

INTERNATIONAL CONFERENCE

ON

**“PROMOTING FAMILY PLANNING AND
MATERNAL HEALTH FOR POVERTY
ALLEVIATION”**



**YOGYAKARTA, INDONESIA
26-27 OCTOBER 2010**



PPD

Partners in Population and Development

INTRODUCTION

PPD in collaboration with the Government of Indonesia organized an International Conference on “**Promoting Family Planning and Maternal Health for Poverty Alleviation**” at Yogyakarta, Indonesia on 26-27 October 2010. The participants were the 25 Ministers of Health/ Population/Social development and senior government officials, representatives of UNFPA, WHO, MSH, World Bank, IntraHealth International, Ventures Strategies for Health and Development, Populations Communications and other international organizations, civil societies and NGOs. The objective of the conference was to advocate for greater investment from developing countries on Family Planning, Reproductive Health and Maternal Health programs, sensitize participants on the salient and emerging issues of concern, share knowledge on successful and innovative practices and reinforce commitments for South-South Cooperation for the advancement of the ICPD goals and MDGs. The Conference addressed the following issues:

Session one: Meeting the Global Agenda for Family Planning and Maternal Health: Challenges and Opportunities

Session Two: Promoting Financial and Human Resources for Family Planning and Maternal Health

Session Three: Integrating Family Planning and Maternal Health into Poverty Alleviation Strategies

Session Four: Sharing Experiences for South-South Leverage

I. OPENING SESSION

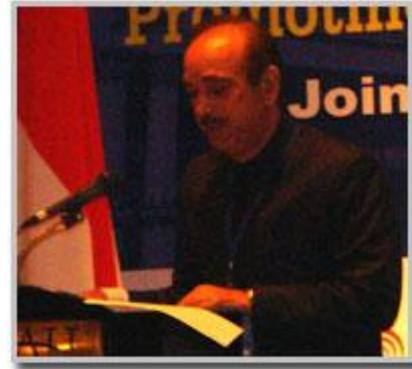
His Majesty Sri Sultan Hamengkubuwono X, King and Governor of Yogyakarta was the first speaker of the international conference. He welcomed all the Ministers, PPD Board members and the participants in Yogyakarta. H.M thanked PPD for organizing the event in Indonesia and particularly for choosing Yogyakarta as a venue. He wished great success to all and invited all participants for dinner at Royal Palace.



*His Majesty Sri Sultan
Hamengkubuwono X, King and
Governor of Yogyakarta*

In his address, **H.E Ghulam Nabi Azad, Chair of PPD and Minister of Health and Family Welfare, Government of India** acknowledged with thanks the commitment of the Government of Indonesia to maternal health, South-South Cooperation and PPD, and hosting the international conference. On behalf of all PPD board members he thanked Indonesian Government for its assistance in organizing the Conference and the warm hospitality extended to all participants.

He stated that the conference was more than opportune as the UN Secretary General has just launched the Global Strategy for Women's and Children's Health which aims to give a renewed thrust to scaling up efforts under maternal and child care in order to achieve the Millennium Development Goals 4 and 5 by 2015. Also, 15 years after ICPD, some impressive progress have been made, maternal mortality is estimated to have fallen by 34%, from an estimated 546 thousand in 1990 to 358 thousand in 2008. Still, the Chair said, it is worrisome that 99% of



*H.E Ghulam Nabi Azad,
Minister of Health and Family
Welfare, Government of India*

all maternal deaths occur in developing countries, with sub-Saharan Africa accounting for 57% and South Asia accounting for 30% of the all deaths. He further said that by doubling current levels of investment, by following a targeted approach to comprehensive reproductive health care and by expanding access to family planning services including safe abortion, maternal health can be significantly improved and mortality reduced by over 70%. He urged national governments and donor countries to renew their pledge to maternal health and family planning and commit much greater funding for accelerated progress, as with deeper political commitment and enhanced financial investments, the MDG targets can be achieved by 2015.

H.E. Mr. Ghulam Nabi Azad, highlighted the Indian experience in achieving the MDGs and ensured that all PPD member countries have valuable experiences to share, and that PPD can play a critical role in enhancing advocacy efforts to mobilize additional resources for Reproductive and Maternal Health and in fostering greater south-south collaboration and peer country learning, document successful programmes implemented by countries and be an effective platform for exchanging innovation and technologies successful in low resource settings. He raised his hope that the conference will have very productive deliberations and come up with valuable recommendations which can act as a springboard for accelerated program to meet the Family Planning and Reproductive Health needs in developing countries. He called upon for concerted efforts from all countries to promote South-South Cooperation and build partnerships with governments, NGOs, Civil Society, the private sector and all other stakeholders.

UNFPA Technical Director, Mr. Werner Haug, focused his remarks on the linkages between Reproductive health and poverty alleviation. He addressed 2 critical building blocks, Health Financing and Human Resources for Health in the context of Reproductive Health. He said that the current investment levels in health, and in particular reproductive health, is in many countries neither sufficient nor equitable. What is needed is more money for health and more health for the money. Empirical evidence has shown the close relation between poor maternal health and



*Mr. Werner Haug, UNFPA
Technical Director*

poverty and a recent UNFPA research clearly shows ways on which FP and MH contribute to Poverty Alleviation. He referred to the publication; ***“Adding it up: the Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health”***. It reported

that in developing countries, an estimated \$13 billion is currently spent on family planning and maternal and newborn health services. By doubling this investment, one would reduce deaths of women and newborns by almost 2 million a year. Considering that pregnancy-related death among women and newborns in developing countries results in an estimated \$15 billion loss in productivity each year, these investments pay for themselves. Likewise, investing in family planning is not only an investment in Human Rights; it is also smart economics as every dollar invested reduces the costs of pregnancy related care by \$1.50.

To conclude, Dr. Haug mentioned that there is a need to more concretely address the crucial role of gender equality, equity and equitable access to health services for the poor and marginalized (e.g., women, young people, ethnic minorities) in accessing health services, including Reproductive Health. He concluded by stressing the role south-south collaboration and peer country learning can play in strengthening national efforts to advance reproductive health and on the need to strengthen the engagement of public private partnerships, looking at opportunities through innovation, technologies (e.g., Health) and the potential to further expand the resource-base (financial, human, material).

In his opening address, **H.E. Prof. Dr. Boediono, Vice President of Indonesia**, stated with pleasure that it was the second time that Indonesia hosted PPD's annual events, the first time was at the occasion of its 8th Board meeting in 2003. He mentioned that he was proud that PPD, the product of a genuinely South-South initiative, has been growing in strength and importance in the global forum and that its 25 member countries constitute the home of more than half of humanity and include the most dynamic economies in the world. However, he said, the rapidly growing demographic and economic power of developing countries and the probable widening of disparity among the PPD countries and within countries underscore the need for a fresh thinking about the future role of the PPD for its members and for the world at large. Taking the example related to maternal and child health or more specifically to the MDG number 4 and 5, where many developing countries are well behind their committed MDG targets, he said their achievement in 2015 is still possible with hard and coordinated work, within and among countries. Prof. Boediono highlighted the need to develop bigger, better targeted and more effectively executed programs and also the need for more active and engaged role of the PPD, UNFPA and other stakeholders. He shared the example of Indonesia who, despite tremendous efforts made to reach MDG 4 and 5, still has a lot to do and is committed to the UN secretary General recently launched Joint Action plan for maternal and child health. Unfortunately, he said, while some progresses are made, there are challenges to face and they are more complex as they are sometimes related to nature. While the International Conference is being held, a volcano has erupted, flood, tsunami have happening the country. Following recent global news, he continued, Indonesia is not alone as the whole world seems to be increasingly prone to disasters, natural or man-made. But, Prof Boediono said he believes in human ingenuity and that if we resolve to work harder, to do better, more imaginatively and in more coordinated fashion none is insurmountable. On those words, he wished a productive meeting to all participants and a memorable stay as well.

As per the tradition in Indonesia, the gong was hit 9 h42 to officially open the international Conference on **“Promoting Family Planning and Maternal Health for Poverty Alleviation” Indonesia 2010**.

II. SESSION ONE: MEETING THE GLOBAL AGENDA FOR FAMILY PLANNING AND MATERNAL HEALTH: CHALLENGES AND OPPORTUNITIES

The first session of the International conference addressed the salient issues and concerns on Family Planning (FP) and Maternal Health (MH) globally, discern specific areas for intervention especially using South-South Cooperation. The session was chaired by **H.E. Dr. Shamsudeen Usman, Member PPD Board and the Honorable Minister and Deputy Chairman of National Planning Commission (NPC), Government of the Federal Republic of Nigeria.** He highlighted the importance of the first session of the international conference which will set the floor for discussion of the two days and recalled the fact that Family Planning program throughout the world has not received the desired attention since the last decade. As a result of a fall in funding to Family Planning program, access to Family Planning services in most developing countries has further been jeopardized, causing increasing unmet needs. He shared his concerns about the fact that the world is having the largest youth population ever entering child bearing years and the demographic change is accelerating even faster than predicted by world community which will increase even further the Reproductive Health demand gaps and increase unmet need for family planning. Investment in family planning may boost the overall effectiveness of every dollar spent on the provision of pregnancy related and newborn health care, he said. Before inviting the high level guests' speakers to the floor he further added: "If we are to improve the lives of people in the developing world, we need urgently to reframe our strategies. While we invite the North to provide additional assistance to developing countries, countries from the south need to put hands together in a concerted effort to help each other. We have got capacities and emerging economies in the South have also the responsibility of sharing their advantages and gains with other countries in the South, and strengthen South-South Cooperation."



*H.E. Dr. Shamsudeen Usman,
Honorable Minister and Deputy
Chairman of National Planning
Commission (NPC), Government
of the Federal Republic of Nigeria*

The Keynote Speech was delivered by **Dr. Malcolm Potts, Professor, MB, BChir, PhD, FRCOG, University of California.** Dr. Malcolm Potts cited the demographic situations of Bangladesh, Mali and other countries as to the challenges they are facing in family planning and maternal health and also their best practices in these areas. He indicated that the unmet needs which are high in most developing countries need to be reduced in order to address maternal health issues and the fact that misinformation is one key barrier to the practice of FP. He cited Africa as a place where misconception surrounding the use of FP services is a serious issue. To demystify those false claims about the use of FP, he said studies have shown that women who use oral contraceptives have higher chances of survival than the one who does not use it and are less likely to contract cancer.



