraceptives and reproductive health commodities to the PPD member countries.

Ladies and Gentlemen,

As we all know, China is the most populous developing country in the world. Over the past three decades, China has achieved two wonders, namely the completion of a historic demographic transition and a rapid economic development. The population and family planning program has achieved remarkable accomplishments. With a decline of the total fertility rate from 5.8 in 1970 to 1.8 at present and over 400 million fewer births nationwide. In 1996, average life expectancy in China exceeded 70. At the beginning of the 21st century, China is already on the list of countries that feature low fertility rate, low population growth and high life expectancy. Over the past 20 years, China has been keeping its average economic growth rate at 9.6% per annum and has increased its economic aggregates by 11 times.

Although great achievements have been made in population programs, China is still facing enormous challenges. During the first half of the 21st century, China will embrace three population peaks, namely, peak of total population, peak of working-age population and peak of aged population. It is predicted that in the next dozen or so years, China's population will maintain its strong growth momentum with an annual net increase of 8-10 million population. In the face of such a large size of working population, the employment situation in China would face more severe challenges. The higher than normal sex ratio at birth implies a potential risk to social stability. The increasingly growing migrant population constitutes a huge challenge for the distribution of public resources. The diversifying poverty population structure renders promotion of balanced social development an arduous task. And China's population ageing trend constitutes another severe challenge and exerts unprecedented pressure on social security. Population issues remain a significant constraint on China's attempt to achieve all-round, coordinated and sustainable development. China is very much willing to continue the policy dialogue, experience sharing and commodity exchanges with other developing countries in its strive to address population issues in a comprehensive way.

Ladies and Gentlemen,

As we move into a new stage, it is clear that a brand new paradigm for capacity development has merged with cooperation among developing countries. Continuous efforts need to be made in the capacity development of policy-makers, program managers and service providers as well as the strengthening of institutional capacity development. I fully agree with the five essential elements for capacity building put forward by Mr Harry Jooseery just now. It is time for concrete action, and let's do something first. I am sure the outcome of this consultative meeting will help to better understand the training needs in developing countries, and help to develop a comprehensive strategy for the institutional capacity development in PPD member countries.

Finally, I'd like take this opportunity to extend our thanks to UNFPA for supporting this meeting, and our thanks to PPD Secretariat and CTC team for the excellent preparations they made for this meeting. I wish the Consultative Meeting of Expert on Capacity Development a great success, and our friends from afar a pleasant stay in China.

Thank you.

ANNEX C:

STATEMENTS MADE AT CLOSING

Vote of Thanks By:

Mr. Jianhua Cai
President, China Training Center of Reproductive Health and Family Care

Dear Mr. Harry Jooseery,
Dear Mr. Robbi Royan,
Dear Dr. Hao Linna, Mr. Hu Hongtao,
Distinguished guests, Ladies and Gentlemen,

I deem it a great honor to be able to propose the vote of thanks on behalf of PPD, China, and CTC to all of you here. We are deeply indebted to you for articulating the voice of training experts and institutions from PPD member states.

I would like to take this opportunity to extend our most sincere thanks to all our guests who have come to Taicang from various destinations. I do thank Mr. Harry Jooseery for selecting CTC as the venue of this important meeting. My special thanks go to Dr. Rao, Mr. Robbi Royan, Mr. Joyti Singh, Mr. Musinguzi, Dr. Wilopo, Mr. Hu Hongtao, and every one of you here for your great efforts for the successful conclusion of this meeting. Also, we thank Dr. Hao Linna, Director-General, Department of International Cooperation of NPFPC, who came by all the way for the closing ceremony last night.

During the past four days, reports on regional capacity building needs and potentials were listened to; and visions covering training strategies, research agenda were shared in support of ICPD and MDGs. Great attention has been paid to the development of training modules in reproductive health, gender, poverty. I believe you will all agree with me that this meeting has been a highly productive one.

Based on our discussions, I'm sure we have reached consensus on the following point, that capacity development is the basis for population and development. The capacity development, here I mean, does not only refer to the knowledge and technical know-how relating to reproductive health services, but also involves the capacities of designing efficient and practical population programs, coordinating with other social and economic policies, and ensuring RH commodity supply security. Moreover, optimized resource integration is a key for capacity development. We shall, on one hand,

focus on the resource integration among international stakeholders, public sector, private sector and NGOs and on the other hand, attach great importance to the integration of training resources. CTC, as one of the Partners Institutions, is willing to work closely with you, for our future follow-ups on capacity development in South-South Cooperation.

Dear all,

Before I pass the microphone to Harry and Dr. Hao, I would like to extend my heartfelt thanks to you all again for taking your time and sharing your wisdom here during the past four days.

This afternoon, we are going to leave for Shanghai, which is China's major industrial, commercial and financial center. I am sure you will have a good time there, and I wish you all a wonderful journey home.

Thank you.

Closing Address By:

Dr. Hao Linna
Director-General
Department of International Cooperation
National Population and Family Planning Commission of China

Respected Mr. Harry Jooseery, Executive Director of PPD
Respected Mr. Robbi Royan, Technical Advisor of UNFPA
Respected professors, resource persons and guests,

Ladies and Gentlemen, Good afternoon!

I am very glad to have this opportunity to attend today's closing meeting. With the great joint efforts of all the participants, the Consultative Meeting of Experts on Capacity Development is drawing to an end today with a fruitful outcome. First of all, please allow me, on behalf of National Population and Family Planning Commission of China, to extend my warm congratulations for the success of this meeting, and my sincere gratitude to all of you, the distinguished professors and resource persons coming all the way to China, for attending this important meeting. My gratitude also goes to PPD Secretariat and CTC team for their excellent logistic support to this meeting.

I am so pleased to see our old friends and to meet our new friends gathered at CTC to discuss such an important issue as capacity development. I am also quite encouraged and inspired by the outcome of this meeting. During the past three days, heads and professor from 17 Partners Institutions, together with resource persons reviewed the status of the training programs, exchanged experience in training and research activities and discussed the strategies of capacity development in PPD member countries. The outcomes this meeting has achieved, I believe, have laid a very good basis for capacity development. In this view, I would like to thank you all very much again for your great contribution made to the fruitful outcomes of this meeting.

Ladies and gentlemen,

According to UN population estimates and projection now recently made public, the world population, which now stands at 6.67 billion will reach 9.19 billion in 2050. The population in less developed region is projected to grow from 5.45 billion to 7.95 billion. This means that the increased population will exert enormous pressure on the environment and natural resources in developing countries. Our PPD countries are still facing big challenges on population increases. It is a common understanding that implementing family planning and reproductive health and alleviating poverty in developing countries are very essential and critical to the realization of the ICPD goals and MDGs.

Therefore, making family planning information accessible and improving reproductive health in developing countries will also become important not only to help slow the population increase but also to increase opportunities for education and career development for women in those countries. In this regard, capacity development is basic a guarantee for the slow down of population increase in PPD countries. I really appreciated that there are 17 Partners Institutions represented here who are the main force in capacity development of PPD member countries, and they have carefully discussed the needs and requirements in the last three days. I believe it is very perceptive and judicious of PPD to give priority to these training institutions for capacity development. Without the active and full participations of the training institutions, it will be very difficult to ensure good progress in capacity development in the PPD member countries, in which 54% of the world population is living.

In the years to come, the training institutions will definitely play an even greater role in the capacity building of South-South Initiatives. I am very glad to have seen that in the past ten years or so, the Partners training institutions have been already playing a very active role in South-South Cooperation. China's training institutions have trained a total of over 1000 program managers and service providers. And also quite a number of our own program managers and service providers have received training from the training institutions in other developing countries, and some of those training institutions are represented here. We are very grateful to all of you!

The outcome of the meeting will certainly have very positive implications at global, regional and national levels. In China, we have about 430,000 population and family planning workers nationwide. The level of the quality of care depends on the capacity of the program managers and service providers. During the 11th Five-year Plan (2006-2010), the Chinese government will give greater emphasis on the systematic training of program managers and service providers through various training approaches including e-learning methods. It is my sincere hope that we could continue to have cooperation with Partners training institutions in this regard in the future. Also, during the years between 2006 and 2010, according to the MoUs signed between our Commission and PPD, China will offer 300 fellowships to program managers and service providers in family planning and reproductive health from other developing countries. And we will try our best to promote networking and cooperation among the Partners training institutions.

Ladies and gentlemen,

Though our meeting is short, our friendship will last long. For the wellbeing and happiness of the people in the developing countries, let us join our hands to work together. We can surely make a difference. Once again, I would like to express my heartfelt thanks to you all for coming to China for this meeting, and to PPD and CTC for having organized such a productive event. I would like to thank

UNFPA for your consistent and valuable support to South-South Cooperation. Finally, our Vice Minister Dr. Zhao Baige has asked me to convey to all of you his greeting and regards, and to thank you all for your contribution to this meeting. I know you will leave for Shanghai this afternoon, and our Commission is very much pleased to host your stay in Shanghai. Please enjoy your stay in Shanghai. For those who are going to return home tomorrow I wish you a safe and pleasant journey back home. Thank you very much!

Closing Address By:

Mr. Harry S. Jooseery
Executive Director, Partners in Population and Development (PPD)

Dr. Hao Linna, Director-General, International Cooperation, National Population and Family Planning Commission (NPFPC) of China

Mr. Hu Hongtao, Deputy Director-General, International Cooperation, National Population and Family Planning Commission (NPFPC) of China

Mr. Jianhua Cai, President, China Training Center (CTC) and Director PPD China Office

Mr. Rabbi Royan, Senior Technical Advisor, Population and Development, UNFPA New York

Experts, Consultants, Ladies and Gentlemen

We have gathered here for 4 days to discuss Capacity Building, in relation to PPD future involvement, Partner Institutions' involvement, and countries' involvement in the context of achievement of ICPD and MDGs. We have among us 17 major institutions from Partners' Member States that are directly involved in the process together with experts in the field to enable us to come up with concrete proposals for action. We have prior to this meeting conducted an inquiry among Partner Institutions and commissioned 4 Regional Papers that have provided us with resourceful information on the existing Capacity Building programs and the gaps that exist. From this stock gathering exercise, we have discussed strategies to fill the gaps through a process of prioritization. We have discussed the following:

- Regional Implications
- Institutional Implications and
- Global Implications

This will help us move strategically, with well-defined goals and objectives for the coming 4 years. I am pleased by the high-level discussion we have had. We have noted during the discussion the need for Capacity Building of the Partner Institutions, for developing mechanism for the integration of new

thematic areas within the existing capacity building program of Partner Institutions and for fostering an ownership of the initiative.

We have also discussed the development of a new Capacity Development Framework, that will address new emerging areas tailored to the specific regional needs in relation to Reproductive Health, Population and Development that could be used both by the Partner Institutions in the process of integration as well as by other emerging institutions like CTC. This will not only help to synergize effort but also pull training institutions along or into the mechanism. Other concerns that were addressed were:

The need for networking: although lots of efforts are being made by Partner Institutions, there is an absence of proper linkages among them.

Exchange of expertise and program: we have seen that all institutions are not experts on all issues of Reproductive Health, Population and Development. Hence a mechanism should be in place to link all these institutions.

Then there is the issue of Capacity Building Program Sustainability. It is true that major players have abandoned research in particular. But you will find now the emergence of a new direction at promoting Capacity Building internationally, thus creating additional opportunity for sustaining programs. There is, however, the need when developing programs to define properly the "cut-off point"; in general we tend to agree spontaneously from the recipient side whenever the resources come, without negotiating with the funders the "cut-off point". Resource as stated by Dr. Rao thismorning, is a very critical issue, which needs the involvement of all. I appeal to UNFPA to substantially fund PPD to enable us to implement our Capacity Development Plan. We are happy to learn that UNFPA is in the process of developing its Capacity Development Strategy for the coming years. We will shortly make a formal request. I am very appreciative that China is now taking the lead. We will also tap other sources, and we have already started knocking at the doors of donors.Some have their ears to the door, but we would like them to the doors open widely. We do not want the resources to come to PPD alone, but to all of you; and if this happens, we will succeed.

The Role of PPD: this meeting is an initiative of PPD, of course without minimizing the tremendous support from UNFPA and China. We mean Business. But business with a difference. Ask yourself what is the added value of PPD. This meeting is indicative of PPD's drive to synergize the efforts of all actors, conceptualize strategically and come up with concrete actions. We have agreed on the thematic areas in concert with all of you, and also assigned responsibilities for the development of related modules. Those involved in the Modules Development together with the consultants will meet

in Dhaka between 18th and 19th of June to further elaborate, and finalize the modules. All of you would be involved through the process of collecting materials between now and 18th June.

PPD will continue to be the catalyst in making things happen and has already done so with impressive input from CTC China. We will be the facilitator, as I said before. I would like to ensure all of you of our commitment to address with meaningful results the achievement of the desired outcome in terms of Capacity Building. We will set up a mechanism for coordination and monitoring of Capacity Building programs and plans we have discussed, on forming the network, on exchange of experts and set up of a special website for information sharing and communication, which we wish will be interactive.

To conclude I would like to thank all of you for your valuable input, and I am happy that we have come up with concrete proposals. We will be in contact with you, and you will be informed of new developments. Thank you to all the Consultants who have facilitated this workshop. Thanks to CTC and Mr. Hu Hongtao for all logistic arrangements. Thank you to UNFPA for financial assistance. I wish all of you a pleasant and safe journey back home.

2. Consultative Meeting of Experts

on Capacity Development

Date: 10 – 15 May 2007

Venue: China Training Center,

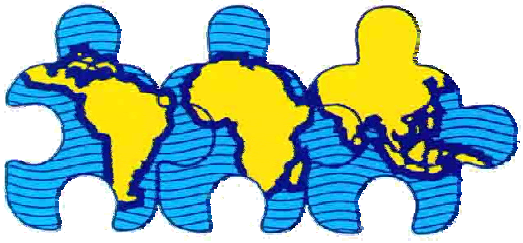
Taicang, Jiangsu, China

Priority Issues and Strategies Needed to Meet MDGs and ICPD Goals: An Overview of Francophone Africa Region

(Benin, Mali and Senegal)

By

Mr. El Hadji DIOUM



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Training at Different Levels: long-term courses; short-term courses; country courses; policy dialogues; policy advocacy; overseas study tours; policy orientation.

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Humans Resources;

Technical resources;

Financial resources: fellowships, international expert assistance; etc

Other

Chapter VI: Summary and Conclusions

Appendix

Needs in training and search

References

Interviewees

ABBREVIATIONS

AP/ICPD: Action Program of the International Conference on Population and Development

DDN: Dakar-Ngor Declaration

DT: Doctoral Training

ECA: Economic Commission for Africa

ICPD: Conference on Population and Development

MDGs: Millennium Development Goals

PDD: **Pre Doctoral Degree**

PPD: **Partners in Population and Development**

PROFILE:

PRSP: **Poverty Reduction Strategic Paper**

RAPID: **Resources for the Analysis of the Population and of its Impact on Development**

RH: **Reproductive health**

ROP: **Regional Operation Plan**

SHED: **Specialised High Education Diploma**

UNFPA: **United Nation Founds for Population Activities**

US: **United States (of America)**

USAID: **United States Agency for the International Development**

WHO: **World Health Organization**

CHAPTER I:

INTRODUCTION

a) Context and justification

Since the adoption of the Action Program of the International Conference on Population and Development (AP/ICPD) in Cairo, reproductive health has become a prime target of health programs worldwide.

Moreover, in 2000, the Heads of State and Government of 191 countries adopted the Millennium Declaration which focuses on peace, security and development issues, including such areas as environment, human rights and good management of public affairs. That declaration, better known as Millennium Development Goals (MDGs), contains eight (08) objectives divided into eighteen targets (18) and forty eight (48) consensus indicators enabling the measure of progress made by differentcountries in implementation.