Dr. Malcolm Potts

Dr. Potts indicated that PPD member countries have made successes in ensuring the availability of contraceptives and acknowledged the efforts made by India, China and Bangladesh in encouraging community out-reach FP services and the introduction of social marketing of FP services. He also recognized the significant role China is playing in providing contraceptives to those countries where there is high demand showing that collaboration among countries is essential for reducing maternal mortality. He mentioned that FP would never be possible without the availability of contraceptive supplies and social marketing of contraceptives is essential for ensuring greater accessibility and also that FP and safe motherhood should be universally available. He underscored the importance of increasing funding in RH commodities by 60% as they are inadequate. He said most governments are preoccupied more with buying ARVs than contraceptives.

Dr Potts also mentioned that there has been a decline in both childhood and maternal deaths. Half of the reductions in deaths are due to the use of FP services. However, there has been no reduction in deaths among women who are not assisted by skilled birth attendants. He recognized the fact that there is high attrition among nurses and doctors in developing countries and emphasized the need for training more nurses and birth attendants. Birth attendants could be trained to prevent post-partum hemorrhage.

He also indicated that access to safe abortion is a key to reducing maternal mortality. He said women who have done abortion in the hospital should not leave without having a contraceptive in their hands. He indicated that early marriage and hunger are significant causative factors for deaths among women within the age cohort of 1-15 years. He went on to say that growth in population if not matched by economic growth would definitely lead to the emergence of poverty. He called on countries that have made successes in FP and RH service provision to help others who are not making headways. He said the partnership that exists between Tunisia and Niger should be scaled-up by the World Bank and other donors through the PPD partnership.

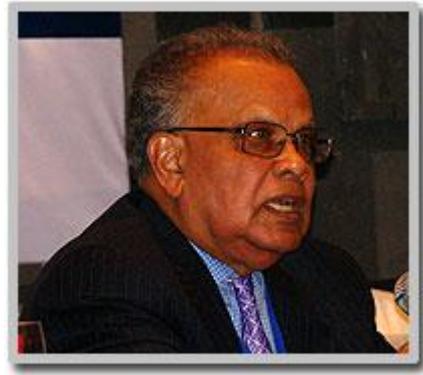
In his intervention, **Mr. Jose Ferraris, UNFPA Representative in Indonesia** stressed the importance of addressing adolescence reproductive health as it is of significance to Asia and Pacific regions where the adolescences do not have access to information and FP services. He highlighted the issue of early introduction to sexual activities among adolescences in the regions as a serious issue and said most of the adolescences enter into this without information and FP and could lead to unintended pregnancies and other RH related problems. He said best practices need to be disseminated and shared and that emergency obstetric care should be looked into and countries should ensure that their health personnel are trained in order to address maternal health issues.



Mr. Jose Ferraris

He also mentioned the limited nature of financing of FP and maternal health in the Asia and Pacific region and that donors are the main source of contraceptive supplies in the region. He cited decentralization, in the case of Indonesia, as a challenge to the provision of health services in the region. It can only have opportunities if it could be supported by political will and commitment. It could work if the private sector, CSO and other stakeholders could be involved in the process, he said.

Mr. Jyoti Singh mentioned that in most cases Family Planning and maternal health are confused and quite often, FP is always left out when maternal health issues are addressed. It was expected that funding for FP and maternal health would increase but on the contrary it has declined in general. He cited India and China as those few countries where it has increased. He indicated that assistance in equipment has also improved over the years.



Mr. Jyoti Singh

Within the framework of south-south cooperation, or through UN or others agencies, he indicated, there are opportunities for transfer of skills and equipment. Mr. Singh said that attention should be given to the integration of RH and FP services and it should be seen in the broader perspective of poverty alleviation and women empowerment. He re-echoed the need for the provision of Adolescence reproductive health services.

Dr. Halida H. Akhter's intervention captured the Bangladeshi experience in FP and maternal health. She highlighted the demographic gains of Bangladesh over the years and mentioned that TFR, MMR and overall mortality have all declined. In highlighting the importance of maternal health, she said that maternal health should be seen as a right and social justice issue and not only a health issue. She cited Female Genital Cutting (FGC) as a source of blood loss, shock and death for the victim and it is harmful and violent to the woman concerned. She mentioned that women should be given the opportunity to earn so that they could be empowered to make decisions in the household. Women agencies need to be promoted in a way to help give women the voice and empower them.



Dr. Halida H. Akhter

Dr. Siti Pariani presented the Indonesian experience regarding opportunities and challenges in Family planning and Reproductive health. She explained that Family planning, reproductive health and maternal health programs in Indonesia have been an emerging issues of concern since new era of the Soeharto president (2nd President of RI). Nowadays , the country has decentralized primary health care or community health center and family planning programs are under local autonomy and authority decision maker: planning, implementing, monitoring , evaluation and budgeting of family planning and primary health center programs are depending on local government decision makers. The success of family planning program have been proven as it has prevented 100 million of pregnancies or new born, but its implementation still face challenges and difficulties such as disparities on contraceptive user rate, dropout rate, unmet need rate and total fertility rate between regions or provinces. Also, total fertility rate in the poor community remain higher compared to middle and high class group in any regions or provinces. Dr. Pariani highlighted the importance of data availability on abortion and also indicated that resources are necessary for FP and martenal health service delivery. She highlighted knowledge gap in FP as a problem in the communities and recommended tartgeting awareness programs for the poor.

In his presentation, **Mr. Shaukat Hayat Durrani** highlighted the fact that in many countries, populations are young. He advised that more investment should be directed towards this target as it poses a big challenge for future demographic situations of developing countries. He stressed the need for increasing funding to address FP and maternal health issues and indicated that there is high unmet need for FP service in many countries. He emphasized the importance of sensitization in order to



Mr. Shaukat Hayat Durrani

demystify the misconceptions surrounding certain contraceptive methods. Public and private sector involvement in FP and maternal health is essential he said. He also said despite the intervention of social marketing in FP service, indicators are still poor. Commodity security is lacking in some countries and a technical support would help in ensuring that it is strengthened. More budgetary allocation for contraceptive supplies is necessary for avoiding any instances of stock-outs that could have dangerous demographic implications for any country.

Mr. Tomas Osias started his presentation by describing the tragic reality of Filipino mothers dying every day due to pregnancy and childbirth and Filipino women continue to experience high unmet needs for family planning in a context of a highly conservative catholic system. He gave the example of the 3.4 million pregnancies in 2008, from which 1.9 million were unwanted and 560,000 ended in abortion. Also teenagers who have begun childbearing increased from 18% to 26% in 2003. Regarding Family



Mr. Tomas Osias

planning which is the weakest link, 22% of Filipino women has unmet need for family planning and this is particularly high among poor, uneducated, and those in rural and geographically isolated areas .To respond to these many challenges, the government has set up interventions such as :

- The Maternal, Newborn, and Child Health Program (MNCHN), a national policy that works under the principles that all pregnancies must be wanted, planned and supported and that the mother-baby pair receive quality continuum of care throughout their life cycle
- Continuous advocacy for establishing national population and reproductive health policy
- The enactment of Magna Carta of Women
- Poverty reduction strategies : Health insurance coverage of indigents and KALAHI and Conditional Cash Transfer for the poor households
- The Philippine Population Management Program (PPMP) : Assisting couples to achieve their fertility goals

Mr. Tomas Osias ended his presentaion aknowledging that the road toward full development is difficult but he strongly believes that ...with the support of all stakeholders in the country

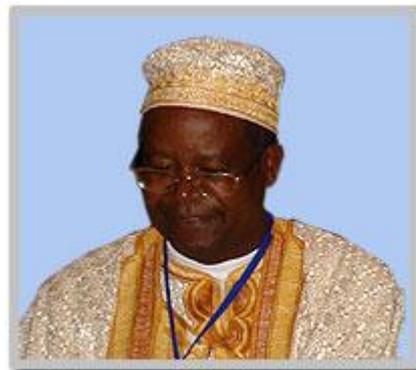
and international cooperation most especially through south south cooperation and PPD leadership, the Philippines can have healthy, progressive and empowered Filipinos today and in the future!

Discussions /recommendations

- Supply chain management is central to success, it should be moved forward and implemented by using the experience of India and South Africa to assist other PPD members
- PPD's new initiative to create a platform, where India, China, South Africa, Brazil, Bangladesh and Egypt can exchange information, expertise and experiences on manufacturing standards should move forward without delay.
- Spacing of pregnancies through family planning is essential for saving millions of infant and maternal lives.
- Every government, private sector and faith-based hospital system must commit themselves to ensuring that all women who have abortions should leave the hospital or clinic with contraceptives.
- Assistance that China is providing in RH commodity security should be continued and expanded to other countries
- A variety of family planning choices should be provided through a wide range of distribution channels to meet the unmet need for family planning
- Communities need to be empowered for them to be able to help themselves in accessing FP services as family planning is not a diagnosis but a choice, and that even poor and illiterate individuals in villages and slums access it.
- Family planning and access to safe motherhood should be made universally available in a human rights framework.
- Emergency obstetric care should be looked into and countries should ensure that their health personnel are trained in order to address maternal health issues
- Donors and governments are encouraged to be more committed to financing FP and maternal health programmes; regular and adequate budgetary allocations for RH commodities are essential means for reducing maternal mortality
- Political will and commitment and private sector involvement in decentralization processes could help in ensuring the availability and accessibility of FP and maternal health services
- Women should be given the opportunity to earn so that they could be empowered to make decisions in the household and women agencies need to be promoted in a way to help give women the voice
- Attention should be given to the integration of RH and FP services should be seen in the broader perspective of poverty alleviation and women empowerment.
- Community sensitization is essential for creating awareness on the importance of FP services.
- Training and provision of incentives for health personnel are essential to addressing staff attrition within the health sector
- Data production in RH and FP is key to measuring progress and finding solutions to problems faced in service delivery.

III. SESSION TWO: PROMOTING FINANCIAL AND HUMAN RESOURCES FOR FAMILY PLANNING AND MATERNAL HEALTH

The second session of the conference was chaired by **H.E. Hon. Prof. Ephraim Kamuntu, Member, PPD Board and Hon. Minister of State for Planning, Government of Uganda**. In his introductory remarks, he stated that: “Family Planning is one of the most cost-effective interventions in the developing world and research has shown that for a relatively modest investment, family planning saves lives and improves maternal and child health. According to a recent report of Guttmacher Institute and UNFPA, maternal deaths in developing



H.E. Hon. Prof. Ephraim Kamuntu, Member, PPD Board and Hon. Minister of State for Planning, Government of Uganda

countries could be slashed by 70% and newborn deaths cut nearly in half if the world doubled its investment in family planning and pregnancy-related care.” Unfortunately, he noted, the global economic crisis has put the health of women and children at a greater risk, but it is obvious that MDG 5 will not be met unless the donor communities relook at their priorities and invest more, and the Governments, especially those of poor countries revise their policies and put back Family Planning, Reproductive Health and Maternal Health high on their priority agenda. The chair ended by highlighting the expertise of the panelists who came from different leading Reproductive organizations.

The floor was then given to **Mr. Werner Haug, UNFPA Technical Director in New York**, to present his keynote speech. Mr. Haug focused on MDG 5-related progress, challenges and opportunities in his keynote speech. He highlighted the role of finance and human resources to achieve the MDG5-targets across the developing world. He also stressed that health system strengthening is not an end in itself but a means to achieve better health, linked to the social determinants (gender equality, culture, human rights) and reinforced by the critical role of other sectors such as education, infrastructure, agriculture, water and sanitation, etc.



Mr. Werner Haug

Mr. Haug said that guaranteeing universal and sustainable access to essential health services requires strong national capacity. More specifically, it requires robust health systems that are fair, accountable and adequately resourced. Governments, civil society organizations and development partners are scaling-up efforts to strengthen health systems in developing countries. He mentioned that UNFPA’s mission is to support and strengthen national efforts aimed at making reproductive health services universally and comprehensively available as part of an essential package of health services across the life cycle and the different levels of care. He commented that for UNFPA, engagement in health systems strengthening means better positioning reproductive health across all aspects of the 6 health system building blocks - Governance, Financing, Human Resources, Medical Supplies, Service Delivery and Health Information Systems. He

said that, UNFPA believes that the ability to meet reproductive health needs is a signal indicator of the overall coverage, accessibility and quality of services in the health system.

Mr. Haug then moved to human resources for health which is also strategically linked to financing and an integral part of the health care system. Desirable reproductive health outcomes require the mobilization of health workers across the continuum of care to deliver quality reproductive health services as part of an essential package where and when required. He mentioned that, over the past decades, considerable progress has been made in many countries to promote skilled attendance at birth. Egypt, Sri Lanka and Malaysia have successfully reduced maternal mortality by substantially scaling-up the proportion of women delivering in a health facility assisted by a skilled birth attendant (trained midwives, nurse midwives or doctors). He said that an area that is gaining increasing momentum is task-shifting, that is, where identified tasks are moved to health workers with shorter training and fewer qualifications or it may also involve the creation of new cadres with clearly defined tasks to further expand the capacity of the health workforce to deliver services.

Mr. Haug commented that strong political leadership and a sustained commitment will be critical over the longer term. This includes an endorsed comprehensive health workforce policy and plan that addresses training, recruitment, deployment, retention, equitable distribution, efficiency gains, motivation and a balanced skill-mix with both a short-term perspective and a longer-term vision. Important within this is strengthening the role and involvement of nurses and midwives. UNFPA has long given priority to increasing access to skilled care at birth as part of its strategy to reduce maternal mortality and ensure universal access to reproductive health. Mr. Haug concluded his speech mentioning the need to more concretely address the crucial role of gender equality, equity and equitable access to health services for the poor and marginalized in accessing health services, including Reproductive Health.

Dr. Pape Gaye President & CEO of Intra Health presented his paper on ‘Promoting Financial and Human Resources for Family Planning and Reproductive Health’. He reflected that contraception use in Senegal has been increasing since early 1990’s from 4.8%, 8% & 12% for the years 1992/3, 1999 & 2005 respectively. A study revealed that this has been attributed to the Family Planning drive initiated by the government with support from various agencies. The government adopted a



Dr. Pape Gaye

Repositioning of Family Planning Policy to curb the growing population. Repositioning of Family Planning policy identified 3-Governing Parameters for implementation i) National Commitment ii) Health System Strengthening and iii) Community Engagement. He insisted in importance of “National Commitment” which is strongly influenced by factors such as leadership, Political will and resources.

Dr. Pape Gaye said that “Repositioning Family Planning” also addresses many factors which influence many social issues such as Reducing *Child Mortality*, Improving *Maternal Health*, Promoting *Gender Equality*, Eradicating *Extreme Poverty & Hunger*, Achieving *Universal Primary Education*, Combating *HIV/AIDS* and Ensuring *Environmental Sustainability*. It was

revealed that an estimated 24% of married women in sub-Saharan Africa have an ‘Unmet Need’ for family planning. Reasons for ‘Unmet Needs’ are various and were identified in a study: 38% is due to Supply of Methods & Services, 37% to Exposure and 23% to Opposition. Statics on ‘Unmet Needs’ of married women aged 15-49 years for African States of Senegal and Rwanda was also revealed in the same study.

Dr. Gaye moved to the Senegalese experience which has been proven to be very effective for curbing the population. The success for Senegalese Approach was due to following reasons: i) National Family Planning Communication Strategy, ii) Expansion of Delivery capacity & iii) Mobilization of Religious Leaders, Woman’s Groups & Musicians (local champions) He quoted the message delivered by a local young Senegalese musician and family planning advocate, *“Family planning is good for the family – it helps bring harmony. Young people – go and talk to the family planning counselor. You’ll learn more about the benefits of family planning. You will learn that family planning is good for you, your family, your children and community.”*

Dr. Martha Campell’s presentation focused on barriers to Voluntary Family Planning that she said include the high prices of contraceptives. She also mentioned that outlets are unreachable and medical rules generally have no evidence base (ex: Pills are on prescription for reasons not evidence-based). She said that misinformation about contraception is very high and that another problem is that in many countries community workers are not permitted to provide contraceptives. Method choices are limited in addition to the fact that government health services are



Dr. Martha Campbell

often not adequate and that the private sector providers are not included in the system. As part of lack of information, she added, emergency contraception is used as existing birth control pills by many women and safe abortion is hard for poor women to obtain. Additionally, advertising about family planning is not allowed in many countries mainly because of religions constrains. Young brides lack power to chose when to have children and how many and unmarried young females are very often excluded from family planning services.

Mr. Ali Gufron started his presentation on “Promoting Financial and Human Resource for Family Planning and Maternal Health” by describing the problems of the health care system in the developing countries and concluding that it’s all linked to poverty. He then cited the Indonesian example in trying to overcome the unmet reproductive health services of women. Indonesia has set up a three-tiered health insurance system divided as follow: First Tier (SHI, PT Askes, Jamsos), Second Tier (PHI the rich, big corporation) Third Tier MoH (Jamkesmas) and Local Government Initiatives. In Yogyakarta special province, the system is called: Goa Garba and allows all pregnant women to get ANC, delivery and postnatal and newborn care covered for free. The maternal mortality rate has then decline to 228/100,000 in 2010 compared to 421/100,000 live birth 2005-The success of that will be scale up to national level.

Mr. Gufron highlighted also the importance of financing family planning services as he said “Providing modern contraceptives to all women who need them would increase the cost of

family planning services from \$1.2 billion to nearly \$2.1 billion annually. But it would substantially reduce the number of unintended pregnancies, thereby making improvements in maternal and newborn care more affordable.” To provide such services, investing in human resources for reproductive health is critical and Midwives play a central role. Unfortunately, according to Mr. Gufron, the critical midwifery competencies been neglected because : Human resources have not been paid attention to the need for “proficiency” in the various competencies to assist women and newborn, too long has been accepted that as long as the health worker receive some or little training in midwifery was sufficient and the Lack off understanding and appreciation of what the professional midwife can offer and the historical prioritisation on medical training of physicians over other health care providers. Yet, investing in midwives and others with midwifery skills has been shown to make a difference in reducing maternal mortality in many countries and there is general consensus that maternal morbidity and mortality can not be reduced without midwives and other midwifery skills, the number of these skilled providers have not significantly increased over the last two decades, Mr Gufron added. In summary and as noted by the presenter, government must provide sufficient expenditure and proportionate investment of public resources in the maternal and child health sector and focus expenditure on rectifying existing imbalances in the provision of health facilities, health workers and health services.

Discussions /Recommendations

- SRH should be universally available as part of health services;
- Strengthen national processes and build on the current momentum around women’s and children’s health;
- Harmonize and align country health plans and strategies, and adopt a more integrated approach in health general and SRH specifically;
- Strengthen management for results and mutual accountability at all levels;
- Scale up human, financial and material resources for SRH
- Use resources more effectively and efficiently;
- Address gender equality, equity and equitable access to health and SR services for the poor and marginalized (women, young people, ethnic minorities);
- Develop, strengthen and scale up social protection mechanisms, put safety nets in place and protect a minimum level of access to essential services, and income security for all;
- Elevate the role of south-south collaboration to strengthen SRH;
- Strengthen the engagement of public private partnerships (including universities, investors, professionals, development partners, private sector, community), especially for innovation, technology and expansion of the resource base;
- Engage with communities and their leaders (including religious and popular leaders) on their specific health and SRH needs, to deliver services as a partnership;
- Adopt national Family planning communication strategy; IEC on contraception;
- Expand service delivery capacity;
- Accessible and affordable services to the poor;
- Free maternal health, neonatal and child health services to all;
- Invest in training midwives;
- Remove unnecessary policy barriers to contraceptive service delivery;
- Provide safe and accessible abortion services;
- Address cultural and religious barriers to family planning;

- Empower women, including young women, with knowledge and choice of SRH services and commodities;
- Scale up the use of “health extension workers”;
- Advocacy to and by members of parliament;
- Place people and their rights at the centre of SRH and FP services

IV. SESSION THREE: INTEGRATING FAMILY PLANNING AND MATERNAL HEALTH INTO POVERTY ALLEVIATION STRATEGIES

The Session was Chaired **H.E. Dr. Moushira Khattab, Member of the PPD Board and Honorable Minister of State for Family and Population, Government of the Arab Republic of Egypt**. In her introductory remarks, she noted that population growth has become a major concern especially in third world countries which are burdened with huge population and high annual population growth rate. She further noted that the territorial area and resources of these countries remains almost constant whereas the population rises at a steep gradient reflecting less area allocation per human. Moreover, she observed, these countries face numerous problems like illiteracy, low economic growth rate and scarcity of resources which has led to growth of acute poverty.