In 2002, the United Nations Secretary General implemented the Millennium Project in order to help realize the MDG, within the time given, in eight (8) countries among which there were Mali and Senegal. The UN assistance enabled these countries to define sector strategies for the realization of the MDGs.

Remaining true to their commitments, a great number of countries in Africa (particularly in Sub-Saharan Africa) have tried to review the development policies of their basic social sectors, in accordance with the AP/ICPD and the MDGs. The newly conceived policies in that respect are being carried out, followed up and assessed as shown by the two major events organized at the continentallevel which are mentioned below:

- The organization of the regional Conference of Ministers for the review of the Implementation of the Dakar-Ngor Declaration (DDN) and of the Action Program of the International Conference on Population and Development –ICPD- 10. This conference was organized by the Economic Commission for Africa (ECA) from June 7th to June the 11th, 2004 in Dakar, Senegal. The conference concluded with a report evaluating the progress made, the constraints encountered and the way to be followed.
- The evaluation of the progress made in the implementation of the MDGs in Africa was organized by the Department of Social Affairs of the African Union Commission in Addis Ababa, in May 2005.

Through their reports on the AP/ICPD and timely follow-up of the implementation of the MDGs, a few French speaking West African countries (Benin, Mali and Senegal) played an active role in the two above-mentioned events. It is important that African countries set a process of evaluating progress in order to ensure the future success of national policies and programs defined according to IPCD and MDGs framework. Within this context, the decision of Partners in Population and Development (PPD), in 2007, to write regional reports for a critical analysis on training and research programs, relative to the implementation of the AP/ICPD and the MDGs, seems particularly pertinent because of the targeted objectives and the results expected from the reports.

b) Objectives

b.1 General objective

The purpose of the reports is to determine, in the region composed of the selected countries, "the needs in training and research for institutional capacity building for a good implementation of the AP/ICPD and the MDGs."

b.2 Specific objectives

The report aims to identify the specific needs of each region selected by PPD. In this regard, the following issues will be investigated:

- Assessing the capacity building of training and research institutions, in relation to the realization of the AP/ICPD and the MDGs;
- Evaluating the trainings and research which were carried out and the lessons learned ;
- Selecting priority training and research issues according to the MDGs and the ICPD targets;
- Defining adequate strategies in order to reach targets;
- Listing the needs of the institutions' capacity building, for effective implementation of the selected strategies.

For the realization of the above-mentioned objectives of the report, the following methodological approach has been adopted.

c) Methodological Approach

To meet the objectives of the report, especially to obtain the expected results in each regional report, its orientation and its elaboration, it was necessary to adopt a combination of the approaches using both qualitative and quantitative methods. The report was based on data collection and the fine analysis of the data.

The first approach consisted of current literature review, mainly from journals, and the collection of quantitative data on the operational structures and the current training and research programs in target areas of the report, that comprise Benin, Mali and Senegal.

The second approach involves qualitative methods, with interviews of the target group as an instrument of research. This approach offers the advantages of drawing together detailed and accurate information on the perceptions, opinions, justifications and objectives of the interviewed people. The key characteristic of the selected sample is that it is composed of actors who are directly engaged or influence decision-making, elaboration and execution or use of training and research programs.

In spite of the effectiveness, the use of interviews was limited to Senegal only due to constraints (time and means) in preparing the report. Nonetheless, the information obtained from Senegal has relevance for the understanding of the particular sub-regional sector and in evaluating the situation of the other two countries, Benin and Mali, due to the similarities between the three countries.

Interviews were taken at the level of technical ministries, donors, training institutions, government decentralized departments, public and private structures, networks, opinion leaders and community based organizations selected for the implementation of the AP/ICPD and MDGs, or likely to be selected. (See table of interviewed people and locations/structures in appendix).

The interviews were carried out with the help of a semi- structured guide and focused on: mainly about:

- The priority issues and the strategies which were necessary to reach the objectives targeted by the MDG and the ICPD;
- The lessons learned from the training on research efforts in the sub region.

As a total, 15 people were effectively interviewed (national level 9 and regional level 9) and were distributed between 11 visited structures (national level 5 and regional level 6). The analysis of the data collected from the above-mentioned approaches yielded the following results.

Chapter II

Assessment of Past Training and Research

Programs and Lessons Learned:

The assessment of the training and research programs and the lessons learned from their implementation was based on journal reviews and interview sessions with the people selected in the sample defined by the methodological approach.

a) National and regional training programs

It appears after the review of the DDN and PA/ICPD, on the other hand, and the evaluation of the MDGs, on the other hand, that major progress was made in Africa in the last decade.

In regard to the aims set out in the Cairo Action Plan, the evaluation after ten years of implementation reveals that considerable achievement has been made in several domains in a number of African countries. As a matter of fact, review of current research indicates that many African countries (including in those sub Saharan Africa) have succeeded in creating an enabling environment to attain MDGs. This was evident in the formulation of population policies, the setting up of institutional mechanisms for the coordination of these policies, the improvement of the data quality, the strengthening of women's rights and capacities, the taking into account of the youth reproductive health and the beginning of fecundity transition.

Regarding the MDGs specifically, analysis shows that this has been due to the adoption of strategies aiming at reducing poverty, of programs aiming at improving the life quality of populations and a better consideration of gender dimension in policies and programs, for a greater promotion of target groups.

In the subregional countries of Benin, Mali and Senegal, it must be noted that all the actions in the ICPD action plan are, either under way in the current sector policies, or taken into account in the Population Policy Declaration.

For example, as far as the health sector is concerned, a better care for reproductive health (RH), particularly that of teenagers, the improvement of the quality of service providing, the improvement

of the legal environment in terms of RH (law on HIV/AIDS and the law on Female Genital Mutilations) were evident.

Moreover, Benin, Mali and Senegal have adopted, within the framework of MDGs policy, a Poverty Reduction Strategic Paper (PRSP) and its execution is frequently followed up. For instance, Senegal has already published two follow-up reports of MDGs in 2001, and in 2003 and a third one in 2006 which evaluates the performances (fairly satisfying) of all sectors and offers for each of them a financial evaluation of programs to be implemented.

To further evaluate the measures taken so far, 15 people were interviewed at the national level and in the remote regions of Senegal. The interviews consisted partly of obtaining getting perceptions and opinions on the links to be established between the contents of current training programs in the sub regional countries and on the progress made in the different above-mentioned domains. **The 15 interviewed people unanimously acknowledged that in the absence of good training institutions with pertinent programs, articulated around the objectives targeted by the AP/ICPD and the MDGs, the commitment and the states political will, would allow with difficulties, the realization of the progress recorded at the various mid-term evaluations of the programs implementation.** ***The 15 people interviewed unanimously acknowledged that without good training institutions it would be difficult to realize the state commitment to AP/ICPD and MDGs, and the progress recorded in mid-term evaluations will always be slow.?????***

More than half of the people interviewed (8/15) think that the achievements gained , specifically in the areas of Population, Gender and Reproductive Health, partly come from the pertinence of the contents of the training programs given by institutions working in the sub-region. The same group further commented that:

"Thanks to the intervention of some local institutions, the training product progressively gives the national and sub-regional market, a number of well trained agents, likely to be operational within the framework of the elaboration and execution of population and development policies and programs". The extent of the training attained is illustrated in the following table that gives an overview of all agents trained by the Senegalese Institute of Population Development and Reproductive Health of Dakar University (see the following table)

Table of the distribution of people trained by level and per year at the Institute of Population and Development and Reproductive Health in Senegal/Dakar University

Years	Master	Pre Doctoral Degree	Specialised High	Doctoral

		(PDD)	Education Diploma (SHED)	Training (DT)
2000/2001	**11**	**-**	**-**	**-**
2001/2002	**18**	**-**	**-**	**-**
2002/2003	**18**	**7**	**-**	**-**
2003/2004	**22**	**9**	**-**	**-**
2004/2005	**23**	**8**	**5**	**-**
2005/2006	**22**	**7**	**7**	**-**
2006/2007	**23**	**5**	**12**	**4**
Ensemble	**137**	**36**	**24**	**4**

Total of people trained at all levels: 201

On the basis of various opinions given, it is possible to say that globally, the training programs which were carried out up to now in the sub-region, ensure a relatively correct coverage of competence domains which are indispensable for an effective execution of policies, programs and projects which were defined within the framework of the implementation of AP/ICPD and the MDGs.

However, one must note that, though the progress was somewhat satisfactory, constraints were recorded and gaps identified by the experts during the reviews of the AP/ICPD and MDGs implementation. Thus, it is felt that in order to reach the targets, it will be necessary to take complementary measures on the political plan and in the areas covered by the training and research programs.

A repeated concern of the interview group was the constraints of the programs. . In fact, during the individual interviews, a series of questions relating to weaknesses in the elaboration and carrying out of population development projects and programs were noted. When asked to give opinion on the current population development policies and programs and their implementation, all the **5 interviewees??** Said that more progress would have been made with readjustments in the contents of training programs, destined for working agents.

As trainers and demographers experience in the elaboration, the implementation, the follow-up and the evaluation of the Population Policy Declaration, Priority Investment Action Plans, and the Poverty Reduction Strategic Paper (PRSP), the 5 interviewees underscored the need for a better consideration, by the training programs, of the following aspects:

- Policy formulation
- Conception and elaboration of programs
- Identification of objectively verifiable indicators
- Management of programs and leadership

When asked to give his opinion on the place given to population issues in the national political choices for economic and social development, one of the five demographers remarked with bitterness: **"Today, population issues seem to lose ground for an ambient "economist" who more and more make the first move in the elaboration and the execution of the socio-economic development policies and programs".** The interviewee offered as proof (of his contention) the absence of a demographer in the national delegation which went to negotiate with donors, the funding of the PRSP in Senegal.

The same candidate concluded by insisting on the exigency of a vigorous political measure to repositioning population issues, and he strongly suggested the setting up of a national advocacy strategy, as an accompanying measure, in order to create the conditions of success.

For each of the identified constraints, precise recommendations were formulated in terms of priority questions of training and research and of strategy to be developed for its realization.

b) Overall view of the research at national and/or regional level

In view of the information collected from the journal and the detailed individual interviews, the research appears to be the weak link in the set up for the realization of the AP/ICPD and MDGs objectives. Indeed, some research has been carried out, but according to the interview focus group the major portion of the research deals with the donors' concerns, the needs of the projects action plans and the proposals of dissertation topic at university level and in higher education institutes.

One interviewee pointed out the regularity of Health Demographic Surveys (HDS) and the surveys on Knowledge, Aptitudes and Practices (CAP), in spite of their relatively high cost. He is opposed to these costly interventions because more necessary numerous research projects in the remote regions of the country are never carried out because of a lack of funding. In such an environment, the discouragement of the heads of some state departments is absolutely understandable. This dissuasion

is perfectly illustrated by an almost total absence of research activities in the Regional Operation Plan (ROP) elaborated within the framework of the PRSP review, and by request of the National Follow-up Cell. When asked about the situation, the head of a regional planning section answered**: "Even if our research proposals are pertinent, they seem to raise very little interest for the funding organizations and are therefore, rarely or even never realized".**

Unanimously, the interviewed people (8 in total) recognized that the research already carried out rarely meet the needs identified on the basis of the requirements for the follow-up and evaluation of population and development policies and programs defined by the government.

According to three interviewees, a series of political and strategic measures for a revival is necessary in order to remedy the weak level of realization of studies and research in the domain of population and development issues. For the success of those measures, it will be needed, according to the same interviewed people, a strong advocacy towards policy makers and opinion leaders, for a better consideration of population problems and of the research dimension in the macro-economic frameworks such as the PRSP.

c) Lessons learned from research programs, with examples of efforts of the national or regional level

The information journal and the interviews allowed the identification of a few lessons learned and examples within the framework of the research programs implementation. For the national and regional level, those lessons learned and the selected examples are relative to advocacy and sensitizing aids, and the results they allowed to obtain.

National level (Senegal)

Lessons learned: "The effective implication of young people in the conception and the elaboration of sensitizing aids, taking into account their needs which were expressed, is an important factor of appropriation of tools designed by the young themselves".not clear

The effective intervention of involving young people in the conceptualising and elaboration of sensitizing aids, taking into account their needs which had been expressed, is an important factor in ???? tools designed by the young themselves. Are the tools to be appropriated by the young or the tools more appropriate as a result of this intervention?

Example:

The TV film "*Fakastallu*" or "Error of youth" is an audiovisual aid dealing with the consequences of early pregnancies in formal areas. At the conception and elaboration of this sensitizing aid on teenagers' reproductive health, young people were strongly involved. Today, this TV film is the main animation tool of family life education clubs (communication and awareness framework for the young) which cover about 75 % of the Senegalese colleges and high schools.

Regional level

Lessons learned: "<u>The advocacy tools which were selected as the most pertinent ones and raised more enthusiasm and commitment and were effective implications of policy makers, opinion leaders, the private sector, organizations of the Civil Society and Communities, for the success of population and health policies and programs are those which were based on survey and reference studies data</u>".

Examples:

1. The Model Resources for the Analysis of the Population and of its Impact on Development (RAPID). The RAPID Model is applied in Mali and in Senegal. For Senegal, its presentation at the Cabinet Ministers meeting was a success, in the sense that the President of the Republic took the decision to make the RAPID Model, a national instrument of the analysis of population with applications in all regions of the country. Four of the eight regions at the time had their models supported by a religious leaflet.

2. The Reduce Model. It deals with maternal mortality and it has been adopted today by the governments of 9 sub-Saharan countries (Burkina Faso, Ghana, Mauritania, Mozambique, Niger, Nigeria, Uganda, Senegal and Togo). The results obtained through the use of this model can be seen country-wise as presented below:

   Burkina Faso: reduction of caesarean cost;

Mozambique: allocation of USD two million to fight against maternal and child mortality;

Senegal: elaboration of modules on RH for Primary School Teachers' Training Schools, which appoint annually 3500 teachers in the rural areas, and the translation of the Model in Arabic with a religious leaflet.

3. The Allocate Model. It is about low risk maternity, family planning and post miscarriage care. It is an instrument which helps in decision- making, within the framework of maternal mortality control. Today, it is applied, for sub- Saharan Africa, in Burkina Faso and in Senegal. As far as Senegal is concerned, the tool is recognized by the government and the development partners (USAID, UNFPA and WHO) as a pertinent instrument for the allocation of resources. Its use has strongly been recommended within the framework of the implementation of the Senegalese "Road Map" for the control of maternal and child mortality.

4. The PROFILE Model, MDGs: Millennium Development Goals on nutrition. Its use in Senegal obtained among other results, the beginning of a promising commitment of local communities and their effective implication in the carrying out of control programs against malnutrition.

Chapter III:

Priority issues in the context of the objectives targeted by the MDGs and the ICPD

The study clearly indicates the emergence of certain priority issues. Given the constraints faced by the governments of sub-Sahara nations, it is important to target the most crucial issues so that valuable resources are effectively mobilized. The determination of the proposed priority issues is the result of the harmonization and the correction of two factors in order to make them coherent:

- First, the recommendations formulated in terms of capacity building and research to be carried out for emerging issues (judged as having a great importance for sustainable development) raised during the implementation reviews of the AP/ICPD and of the MDGs;
- Then, the perceptions and opinions collected during the detailed individual interviews on the current training and research programs and on those to be elaborated in order to reach the objectives targeted by the AP/ICPD and the MDGs.