*H.E Dr. Moushira Khattab,
Honorable Minister of State for
Family and Population,
Government of the Arab Republic
of Egypt*

Furthermore, developing countries continue to suffer from population growth induced problems like malnutrition, famine, environmental degradation. She noted that given this situation coupled with low access to family planning and high maternal mortality in developing countries, there is fear that the quality of life of people in developing countries will deteriorate further and the poor would become poorer. However, she noted there are some countries in the South who have had very important and innovative approaches to address both the health and poverty issues. She gave examples of the micro credit scheme of Bangladesh which has a worldwide renowned women empowerment and poverty reduction program; innovative programs like the voucher program of India, poverty alleviation program from Uganda, Jordan, Vietnam and Indonesia. She hoped that participants would have an opportunity to share information about these and similar programmes. She introduced the Director of the Department of Reproductive Health and Research from World Health Organization, Dr. Michael T. Mbizvo, and invited him to present his keynote paper.

Dr. Michael Mbizvo, Director, Department of Reproductive Health and Research (RHR), World Health Organization, Geneva, Switzerland started his keynote address sharing the benefits of family planning and informed that an estimated 137 million women in developing countries would like to delay or stop childbearing but are not using any contraceptive methods. He mentioned that a) limited choice of methods, b) limited access to contraception, particularly among young people, poorer segments of populations, or unmarried people c) fear or experience of side-effects/mis-information d) cultural opposition e) poor quality of available services and f) gender based barriers as obstacles to address the unmet need. He told that if unmet need is addressed, nearly 135 million unplanned pregnancies could be avoided and increase used of contraception has an obvious and direct

effect on maternal death, by reducing the number of pregnancies. He reemphasized that Reproductive rights are human rights and family planning empowers people by increasing their control over their sexual and reproductive lives and empowers women to participate fully in socio-economic developments/alleviates poverty. He also shared the long term benefits of family planning and its effect for the health sector and MDGs. With all other effects, he mentioned that reducing unplanned birth and family size would save public sector spending for health, water, sanitation, social services and reduce pressure on scarce resources, making socio-economic goals more achievable. He also added, reducing unintended pregnancies would improve educational and employment opportunities for women. He then introduced the “Trends in maternal mortality: 1990-2008” estimates developed by WHO, UNICEF, UNFPA and the World Bank and focused on the variations of the MMR over the regions and countries. In this connection he mentioned that to address MMR, we also need to focus on the higher risks associated with higher maternal age, not being married/cohabiting, higher parity, lack of education and lower public expenditure on health.



Dr. Michael Mbizvo

Dr. Mbizvo described a three way relationship model on maternal mortality, family planning and poverty, as both are affected by poverty and have adverse effect on household and societal wealth. He cited several evidences in this regard. He also shared evidences from several countries on how high fertility had adverse effects on educational attainment and impact on household wealth and well-being.

At the latter part of his presentation he focused on health system challenges to achievement of universal access to SRH services and mentioned the challenges in integrating SRH in poverty alleviation perspectives. He mentioned the challenges as a) politicization of family planning, b) place and status of women in society c) failure to link prevention interventions to investment in poverty reduction and d) training/staff orientation. He also mentioned the opportunities to consider in this regard. He concluded quoting the UN Secretary-General “we must not fail the billions who look to international community to fulfill the promise of the Millennium Declaration for a better world”.

Mrs. Anuradha Gupta, Joint Secretary, Government of India and Partners Country Coordinator of PPD presented “Health System Strengthening Under the National Rural Health Mission (NRHM) in India” in the session III of the international conference. In her presentation Mrs. Gupta provided a brief on the current indicators of MMR (254/100,000 LB), IMR (53/1000 LB) and family planning (TFR, 2.6) and informed that there exists wide variation of the indicators among the 35 states. She informed that there are 146,036 sub-centres, 23,458 Primary Health Centres, 4,276 Community Health Centres and 642 District Hospitals in India. National Rural Health Mission was launched in India in 2005 with a mission to rejuvenate the health delivery system, provide quality



Mrs. Anuradha Gupta

universal health care which is accessible, affordable and equitable, and to reduce IMR, MMR, TFR and disease burden. It was planned to implement through Sector-Wide Approach by means of a) decentralization-planning, program design and implementation b) flexible financing-need based, responsive to innovation and c) community participation-nearly 0.5 million village health and sanitation committees. She also described the Accredited Social Health Activists (ASHA), their activities and incentives provided for a) Reproductive and Child Health b) Malaria c) RNTCP and d) Leprosy treatment. She also talked on “Janani Suraksha Yojana (JSY)” which is a centrally sponsored scheme for promoting institutional deliveries. She described the key features of the scheme and described the different cash packages for urban and rural women. She reported that following the scheme; a) institutional deliveries substantially increased b) majority deliveries took place in primary care institutions c) social equity issues got addressed d) increased utilization of ANC services e) field level workers emerged as main source of information. There were marked increases in antenatal care, institutional delivery and post natal care in the JSY beneficiaries compared to non-beneficiaries. There were also notable gains in newborn care practices and improved breastfeeding behavior. She informed that according to the UNICEF 2009 survey a) 68.7 % of women received at least 3 ANC check-ups during last pregnancy b) 72.9% women had institutional delivery and c) 76.2% women had safe delivery. She claimed that JSY is reaching the poor and disadvantaged women and also has an impact on reducing maternal, perinatal and neonatal deaths. It has also increased institutional deliveries, resulted in effective referral system and safe abortion facilities strengthened. She described JSY as an effective program to achieve the MDG4 and MDG 5a & 5b.

Dr. Sonny Harry B. Harmadi started his presentation with a demographic profile of Indonesia and shared the status of relevant indicators in terms of achieving the MDGs. He then briefed the participants on the history of family planning in Indonesia. He mentioned that in terms of the achievement of the MDGs, Indonesia has achieved most of the targets faster than expected. However, he added, maternal mortality ratio as a basic maternal health indicator is struggling with difficulties in achieving the target. He mentioned, nevertheless, that to achieve the MMR’s target, government should revitalize the family planning and set up a population grand design.

Dr. Harmadi also mentioned that Indonesia should make sure that its societies will be prepared for and benefit from economic development by, among others, alleviating poverty and socioeconomic disparities and ensuring to improve the quality of life of the people. To meet these objectives, it is important to ensure that sustainable development could only be achieved with the view of strengthening population policy in the future. Indonesia has success stories of its population policy, through family planning program, prior to the implementation of decentralization (in 2000). However, that strong national family planning program is no longer consistent with the local government’s population programs. Hence there is an urgent need to integrate the central and local government policy on population and to establish a high level population committee.



Dr. Sonny Budi Hari Harmadi

He stated that since Indonesia underwent a major political transformation, the old centralized system of government was replaced by a decentralized one. This transformation became

effective in 2001. The essence of decentralization is improvement of people welfare through betterment of public service provision. Therefore decentralization cannot be viewed as a separate issue from national development objective, especially poverty alleviation. Nonetheless, implementation of decentralization has brought about some undesired effects. Many local governments focus more on physical infrastructure development rather than long term development performance such population policy. On the other hand, the progress of people's welfare level has not moved back to pre-crisis level.

Dr. Harmadi stated that demographically, poor households in Indonesia tend to have large members of family, and this is true either in rural or urban areas. The reason behind this tendency may be simple, with low level of health; mortality rate tends to be high so that poor people assume that increasing number of children reduces the risk of having no descendant at all. Thus, it is obvious from this notion that children are valued high in most Indonesian poor communities. This is because they view children as a crucial factor of production. Nonetheless, this also reflects that poor household carry heavier burden than the non-poor. He commented that the family planning program has become a very important policy in Indonesia and has shown success in controlling the total population growth. The total fertility rate in Indonesia has declined quite drastically. The impact of the fertility decline is not only hampering the population growth rate but is also related to the improvement of family's welfare of the Family Planning participants.

Dr. Harmadi said that along with the family planning implementation started in the early 1970s, the employment expansion has benefited female to work outside their home. Indonesian labor market has experienced feminization during the last three decades. There is rapid growth of female workers joining labor force in agricultural, manufacturing and services sectors. The structural transformation resulted from the economic growth during 1970s and 1980s has increased absorption of working age population in the labor force, especially in industry.

He mentioned some of the present and future challenges which confront Indonesia including; the young dependency burden (as the proportion of the population below 15 years) - Indonesia experiences around 4 million new baby born each year -, an "inter-generation poverty trap" from which it is difficult to escape (poverty still continues to haunt 31 million people in Indonesia), and a less educated labour force with more than half of labor force having only primary or less education level.

As a way forward, he called on Indonesia to focus more on the issues of a quality population and not population control. He further called on the need for strengthening commitment by the local governments, religious leaders and faith-based organizations toward family planning program, safe motherhood and women empowerment.

Dr. Betty Kyaddondo, PCC of Uganda presented "Integrating FP and Maternal Health in Uganda's National Development Plan" in the 3rd session of the international conference. She mentioned that in general, Uganda is progressing slowly towards the MDG5 targets. Maternal mortality remains high at 435/100,000 with unsafe abortion causing up to 26% of the maternal deaths. There is a 1 in 25 life time risk of pregnancy related death. She stated that there are a number of bottlenecks that contribute to weak performance on maternal health in Uganda. She shared the strategies and policies of Uganda, especially the road map for accelerated reduction of maternal and neonatal morbidity and mortality, national family

planning advocacy strategy, RHCS strategy, national health policy, Reproductive health policy, adolescent SRH strategy etc.

Dr. Betty stated that potentials for investing in reproductive health exist within Uganda's planning & budgeting processes. Over the last 2 year, Uganda went through the process of developing a 5-year National Development Plan (2009/10 – 2014/15), a successor document to the Poverty Eradication Action Plan I & II (2000/1 – 2008/9). She mentioned that in Uganda sexual and reproductive health has been integrated within this document, with clear set targets. Dr. Betty commented that education will also assist Uganda in harnessing the



Dr. Betty Kyadondo

“demographic bonus.” Nearly 50% of Ugandan population is made up of young people aged less than 15 years. It is now argued that fertility decline and associated changes in the age structure of populations creates “demographic windows of opportunity”, i.e., (rapid decline in youth dependency before dependency associated to population aging starts to increase). If well planned for, with sound economic policies, the favorable age structure/distribution creates a “demographic bonus” favorable to economic growth, savings, etc.

She also stated that Uganda's economy has had an impressive growth over the years. Even during the global economic meltdown, the country's real GDP growth rate was 7.1%. The 2009 Human Development Index puts Uganda's GDP per capita at US \$889, lifting Uganda from the lower to the middle rungs/categories of developing countries. However, there are still 31% (2005/6) of the population living below the poverty line. According to *Annual Health Sector Performance Report 2007–2008*, budgeted public health expenditures equaled about US\$8.20 per person per year.

Dr. Betty mentioned mentioned that though there is significant progress in improving child survival, the high infant mortality has had a negative impact on uptake of family planning and reproductive health services in Uganda. She stated that Uganda's National Development Plan displays a high degree of integration of family planning in poverty eradication strategies and fertility reduction can be achieved by accelerating declines in infant mortality and meeting current family planning demand. She also commented that sustained political commitment and efficient utilization of resources will translate into desired outputs.

Dr. Betty concluded her presentation saying; there are opportunities and challenges for investing in sexual and reproductive health. How these opportunities and challenges are utilized, requires evidence for the investment case and policy dialogue in developing a holistic, integrated and consistent policy framework and instruments that portrays sexual and reproductive health as an investment rather than as a cost.

Mr. Dinh Huy Duong, Partner Country Coordinator (PCC) Vietnam made a presentation on how improved Family Planning and Maternal Health have contributed to poverty reduction in Vietnam. He pointed out that MMR indicators in Vietnam are showing a downward trend and this reflects better prenatal maternal health care; better attitude and behavior of mothers towards health care during their pregnancy; and better RH services. In

Vietnam, prenatal checks- up is high at about 88.3%. It is an important factor contributing to safer deliveries, reduction of obstetrical complications, maternal mortality and neonatal death in Vietnam. He pointed out that there is a steady increase in births attended by trained health workers. In Vietnam, over 60% of maternal mortality & more than 70% of infant mortality take place during delivery and 1st week. It is obvious that postpartum care is extremely important.

He enumerated some of the challenges of the Population and Reproductive Health Programme in Vietnam which include sustaining an appropriate level of fertility; preparing the country to take advantage of the demographic bonus; the ageing population (9.9% are over 60 yrs and 7.5% over 65); improving maternal health (prenatal, neonatal and postnatal), especially in mountainous, remote and isolated areas; availing adequate and good quality contraceptive commodities suitable to clients' needs; providing good quality FP services and infertility treatment; and reducing abortion incidences as well as eliminating unsafe abortion.



Mr. Dinh Huy Duong

In responding to the SRH problems, the Government of Vietnam has also established 12 development goals (referred to as Vietnam's Development Goals or VDGs), which include poverty reduction targets. The Government has also developed many policy documents to guide the implementation of MDGs and VDGs including the Comprehensive Poverty Reduction and Growth Strategy. In these documents, population, RH/FP and maternal health have been given prominence and recommended for integration into various programmes/projects for poverty reduction.

He shared with the meeting a model which has integrated communication on population and reproductive health with savings, credit and agricultural extension. Through this model, hundreds of thousands groups have been established throughout the country. The group members have acquired new knowledge and skills on RH/FP and maternal and child health care as well as knowledge on production using the latest technical advances in agricultural production, cattle raising, handicraft or small business etc.

V. SESSION FOUR: SHARING EXPERIENCES FOR SOUTH-SOUTH LEVERAGE

This session was chaired by **H.E. Prof. Dr. AFM Ruhul Haque, PPD Board and Executive Committee Member and Honorable Minister of Health and Family Welfare Government of the People's Republic of Bangladesh**. He thanked the Government of Indonesia for the excellent organization of the International Conference and kind hospitality of the people of Indonesia rendered towards the participants of the conference. He also thanked PPD for arranging this conference on the theme "Promoting Family Planning and Maternal Health for Poverty Alleviation" as the theme more opportune given the prevailing context of Family Planning and Maternal Health in developing countries.

Prof. Haque stated that developing countries are getting greater influence on the world stage and emerging economies like China, India, South Africa and Brazil are now world leaders in their own right and are challenging the West. He commented it shows that the South has the

capacity, capability and potentials to reshape the course of international development assistance.

Prof. Haque mentioned that as highlighted by ICPD and reinforced by the MDGs, countries from the South need to synergize their efforts to build partnership with each other in a concerted manner. He told that South-South Cooperation needs increasingly to be mainstreamed in the work and agenda of all developing countries and be seen as an effective strategic framework to alleviate sufferings of people in the developing world.



H.E. Prof. A. F. M. Ruhul Haque

He told that it is unacceptable that 1.4 billion people subsist on US\$ 1.25 or less a day in the developing world. 8.8 million children die before their 5th birthday and more than 300,000 mothers die yearly due to preventable pregnancy related complications. He mentioned that the countries need to acknowledge the commonality of problems in the south and act accordingly. The solutions rest with the countries. Many countries of the south are on the track of meeting the MDGs and can share lessons learnt to others.

He mentioned that documentation of successful experiences has been undertaken in many countries. He also mentioned that Bangladesh has one of the most successful Family Planning programs in Asia. The micro-credit program initiated by Bangladesh is today a world reference and is being replicated both by countries from the South and the North. He expressed his satisfaction that that PPD has documented on “Providing Domiciliary Services for Improving Reproductive Health & Family Planning Activities in Bangladesh” which to be shared with others in the developing countries.

Prof. Haque informed that in this session Partner Country Coordinators (PCCs) of South Africa, China, Morocco, Indonesia and Egypt would share their countries experiences. He also informed that the Keynote Speaker Dr. Nafis Sadik, the Special Envoy to the United Nations Secretary-General sent video-recording of her message for the session. He wished excellent deliberations from the countries and thanked the presenters and participants.

Mr. Jacques van Zuydam, PCC and National Population Unit, Development of Social Development, Republic of South Africa referred the ICPD PoA, SADC’s “Maputo Resolution” 2004 and Population policy and P&D strategy as backgrounds of his presentation. He informed that UNFPA, Lead, University of Cape Town, University of the Free State, Nelson Mandela Metropolitan University and Department of Social Development, South Africa were the partners in integrating population and environment issues for sustainable development for leveraging South-South Cooperation. He mentioned that the course contents included a nexus of population, environment and development.

He described the pre-course reading and pre-course evaluation. He mentioned that main theme as Population, Environment and Development (PED) for sustainable development and topics as a) overview of key population, development and environment concepts and linkages; international agreements b) systems thinking c) fish banking d) the role of

indigenous knowledge systems in sustainable development, and e) globalization, trade and sustainable development.

Mr. Zuydam then described the PED nexus. He mentioned the topics of the theme “environment and development” as a) ecosystems and global change b) ecological footprint c) resource utilization, and d) case studies (e.g. mining). The topics of the theme “population & development” were a) population, gender & development b) reproductive health and development, and c) socioeconomic impacts of HIV/AIDS. He also mentioned the topics of the theme “population and environment” as a) land tenure and human settle, and b) agriculture and food security.



Mr. Jacques van Zuydam

Mr. Zuydam also described the competencies in leadership and management. He also shared the topics as a) communication skills b) conflict resolution, negotiation and decision making c) change management d) group dynamics and team work, e) talk on what is leadership, and f) monitoring and evaluation. He described the environment management tools and frameworks e.g. a) EIA b) SIA, c) IDP. He mentioned that all the courses had requirement of case studies and site visits.

Mr. Zuydam informed that since 2005, 465 participants were offered 18 courses in 5 universities. Eighty six participants were from 13 SEA countries and 5 participants from other PPD member countries. He also shared few of the evaluation comments which highly praised the endeavors. He concluded mention other developments on a) PED research b) PED newsletter c) provincial PED networks d) P&D in information and knowledge service e) PED in conference and seminar f) National climate change strategy: adoption g) partnerships: regional and national h) PPD scholarships i) PPD “best practice” case study, and j) Port Elizabeth/Eastern Cape “Local Footprint Programme”: awareness, capacity building, dialogue and strategy.

Mr. Hu Hongtao, PCC and Director-General, Department of International Cooperation, National Population and Family Planning Commission of China, mentioned that SFPC was announced in 1995 with an expectation that family planning program in China must make two re-orientations in guiding ideology and program approach. The objective was to integrate family planning with economic and social development. The Quality of Care (QOC) in family planning/reproductive health program was initiated in China in 1995 in six districts with better-off conditions in China’s east coast as the first group of QOC pilots; five more were added in 1997. He shared that the goal of the QOC was to improve RH status of people by reforming national family planning program. The specific objectives were: changing ideology; upgrading of services and improving program management.