The result of this exercise enabled the report writer(s)to identify a number of proposals or themes for each of the selected domains, within the framework of the present report.

a) Training

As for the Training Unit, three areas emerge from the analysis of the collected information, for which actions of capacity building were proposed (see table below):

Table of areas and types of identified priority trainings

Areas	Types of training
Population, poverty and environment	**Formulation of population and development policies** **Conception and elaboration of programs and projects** **Multi-sector approaches in the conception and execution of programs and projects** **Training of policy makers and technicians on the management of natural resources**
Gender equality and equity and promotion of women	**Capacity building on gender and on the integration of its dimension in the programs of reproductive health and of development** **Capacity building of women concerning the management of micro/macro enterprise**
Advocacy:	**Advocacy techniques** **Creation of networks for the change of policies**
Follow-up and evaluation	**Information systems for the management of programs and projects**

	Choice and formulation of indicators for the **Follow-up and evaluation of programs**

b) Policy

In order to address the emerging issues which were identified during the implementation reviews of the AP/ICPD and the MDGs, and the weaknesses raised during the interviews, a series of political measures were suggested as emergency measures to be taken by governments.

After analysis, it seems that, in general, the opinions given by the interviewees in Senegal match up with and complete the recommendations formulated in order to tackle emerging issues. Within that context, one can note the following, as priority issues in the political plan:

a) Setting up of a national reference structure for the identification of the needs for research in population and development, the coordination, the follow-up and the evaluation of activities.

b) Adoption of a national advocacy strategy

c) Setting up of listening centres and psychosocial care for victims of all forms of violence endured during conflicts, particularly rapes

d) Strategic planning

Relative to the strategic planning, the priority lines which were drawn are about the following three action plans:

(i) National repositioning plan of population and development issues

(ii)National popularisation plan of studies, research and of sharing of results in order for better integration in planning activities and decision making in the area of population and development;

(iii)National advocacy action plan with, as a priority line, the promotion of:

a) Population and gender issues;

b) Integration of population and gender issues in the macro-economic frameworks such as the Poverty Reduction Strategic Papers (PRSP)

e) Research

Gender, the young, international migrations and situations of crisis and their consequences on population, are the main areas for which indicators were given in order to carry out studies and research (see table below).

Table of areas and research of identified priority

Areas	Research themes
Equality, gender equity and women promotion	**Statistics collection and setting up of data base on gender**
Children and the young	**Socio-cultural studies on how to proceed in order to reduce the rate of school drop outs among girls.**
International migrations	**Study on the causes, consequences and impact on the economic and social development of international migrations.** **Collection and analysis of data on migrations in order to better use the labour potential they provide for a sustainable development.**
Situation of crisis and consequences on population	**Studies on the psychological impact of crises on victims in order to better understand and define the reintegration needs of those victims in society**

f) Data and indicators

To introduce more demographic indicators in the programs to better understand the youth issues.

(i)Choice of monitoring and evaluation indicators of programs and projects.

(ii)Reinforcement of statistics on gender

g) Implementation, Monitoring, Management,
Service providing and Evaluation

In the perspective of creating the best conditions for the realization of AP/ICPD and MDGs , a few major concerns were raised in relation to aspects linked with the organization of population and development programs. In fact the analysis of the data obtained study indicate that the following corrective measures (see table below) are essential for the improving the management of current programs.

Table of themes to be dealt with for the improvement of the programs and projects execution

Areas	Themes to be deal with
Implementation	**Sector and inter sector coordination of programs and projects**
Management	**Management and leadership**
Offer of services	**Multi-disciplinary approach**
Monitoring and evaluation	**Monitoring and evaluation plan**

Chapter IV:

Strategies needed to meet MDGs and ICPD goals

In order to address the priority issues and constraints that have emerged from the investigation appropriate strategies and responses have to be developed. New approaches are needed in the areas of training and research. The following strategies along with relevant content and the following solutions are recommended. .

a) Training at different levels:

Relative to the different training levels, the choices were guided by a concern for a strict respect of the coherence between the content priority level, the type of training (pre or in-service) and the people to be trained (new agents or already operational staff to be supervised and retrain)

Thus, medium and long term courses and study trips (at the national as well as international level) were considered as opportunities for in in-service training, and experience sharing and exchange for the trainers and field technicians. They constitute, according to the interviewed people, an important element of an in-service training system which must be urgently put into place and made functional in different countries of the region.

The dialogue, advocacy and political orientation sessions on population and development issues were also identified by a number of interviewees, as opportunities for a perfect in-service training. According to the same interviewees, the frameworks of meeting and dialogue between policy makers, development partners and the private sector are very enriching for they constitute communication areas *where leaflets are supposed to be based on reliable data because they come from reference studies and research.???? Unclear (italics)*

These selective opportunities, that have to be organized for in-service training on population and development issues should, according to one interviewee, be a continuation of a national system of pre and in-service training managed with intelligence, by government departments and the training institutes in each country. In other words, it should not constitute the entire training curriculum.

b) Training modules on priority themes and research calendar

The majority of interviewees (12/15) recognized the urgency to deal with, through research and training programs, all areas selected in the *Table of areas and identified priority research themes and studies.*

However, the setting up of a calendar, even approximate, was found to be difficult to not only because of the low level of implication of the solicited structures in the area of research, but also due to the lack of representativeness in relation to the potential actors.

Chapter V:

Capacity building towards institutions in order to implement strategies

The nature and dimension of the newly planned strategies to meet the AP/ICPD and MDGs goals require a capacity building of institutions in charge of their implementation. For each of the three selected areas, the given elements are the accompanying measures that were judged necessary by the heads of the structures interviewed.

a) Human resources

It is important to point out that a lot of institutions operate with a limited staff and remain largely dependent on external communicators. Therefore, a high-quality implementation of the new strategies requires an increase and a diversification in the members of the institution teams. In this context, one must note, the special needs of some structures dealing with research, advocacy and policy dialogue, monitoring and evaluation units.

It is equally important to specify for the different heads of institutions the nature of the expected support will focus less on the undertaking of staff and instead emphasise the training or the intervention capacity building of agents who are already working or are to be hired in the future.

b) Technical resources

On the technical level, the needed institutional support is about the capacity building of the team members in the below-mentioned areas:

- Conception of advocacy tools (models of sensitising and support for decision making) on population and human development issues;
- Advocacy techniques
- Monitoring and evaluation
- Marketing for the promotion of institutions and the sale of service provided
- Acquisition of logistics: computer and other tools

c) Financial resources

In the domain of financial resources, the heads of the structures who gave their opinions, expressed the wish to see the creation of funds to boost research, in addition to those needed for the realization of the capacity building sessions.

In their opinion, the availability of funds is one of the accompanying measures for repositioning policy of population and development issues, strongly recommended for the different countries of the region.

According to them, the realization of such an initiative would allow, among others, a new start for studies and research, and a large scale sharing of the obtained results for the benefit of potential users (technicians and policy makers in particular).

d) Partners

It seems clear to the heads of training and research institutions that for the new ambitions to efficiently contribute to the meeting of the AP/ICPD and MDGs goals a strong partnership is essential.

This partnership should not only be established and/or reinforced between institutions at the national level and the regional level, but also with international structures with reputed expertise in the new areas to be selected for training, research and reinforcement of needed technical competences.

According to technicians from the relevant technical ministries, , the partnership to beestablished will have to , give importance to international institutions specialized in the conception and elaboration of advocacy model on population and development issues.

e) International Assistance by experts etc.

In the view of some interviewees, the desired partnership should be based on mutual technical assistance, so as to develop and share the field experiences and the best practices of the structures involved in the collaboration process.

It remains obvious, said an interviewee, that the operationalization of the partnership and of the exchanges between institutions will depend, to a large extent, on the setting up of functional meeting frameworks and the establishment of a permanent dialogue between the different parties.

Chapter VI:

Summary and conclusion

Beyond the political will and the commitment of countries, the significant progress noted during the reviews of the AP/ICPD and the MDGs implementation, raises the question of the competences of the human resources who were responsible for the conception and the execution of policies and programs which yielded those results. It is in this regard that the question on the pertinence of the training and research programs, which will develop competence necessary for the success of political options, is meaningful.

This report has shown that in some cases of uneven development, the relative quality of training and research had an impact on the performances which were achieved. In fact the anlaysis of the current training programs' contribution to the realization of the level of progress noted within the framework of the implementation of programs, in relation to the AP/ICPD and to MDGs, was greater than those of studies and research.

The analysis of the situation based on the review of documents and interviews with experts opened up not only limits but also revealed new dimensions (specially emerging issues), during the evaluation of population and development programs. There are so many constraints which require both readjustments of the current national policies and strategies and definition of new priorities that a review and an improvement of the training and research program contents were proposed.

In summary, a number of reorientations are considered absolutely necessary in order to meet the AP/ICPD and MDGs goals. But complete success can not attained unless the changes are complemented with accompanying measures, in terms of institutional support which is specified in the present report, and which correspond to what the heads of institutions considered as prerequisites, to guarantee the results expected from their respective structures.

In conclusion, it must be admitted that even though the results of the report are important and pertinent, the study itself contains limitations because the qualitative analysis was carried out only in Senegal. By leaving out Benin and Mali due to constraints, the scope of the study was restricted to one country instead of being sub-regional as planned. However, due to socio cultural and economic similarities between the three countries, one can be still apply the data collected to a wider context. The information gathered in this document could serve as a basis for discussion in order to understand all the parameters that must be mastered so as to correct and achieve the results which the three countries have targeted within the framework of AP/ICPD and MDGs.

Appendix

Needs in training and search

Needs in training

- Formulation of population and development policies
- Conception and elaboration of programs and projects
- Multi-sector approaches in the conception and execution of programs and projects
- Training of policy makers and technicians on the management of natural resources
- Capacity building on gender and on the integration of its dimension in the programs of reproductive health and of development
- Capacity building of women concerning the management of micro/macro enterprise
- Advocacy techniques
- Creation of networks for the change of policies
- Information systems for the management of programs and projects
- Choice and formulation of indicators for the follow-up and evaluation of programs
- Theory, concept, formulation and implementation for population policy
- Technique, of elaboration of program action and priority investment in term of population
- Coordination, monitoring and evaluation of population program
- Creation and management of socio- demographic database
- Gender and rights in reproductive health
- Importance of management and leadership in programprogram execution
- Elaboration of indicators of population program monitoring and evaluation
- Designing of sensitizing and advocacy tools for population, health and development issues

Needs in searches

- Statistics collection and setting up of database on gender
- Socio-cultural studies on how to proceed in order to reduce the rate of school drop-outs among girls

- Study on the causes, consequences and impact on the economic and social development of international migrations:
- Collection and analysis of data on migrations in order to better use the labour potential they provide for a sustainable development.
- Studies on the psychological impact of crises on victims in order to better understand and define the reintegration needs of those victims in society
- Surveys on family
- Surveys on migrations
- Survey on aging phenomena of the population on the demographic side and its consequences on the socio economic development
- Updating the data of RAPID and Reduce Models

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Interviewees

REGIONAL LEVEL-

- **Nfaly Badji, Chef de la division aménagement urbanisation et planification de l'Agence Régionale de Développement (ARD0 de Diourbel.**
- **Ibrahima Ndong, Chef de Service Régional de la Planification de Diourbel.**
- **Issa Diop Chef l'Agence Régionale de la Statistique et de la Démographie de Diourbel.**
- **Galo Kébé, Coordonnateur Régional du Programme de Lutte contre la Pauvreté de Diourbel.**
- **Mamadou Sall, Chef de Service Régional de la Planification de Louga.**
- **Ousmane Diouf, Chef du projet pilote du Programme des Nations Unies pour le Développement (PNUD) « Village du Millénaire » dans la région de Louga.**

NATIONAL LEVEL:-

Cheikh Fall, Assistant du représentant résident UNFPA Dakar/Sénégal

Ousmane Ndoye, Conseiller en Planification Stratégique /Ministère du Plan et du Développement Durable Direction de la Planification Nationale/ Ministère du Plan, du Développement Durable et de la Coopération Internationale, Sénégal

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Edmon Rodriguez, Consultant/Démographe

Amadou Assane Sylla, Coordonnateur du Centre de Formation et de Recherche en Santé de la Reproduction (CEFOREP), Dakar/Sénégal

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Priority Issues and Strategies Needed to Meet MDGs and ICPD Goals: An Overview of Anglophone Africa Region

(Gambia, Kenya, Nigeria, Uganda, Zimbabwe)

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CHAPTER I

Introduction

This paper presents an overview of priority issues and strategies needed to meet MDGs and ICPD goals based on an assessment of and lessons learned from previous training needs and related research needs in population, gender and reproductive health in the Anglophone Africa region. It is a review which will specifically be used in enhancing the capacity of human resource to support the acceleration of progress towards the MDGs and ICPD goals. The countries included in this review are Gambia, Kenya, Nigeria, Uganda and Zimbabwe.

Meeting MDGs and ICPD goals in Anglophone African region is a mission that will require a well concerted effort at different levels and several fronts in any given country. There is an apparent overlap in the MDG and ICPD goals as they both translate into advancement of social development for economic development. Attainment of both sets of goals by the countries under review, which are currently challenged by an over growing population, will not be realized unless there is adequate attention to allocation of resources to implement strategies that directly impact on improving the welfare of the majority of ordinary people categorized as extremely poor. The achievement of MDGs will not only depend nor be reflected in increasing rates of economic growth at macro level or the volume of investment or the wealth of natural resources but will greatly depend on the availability of environmental and other resources commensurate to the size of the population, ensuring that population growth does not outstrip whatever developments a country might have realized to-date. Nigeria, Uganda, Gambia, Zimbabwe and Kenya represent a Sub-Saharan Africa that is currently under serious attack from an over growing population and persistent poverty to the extent that a major percentage is living below the poverty line and not meeting the basic needs of everyday life. Presently, in spite of the different governments' current reform programs and poverty eradication strategies, the proportion of poor people in each of these countries is still high. The proportion living below US $2 per day is 84% in Gambia, 91% in Nigeria, 58% in Kenya, 97% in Uganda and 83% in Zimbabwe.

It will be difficult if not impossible for any country in Sub-Saharan Africa to achieve the MDGs unless the forecasted catastrophe from overgrowing populations is arrested sooner than later. The countries will also have to attend to inadequacies in current population control checks, particularly those that directly relate to and attack poverty from a human development perspective. There has to be elimination of the deprivation of opportunities and choices that are essential for human dignity and

decent standard of living. It is both a correlation and a causal relationship between population growth and development that needs to be understood and planned for in all these countries. Gambia, Kenya, Nigeria, Uganda and Zimbabwe represent unique issues of countries in Sub Saharan Africa that are presently threatened by an apparently uncontrollable population growth. With an annual population growth rate of 3.5% and TFR of 6.9 for Uganda, 2.9% and 5.9 for Nigeria, 4.2% and 5.5 for Gambia, 2.4% and 4.9 for Kenya and 2.5% and 3.8 for Zimbabwe, it is evident that the populations in these countries will more than double in less than 25 years.

The ability of women to influence the direction of social change for a more just social and economic order, their right to have and determine choices, their right to have access to opportunities and resources, and their right to have the power to control their own lives in and outside the home has made gender inequalities a major obstacle to the attainment of poverty and population control goals. In Gambia the proportion of seats held by women in national parliament is only 10%, while in Uganda it is 24.7%, 8.3% in Kenya, 6.7% in Nigeria and 10% Zimbabwe %. MDGs and ICPD goals embody a struggle to increase women's participation and control of economic activities, politics and household arena

Comparing FP strategies and fertility preferences in all these countries shows that direct population checks are apparently off track and do not necessarily address what needs to be done to achieve MDGs at micro level. There is high unmet need for family planning and low CPR for modern contraceptive methods considering the population growth rate and current total fertility rate of each of these countries. Uganda' unmet need for FP among married women 15-49 yrs stands at 35%, want no more children is estimated at 38%, want child later after 2 years is at 35% and contraceptive prevalence rate for modern contraceptive methods is at 18%. Whereas the case for Uganda is inadequate supply of services to meet expressed demand for family planning, in Nigeria's case it is about low demand for family planning that will perpetuate a population explosion. Preferred family size for Nigerian married women15-49 yrs is 7.3 children and 10.6 for men which is strongly associated with infant mortality rate of 100 per 1000, and at the same time there is a glaring missed opportunity where 24% women who visited a health facility did not discuss family planning, therefore, keeping the CPR for modern method as low as 8%.

Zimbabwe is a country where over the last three decades, at least up until mid 1990s, there has been a notable achievement that yielded a high CPR of 50% for modern contraceptive methods through the then steady public sector health service delivery system, and a CBD program as the principle outreach mechanism for family planning. Today the critical issue demanding attention is the sustainability of

this achievement amidst a collapsing economy. Current political and economic environment has grossly impacted on the welfare of ordinary people and families; furthermore it has and will continue to contribute to the collapse of the social service system. There are already notable issues affecting contraceptive use considering missed opportunity to reach nonusers and weak response to control discontinuation rates and low reach of family planning communication, education and motivation efforts. These among many other factors are likely to undermine sustainability of the already recorded positive decline in fertility indicators and upward trend for contraceptive use. The increasing shift in Zimbabwe from the collapsing public sector health service delivery system which for decades has been the main source of family planning services to the private sector suggests that an opportunity could be seized to target quality improvements in the private sector as a replacement or a complementary source of services for consumers who are already turned to that source.

Just like Zimbabwe, Kenya is also among countries in Sub-Saharan Africa with lowest fertility, a fair contraceptive prevalence rate but currently experiencing an increase in fertility and a stagnant CPR for the last two decades. The population issues in Kenya, therefore, is the threat of declining rates in contraceptive use, all of which are associated with low quality of service expressed by 29% wanting children later and 44% wanting no more children. The reduction in promotion and access to long-term methods such as IUD and voluntary surgical sterilization in the last decade is one of the issues that is affecting both fertility and CPR. Reduced focus and funding of family planning services by external development support agencies with increased attention and funding for HIV/AIDS pandemic is also visible.

The Gambian situation presents a unique case where increasing poverty has manifested in the form of multiple deprivations of food poverty, income inequalities among regions and overall poverty. Infant mortality rate due to malnutrition and increasing general poverty could be contributing to desire to have more children and consequently be reflected in the high population growth. Improving household income, creating awareness about IMR issues, increasing access and utilization of health services and increasing supply and retention of health workers are critical in paving the way to attaining MDGs and ICPD goals. In addition, unmet need for family planning is challenged by religious campaign against family planning and negative practices like FGM which continue to persist.

CHAPTER II

Assessment of Past Training and Research

Programs and Lessons Learned

Training programs addressing MDG and ICPD goals have typically been organized by sectoral ministries and NGOs engaged in development work. These training programs are either preparing individuals to be assimilated in the development job market in a particular country or imparting skills, knowledge and attitude for specific job tasks. Typically, training for job market or developing human resource of a country has been a responsibility of universities and other tertiary institutions such as teacher training colleges or agriculture training institutions whereas training for job performance is usually a business of development programs or training institutions such as CAFS, specializing in selected aspects of development.

Pre-service or pre-employment training in areas of community development, poverty, population studies, gender studies, environmental studies and reproductive health is covered by diploma, graduate and undergraduate courses in each country. They are at national level and are accredited by national examination boards or faculties of the universities.

Diploma courses have covered basically three modules: organizational management and administration, project planning and management, community development, social work, social administration, psychology, counseling and guidance, basic statistics, sociology and research.

Undergraduate and graduate courses have covered: demography, statistics, population, development planning, rural development, population and development, economic growth and population, social research methods and computer techniques. The package is different for statisticians, demographers, reproductive health specialists, and population and development scientists. These are two to three year programs with restricted closed curricula, which probably is never reviewed or updated over time.

The regional United Nations Regional Institute for Population Studies organizes ad hoc, special and in-service training courses in population issues. The program of training particularly emphasizes demographic techniques, substantive demography, population and development, and population policy and planning.

In addition to courses leading to formal academic qualifications, universities like Makerere in Uganda recognized the need for specialized skills to enable people to carry out their functions more effectively. Consequently, short customized training courses have been designed for various target groups and are conducted from time to time. These courses are conducted both at national and regional levels. The courses include the following:

- Regional training in Data Handling, Biostatistics and Use of Stata for Windows
- Regional training on Economic Statistics and National Accounts

- Regional training on Monitoring and Evaluation of Population, Health and Nutrition Programs within a Decentralized System
- A Practical Approach to Data Analysis Using Stata/SPSS
- Data Analysis Using EPIINFO
- Regional training on Agricultural Statistics
- Data Processing and Data Communication in Africa
- Compilation and Computation of Consumer Price Indices
- Statistics for PhD students
- Adolescent Sexual and Reproductive Health within a Context High HIV/AIDS Prevalence [conducted in conjunction with PPD].

These short courses were mainly targeting mid-career professionals to equip them with practical skills needed in the performance of their jobs or as bridging steps to higher studies.

In-service training in reproductive health, health management, HIV/AIDS, maternal and child health, gender and women empowerment, quality of care, supplies logistics management, monitoring and evaluation, small scale business management, legal aid, human rights and family planning are short term trainings. These training programs target community change agents or development workers, service providers, managers and sometimes policy makers. This type of training is mostly national but sometimes regional as well. For example, the sub-Saharan Africa region has had access to management, training of trainer, gender, health communications and reproductive health training offered by CAFS. Quality assurance management training offered by Regional Quality of Care Training Center; management training offered by East and Southern Africa Management Institute (ESAMI), AIDS Counseling course offered by the AIDS Support Organization (TASO) based in Uganda, MCH, ASRH and reproductive health training organized by ministries of health and supported by various UNFPA country programs, safe motherhood training supported by various WHO country programs, family life education and sexuality training supported by UNICEF, clinical skills, integration of nutrition, education and growth monitoring training programs supported and organized regionally by USAID, community health management offered by African Medical Research Foundation (AMREF), counseling courses offered by Zimbabwe Institute of Systemic Therapy, management of primary health care and community based family planning programs and training of trainers course offered by University of Ibadan in collaboration with Columbia University, NY, voluntary surgical contraceptives training offered by the then AVSC (Engender Health) and reproductive health, MCH and family planning clinical skills courses offered by INTRAH and JHPIEGO. Some of these training programs have evolved over the years since the early 1990s and have turned into more specialized or more comprehensive courses.

It is important to note that emphasis of these kinds of training programs has changed over time since the early 1980s. Family planning and primary health care was the main area of focus in the 1980s up until 1991; next MCH, HIV/AIDS and reproductive health came on board; then HIV/AIDS training was gradually introduced by 1993; and it seems to have become the leading area of focus by the year 2000 with less and less mention or support to family planning where it all started. Gender issues were only incorporated in the training in the late 1990s.

National and/or Regional Research

In each country under review, the research on population, development, gender, reproductive health has been carried out mainly by bureaus of statistics, MOH and institutions at the universities. There is the Central Statistics Department of The Gambia, Central Bureau of Statistics, Ministry of Planning Kenya and Uganda Bureau of Statistics. There are, however, regional research institutions like United Nations Regional Institute for Population Studies in Ghana, The Union for African Population Studies in Senegal, Population Council, Family Health International and independent researchers.

The Union for African Population Studies in Senegal is a scientific pan-African organization involved in the study and promotion of an understanding of Africa's population and demography. This institute has principally aimed at: encouraging collaboration among scientists interested in the study of Africa's population and related issues; facilitating the conduct of studies and research on key population issues in Africa; ensuring the broadest possible dissemination of scientific information concerning population problems in Africa, and use of such information in the development strategies of African countries.

In the past, the Institute of Statistics and Applied Economics, Makerere University, Uganda, used to be very strong and prolific in the area of research. There were also attempts to formulate and implement a regional research agenda. This was mainly focused on the three East African States of Uganda, Kenya and Tanzania. However, due to a shortage of funds and reduction in the numbers of highly skilled personnel available, research activity has tended to lessen. Some of the research projects carried out by the institute included:

- Determinants of fertility in agrarian societies in Uganda
- Adolescent fertility in Uganda
- Household functioning in the context of HIV/AIDS
- Negotiating Reproductive Outcomes in Uganda
- Barriers to gender equality and contraceptive use in Uganda

- Baseline infant and child mortality survey for the implementation of the IMCI program in Uganda [carried out in conjunction with the Institute of Public Health]
- Baseline survey for adolescent sexual and reproductive health in Uganda carried out as part of the AYA project.

At all levels , research activities have focused on knowledge attitude and practice studies, service delivery approaches/strategies, contraceptive technology, clinical trials, drug efficacy, disease patterns, impact studies, environmental assessments, cost studies, service utilization studies, quality of care assessments, health financing, facility assessments and organizational effectiveness.

Lessons Learned

Training

Lessons learned over the years from training programs indicate two trends; training as a means to achieve social-economic development and training as a process of transformation of individuals, communities and society at large. At the policy and implementation level, managers have learned that:

- Training female community based health workers did not only develop a network of skilled service providers at that level but also transformed ordinary women from attending exclusively to household chores to positions of leadership and responsibility in communities, and moving on to active participation in parish, sub-county and district level councils. Acquisition of skills and deployment in technical roles has a spill over effect on individual lives at community and household levels. This proved to be true in the case of Busoga Diocese FLEP program in Eastern Uganda. Over 80% of women community health workers who served from 1986 to 1998 are currently serving as local council chairpersons or members at the county and sub-county level.
- Integrated training applied in integrating STD, and HIV/AIDS into family planning reduced the cost of training, and increased the volume of multi- disciplinary service providers who are needed especially in countries where human resource capacity of medical practitioners is limited. However, application of integrated training curricula necessitates multi-disciplinary training teams which have been difficult to assemble. This was the case in Mukomani Family Planning Clinic program in Mombasa Kenya.
- Much as in-service training is important both for giving skills not included in pre-service training and for refreshing/updating skills and knowledge, service providers end up spending a lot of valuable time in workshops organized by vertical programs instead of providing services. This is true in Uganda' public sector programs.

- In countries with extreme human resource constraint and extreme low literacy such as Sudan, innovative merger of adult literacy education and community health training yielded sustainable results and responses to gender inequalities. This has been the case with the Church Ecumenical Action for Sudan health program. Literacy education for illiterate young women combined with primary health care service delivery skills has been used in to develop capacity for service delivery.
- Training of community workers can be a public sector mandate if the government is committed to seeking results for important goals in social economic development. Zimbabwe managed to slow down population growth by going beyond the traditional clinic based service delivery system which has limitations of reach. The CBD program has over the years been sponsored by public funds from the late 1970s, and a significant percentage of the CPR of Zimbabwe is attributed to the training program and deployment of CBDs. The same experience is true for Nigeria in strategies used from about 1986 in Oyo state under the University of Ibadan.
- Regional training institutions like CAFS are a good idea but they end up not being sustainable unless sustainability is planned from the start stage.

Research

Lessons learned from research that is related to MDG and ICPD goals mainly emphasize the need to promote translating research findings into programs. In addition, participatory methods in research involving beneficiaries or populations affected by the issues not only as sources of data but as data collectors could be costly in terms of initial process, but goes a long way in building capacity of communities by helping them articulate real needs or real issues. This has been the case in studies conducted for the African Youth Alliance project by UNFPA, Pathfinder International and Path in Uganda, Tanzania, Botswana and Ghana.

CHAPTER III

Priority Issues in the Context of MDG and ICPD Goals

The challenge faced by the countries under review is protecting the population from a vulnerability that is induced by poverty and insufficient social services particularly for the ordinary poor people. In light of declining living standards, persistent high maternal mortality, persistent high fertility rates and inadequacies in social services, strong partnerships need to be developed at country level. Coordination and partnerships between sectors, between development support agencies and between public and private sector seem to be the best catalyst to bring change in the approach towards the MDG and ICPD goals.

Training

Developing human resource capacities to effectively manage the monitoring and evaluation function of management at national and sub-national levels is a priority issue at all levels of decentralized local government system. In addition, limited reach and quality of social services such as in education, health and agriculture is another major priority issue observed in all countries under review. In Gambia it is vital to expand and improve rural health system and community based interventions for effectively dealing with food security crisis, maternal and child health, family planning and malaria. In Nigeria the priority is increasing capacity to improve and expand coverage for malaria prevention, family planning acceptance and use, extensive child malnutrition, immunization coverage and maternal health. In Kenya the urgent need is increasing capacity to improve coverage for child health, malaria control and prevention, family planning and HIV/AIDS prevention. In Uganda capacity priorities are mainly required for expanding family planning, malaria control and prevention, maternal and child health, HIV/AIDS prevention and care, child health and maternal health. In Zimbabwe, due to challenges created by the brain drain of professionals, capacities need to be strengthened and expanded in the non-traditional service delivery systems like CBD. In none of the countries the implementation of programs and services are not reaching a significant majority of the populations being targeted.

From the above conditions, the gaps in training have led to priority issues as follow:

Pre-service training for health workers, teachers, agriculturalists and other development workers does not include management training or technical training in recently emerged diseases, health issues and technologies. Graduates from these programs begin service delivery without essential skills and knowledge about current health priorities.

Most of the training programs in reproductive health and maternal and child health are in-service trainings that are conducted separately for each specific service delivery area of required technical competence. Service providers therefore spend 50% of the time they are supposed to be providing services on attending trainings.

Social workers and community development workers who are charged with overseeing and promoting development work at community level are not fully equipped with knowledge of current development issues like gender, basic poverty and population issues and management skills. Their background is limited to the professional training they have received as undergraduates or diploma course students.

Core curricula for primary education, social work and social administration and teacher training does not adequately address family life education, sexuality education and development issues such as gender, human rights, agriculture and vocational skills.

There are regional and national training programs which are supposed to provide in-service training to development workers and social workers. Regional programs are too expensive because larger number of output is needed per country. National programs do not attract enough participants for them to be affordable by employers. Even then the curriculum they offer is neither comprehensive enough nor tailored properly to require practical experiences, and the major intake of participants is not from the desired lower levels of program implementation. These institutions do not necessarily have one curriculum for short courses that covers the bare minimum on development aspects.

Institutional capacity of CSOs and CBOs is very limited, yet their role as technical resource and implementers of government strategies is important. Increasing managerial and technical roles at the implementation level in advocacy, appraising government programs, civic education, service delivery and watch dogs over public funds requires training to strengthen and/or build their capacities.

Policy and Advocacy

There are gaps in the policy environment for most of the MDG and ICPD goals, and as such many countries have expressed possibility of not ever meeting the target. Priority issues include non-availability of policies, challenges and constraints caused by existing policies, policies being unknown by majority of public, policies not respected or adhered to and delayed approval of important policy. It is observed that:

In the wake of declining economies and increasing poverty among middle class income populations and the rural populations, countries are experiencing brain drain particularly from the most needed technical capacities in the sectors of health and education. Governments have failed to give reasonable salaries to retain staff in public service. The supply and retention of staff is a huge setback in the service delivery system yet there are no attractive policy, and this needs to be attended to urgently.

A number of policies are not in place, for example, the Domestic Relations Bill for Uganda has not been passed into a law, and Nigeria, Zimbabwe and Gambia have not yet come up with one unified domestic Relations Act. There are also no strong policies to deal with issues of fake drugs on the market which cause resistance to diseases, and the gender policies though in place are not yet popularized in these countries. No clear policy on ASRH in schools, gender based violence and on re-enrollment of girls who drop out of school due to pregnancy exists. The FP policy in Kenya is silent

on family planning services to young people even though a large percentage of girls 15 years and below are sexually active, while that of Gambia categorically stipulates that family planning must not be provided to women below 21 years of age yet median age of sex debut is 18.8 years.