Mr. Hu Hongtao

Mr. Hongtao said that to implement the program, the leadership group at the national level was first setup followed by setting up local leadership groups in all pilot counties/districts and developing work plans. The activities to implement the programs were a) partnership b) capacity building c) supportive communication, and d) supervision and monitoring. The achievements were a) informed choice and changes in contraceptive mix b) improved IEC approaches c) improved quality of services d) expansion of the scope of services to reproductive health care, and e) Change in administrative and management practices. He shared that the main outcomes/direct impacts were; from clients perspective a) fewer cases of contraceptive failure, and fewer unintended pregnancies b) clients, especially women, felt that they were respected. From impact on service system the main outcomes/direct impacts were a) changes in the age and knowledge structure of service providers b) more inputs to improve local service facilities c) service provision standardized.

Mr. Hongtao informed that the major impacts of the QOC programs were a) people were more aware of reproductive rights and benefits b) improved relationship between clients and FP workers c) improved image of the FP program, and stabled low fertility level. He told that there were marked differences in decision making process of contraceptive use in 1998 than in 1995. About half of the clients informed that they made decisions by themselves or with their husbands, which was non-existent in 1995. Eighty six percent respondents were satisfied with family planning services and 77% have participated in FP activities in 1998.

Mr. Hongtao stressed that the main lessons which were learnt from the QOC programs were flexibility of the programs and voluntary participation of the clients. The Government needs to mobilize financial and technical resources and issue required official documents and modify the policies to promote QOC. He informed that in 1998-99 there was spontaneous replication of the QOC approaches in more than 88 counties/districts. During the scaling up period of 2000-10, innovations of QOC pilots were documented, standardized QOC approaches were developed. There was a national campaign of “Advanced County of QOC” was adopted and 2021 (70.7% of 2860) were targeted up to 2009 and required institutional building activities were completed (e.g. training, supervision etc.). He shared that the areas in which experiences and lessons were learned from scaling up were a) advantage and disadvantage in top-down promotion b) centralization vs. decentralization c) unified standard vs. flexible adaptation d) ownership vs. resource sharing, and e) quality control vs. speed up. Mr. Hongtao concluded informing the future plans as; QOC approach be further upgraded and speeding up in future (2010-15) in all counties in East China and 80% counties of Mid and West China.

Dr. Lahsen Rachidi presented the Moroccan experience and its health plans (2008-2012) objectives which are among others to reduce maternal mortality from 50 /100000 live births to 15/100000 by 2015. In this line, a specific plan to reduce maternal mortality has been developed and it comprises free services delivery including cesarean section, free medicine and even free transportation. The list of essential medicine has been revised and they have been made available in all delivery facilities. The number of health professionals in these facilities has been also increased.

In addition of that, Emergency Obstetric and Neonatal Care (EmONC) facilities have been opened in rural areas, all delivery facilities have been audited country wide, the mobile strategy in the rural areas have been revitalized and many community projects set up. For better follow up of patients and their babies’ after delivery, it has been decided to set up a

mandatory stay of 48 hours after delivery in all the facilities. Health professionals' skills have also been upgraded in line with the new guidelines. Gains in family planning programs have been reinforced and sensitization session offered to all visitors in health facilities.

These initiatives were justified by the fact that many rural areas were not accessible and many pregnant women lost or risk their lives of their babies by delivering at home. This is how the concept of « Dar Al Oumouma » was born: it's a welcoming space for all parturient from rural and remote areas: they are admitted 7 days before delivery and kept 2 days after free of charge. It's a result of a partnership between local authorities and associations who bear all the costs and ensure the management.



Dr. Lahsen Rachidi

The « Dar Al Oumouma » approach was evaluated (2005 - 2009) to measure whether it an adequate response to the fight against Maternal and neonatal mortality in rural areas. Results showed that it was without doubt a pertinent approach the reply both to the needs of rural populations as well as to national priorities in line with international standards. However, sustaining this approach is seen as a challenge in the future.

Dr. Siswanto Agus Willopo presented the key features and values that guide FP/RH promotion practice in Indonesia which he listed as being: a holistic view of FP/RH; a focus on participatory approaches; a focus on the determinants of FP/RH, the social, behavioral, economic and environmental conditions; building on existing strengths and assets, not just addressing FP/RH problems and deficits; and Using multiple, complementary strategies to promote FP/RH at the individual and community level.

First, FP/RH promotion adopts the definition adopted by the ICPD 1994 and views health as a positive concept emphasizing social and personal resources as well as physical and social-economic capabilities. Indonesia FP/RH program covers issues from adolescents to post-menopause period; from male participation to sterilization he added.



Dr. Siswanto Agus Willopo

Second, a Focus is given on Participatory Approaches and wherever possible, FP/RH promotion workers address reproductive health issues by doing things *with* people rather than doing things *for* them and this embodies key Indonesian FP/RH promotion values which are : empowerment, social justice and equity, inclusion and respect.

Third, Determinants of FP/RH refer to the range of social, economic and environmental factors which determine the reproductive health status of individuals or populations which include : income and social status' social support networks, education, employment and working conditions, physical environments, social environments, biology and genetics endowment, healthy child development, health services. As FP/RH promotion practice is fundamentally concerned with addressing the determinants of RH, in Indonesia, those

determinants have been used in the “Family Welfare Indicators” and each family has been mapped according to this status.

Fourth Builds on Strengths and Assets and wherever possible, FP/RH promotion practice builds on positive factors promoting the reproductive health of individuals and communities. Examples of these strengths and assets include community leaders, FP/RH cadres, existing programs and services, strong social networks, or institutions and events in the community that bring people together. The importance of this fourth feature is that it helps to distinguish FP/RH promotion from concepts such as disease prevention and population health.

Fifth, highlights the use of Multiple, Complementary Strategies : in Indonesia, FP/RH promoters use multiple strategies focused on individuals, families, groups, and multiple strategies are used by identifying five action areas for RH promotion practice: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting reproductive health services, including financing system.

FP/RH promoters have worked on five action areas through the use of multiple, complementary strategies and all strategies aim to enhancing community participation. Networking is seen as key strategy in the country he concluded.

Prof. Dr. Maha Mostafa Kamel Morad, PCC and Secretary General of National Population Council, Ministry of State for family and population, Government of the Arab Republic of Egypt informed that there was a tailored program for promoting capacity building and experience sharing in 88 villages of 9 Governorates in Upper Egypt targeting 13,984,543 population including 2,330,757 females of child bearing age. The Governorates were Fayoum, Beni-suef, Menia, Assiut, Sohag, Quena, Luxor and Aswan. She mentioned



Prof. Dr. Maha Moustafa Kamel

that the emphasis was on the unmet needs; the aim was to raise the rate of contraceptive use from 52.7% to 57.1% in 1 year (January to December, 2011). The program employed mobile teams in addition to ongoing services. The targets were university students, professors, local religious leaders and natural community leaders. Prof. Mourad informed that the coordination between the mobile teams and local authorities was assured. She also mentioned that the program trained 7317 “family friends” and the plan was to train another 5000 by the end of October, 2010. She also shared that so far 39 cadres of trainers and 686 supervisors had been trained for the purpose.

VI. ADOPTION OF THE DECLARATION

This session addressed the adoption of the Yogyakarta declaration and road map and was chaired by Dr. Sugiri Syarief, MPA, member PPD Board and chairperson of BKKBN, Republic of Indonesia.

The presentation and explanation of declaration road map was carried out by Dr. SLN Rao, PPD permanent observer to the United Nations and Mr. Jyoti Singh, PPD consultant and the discussion and adoption were led by Dr. Boniface Omuga and Dr. Jotham Musinguzi.



In the panel from the left Dr. S L N Rao, PPD Permanent Observer to the United Nations, Mr. Jyoti S Singh, PPD Consultant, Dr. Sugiri Syarief, MPA, Chairperson, BKKBN, Dr. Boniface O. K'Oyugi, MBS, CEO, National Coordinating Agency for Population and Dr. Jotham Musinguzi, Regional Director, PPD Africa Regional Office

Dr. Sugiri started the session by greeting the attendees and he asked them to read the declaration copy for 10 minutes to be oriented by the different items and recommendations. Mr. Jyoti announced that they will read the items of the declaration copy then they will discuss it section by section and paragraph by paragraph. Following that Dr. Rao read all the sections of the declaration. Each section was analyzed, thoroughly discussed and participants' suggestions and recommendations were noted.

Mr. Jyoti Singh, Dr. Rao, Dr. Musinguzi and Dr. Boniface Omuga answered to all queries. He ensured that linguistic errors in the draft will be reviewed and corrected. Mr. Jyoti Singh clarified that FP/MH and eradication of poverty are considered cross cutting to empower the women and that the session for FP/MH and poverty eradication is not a family planning only, but the aim is funding FP and other RH services including MH.

Dr. Boniface, Dr. Rao and Dr. Jotam Musinguzi shared that this conference is focusing on FP and maternal health because FP is an important strategy that can improve maternal health, reduce maternal mortality rates and slow population growth. However, expanding and upgrading formal and informal training in sexual reproductive health care and FP for health care provider was written in page 5 & 6 of the declaration.

After long clarification and discussion, the chairman opened the general discussion for the participants to give their final inputs, the Declaration was then adopted.

VII. CLOSING CEREMONY

Dr. Li Bin, Minister of National Population and Family Planning Commission of China (NPFPC) recalled China's experiences in carrying out strategy of sustainable development and addressing population issues in a comprehensive way, she summarized China's population and family planning work as follows: China had adhered to its basic national policy of family planning and gradually improved its population policies, while promoting

the long-term balanced development of population. Moreover, it had also strived to build a population-balanced, resource-saving and environment-friendly society and realize a coordinated and sustainable development of population and economy, society, resources and environment. She stressed that all countries, especially the developing countries, should make mid- and long-term strategies for population and development in accordance with their own national conditions. In addition, with special focus on the important and difficult problems of their own, they should, according to their conditions in realizing the Millennium Development Goals and the goals set by the International Conference on Population and Development (ICPD), establish their own indicators and monitoring systems for population development, while striving to improve their systematic population development policies.