Religious prohibition is still a constraint to acceptance and utilization of reproductive health in all these countries in spite of efforts to involve the inter-religious council in Uganda and the *Madrasa* educational system in Gambia. The integration of religious bodies in the promotion of family planning is a positive step because non-users of FP commonly cite religion as a reason for rejecting services.

Strategic Planning

All countries are overwhelmed with challenges of meeting the MDGs and ICPD goals within the set timeframe amidst current resource constraints. Long-term planning is therefore an important systematic process that will involve decision-making or making choices from a pool of challenges and considering alternative ways of using the scarce resources to meet predetermined future goals. Generally speaking strategic objectives set for meeting the MDGs and ICPD goals are ambitious and not aligned to complement each other.

The strategic planning priorities observed are as follows:

There is very little use of statistical evidence from research and evaluations in: determining priority mid-term goals and objectives; identifying proven implementation models/strategies that indeed make a difference; and setting targets in accordance with established baseline. Statistical evidence or data is not specific to a particular sub-national level of implementation. There are national estimates which may be true for some areas but not for all. Planners are thus using national estimates to determine a uniform response. Priorities by district or local government have not been ascertained for all outcome indicators. Variations among regions or districts are determined from planning and therefore development responses/solutions that are prescribed do not reflect accurately reflect or pertain to each geographical catchment area. At the same time development planning in the context of MDGs seems to have been treated like emergency planning with emergency responses.

The approach to planning for the MDGs and ICPD goals in all the countries exhibits three risks: individual sector plans are too big and there is a high possibility that important activities could have been left out; implementers will often fail to execute designated activities properly; and implementation teams may fail due to lack of integration and uncoordinated team effort. The challenge is translating big national frameworks into smaller result-oriented plans. There is limited application of performance based planning in the public sector.

Furthermore, there is inadequate participation of communities, CSOs, and vulnerable populations such as PLWHAs as key players in the development planning processes. Due to this, public accountability is unreliable and lacks independent appraisal by CSOs on behalf of the citizens. Discrimination and stigmatization of families and people affected by HIV/AIDS is still an issue in many countries since HIV/AIDS is not given political support; this also leads to the abuse of HIV/AIDS resources by the entrusted bodies in many countries.

Unlike gender and women empowerment where there are several women's coalitions and associations at all levels with strong leadership, other millennium development goals lack firm structures. There are limited farmers associations or PLWHA networks to voice concerns and aggressively pursue agenda. These networks could be strengthened with the creation of a common market for products and for procurement of needed technical assistance.

The situation regarding FGM and gender inequality is alarming in countries like Nigeria, yet there are strong social-cultural attitudes and religious interferences. Over 50% of girls undergo FGM before they are one year old and 20% of all women in Nigeria have been subjected to FGM. Community advocacy is not systematic although there are efforts by NGOs at the national level. The need for great community awareness building is evident in the prevalence of strong socio-cultural l attitudes that attach less value or neglect education of girls, the promotion of early marriages and traditional harmful practices like FGM. .

Initiatives aimed at improving food security, increasing agricultural productivity, reducing unemployment and underemployment, and reducing rain-fed agriculture through irrigation schemes for smaller farmers and communal farmers do not necessarily promote development of appropriate renewable resources and technology.

Resource mobilization strategy to address cost of schooling and to encourage poor parents to send children to school especially, the girls is weak and limited. There is a significant low transition from primary to secondary schooling especially in the case of orphans and girls from poor families.

Quality assurance strategy in most of these countries is available but is not effective and innovative enough to make any impact. It is more of a centrally managed process that is not translated fully into a sound QOC program at implementation level. The range of family planning methods is limited with little emphasis on long- term methods yet women who want no more children are 35% in Uganda, 47% in Gambia, and 17% in Nigeria. Commodity security is acknowledged in all countries as the key to achieve significant results in reproductive health status but logistics management remains a major challenge. Monitoring stock levels which depend on local capacity is problematic due to poor

inventory management at service delivery level. The referral systems are also not efficient and the mechanisms to promote continuation in contraceptive use are weak. In addition, there is a lack of technical assistance for health planning and poor coordination of stakeholders at the national and district level.

Over- emphasis on abstinence as the best strategy to preserve the young generation from the AIDS epidemic at the expense of giving less attention to increase in education and services to an already sexually active young population is detrimental to preventing a second wave in countries like Uganda and Botswana.

Research

Generally speaking the knowledge base in all these countries is limited both in scope and timeliness. Not enough is known about the shortcomings in implementation arrangements, community participation and outcomes of all development efforts. It is observed that:

There is no detailed learning of outcomes of the various strategies like universal primary education, education financing of secondary and tertiary level and girl-child education. Planners are working on assumptions that every thing is working and is in the right direction, and this has been basis for developing plans to advance these reforms further. There is inadequate information for advocacy let alone rational allocation of public resources.

Every country is struggling with universal primary education as a means of increasing educational opportunities to raise literacy levels particularly among the poor. Although the intention in terms of increasing literacy is mainly to augment the national proportion of skilled work force for higher productivity or to expand the base of earning group (that can earn, save, and invest) for economic growth, there is the added motivation of using education as a fertility check. Knowing the relationship and inter- linkages between the educational, reproductive health and gender goals is a priority issue. As a development theorist put it subsidized public service at the expense of not spending resources in other sectors could itself be a negative externality. In such cases e communities will fail to value education at its real cost, and therefore, continue having more children since it is the government that will bear the cost and not the individuals. Thus it is a research priority to establish the impact of free education on fertility.

Agriculture is the main backbone of the economy in all the countries under review, and over 80% of each country' labor force is in this sector. The development strategy in each country is to modernize

agriculture for increased productivity. With over 70% of the population living in the rural areas, it is unfortunate that there is no agricultural research to support rural development of agriculture.

With low contraceptive prevalence rate in most of the countries which have high population growth and high fertility, it is worthwhile to understand factors contributing to a decrease in demand, issues related to quality which may be motivating or demotivating women from using long-term methods of family planning and causing a shift from long-term methods to short-term methods, even when the unmet need is high

Recent studies in Uganda show that a big percentage of PLWHAs who are registered with support organizations and are receiving material, medical and emotional support do not necessarily adhere to safer sex practices despite teachings of "positive living". When this situation is coupled with the coming of ARVs, it is crucial to understand the impact of the use of ARVs on HIV/AIDS prevention strategies. Most countries have the strategic objective of mitigating the social economic impact of HIV/AIDS among infected people with the hope prolonging productive life of individuals as an outcome. However, there is no knowledge yet on this expected outcome, and the overall impact/influence of ARVs on other prevention strategies

Meeting the goal of combating HIV/AIDS was embraced by all countries, and in all cases it was considered a state of emergency. It is in this spirit that many players jumped in and responded. Subsequently plans were adopted without enough monitoring and evaluation. . To date a lot of resources are available to all countries and it is difficult to rationalize allocation of resources to a particular strategy or model. In countries where the epidemic is advanced and persistent programs need considerable knowledge of behaviors and the most effective means to influence behavior. It is, therefore, a research priority to know which models work best and are sustainable. In the case of family planning, which seems to be receiving less attention as of now, similar research is necessary to understand the demand and supply better so as to advocate for increased support. Because the program implications have diverse impact on already worrying population growth

Lack of improvement in infant mortality is largely attributed to strong relationship between fertility and infant mortality**. Kenya MFPED 2002** found that reducing one birth within 5 year period would reduce the risk of infant mortality by about 30%. In all the countries of the region there is high value for children particularly strong in poor families. Loss of a child or anticipated loss of a child translates into a desire to replace or to "hoard children in anticipation of a loss". Infant mortality is 80% among the poorest compared to 20% among the richest. Hence there is an urgent need for research to establish causes of infant and child mortality.

Governments have not fully developed mechanisms through which to absorb and utilize research results in policy and development program formulation. They should be assisted in developing this capacity. There exists very little cross-border research; yet the problems being dealt with know no national borders.

As there is very little collaboration between training and research institutions in the region, this further hampers a lot of professional development. Given this situation, it is important to place emphasis on expanding research.

Data and Indicators

There are a number of priority issues related to data and indicators which if attended to will go a long way in increasing accountability in public financing, will hold each implementing agency accountable for the results, facilitate frequent improvements and tactical changes in programs and will further promote decentralization of local government system. It is observed that:

Available data on outcomes of the MDGs and ICPD are estimates at national level and regional level, leaving lower implementation levels with no data to gauge progress, set targets and determine priorities for funding in a given fiscal year. District or LGA levels which are charged with the responsibility of planning and allocating resources do not have data for planning and monitoring purposes.

There are no household surveys for frequent monitoring of progress on the MDGs and ICPD. The little that exists is done at an interval of 5-10 years. Simple cost-effective analytical techniques such as Lot Quality Assurance Sampling are not in use at national or regional levels to generate quantitative data on a yearly basis; the data could have served as pointers to where the problems exist in implementation of programs. Large national surveys do not give data lower than regional level, yet the planning and resource allocation function is at the lower level.

In the case of HIV/AIDS programs there is limited data on behavioral and biological characteristics of risk groups like commercial sex workers, track drivers, fishermen, miners, PLWHAs etc. Communication and preventive strategies applied on these groups are the same as those used with the general public. Available data from recent studies in Uganda indicate that a lot needs to be discovered about these groups in order to design appropriate tailor-made strategies.

Indicators used in gender and women empowerment do not deal with women empowerment beyond education and participation in positions of authority and decision- making. Other aspects of women empowerment such as equity in economic activities, their right to determine and to have choices, their

right to have access to opportunities and resources are not captured even though there are a number of strategic objectives that focus on these issues.

There is no data on how poverty impacts on gender, and poverty impact on population.

In many cases denominators for estimating progress on key outcome indicators have not been established for programs targeting special groups such as orphans. Many agencies are taking advantage of this and don't necessarily account for results like they do with finances. Attempts by UNICEF to support a project for establishment of birth and death registers at community level has not extended rolled out beyond trial districts though this is a useful source of information at community level.

There is no food and nutrition surveillance in countries where food-poverty is severe and planners lack specific data for planning and programming strategies that improve food security.

Existing databases are not updated frequently, for example the land database in Zimbabwe was last updated in the 1960s**.**

Implementation, Management, Monitoring & Evaluation and Service Delivery

Translating national level strategies like those addressing MDGs and ICPD goals into effective programs is a challenge for the public sector planning unit. The planning process is lengthy, and in most cases done independently by each sector. However, they all call on the same local governments that have limited capacities and are visibly overburdened. Priority issues are observed as follows:

National HIV/AIDS responses are facing the challenge of implementing new strategies.. This is due to institutional arrangements which make HIV/AIDS a part of the ministry of health affair. Channeling funds through mechanisms other than the national coordinating bodies undermines the authority and coordinating mandate of national AIDS control councils which are the legal coordinating bodies for HIV/AIDS response. This has posed challenges to the overall monitoring and evaluation function of this body. It is true that each country has one strategic framework to which all players are contributing, but each player has its own monitoring and evaluation framework. Coordinating structures are not strong at sub-national level; the structures exist but are not adequately financed, and they also lack technical capacity to undertake technical roles like meaningful monitoring and evaluation.

In most cases monitoring and evaluation varies according to donors and implementers, and so it is not harmonized. Often each party is using different indicators and different approach. As a result, it is

difficult to hold implementers accountable and in addition allocation of roles and resources is not rational.

There is limited awareness of the issues of environment and gender among communities and key stakeholders. Mostly it is only the women's groups that struggle with this agenda. Religious and cultural institutions are not fully engaged, yet they are very influential and form the obstacle to balancing gender inequalities. Community mobilization on environmental and gender issues is a priority to increase appreciation, contribution and support of gender and women empowerment related interventions. Interventions need to go beyond advocacy and include financing of activities that yield results on empowerment agenda.

Monitoring and evaluation is still a national level function much as decentralization of local governments has occurred. Local government level does very little monitoring which is ineffective. One of the reasons for inadequate monitoring and evaluation is lack of capacity to carry out effective monitoring and evaluation. Very few technical staff at local government level has adequate monitoring and evaluation skills or knowledge, either by training or by exposure. Secondly, monitoring and evaluation emphasizes outputs with no link or emphasis on outcomes leaving room for programs to be off track, unnoticed and unable to be rectified on time. Targets were set without establishing baseline; in fact there are no statistics specific to sub-national level of operation. Contents of national monitoring and evaluation conceptual frameworks, where it exists, is never translated into M&E plans at sub-national level. This is true for most sectors and therefore all MDGs and ICPD goals

Supply logistics management for all services is a huge challenge in all countries. Financing, forecasting and procurement of commodities is fragmented with contraceptives procured and funded vertically by different donors. Service delivery is greatly affected by lack of essential supplies and equipment, weak distribution systems, quality of supplies on the open market and cost of supplies to the consumers. Immunization coverage in some countries has declined, and discontinuation rates in contraceptive use are linked to supply issue, ARVs are still limited in reach, with some countries having experienced shortages of condoms and non-availability of malaria drugs at service delivery level. It has been found the percentage of households with ITN is minimal in all countries, while there is a visible influx of fake drugs on the open market and non-prescriptive supplies are only available at traditional static settings.

The unmet need for family planning stands at 35.5% for Uganda, with CPR for modern methods at 18% for the last decade. In Kenya it is at 35% and 44% of married women 15-49 want no more children. In Gambia, CPR for modern methods is only 9% with high fertility of 6.7. Although in Nigeria unmet need for family planning is 17%, the CPR is only 8% and 24% of women who visited

health facility did not discuss family planning. In Zimbabwe there was missed opportunity to reach non-users and discontinuation rates are on the increase while IEC has low reach. All the above factors render quality of care and programming of services a priority issue.

Service delivery in the agriculture and gender sector is characterized by limited technical capacity in extension services to reach more and to cover adequate ground in terms of scope. Access to land and credit for women who happen to be the main target for these services is very limited, yet it is the capital that they can use in order to participate meaningfully.

Currently none of the countries under review is applying a specific implementation strategy that accelerates implementation for quick results even though the time set for accomplishment of MDG and ICPD goals is running out.

CHAPTER IV

Strategies to meet MDG and ICPD goals

Management strategies

National programs are a big undertaking involving many teams at various levels. Even at implementation stage the effort involves many people working over extended periods of time and this is problematic. Appropriate programming in terms of planning, implementation and coordination is the key to the success of any long- term strategy. There are a number of strategies that can address issues related to accelerating implementation for impact; they are appropriate not only in scale up programs but also cost effective and contribute to sustainability. The following are strategies related to planning and implementation:

Although long-term strategic planning processes are applied in the public sector there could be an improvement by introducing approaches that would reduce the risks caused by poor planning. Rapid Response Initiatives (RRI) is an approach to planning and implementation which has proved useful in accelerating implementation and scaling up responses. The idea is to have small projects designed out of big strategic frameworks to quickly deliver mini-versions of the big project's end results. Rapid result initiatives have three characteristics; they are result-oriented, producing measurable payoffs on a smaller scale; they are vertical, including people from different parts of the organization or even different organizations who work in a tandem within a very short time frame to implement slices of several horizontal or parallel track of activities; and, they are also fast, striving for results in short time, often less than , 100days. The short timeframe gives the projects a sense of urgency which in turn leads to creativity.

Coordination of development assistance in the various sectors at national and sub-national levels and coordinating the various funding mechanism and program implementation are constrained by inadequate capacity of the decentralized health sector at sub-national level. National health assemblies, sector working groups, and district level coordination committees are structures that need to be technically and financially supported in order to be effective. They will go a long way in translating national priorities into district agendas and mobilizing enough resources for reproductive health agenda.

Innovative strategies that expand performance management or quality assurance management to include a community component would go far in tapping views and opinions of consumers for project improvements. Engaging community members who are independent of the service delivery system to

frequently collect and convey the views and opinions of beneficiaries about the services will enable services to be responsive to quality concerns of the beneficiaries.

Other implementation strategies which are not used optimum levels but need improvement are: mainstreaming of issues like gender and HIV/AIDS into all sector plans; adopting the lead agencies' approach at the sub-national level as a funding and technical assistance mechanism that takes care of smaller but important implementers like CBOs; using integration as a cost effective approach that harmonizes and promotes synergies among various services; multi-sectoral approach to engage many sectors in addressing complex issues that have multiple dimensions; and a holistic approach to health management.

Training Strategies

Training is one of the strategies through which systems and human resource capacities are developed or strengthened for programs to have the potential of effectively engaging and increasing popular participation of communities in social-economic development processes and in having access to and utilization of essential social services. Training strategies to be used in pursuing the MDG and ICPD goals are those that yield high supply of technical and managerial capacities in a cost-effective faster ways. They include:

It is important to introduce sexuality education, family planning, maternal health, and reproductive health into pre-service training programs for teachers, medical practitioners and community development workers. This will reduce expenditure that is currently high on service delivery when service providers and teacher have to be taken to several in-service training programs at the cost of not rendering services. This will not only serve as a cost-effective measure but will also ensure continuity in producing individuals already equipped for the task which is a key element of sustainability.

Developing integrated curricula for- multi disciplinary comprehensive education and training of key target populations and change agents or development actors are other essential strategies.

Creating or strengthening an existing resource training center/institution at national level and sub-national level for large countries, specially centers which could provide short term in- service courses to for advanced or refresh technical and managerial competencies in: gender studies; human rights studies; development advocacy; social research, monitoring and evaluation; basic population studies, and concepts of poverty and development.

Modifying existing training modules to train community level advocates and change agents to undertake extension services that accelerate growth in agricultural sector in rural areas and to expand outreach services for family planning, reproductive health, IMCI, nutrition education, HIV/AIDS, small scale business management and environment management education. This will lead to a holistic approach of development learning for the key players.

Study tours across countries are a good strategy to expose managers and implementers to different approaches that have proved to be effective and cost-effective.

There is a very urgent need to create a centre of excellence in both training and research at the regional level to serve as a resource centre for the various activities of the region

Short courses are very powerful and constitute low cost capacity building tools. They should be utilized more effectively.

Policy and Advocacy Strategies

There are gaps in the policy environment for most of the MDG and ICPD goals, and as such many countries have expressed the possibility of not ever meeting the target. Priority issues include non-availability of policies, challenges and constraints caused by existing policies, policies being unknown by majority of the public, policies not respected or adhered to and delayed approval of important policy. General lack of political will to tackle reproductive health issues is another major setback. Strategies for consideration could be to:

Increase remuneration and incentives for civil servants who are abandoning service due to poor conditions of service. This can be realized by promoting and supporting the creation of associations of civil servants in their respective professions for them to have a common voice for negotiating improvements in conditions of service and also to enable them to access loans/credit for personal development. This is applicable for Zimbabwe, Kenya, Nigeria and Uganda.

Engage CSOs in civic education to create awareness of what is needed and to increase public pressure on representatives to get bills passed and neglected or absent policies formulated. This will accelerate completion and approval of important outstanding policies.

Engage high profile advocates of family planning such as pro-family planning parliamentary groups, and religious and cultural institutions in counteracting the negative social environment that does not support family planning.

Generate and disseminate research findings that draw the attention of parents, community and religious leaders to the crisis in order to accelerate formulation and clarification of policies on ASRH in schools and gender based violence.

Proposed Training modules and Priority Themes

There are several training proposals which can be categorized into three clusters: training for service delivery, training for management and training for empowerment

Training for effective service delivery with the strategic objective of increasing access to and availability of services and training to improve quality will include modules on: Integrated Reproductive Health; Quality Assurance; techniques in long-term family planning methods; appropriate technology in agriculture; and adolescent sexual reproductive health

Training to improve management of programs will include modules on: community management; advocacy, gender studies; monitoring and evaluation of population, health and nutrition programs within decentralized systems; supplies and logistics management; statistical and analytical skills; Lot Quality Assurance Sampling techniques; and human rights.

Training to enhance sustainable empowerment will include modules on: vocational skills training, small scale business management and consultancy management skills.

In order to holistically approach development learning for the key players, it will be crucial to develop or modify available training modules for training community level advocates and change agents to undertake extension services to accelerate growth in agricultural sector in rural areas and to expand outreach services for family planning, reproductive health, IMCI, nutrition education, HIV/AIDS, small scale business management and environment management education.

Monitoring and evaluation of aspects of all the goals need to be strengthened. It is evident that most programs are experiencing inadequate statistical and analytical skills. Training of sub-national level managers in monitoring and evaluation is crucial

The table here below outlines some of the short-term trainings being proposed:

THEMATIC FOCUS	**TYPE OF TRAINING**	**DURATION**	**TARGET**

Adolescent Sexual and Reproductive Health	**Advocacy Symposiums**	**3 day**	**Parliamentarians, LGA leaders, Religious Leaders, Cultural Leaders, Parents, Youth Councils**
	Advocacy	**5 days**	**Youth Advocates**
	TOT	**15 days**	**Trainers**
	Life Skills Development	**10 days**	**Facilitators**
	Program Management	**15 days**	**Mid-level Managers**
	Communication Strategy Design	**10 days**	**Managers of Communication Programs**
	Managing youth friendly service	**5 days**	**Service Providers**
HIV/AIDS	**TOT**	**15 days**	**Trainers**
	Home Based Care	**15 days**	**Managers, Facilitators**
	Counseling	**30 days**	**Service Providers**
	Communication Strategy Design	**10 days**	**Managers of Communication Programs**
	Clinical Skills	**15 days**	**Service providers**
Gender	**TOT**	**15 days**	**Trainers**
	Advocacy symposium	**3 day**	**Parliamentarians, LGA leaders, religious leaders, cultural leaders**
	Advocacy	**5 days**	**Community mobilizers, Advocates**
	PRA	**5 days**	**Managers**
	Community management	**5 days**	**Managers, community development officers**
	Women empowerment	**3 days**	**Managers, advocates, development workers**
Reproductive Health & Family Planning	**Advocacy symposium**	**3 day**	**Parliamentarians, LGA leaders, religious leaders, cultural leaders**
	TOT	**15 days**	**Trainers**
	Service delivery Approaches	**10 days**	**Managers, service providers**
	Quality Assurance	**15 days**	**Managers**
	Clinical Skills	**10 days**	**Service providers**

Management & Coordination	**Strategic Planning**	**5 days**	**Managers**
	Statistical and Analytical skills	**10 days**	**M&E specialist**
	Monitoring and Evaluation	**15 days**	**Managers & M&E officers**
	Sustainability	**5 days**	**Managers**
	Public/Private partnership	**3 days**	**Managers**
	Data analysis and dissemination	**10 days**	**M&E Specialists**
	Management information systems	**5 days**	**Program analysts**
	Supplies logistical management	**5 days**	**Logistics managers, program managers**
	Community Development	**5 days**	**Managers, extension workers**
Training Material Development	**RH pre- service training modules**	**15 days**	**Teacher trainers, medical practitioner training programs**

Related Research Agenda

Research agenda should focus on**:**

Understanding factors contributing to decrease in demand for family planning in Kenya, Gambia and Zimbabwe; and. assessing issues related to quality of care that may be motivating or demotivating women from using long-term methods of family planning and causing a shift from long-term methods to short-term methods even when the unmet need is high.

Establish causes of infant and child mortality. Lack of improvements in infant mortality is largely attributed to strong relationship between fertility and infant mortality. **Kenya MFPED 2002** found that reducing one birth within a 5 year period would reduce the risk of infant mortality by about 30%. In all the countries under review there is high value for children, particularly strong in poor families. Loss of a child or anticipated loss of a child translates into a desire to replace or to "hoarding children in anticipation of a loss". Generally speaking, infant mortality in Sub-Saharan Africa is 80% among the poorest compared to 20% among the richest.

Learning the impact/influence of ARVs on other HIV/AIDS prevention methods. Recent studies in Uganda show that a big percentage of PLWHAs who are registered with support organizations and are receiving material, medical and emotional support do not necessarily adhere to safer sex practices despite teachings of "positive living". This situation coupled with the coming of ARVs makes it crucial to gauge the impact of the use of ARVs on HIV/AIDS prevention strategies. In addition, most countries have a strategic objective of mitigating the social economic impact of HIV/AIDS among infected people in the expectation of prolonging the productive life of individuals.

Follow up studies associated to risk perception are crucial at a time when declines in HIV/AIDS transmission cannot be attributed to any one prevention strategy. Risk perception is yet another important entry to which individuals could be persuaded to adopt positive behavior. People must be able to correctly assess their risk, and if they wrongly assess their risk factors they cannot protect themselves correctly either. Programs should be able to bridge the gap between considering being at no risk and correctly realizing the risk, and thereby reducing the state of pseudo confidence in which many people mistakenly belief and put themselves in even greater risk.

Cost-effective studies of various service delivery and implementation modules to learn most effective practices.

Learning the impact of free education on fertility.

Areas identified earlier in the research agenda for the East African states in which research has not been possible due to lack of funds include:

- Poverty and reproductive health
- Gender inequality, poverty and infant and child mortality
- Unmet family planning need and persistence of high fertility in Uganda
- Level and determinants of maternal mortality in Uganda
- Positive deviance and the spread of HIV/AIDS in Uganda

Some of the areas that had been identified in the regional research agenda are:

- Labor movement and poverty reduction in East Africa
- Migration streams and HIV/AIDS patterns in East Africa
- Comparative study of fertility determinants in East Africa
- Comparative study of gender and reproductive health in East Africa

CHAPTER V

Towards Strengthening Capacity of Institutions to Manage Strategies

The goal of institutional capacity building should be to strengthen an organization in terms of its overall sustainability. Sustainability should be viewed in three components: organizational or managerial sustainability, program or technical sustainability, and financial or resource sustainability. Organizations become sustainable when they have the managerial, financial, and technical capacity to provide needed programs effectively and efficiently over an extended period of time, overcoming changes in the operating context, and when the environment supports these operations politically and materially.

Institutional Capacity Building or strengthening should be the provision of technical or material assistance designed to strengthen one or more elements of organizational effectiveness. Although the elements of organizational effectiveness include governance, management capacity, human resources, financial resources, service delivery, external relations and sustainability, this paper limits itself to human, technical and financial resources.

The institutions in every country that contribute to implementation of strategies discussed in this paper include: government organs at the central level whose role is to undertake decisions and choose priorities to be tackled; local government administrations whose role is to coordinate implementers as well as the planning process and monitoring implementation; development training institutions who develop and continuously strengthen human capacity; research institutions that generate knowledge about conditions to which development efforts respond ; CSOs who have proximity to realities of communities and promote development as a human right, people centered and sustainable; and cultural and religious institutions who happen to be gatekeepers of the social environment which determines the direction things should take.

Institutional capacity strengthening in selected areas is discussed here bellow:

Organizational Capacity

Organizational capacity of local governments to coordinate implementers and the planning process will include creating an inventory and mapping of implementing partners and available services; strengthening monitoring and evaluation function by introducing result oriented approach/system to M&E; and strengthening technical capacities of the planning unit at that level.

Organizational capacities of CSOs to mobilize popular participation, lead advocacy for change, serve as technical organizations, serve as independent evaluators of progress and watchdogs of public accountability could be achieved by providing finances and developing systems to be deployed.

Organizational capacities of development training institutions will be strengthened by supporting development of a marketing strategy and of a resource mobilization strategy for each institution and developing systems for effective delivery of technical services.

Organizational capacities of research institutions should be in terms of: providing financial assistance to undertake research, develop and scale up application of cost-effective research methods and to build human capacities of implementing institutions; and strengthening their technical capabilities.

Organizational capacities of parliamentary groups, and cultural and religious institutions should be in terms of: provision of financial assistance to undertake advocacy work within their constituency, policy change/formulation and dissemination, and strengthening planning and external relations; and strengthening their technical capabilities.

Organizational capacity for effective and efficient management of supply logistics should be strengthened particularly in a large country like Nigeria. This could be in the public sector or in an institution which will do it for the rest of the country. Logistics management for supplies needed in development work is the biggest bottleneck to service delivery in a decentralized sector where the federal state or LGA level is not prepared for this function yet receives the burden from the central level. Capacity strengthening should be through designing systems that are cognizant of all challenges or issues related to failure in the public sector to deliver public goods to the public. Strengthening should be in policy, structure, human capacity, physical infrastructure etc.

Technical Capacity

Program sustainability has two major elements to it; capacity to continue and community participation and contribution to long-term plans for meeting long-term problems. Technical capacity, therefore, which is also seen as program capacity should be strengthened by doing those things that will build capacity for continuity and those that will generate significant contribution of the beneficiaries to the programs they consume from. Contribution is in many forms, in-kind about ability to program or technical capacity of training institutions such as medical schools, nursing schools, midwifery schools, teacher training schools and institutes of population studies in universities in each country which will need financial and technical skills to design pre-service training programs for training medical student, student nurses, student midwives, student teachers and social development workers.

Technical capacities of selected institutions, at least one in each country, need to be strengthened to offer short- term training programs on issues of development. Short- term course will be for middle-level managers and policy makers from local government level.

Technical capacity of regional institutions like CAFS should be strengthened to shift from training managers or service providers to training core national teams of master trainers focusing on all MDG themes. By using the cascade method of training each country will then establish local government level training teams to accelerate training of local managers and service providers. It is preferred that national teams be core teams of multi-disciplinary nature, comprising of individuals from various sectors relevant to the MDGs.

National capacity should be developed and financed to apply once again, the cascade method to training. This approach proved to have made fast multiple effects on availability of master trainers, district level trainers, service providers, and community based workers including those in development work other than health. This capacity needs to be facilitated in each country, especially to integrate training themes of more than two MDGD goals.

Training materials for current training programs need to be improved upon to reflect realities in terms of required technical skills. This is true for programs designed for all the MDGs.

Financial Capacity

Capacity to increase financial sustainability of an institution is seen in terms of effective financial planning, ability to generate significant internal revenue, broadening resource base and applying effective resource mobilization strategies. To sum up, it is about long-term plans to meet long-term resource needs.

The five countries under review are constrained by ineffectiveness of or inadequacy in the management of financial resources. Financial capacity strengthening strategies will focus on rationalization of resource allocation, increasing transparency and accountability and increasing resource mobilization capacities.

Financial capacity strengthening will be in form of developing systems and , developing marketing strategies, human resource training and financial provision to bodies or departments of the public sectors and CSO representing organs at national level.

CHAPTER VI

Summary and Conclusion

In conclusion, it is important to recognize that the mult-sectoral nature of the MDG goals and ICPD goals present an opportunity to reap fruits from the interrelationship between population, poverty, gender and reproductive health. Strategic directions to the attainment of MDG and ICPD goals will include innovative strategies that increase access to and quality of social services and improve capacity of institutions to manage and sustain programs. This is specifically relevant in the education, agriculture, gender and health sectors.

On the whole, the situation and the issues related to poverty seem to be fundamental, and they are the key factors of potential failure or success in achieving the MDG and ICPD goals. In all the countries reviewed poverty has had and will continue to have enormous impact on population, education, gender, and environment. It has a direct association with high population growth, poor living standards, poor health, unproductive unskilled labor and degradation of the environment. Wealth or the ability to take care of the basic every day needs of a family is a blessing if it spreads comfort over classes; population is an advantage when everybody is sure of gaining an honest subsistence by his or her labor; and these two seem to be the main issues behind MDG and ICPD success.