From the left Mr. Harry Jooseery, Executive Director of PPD, Dr. Sugiri Syarief, MPA, Chairperson, BKKBN, H.E. Dr. Li Bin, Minister of National Population and Family Planning Commission of China (NPFPC)

The executive Director of PPD extended his vote of thanks to all participants on behalf of the organizers. He also deeply thanked the government of Indonesia and all Board members with appreciation and gratitude for their presence and dedicated time. The Executive Director also appreciated the availability of all of all Special Guests at the discussion sessions and providing the participants with their observation and guidance and all **Resource Persons** who actively participated in the discussion sessions and enriched them with their valuable comments and ideas.

To conclude, he thanked BKKBN for organizing the event and to all **PPD staffs** who worked relentlessly to make these events a success.

In the absence of **Minister Endang Sedyaningsih**, due to a recent earthquake that occurred in Indonesia's Mentawai Islands, **Mr. Pembacaan Menkes oleh Kepala of BKKBN** conveyed his deepest regrets and delivered the closing remarks on his behalf.

He first congratulated partners in Population and Development (PPD) and National Family Planning Coordinating Board (BKKBN) for organizing successfully the conference. He also thanked all the participants who have gathered during two days to exchange views and experiences from various countries and showing the same intention and commitment to achieve the eight development targets stated in MDGs by year of 2015. Placing poverty alleviation in the first order of MDGs, indicates that poverty was one of the main problem

that we have to solve. Hence, improving maternal health will give a real contribution to the welfare of the family and will positively strengthen poverty reduction.

He emphasized that to improve maternal health require a lot of activities and efforts and that national, regional and international supports including collaboration among developing countries and North-South Countries are very important. He then declared that PPD has a great potency in strengthening the capacity of all stakeholders in advocating and looking for the potential institutes and sources to strive against poverty through Family Planning and Maternal Health programs. He requested participants to make good use of result of the conference not only by adopting the declaration, but also by using it as a guidance in developing policies at country level and by implementing it into real action.

He then ended his remarks by inviting the participants to stay longer and enjoy the beauty of Yogyakarta and the hospitality of its people and the uniqueness of their culture. Saying so, he declared the International Conference on Promoting Family Planning and Maternal Health for Poverty Alleviation officially closed.

CONFERENCE OUTCOME

The Outcome of the conference is the Yogyakarta Declaration which is a testimony of the commitment of PPD and its member countries to reposition family planning and promote maternal health for the attainment of both ICPD and MDGs.

The declaration comprises four substantive sections; family planning, maternal health and poverty eradication; family planning and maternal health; financial and human resources for improving family planning and maternal health and leveraging south-south cooperation. Each section includes a list of priority issues, respective recommendations and call for action targeting governments, the PPD, international organizations, donors, non-governmental, private sector and others to commit and take appropriate action. The declaration ends with a commitment made by the participants to actively follow-up and implement the recommendations contained in this Declaration and strengthen cooperation among ourselves through South-South cooperation, and with all the development partners, including parliamentary groups, NGOS, civil society organizations, the private sector and the donor community. The Declaration is annexed to this report.

ANNEXE:

- Yogyakarta Declaration 2010



**Partners in Population and Development (PPD)
A South-South Initiative**

YOGYAKARTA DECLARATION

**Formulated and Adopted
at the
International Conference on
“Promoting Family Planning and Maternal Health
for Poverty Alleviation”
Yogyakarta, Indonesia; 26-27 October 2010**

***Approved with commitment for implementation
by the
Board Members (Ministers of Health / Population / Planning and
Social Development) of 25 Member States
at the
XIV Annual Board Meeting
of Partners in Population and Development (PPD)
Yogyakarta, Indonesia; 28 October 2010***

YOGYAKARTA DECLARATION

I. INTRODUCTION

We, the members of Partners in Population and Development (PPD), an intergovernmental alliance of developing countries*, accounting for more than half of the world's population, along with a number of other developing countries attended the International Conference on "Promoting Family Planning and Maternal Health for Poverty Alleviation" convened in beautiful Yogyakarta, the Republic of Indonesia on the 26 and 27 October, 2010.

As recognized in the Programme of Action of the International Conference on Population and Development as well as in the outcome documents of other international meetings and summits, family planning and maternal health are central elements of reproductive health and are integral components of poverty reduction and development strategies.

In this context, the two day Conference examined the critical challenges facing family planning and maternal health, with particular focus on issues and concerns relevant to developing countries, exchanged experiences on specific intervention programmes that have been proven effective, and discussed experiences in integrating family planning and maternal health into poverty reduction strategies. The Conference examined human, financial and other constraints that limit progress towards achieving goals set at the International Conference on Population and Development (ICPD) and Millennium Development Goals and targets. The Conference also explored the opportunities afforded by leveraging South-South cooperation for addressing the constraints and challenges collectively through enhanced cooperation and partnerships.

We commit ourselves collectively and in our individual capacities to actively promote and implement the actions contained in this Declaration for improving access to maternal health and family planning services and reducing poverty and promoting sustainable development.

* *The Members of the Alliance as of 27th October 2010 are: Bangladesh, Benin, China, Colombia, Egypt, Ethiopia, The Gambia, Ghana, India, Indonesia, Jordan, Kenya, Mali, Mexico, Morocco, Nigeria, Pakistan, Senegal, South Africa, Thailand, Tunisia, Uganda, Viet Nam, Yemen and Zimbabwe*

II. PREAMBLE

We, the participants at the Conference:

- **Recall** the objectives contained in the ICPD Programme of Action adopted in 1994 and those included in the Key Actions adopted during the five year review of ICPD implementation in 1999; the commitments and goals (MDGs) agreed upon by Heads of States and Governments during the Millennium Summit in 2000; and those agreed upon by the General Assembly during 2005 and 2010 and contained in the outcome documents of the 5 and 10 year reviews of the MDGs.
- **Note** that in countries and regions with rapid population growth it is challenging to meet the Millennium Development Goals to alleviate poverty, to reduce infant and maternal mortality, and to make primary education universally available.
- **Recognize** that family planning, maternal health, poverty and women's empowerment are mutually interrelated, and that the Millennium Development Goal of reducing poverty (MDG 1), of achieving universal primary education (MDG2), of promoting gender equality and empowerment of women (MDG 3) and improving maternal health (MDG 5) cannot be achieved unless the ICPD goal of universal access to reproductive health including family planning (MDG Target 5b) is attained.
- **Note with concern** that family planning has lost its centrality in terms of funding and its place in poverty reduction strategies, as well as in population and reproductive health policies and programmes, and that significant efforts are needed to make it a priority in the national and global development agendas.
- **Note** that many barriers of cost, unjustified medical guidelines and practices, misinformation, provider bias, severe shortage of human resources for health, and other social and religious barriers prevent women and men from exercising their basic human right to decide whether and when to have children.
- **Note further** that recent research demonstrates that preventing unintended pregnancies can accelerate economic development.
- **Note with concern** that the ongoing impact of financial and economic crises and the slow economic recovery is having adverse impacts on our economies with potential consequences for our efforts to achieve ICPD Goals and MDGs; this situation is further exacerbated by frequent natural disasters and climate change.

- **Note at the same time** the renewal of interest in an integrated approach to reproductive health including family planning and maternal health, as underscored by the recent pronouncements of major economies.
- **Reiterate** the importance of integrating reproductive health, including maternal and child health and family planning and HIV/AIDS prevention and care into national development plans and poverty reduction strategies,
- **Reiterate** the urgency to significantly increase the allocation of resources to family planning and maternal health, from both domestic and external sources, and
- **Reaffirm** our own commitments made during the previous International Forums held at Rabat (Morocco) in 2007, and Kampala (Uganda) in 2008 and the commitment of PPD and member countries to report regularly on its own achievements and contributions towards internationally agreed goals for 2015.

III. PRIORITY ISSUES AND RECOMMENDATIONS

III(1). Family Planning and Poverty

High fertility, poor maternal health and poverty are inextricably linked. High fertility and poor maternal health are symptoms of poverty and hold back families and communities from escaping poverty.

Family planning is an important strategy that can improve maternal health, reduce maternal mortality, slow population growth, and contribute to economic development. Family planning lowers fertility, reduces youth dependency and opens up a window of opportunity for greater investments in the social sector, in particular education, health, water and sanitation. Family planning helps women delay child bearing and limit the number of pregnancies and provides them with greater opportunities for education and employment. This in turn increases household income and a family's investment in the education and health of its members, particularly children.

Working towards universal access to reproductive health including family planning, which is included as Target 5b of MDG 5, will help reduce maternal mortality ratios and will contribute to MDG1, the eradication of poverty and hunger.

Investing in family planning must be a central component of national policies, plans, strategies and programmes and must be seen as an investment that can yield dividends which can be utilized for the development of other sectors and it should not be viewed just as a cost.

III(1).a Recommendations

- Constitute a multi-sectoral working group comprised of officials from Ministries of Health, Education, Water and Sanitation, Finance and Planning, National Planning Organizations and other relevant organizations to develop

robust action plans and allocate the necessary funds for implementing maternal health and family planning programmes as part of national development and poverty reduction strategies.

- Promote decentralization of service delivery for maternal health and family planning with a view to encouraging community outreach and participation.
- Invest in children's education, particularly the education of girls and women to increase their participation in economic activity and for their empowerment in decision-making process.
- Involve a wide range of stakeholders including the community, local governments, religious and cultural institutions, and faith-based organizations that will promote and integrate family planning in their development initiatives.

III(2). Family Planning and Maternal Health

The outcome document of the high-level plenary meeting of the sixty-fifth session of the General Assembly on the Millennium Development Goals (United Nations, *Keeping the Promise: united to achieve the Millennium Development Goals, A/RES/65/1*) expressed "grave concern over the slow progress being made on reducing maternal mortality and improving maternal and reproductive health" (para.20).

In this regard, the conference welcomed the recent renewed support to maternal health as evidenced, among others, by the United Nations Secretary-General's Initiative on Global Strategy on Women's and Children's Health, discussions at the G8 meeting in Canada, and at the 2009 Kampala Conference on Family Planning.

Recent estimates by WHO suggest declines in maternal mortality ratios (MMR) and in the number of maternal deaths in many countries. It is noted that in 2010 alone nearly 200,000 more women will survive pregnancy and child birth. Improved access to skilled birth attendants (SBAs), emergency obstetric care and family planning have contributed to this trend. Yet, an estimated 46 million women deliver their children without a skilled birth attendant. Most of these women are also poor and marginalized, living in remote areas, are young and have limited or no access to basic health services including family planning services. The resulting unmet need for contraceptives contributes to unwanted and unplanned pregnancies and unsafe abortions, which often result in ill health or death.

It is also noted that many developing countries are entering a period when the number as well as the proportion of women entering their reproductive age is on the rise. This generates population momentum, which will result in a continuous population increase for many more decades. This population increase could hamper efforts to reduce poverty and make developmental gains less likely. To counter this, further reductions in fertility and population growth can be achieved even in illiterate, low income communities with improved access to an unbroken, adequate, free or low cost supply of contraceptives together with accurate information about family planning methods.

Family planning is central to improving maternal health, one of the eight Millennium Development Goals (MDG 5) and to the attainment of other MDGs. Studies show that family planning has immediate benefits to the lives and health of mothers and their children. Studies show that access to family planning services can reduce maternal deaths by a third, yet, family planning services remain out of reach for many, especially the poor, the young and those who are marginalized in their societies. It is estimated that over 200 million women want to use safe and effective family planning methods but lack access to services. An adequate, unbroken supply of contraceptives is the foundation of all family planning programmes and services and is critical for meeting the unmet needs for family planning. A relatively high cost, unjustified medical guidelines and practices, misinformation and provider bias, prevent women and men from exercising their basic human rights to decide whether and when to have children.

III(2).a Recommendations

- Reposition family planning in the national and international development agenda as a priority.
- Redouble efforts and build on the progress made to make pregnancy and childbirth safe. Reduce maternal mortality and morbidity further by strengthening specific health interventions including the presence of skilled birth attendants at delivery and the provision of emergency obstetric care.
- Expand the provision of comprehensive obstetric care and strengthen the role of skilled health care providers, including midwives and nurses, through pre-service and in-service training, task shifting, and incentives, to fully utilize their potential as trusted providers of maternal health-care services. Expand family planning within the local communities. Expand and upgrade formal and informal training in sexual and reproductive health care and family planning for all health-care providers, health educators and managers, including training in interpersonal communication and counseling.
- Examine and take steps to remove barriers to accessibility and affordability to improve access to family planning services and to bridge the inequalities in access between the rich and the poor.
- Take steps to ensure that men, women and young people have information and access to a wide selection of safe, effective, affordable and acceptable methods of family planning.
- Ensure an adequate and unbroken supply of contraceptives by strengthening reproductive health commodity security and logistics management information systems.
- Address inequities in access to health services, including reproductive health and family planning services, by management reviews and such policies as establishing social insurance/protection mechanisms.

- Address the sexual and reproductive health needs, including the need for information, counseling and services for family planning, of the large and increasing cohorts of adolescent and youth population.

III(3). Financial and Human Resources

Family planning and maternal health are central components of reproductive health. Guaranteeing universal and sustainable access to family planning services integrated within the broader framework of reproductive health requires robust health systems that are fair, accountable and adequately resourced. Better positioning reproductive health in the health system as part of national strategies for development and poverty reduction will help increase human resources and funds allocated to family planning and maternal health.

Currently, investment in health, and in particular reproductive health, are in many countries neither sufficient nor equitable. Investments in health need to be scaled up while at the same time, a more effective use of resources is required to maximize the impact of all investment in health.

The ICPD Programme of Action (POA) called upon all countries to take steps to meet the family planning needs of their populations as soon as possible, and to provide universal access to a full range of safe and reliable family-planning methods by 2015. Despite this call, resources allocated to family planning have declined significantly and are lower today than they were in 1995 with adverse implications for countries' abilities to address unmet needs for family planning and could undermine efforts to prevent unwanted pregnancies, reduce maternal and infant mortality, provide adequate supplies of family planning commodities and help improve the quality of services.

III(3).a Recommendations

- Sexual and reproductive health services, including family planning, should be universally available within a rights framework, as part of health services.
- Address gender equality, equity and equitable access to health services including reproductive health and family planning services for the poor and marginalized (women, young people, ethnic minorities).
- Remove unnecessary policy barriers to contraceptive service delivery; provide safe and accessible abortion services, where it is not against the law; address cultural and religious barriers to family planning.
- Encourage local production of contraceptives where appropriate and conduct research for more effective contraceptives.
- Strengthen the engagement of public private partnerships (including universities, investors, professionals, development partners, private sector,

community), especially for innovation, technology and expansion of the resource base.

- Develop, strengthen and scale up social protection mechanisms, put safety nets in place and provide a minimum level of access to essential services, and income security for all.
- Engage with communities and their leaders (including religious and popular leaders) on their specific health and sexual and reproductive health (SRH) needs, and work to deliver services as a partnership.
- Adopt national family planning communication strategies; develop information-education-communication (IEC) on contraception; and support advocacy to and by members of parliament.
- Empower women, including young women, with knowledge and choice of sexual and reproductive health services and commodities.
- Scale up the use of “health extension workers” and social mobilizers at the community level.
- Countries must commit more of their resources to fund, staff and implement family planning and maternal health programmes.
- South-South cooperation does not replace international development assistance; efforts must be increased to help mobilize resources for South-South and triangular cooperation.
- International donors should do their best to increase international development assistance and meet the internationally agreed target of 0.7 percent of GNI.
- International assistance, as additional resources, will be needed to help poorer countries that have difficulty achieving their MDGs. Also, greater efforts should be made to mobilize resources for these countries through South-South modality.
- Strengthen management for results and mutual accountability at all levels; scale up human, financial and material resources for sexual and reproductive health and use resources more effectively and efficiently.

III(4). South-South Cooperation

The possibility to enhance and strengthen South-South cooperation is much stronger today than ever before. This is reflected by the fact that a number of countries of the Alliance are increasing their support to South-South cooperation, and have begun to allocate resources for the provision of fellowships, and the provision of reproductive health commodities and equipment. Over many decades, these countries have also

accumulated high levels of knowledge, experience and expertise in planning and implementing interventions to improve maternal health and family planning; and have built world class institutions for training, making it possible to advance South-South cooperation further and make it more effective. The institutional capacity for training that exists in a number of countries should be fully utilized through South-South and triangular cooperation.

The ICPD Programme of Action highlighted the desirability of countries “learning from one another’s experience, through a number of different modalities. The importance of South-South co-operation in implementing the Programme of Action was further recognized by the special session of the UN General Assembly during the five-year review. In the report entitled “Key Actions for Further Implementation of the Programme of Action of the International Conference on Population and Development” it is noted that “ External funding and support from donor countries as well as the private sector should be provided to sustain the full potential of the South-South cooperation, including the South-South initiative: Partners in Population and Development, in order to bolster the sharing of relevant experiences, and the mobilization of technical expertise and other resources among developing countries”(paragraph 88).

During the past fifteen years, PPD has promoted the implementation of the ICPD Programme of Action through policy dialogue, sharing of experiences, promoting reproductive health commodity security, building national capacity, and strengthening national institutions for training through South-South cooperation. To improve monitoring, PPD has established a mechanism to periodically collect information on the products and services exchanged among member and non-member countries. PPD is documenting best practices to be shared among the member countries and also with other countries. PPD has also developed generic modules on specific issues for incorporation into the on-going training programmes of PPD Partner Institutions (PIs).

III(4).a Recommendations

- Elevate the role of South-South collaboration to strengthen sexual and reproductive health including family planning programmes in member and non-member countries.
- Strengthen institutions in PPD member countries to facilitate exchange of experience and best practices and training among member and non-member countries.
- Utilize South-South modality to supply contraceptives and transfer technology among the countries of the Alliance and with non-member countries.

IV. COMMITMENT AND WAY FORWARD

IV.a Statement of Commitment

We, the participants in the International Conference on “Promoting Family Planning and Maternal Health for Poverty Alleviation” commit ourselves to actively follow-up and implement the recommendations contained in this Declaration and strengthen cooperation among ourselves through South-South cooperation, and with all the development partners, including parliamentary groups, NGOS, civil society organizations, the private sector and the donor community.

IV.b Call on Governments:

- To accelerate progress to achieving gender equality and empowerment of women, to which they committed at the MDG+10 review.
- To invest in training skilled birth attendants, neo-natal care and improving access to emergency obstetric care.
- To empower communities without access to skilled birth attendants to achieve universal access to voluntary family planning and maternal health, especially in low resource settings.
- To identify and reduce unnecessary barriers to family planning; and to give priority to family planning and maternal health and ensure that they are central components of national plans, policies, programmes and strategies for poverty eradication and development.
- To allocate sufficient funding for family planning and maternal health through mechanisms such as the establishment of budget lines for reproductive health commodities; increasing national allocations for health to 15 percent, and improving the efficient use of available resources in a manner that ensures equitable access.
- To engage the private sector, NGOs and other civil society organizations (CSOs) to enhance access to family planning and maternal health.
- Advocate for strengthening and supporting South-South cooperation, as a cost-effective strategy, for accelerating the achievement of MDGs and ICPD Goals.

IV.c Call on PPD:

- Facilitate the exchange of information and experience among member countries and other countries on the efforts and progress in repositioning family planning as part of national development agendas.

- Increase advocacy efforts at national, regional and global levels to gain support for increased investments in health, in particular for family planning and maternal health information and services;
- Facilitate the provision of reproductive health commodities from the manufacturing to non-manufacturing countries of the South. Also, encourage transfer of technology for local production of contraceptives where appropriate;
- Regularly monitor and report on the progress in the follow-up and implementation of the recommendations and actions contained in this Declaration.
- Undertake a mid-term review during 2012 and a final review during 2015 on the status of implementation and progress made in carrying out the actions contained in this Declaration towards achieving MDGs and ICPD Goals.

IV.d Call on development partners:

- Provide technical and financial support for advancing South-South cooperation through their programmes.

The participants wish to express their appreciation to the Government of the Republic of Indonesia for hosting the Conference, for making excellent arrangements, and for their wonderful hospitality.

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