It is imperative, therefore, for all the countries to address the population issue aggressively for the population size to be commensurate to available resources. Addressing population growth issues in Nigeria, Uganda, and Gambia could greatly assist in sustaining higher per capita growth. It is evident that there is a link between economic growth and population growth that cannot be ignored. Wealth and population are not absolute signs of prosperity in a country, they are only so in relation to each other.

Strategic human resource development need to be applied in each of these countries given the drain brain and conservative tertiary training which is not responsive to prevailing job/skills market. Passive use and gains from role models in inspiring young people and shaping their future need to be attended to as well. Efforts therefore that will specifically be tailored for Gambia, Kenya, Nigeria, Uganda and Zimbabwe should be geared towards: focusing on the human development perspective of poverty to combat the would be consequences in heightening the population growth rates; strengthening local government structures to effectively deliver and manage results; increasing participation and the role of grassroots groups, CBOs and CSOs in all development planning processes; creating a policy environment that is more supportive and responsive to the realities; addressing gender inequalities in light of the current fertility related issues; increasing public accountability; adopting a multi sectoral

approach to increase synergies among sectors; scaling up models that have evidently accelerated implementation and made true impact; and synthesizing and integrating strategies.

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3.

Consultative Meeting of Experts

on Capacity Development

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Venue: China Training Center

Taicang, Jiangsu, China

Priority Issues and Strategies Needed to Meet MDGs and ICPD Goals: An Overview of South-East Asia Region

BY

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Introduction

The Program of Action adopted at the International Conference on Population and Development at Cairo in 1994 called for a paradigm shift in how population and development interactions are viewed worldwide. It made gender equity, reproductive health and rights the major focus of action. A five-year review conducted in 1999 identified education and literacy, and reproductive health care to reduce unmet need for contraception, maternal mortality and HIV/AIDS as four specific areas for key actions.

In the meantime, a series of international conferences culminating in the Millennium Declaration, in 2000 by representatives of 191 countries, adopted eight Millennium Development Goals to be achieved by 2015. These called for actions to eradicate extreme poverty and hunger, universalize primary education, promote gender equity and empowerment of women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability and develop a global partnership for development.

In the ten-year review report on progress since ICPD Cairo, the UNFPA pleaded for an integrated and coordinated approach to meet both MDGs and ICPD goals. It pointed out that the MDGs could be achieved only by addressing issues of population and reproductive health (UNFPA, 2004).

Recently, the United Nation has undertaken a review of the progress towards achieving MDGs. As part of this exercise, the United Nations Economic and Social Commission for Asia and Pacific, The United Nations Development Programme and the Asian Development Bank jointly undertook a review of the progress in countries of Asia and Pacific region (UNESCAP et al., 2005, 2006). Asia and Pacific is economically one of the world's most dynamic regions, and so not surprisingly, the report found that this region has made rapid progress towards many of the MDGs. The report analyzed in detail on what goals each country in the region is on and off track. The report provides data on a total of 21 indicators for 6 goals (ones on maternal health and global partnership excluded).

Table 1 summarizes the results of this assessment for the six countries under review here. As can be seen, Thailand and China have performed exceptionally well, as they are expected to reach the MDG targets well before 2015 in 14 and 11 indicators, respectively. Although with 10, Indonesia is close

behind them, it was found to be regressing in 6 indicators. India's performance was found to be creditable with respect to 14 out of 21 indicators on which it is expected to reach target by 2015 or before. Among the six countries considered here the performance of Bangladesh was least impressive, as it is expected reach the target in only 10 indicators by 2015 and in 9 indicators it is showing signs of regression.

Table 1: Assessment of the Progress Made in Achieving Millennium Development and ICPD Goals in Selected Countries of South-East Asia

Country	Progress in 21 indicators for achieving MDGs by 2015					Sexual & reproductive health & rights: ICPD
	Early achiever	On Track	Slow	Regressing	No Data	
Bangladesh	**5**	**5**	**2**	**9**	**0**	***
China	**11**	**3**	**2**	**2**	**3**	**
India	**6**	**9**	**4**	**2**	**0**	***
Indonesia	**10**	**1**	**4**	**6**	**0**	***
Pakistan	**7**	**4**	**4**	**4**	**2**	***
Thailand	**14**	**1**	**0**	**2**	**4**	***

***** Significant progress; ** Moderate progress**

Source: UN-ESCAP et al. (2006) and PAI et al. (2006).

It is also important to know on which goals the progress is on track and on which goals the progress is off track. Table 2 summarizes the combined results of this assessment for the six countries. It can be observed that the countries are generally on track with respect to combating HIV/AIDS and other diseases (mainly TB). But the performance is generally not satisfactory with respect to eradication of poverty and hunger (especially malnutrition), universal primary education, and environmental sustainability (especially water, sanitation and CO2 emission).

How do the countries stand with respect to ICPD Goals? An important additional component of ICPD goals is the sexual and reproductive health and rights. An assessment made jointly by the Population Action International, Family Care International and International Planned Parenthood Federation found that all the six countries except China had made significant progress in the direction

and pace of change in SRHR indicators since ICPD (PAI et al. 2005). Chinese progress was rated as moderate in this area probably because of its continued pursuit of one-child policy.

Table 2: Likelihood of Achieving MDGs by Six Countries in South-East Asia*

No.	Goals	Number of indicators	Early achievers or on track (%)
1	**Eradication of extreme poverty and hunger**	**2**	**55**
2	**Universal primary education**	**3**	**60**
3	**Promotion of gender equity**	**4**	**72**
4	**Reduction of child mortality**	**2**	**83**
6	**Combating HIV/AIDS and other diseases**	**3**	**100**
7	**Ensuring environmental sustainability**	**8**	**65**

*** Bangladesh, China, India, Indonesia, Pakistan and Thailand.**

**** Averaged for the six countries.**

Source: UN-ESCAP et al. (2006).

Assessment of Past Training and Research Programs

For the achievement of MDGs and ICPD goals, training and research would be necessary in wide-ranging areas. The discussion here is limited to the training and research activities in the area of population and development. Faced with the rapid increase of population that began in the 1950s, many developing countries felt the need to establish centers for training and research in the core area of demography. In the region, the International Institute for Population Sciences (earlier known as Demographic Training and Research Centre), Mumbai, India was one of the first such centers to be established with the help of the United Nations. Over the years, it has trained more than 2,000 demographers, many of whom now hold key positions in respective countries and international organizations. Gradually, many such centers have come up in all countries in the region. Table 3 presents some of the important institutions engaged in training and research in the area of population in the countries under review.

Although the training imparted has undergone some changes in recent years, for the most part it was academic in nature focusing on the traditional areas of demography - fertility, mortality and migration. Direct policy-related areas and applied fields such as health program management, costing

and financing of health care, epidemiology and public health, urban planning, insurance and social security, gender and development issues received little attention.

Table 3: Important Teaching and Research Institutions in

Six Countries in the Region

Country	Institution
Bangladesh	**Centre for Health and Population Research: ICDDR, B, Dhaka ***
China	**Institute for Population Research, Peking University, Beijing**
India	**International Institute for Population Sciences, Mumbai**
Indonesia	**Centre for Population and Policy Studies, Gadjah Mada University**
Pakistan	**National Institute of Population Studies, Islamabad ***
Thailand	**Institute for Population and Social Research, Mahidol University** **College of Population Studies, Chulalongkorn University, Bangkok**

*** Primarily engaged in research.**

The type of training imparted has also influenced the research undertaken. While research has yielded a clearer picture of demographic transition taking place in these countries, it has not provided sufficient insights on why the changes have been slow or what can be done to speed up the process. Elaborate statistical methods that are taught and applied have helped to establish a few relationships scientifically, but have failed to suggest why certain policies and programs work, while many do not. Large survey research has helped in establishing benchmarks and evaluating program impact, but has failed to show the direction to follow. Capabilities to do operations research need substantial strengthening.

For the most part, training offered has been for fresh graduates, with the objective of making them pursue a life-long career in demography. However, occasionally attempts have been made to provide in-service training in population studies. One such attempt was made by the UNDP in the late 1980s to train government officials in Population and Development by establishing a cell at the Centre for Development Studies, Tiruvanathapuram, India. The program ran for 10 years before it was wound up. This attempt failed mainly because the training lasted for 9 months, and many of the mid-career officials who came for the training were not willing to stay away from their families that long. Also, on joining duty, many of the trainees were transferred to other departments, before they could put to use their newly gained knowledge.

The short-term courses lasting no more than a few weeks are ideal for training in-service professionals. The East-West Center, Honolulu, Hawaii has been organizing such courses for many years. Taking a cue, a few institutions in the region, such as the Institute for Population and Social Research, Mahidol University, Thailand and the International Institute for Population Sciences, Mumbai, India, have started offering short-term courses on population and reproductive health. These short-term courses are sometimes offered in collaboration with well-known universities and institutions in the west, which have attracted large number of participants.

A Teaching and training population studies through distance education mode or through e-learning is still in its infancy. In the region, only IIPS, Mumbai is offering its course in Masters in Population Studies through distance education. But most of those who get enrolled in this program have been Indians. It is yet to make a global impact that was originally envisaged.

Suggestions for Strengthening Training and Research Programs

At the outset, it should be recognized that there are already many institutions in the region which are engaged in training and research in the broad area of population and development, and which will remain working in this area beyond 2015. Therefore, the effort should not be narrowly focused on strengthening their capability to do training and research on MDG or ICPD goals, but should be directed to increase their all-round capacity to carry out policy-relevant research and training. For such capacity building, one could adopt a three-tiered approach:

To begin with, periodic short-term program for "Training of Trainers (TOT)" should be arranged with the involvement of renowned experts in the area. This training may be entrusted to a developed country institution. Topics for such training should carefully be chosen. They could include, monitoring of MDGs and ICPD goals, reproductive health and gender issues, costing and financial analyses, policy development and analysis, migration and urban policy and planning, health economics and insurance, operations research methods, etc. For each of these topics, training manuals should be developed so that the trained trainers could use them in their respective countries. The UN has already developed a training tool kit on MDGs (http://mdtoolkit.undg.org/). Although this was primarily meant for UN country teams, they could be adopted to train trainers from the developing country institutions on MDGs. Similarly, one could develop tool kits for other topics.

Following the TOT, the training on these topics could be held in respective countries, but initially with the overall supervision of one of the experts involved in the TOT. This expert should also be encouraged to undertake collaborative research projects with the host country institution. After such initial handholding, training and research could be left to trainers who were trained at the TOT.

There are already institutions in the region that have the capacity to train population scientists in specific areas. For example, ICDDR, B, Dhaka, Bangladesh has experts in public health, IIPS has expertise in traditional areas of demography, Institute for Population and Social Research, Mahidol University has expertise in conducting courses in reproductive health. Under the South-South cooperation, their expertise in specific areas could be utilized to strengthen capacities in other member countries.

The third world experts tend to specialize on their own countries, and hardly study other developing country experiences. Experts from the first world and international organizations do most of the cross-country studies. To foster international outlook and for quick circulation of best practices, faculty members of the third world institutions should specialize on at least one other country in their region. This would require periodic short visits to those countries and engage in collaborative research projects especially that deal with cross-country comparisons. To promote such activities, an institution like PPD can offer financial grant.

The member countries of the Asian region are generally on course in achieving many of the MDGs. However, on some goals some of the member countries are lagging behind. These include child malnutrition, maternal mortality, CO2 emission, water supply and sanitation. Interestingly enough, some of the countries in the region have also made significant progress even on these indicators by following innovative schemes. Discussion on such best practices should be part of the training modules, and research should be undertaken to understand the reasons for their success and on the enabling environment that led to their implementation. There is more to learn from schemes that have yielded results in large-scale implementation than from the success stories of small-scale, action research in controlled environments.

In general, to promote policy analysis and improve program management, operations research tools should be made an integral part of all training. The results of operations research in the health field are not easily accessible to academics and policy makers. To promote dissemination of findings from operations research, support may be provided to bring out a scientific journal exclusively devoted to operations research in reproductive and child health. This would provide a single-window reference for those interested to know about findings of operations research and policy studies on population and health programs.

Although they do not explicitly figure in the statements on MDGs or ICPD goals, the process or how the member countries should tackle development issues is bound to influence the progress towards achieving these goals. One such issue is the expanding youth population as a result of demographic transition. This could prove to be a bonus or a curse depending on how this ‘window of

opportunities' is utilized. If sufficient jobs could be created to accommodate the increase in the labour force, then economy would prosper and poverty would diminish. However, if sufficient job opportunities are not provided, unemployment would rise and economy would regress. Another such issue is the rapid pace of urbanization and migration that these countries are likely to encounter as a result of economic growth and globalization of work force. As these are likely problems of near future, both teaching and research on them would be as essential as on MDGs and ICPD goals.

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Priority Issues and Needs for Institutional Capacity Development: An Overview of Arab Region

(Egypt, Jordan, Morocco, Tunisia, Yemen)

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LIST OF ABBREVIATIONS

CBR	**Crude Birth Rate**
CPR	**Contraceptive Prevalence Rate**
DHS	**Demographic and Health Survey**
FP	**Family Planning**
ICPD	**International Conference on Population and Development**
IMR	**Infant Mortality Rate**
MDGs	**Millennium Development Goals**
MCH	**Mother and Child Health**
MMR	**Maternal Mortality Rate**
RH	**Reproductive Health**
TFR	**Total Fertility Rate**

INTRODUCTION

International Conference on Population and Development (ICPD) was held in Cairo in 1994. Its Program of Action was directed to achieve the goals and objectives of the conference. The achievements of the conference goals and objectives were positive, where a great number of innovations in terms of issues, approaches and activities, particularly in the way it dealt with reproductive health and gender issues, its focus on achieving sustainable development, and the role given to education, particularly of girls in affecting change. The Program of Action also caused wide and systematized recognition to the role of non-governmental organization and provided detailed recommendations regarding resource needs and institutional mechanisms for achieving its goals and objectives. In spite of these positive steps in the implementation of the Program of Action, there have been shortfalls and gaps. The progress has not been universal, based on the trends of achievements it appears that many countries may fall short of the agreed goals of the Program of Action. To ensure that ICPD goals and objectives be achieved, the representatives of 189 country included 147 of the presidents and head of the governments of these countries, met in 2000 in a historical meeting in the

UN on occasion of the new Millennium. They adopted eight promising goals named Millennium Development Goals (MDGs). These eight MDGs have focus on the following features:

Make positive changes in the life of world population where they it eradicate extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality, improve maternal health, combat HIV/AIDS, malaria and other diseases, ensure environmental sustainability, and support a global partnership for development.

Not only speeding up the achievements of the ICPD goals and objectives but also furnish a quantifiable system for the follow -up and evaluation.

They consider the starting unequal situation of the countries, regarding the quantitative indicators of the goals and objectives.

Mobilize the human and financial resources to strength institutional capacities.

Nurture partnerships among governments, the international community, non-governmental organizations and civil society.

OVERVIEW AND OBJECTIVES

This paper aims at formulating strategies to be considered in training and related research efforts to meet MDGs and ICPD goals in selected sub- region countries of the Arab Region namely,Egypt, Yemen, Morocco, Tunisia, and Jordan.

In addition this paper will include the following :

- Progress toward the achievement of the MDGs and ICPD goals in the sub region countries (Egypt, Yemen, Morocco, Tunisia, and Jordan).
- The main challenges that jeopardize the achievement of the MDGs and ICPD goals in the five sub- region countries, especially in the areas of training and research.
- A strategy for training.
- A strategy for research.

PROGRESS TOWARD THE ACHIEVEMENT OF THE MDGs AND ICPD GOALS IN THE FIVE SUB REGION COUNTRIES

The progress toward the achievement of the MDGs in the five sub- region countries will be classified according to the following categories: demographic, socioeconomic and health conditions, adolescent reproductive health, and gender equality.

1. Demographic Indicators

Most of the demographic indicators of Table (1) are interrelated, where Population Growth Rate, Crude Birth Rate (CBR), Total Fertility Rate (TFR), and Contraceptive Prevalence Rate (CPR) are interrelated and indicate that four countries out of the five have high population growth, with the exception of Tunisia. Maternal Mortality Rate (MMR) is high in the five sub- region countries especially in Yemen, and considerable efforts have to be taken to achieve the MDG of MMR.

Table (1)

Population Indicators of Achieving the MDGs
in the Sub Region Countries
(Egypt, Jordan, Morocco, Tunisia, Yemen)

Demographic Indicator	Country									
	Egypt		Jordan		Morocco		Tunisia		Yemen	
	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent
Population in Thousands	55,624	74,033	3,254	5,703	24,696	31,279	8,219	10,103	12,086	20,975
Population Growth Rate, %	na	1.9	na	2.4	na	1.5	Na	1.1	na	3.1
Crude Birth Rate/1000 Pop.	31.8	27.0	36.6	30.9	29.4	24.4	27.2	18.7	50.8	46.0
Crude Death Rate/1000 Pop.	8.7	5.8	6.4	4.1	7.9	5.7	6.5	5.4	12.8	8.0
Urban Population, %	43.4	42.3	72.2	79.3	48.4	58.8	57.9	64.4	21.3	26.3
Sex Ratio	1.05	1.05	1.05	1.05	1.05	1.05	1.07	1.07	1.05	1.05
Total Fertility Rate/1000 Woman (15-49)	4.35	3.67	5.51	4.32	4.05	3.32	3.63	2.75	7.95	6.80
Contraceptive	44.8	53.9	26.9	41.2	35.5	42.4	40.4	51.0	6.1	9.8

Prevalence Rate for Woman 15-49, Modern Method, %										
Contraceptive Prevalence Rate for Woman 15-49, Any Method, %	**46.2**	**56.1**	**35.0**	**55.8**	**41.5**	**50.3**	**49.8**	**60.0**	**7.2**	**20.8**
Maternal Mortality Rate/ 100,000 Live Births (MMR)	**170**	**84**	**150**	**41**	**610**	**220**	**170**	**120**	**1,400**	**570**
Infant Mortality Rate/1000 Live Births	**73.2**	**33.4**	**37.5**	**21.5**	**65.4**	**34.7**	**41.6**	**20.6**	**98.3**	**63.8**
Under Age 5 Mortality Rate	**82**	**39**	**38**	**24**	**76**	**42**	**40**	**23**	**130**	**87**
Life Expectancy at Birth, Females	**63.9**	**72.7**	**68.7**	**73.5**	**65.8**	**72.5**	**70.5**	**75.8**	**55.0**	**62.9**
Life Expectancy at Birth, Males	**61.1**	**68.2**	**65.9**	**70.4**	**62.4**	**68.1**	**66.8**	**71.6**	**53.6**	**60.2**
Median Age of Total Pop.	**19.4**	**22.8**	**16.3**	**21.3**	**19.7**	**24.2**	**20.8**	**26.8**	**14.3**	**16.5**
Population 60 Years and over, %	**6.2**	**7.1**	**4.8**	**5.1**	**6.2**	**6.8**	**7.1**	**8.6**	**3.1**	**3.6**
Dependency Ratio	**82**	**62**	**100**	**68**	**77**	**56**	**74**	**47**	**116**	**95**

Source: ***PRB-UNFDA, "Country Profiles for Population and Reproductive Health 2005", March 2006.***

Life expectancy at birth, under age 5 mortality rate, and population 60 years and over are interrelated with mortality indicators, and indicate a distinct health improvement in the four sub region countries with the exception of Yemen**.**

2. Socio-Economic and Health Indicators

From the indicators listed in Table (2), we could conclude that some of the socio-economic and health indicators in the five sub- region countries are very positive and satisfy the MDGs like HIV prevalence and school enrolment in the primary and secondary education for males and females.

Table (2)

Socio-Economic and Health Indicators of Achieving the MDGs in the Sub Region Countries (Egypt, Jordan, Morocco, Tunisia, Yemen)

Socio-Economic and Health Indicator	Country									
	Egypt		Jordan		Morocco		Tunisia		Yemen	
	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent
Gross Domestic Per Capita, Purchasing Power Parity, International Dollars	na	3,950	na	4,319	na	4,012	na	7,083	na	889
Population Below $ 1/Day, %	na	3.1	na	<2	na	<2	na	<2	na	15.7
Population Living Below National Poverty Line, %	na	16.7	15.0	11.7	13.1	19.0	7.4	7.6	na	41.8
Access to Improved Water Supply, %	86	98	99	91	73	80	65	82	na	69
Antenatal Care, at Least one Visit, %	55	49	83	96	35	68	60	79	27	35
Deliveries Attended by Skilled Birth Attendants, %	24	69	86	100	31	40	60	90	na	22
Illiteracy Rate, % Population 15+ Male	40	31	10	4	47	34	28	14	45	28
Illiteracy Rate, % Population 15+ Female	66	51	28	12	75	58	53	33	87	67
Ratio of Girls to Boys,	0.80	0.89	0.94	0.95	0.66	0.84	85	0.91	na	0.60

Primary Education										
Ratio of Girls to Boys, Secondary Education	**na**	**0.90**	**na**	**0.98**	**na**	**0.78**	**na**	**1.01**	**na**	**0.35**
Primary School Enrolment, Gross % of School Age Population, Male	**na**	**100**	**na**	**99**	**na**	**115**	**na**	**113**	**na**	**98**
Primary School Enrolment, Gross % of School Age Population, Female	**na**	**95**	**na**	**100**	**na**	**104**	**na**	**109**	**na**	**68**
Secondary School Enrolment, Gross % of School Age Population, Male	**na**	**88**	**na**	**85**	**na**	**49**	**na**	**75**	**na**	**65**
Secondary School Enrolment, Gross % of School Age Population, Female	**na**	**82**	**na**	**87**	**na**	**41**	**na**	**81**	**na**	**29**
Estimated HIV Prevalence, 15-49 Total	**na**	**<0.1**	**na**	**<0.1**	**na**	**0.1**	**na**	**<0.1**	**na**	**0.1**
Estimated HIV Prevalence, 15-49 Male	**na**	**0.1**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**
Estimated HIV Prevalence, 15-49 Female	**na**	**0.0**	**na**	**na**	**na**	**na**	**na**	**na**	**na**	**na**

Source: ***PRB-UNFPA, "Country Profiles for Population and Reproductive Health 2005", March 2006.***

The percentage of population below $ 1/Day is very low in four of the sub -region countries with the exception of Yemen, and the same thing for the access to improved water supply and ratio of girls to boys in primary and secondary education.

3. Adolescent Reproductive Health Indicators

Most of adolescent reproductive health indicators are not available for the five sub- region countries specially the following:

Median age at first sexual intercourse, the percentage of males and female 15 – 24 who know that a person can protect him (her)-self from HIV by constant condom use, the percentage of males and females 15 – 24 who know that a healthy – looking person can transmit HIV, and HIV prevalence 15 – 24 by sex. In spite of the absence of this data, the indicators listed in Table (3) express that one fifth of the population of the five sub- region countries are adolescent, they marry early, specially true for females, and substantial percentage of them marry by age 18, specially in Yemen where three quarter of the females 25 – 49 are married by age 18.

Table (3)

Adolescent Reproductive Health Indicators of Achieving the MDGs in the Sub Region Countries (Egypt, Jordan, Morocco, Tunisia, Yemen)

Adolescent Reproductive Health Indicator	Country									
	Egypt		Jordan		Morocco		Tunisia		Yemen	
	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent
Proportion of Population (15-24)	18.4	20.9	21.8	20.0	20.5	20.6	20.1	20.8	19.0	21.4
Age-Specific Fertility Rate Per 1000 Women, 15-24	74.5	42.0	50.0	26.0	43.0	24.0	21.5	7.0	130.5	92.0
Mean Age of Marriage, Male	26.4	26.4	27.8	27.8	na	27.2	na	27.1	22.9	22.9
Mean Age of Marriage, Female	21.6	21.6	24.7	24.7	na	22.3	na	22.6	19.1	19.1
Married by 18, Percent, Female 25-49	39.1	33.4	35.1	20.7	34.5	34.5	21.4	21.4	69.2	71.4

Source: PRB-UNFPA, *Country Profiles for Population and Reproductive Health 2005*, March 2006.

4. Gender Equality Indicators

From the indicators listed in Tables (2), (3), and (4), we could conclude that the sub- region countries has made progress in narrowing the gender gap in early education, however inequality still persist in illiteracy, participation in parliament and highly standard positions (legislators, senior officials, and mangers).

Table (4)

Gender Equality Indicators of Achieving the MDGs
in the Sub Region Countries
(Egypt, Jordan, Morocco, Tunisia, Yemen)

Gender Equality Indicator	Country									
	Egypt		Jordan		Morocco		Tunisia		Yemen	
	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent	1990	Most Recent
Labor Force Participation Rate, 15-64 Male	75.6	72.3	na	66.4	48.6	77.4	na	51.8	Na	83.6
Labor Force Participation Rate, 15-64 Female	27.4	21.0	na	12.3	16.8	27.3	na	18.1	Na	30.4
Seats in Parliament Held by Women, %	2.0	3.6	na	7.9	na	6.1	4.0	11.5	3.0	0.3
Female Legislators, Senior Officials and Managers %	na	9.0	na	na	na	na	na	na	Na	4.0
Female Professional and Technical Workers, %	na	30.0	na	na	na	na	na	na	Na	15.0

Source: ***PRB-UNFPA, "Country Profiles for Population and Reproductive Health 2005", March 2006.***

THE MAIN CHALLENGES THAT JEOPARDIZE THE ACHIEVEMENT OF THE MDGs AND ICPD GOALS IN THE FIVE SUB REGION COUNTRIES: SPECIALLY IN THE AREAS OF TRAINING AND RESEARCH

1. Lack of Good Data

It was clear in the previous section of this paper (Progress toward the achievement of MDGs and ICPD goals) that many data items in Tables (2), (3), and (4) have the sign na. Not only that data is not available but also lacks reliability judged on quality, specially in education and RH services. Then better and more standardized statistics are needed to document progress, mobilize political will and design evidence- based reforms.

2. High Growth Rate

Four countries out of the five sub- region countries have high population growth, with the exception of Tunisia**.** This high growth rate is due to high CBR, TFR, and insufficient CPR.

3. Youth and Adolescent Problem

Fertility has declined significantly in all the sub- region countries with the exception of Yemen. This decline is well represented in Table (1), especially in TFR and CBR. The major consequence of this decline is the increase of the youth population and the expected existence of the demographic window, which adds much burden in the presence of high unemployment especially among the youth. In addition to unemployment, adolescents suffer from early marriage. This segment of population still needs to be advocated about sexual hazards, avoiding HIV/AIDS, and female genital mutilation/cutting.

4. Reproductive Health Availability and Affordability

Although RH was considered as a key issue after the ICPD in 1994, the sub- region five countries did not fully integrate RH services within their basic health care system.

5. Gender Equality

In spite of that, the five sub- region countries are acknowledging gender equality in constitutions, legislation and policies. Nevertheless cultural, social and economic factors, as well as lack of political will, undermine the full implementation of gender equality. So inequality is still persistent in illiteracy, participation in parliament, etc.

A STRATEGY FOR TRAINING

The most common definition of strategy is "A number of a long term goals accompanied by the main streams of achieving it". In this section, in accordance to the above review of the achieved progress in meeting ICPD and MDGs goals, and the main challenges that jeopardize the achievement of these goals, we suggest the following:

1. Data Collection and Manipulation

Training data collectors on how to collect from several sources to ensure their availability on a regular and quality basis to ensure the use of up to date data of the most reliable sources of the data, and use the data of the most reliable source. This mechanism requires that data collectors should be fully aware about the techniques of evaluating the data they collect, in addition to identifying the appropriate sources of it.

The indicators of ICPD and MDGs goals are crude where progress is usually monitored at national levels. There is a need to activate furnishing these indicators at the sub- national levels. Data collectors need to be trained on collecting these detailed data from the sources directly or indirectly.

The indicators of ICPD and MDGs goals do not illustrate the full story, for example statistics on school enrollment do not reflect the quality of the education provided, and statistics on contraceptive use do not reflect the quality of reproductive health care. In such cases data collectors have to be trained of how to collect such data.

Due to progress in technology of data manipulation, there is a need for training the staff of data collection and manipulation how to do the following:

Dealing with databases.

Use of computer packages to calculate the required indicators in addition to formulating the required figures that could represent the data and its indicators.

2. FP/RH/MCH Integrated Training Program

FP as such could not be successful when it was introduced isolated from a wide package of services. The five sub -region countries have not fully integrated FP/RH/MCH. So these countries need the provision of high quality FP/RH/MCH integrated training program. This program could help in reducing MMR, IMR, under age 5 mortality rates, and in raising CPR.

In this context, short training courses on operations research in reproductive health and family planning represents a training need priority for the sub- region countries as part of the institutional capacity building in programmatic research to solve problems of the service delivery systems, and to improve their quality as well as promote the utilization of RH services on the basis of quality.

3. HIV/AIDS

HIV prevalence appears to be fairly low in the five sub- region countries, so this is an opportune time for public awareness campaigns to keep the infection from gaining a foothold. These countries should address HIV preventive measures among young people through training, motivation sessions in youth gatherings like secondary schools, universities, factories, and army camps, and educational materials

4. On-The-Job Training

For securing complete and accurate data collection and manipulation, and high quality services in the areas of FP/RH/MCH, each training package has to contain on-the-job training to secure the following:

Evaluate the performance in the actual working environment.

Conduct on-the-job training according to the new issues evolved after the real practice.

Assess the future training needs by observation and interviewing.

A STRATEGY FOR RESEARCH

1. Integrating Population, Health, and Environment

Population, health, and environment are inter-linked issues. Improving and achieving success in one of these three items requires securing the same program in the other two. Research in this area of integration is rare and highly needed, especially for rational and effective decision making.

2. Managing a Multi-sectoral Programs

The five sub- region countries are encouraged to use the MDGs not just as a list of worthy targets but also rather as the basis for policies to achieve socially equitable, sustainable development. Achievement of the MDGs requires multi-sectoral programs that tackle all goals simultaneously. Researches have to be directed to such area, taking into account the specificity of each society, for a successful program for one country may not be the same for another one.

3. Integrating And Coordinating The National Surveys In The Five Sub Region Countries

In each of the five sub- region countries, one of the following two national surveys is conducted from a long time:

DHS (**Demographic and Health Survey**).

Pan Arab Project for Family Health.

Each of the two projects offers valuable data of fertility, health, and socio-economic aspects. A research strategy has to be followed to satisfy the following:

- Comparability of data between the two projects to be able to calculate the same indicators of ICPD and MDGs.
- Ensuring the continuity and sustainability of carrying out such projects.

4. Communicating Population and Health Research to Policymakers and Media

Millions of dollars are spent to produce research results that fail to reach policymakers, or media requirements, and consequently, are not used to shape policies and programs, or viewed properly in the media to create social awareness and support.

There is a need for research strategy to secure research findings that could address the most important issues or information that policymakers would find useful, and be addressed in a simple form to be comprehensible to the policymaker. The presentation requirement has to be taken into consideration achieve awareness and support to the target groups of the research.

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