REPORT ON THE PROCEEDINGS OF THE NETWORK OF AFRICAN PARLIAMENTARY COMMITTEES OF HEALTH (NEAPACOH) MEETING: FROM MILLENNIUM DEVELOPMENT GOALS TO SUSTAINABLE DEVELOPMENT GOALS: CHALLENGES AND OPPORTUNITIES FOR PARLIAMENTARIANS TO ENHANCE REPRODUCTIVE HEALTH/FAMILY PLANNING

JUNE 29-30, 2016 AT SPEKE RESORT, MUNYONYO, KAMPALA, UGANDA

Partners in Population and Development

Africa Regional Office

EXECUTIVE SUMMARY

In September 2015, the international community agreed to an ambitious new development framework "Sustainable Development Goals" (SDGs) that would end poverty by 2030 and universally promote shared economic prosperity, social development and environmental protection. The SDGs followed and expanded on the MDGs and were adopted at the UN in New York in September 2015.

Considering that SRHR remains critically important for the sustainable development of the African continent, it is essential to continue positioning SRHR high on the continent's development agenda. For this to happen, SRHR including FP should be considered as an unfinished business requiring renewed vigor and determination in the post-2015 development agenda especially by policymakers. It is imperative that strong political will, national ownership and support is built and maintained in order to consolidate the gains made, complete the unfinished business and sustain momentum for the success of SDGs.

Successful implementation of SRHR including FP programs in Africa requires enhanced, pragmatic leadership and stewardship from African policymakers including Members of Parliament (MPs). The involvement of legislators is a strategic intervention that contributes to effective and sustained programs. It is important therefore to provide space for Members of Parliament, because of the unique nature of their roles, (legislation, budget appropriation and oversight) to understand the transition from the MDGs to the SDGs and what they need to do in the 2030 Agenda for Sustainable Development.

With this in mind, Partners in Population and Development, Africa Regional Office (PPD ARO) has been organizing high-level policy meetings for African parliamentarians who sit on the committees of health to promote south – south information exchange on best practices and identify areas of follow up action to advance the SRHR including FP agenda in the region.

The meetings, organized under the auspices of the Network of Africa Parliamentary Committees on Health (NEAPACOH), focus on implementation of regional and international commitments including the ICPD PoA, the Maputo Plan of Action, the Millennium Development Goals (MDGs), and the FP2020 commitments, among others. The meetings also update parliamentarians on countries' progress on implementation of SRHR frameworks. In addition, the meetings provide a platform for building capacity and raising awareness of MPs on the interrelationships between SRHR and sustainable development, and emerging concepts like the Demographic Dividend, among others.

Against this background, PPD ARO in partnership with NEAPACOH organized a two days high

level policy advocacy meeting with parliamentarians from June 29 – 30, 2016, at Speke Resort, Munyonyo in Kampala, Uganda. This meeting was the eighth, in a series, that have been organized under the auspices of NEAPACOH. The theme of the meeting was **"**From Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs): Challenges and Opportunities for Parliaments to enhance Reproductive Health/Family Planning". It aimed at providing space for parliamentarians to understand the transition from the MDGs to the SDGs and what they need to do to build and sustain the momentum for political will for SRHR within the context of the SDGs.

The specific objectives of the meeting were to;

- Assess progress made, challenges and lessons learned on achieving the country commitments made at the September 2014 NEAPACOH meeting
- Have a common understanding of the challenges and opportunities for SRHR in the post-2015 development agenda
- Share experiences and innovative practices on the implementation of RH including FP commitments in the 2030 Agenda for Sustainable Development
- Enhance accountability, political leadership and stewardship for the implementation of RH/FP frameworks in the region in the context of the SDGs; and
- Develop country-specific action plans for parliamentarians that promote RH/FP for implementation over the coming 12 months.

The meeting was attended by participants from 19 African countries, both Parliamentarians and technocrats. The countries represented included; Angola, Botswana, Burundi, Chad Ethiopia, Gambia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Senegal**,** South Sudan, Swaziland, Togo, Uganda, Zambia and Zimbabwe. Other participants included representatives of development partners, NGOs, Civil Society and other important stakeholders engaged in Family Planning, Reproductive Health and Maternal and Child Health programs.

By the end of the meeting, the MPs made country commitments towards addressing Reproductive Health/ Family Planning. A resolution (The Kampala Call for Action) was adopted by participants, committing to address a number of issues regarding RH/FP. These included the following;

On Leadership

1. Promote good governance and accountability in all matters of health;
2. Continue providing leadership and stewardship on policy, legislation and budgetary oversight for reproductive health and family planning
3. Champion and undertake actions that enable increased use of evidence in decision making
4. Ensure that FP and population issues are integrated into national development

strategies, including the poverty reduction strategies and action plans
5. Promote and support RH/FP activities in the constituencies
6. Foster general awareness on population issues at all levels in the country

On legislation:

1. Initiate debate and pass bills that support RH/FP programmes
2. Support laws that operationalize task sharing for improved service delivery of RH/FP issues
3. Ensure the inclusion of FP and RH components in the national health insurance
4. Support implementation, oversight and monitoring of global commitments such as Every Woman Every Child; FP2020; Life Saving Commodities that are geared at addressing improvements in the lives of mothers and children
5. Institute studies to ensure existing laws facilitate for achievements of SDGs, and where necessary advocate for relevant new laws.

On Advocacy

1. Promote FP as essential to the achievement of all SDGs, especially SDG 3 and SDG5, in partnership with civil society organizations and the media;
2. Regularly issue public statements supportive of RH/FP to mobilize both political and popular support;
3. Lobby for inclusion of RH/FP activities in government priorities and keep them high on the agenda
4. Advocate for investments in the young people with a focus on education, health, skilling, job creation to enhance the demographic dividend.

On Financing

1. Advocate for increased government resources to health sector including RH/FP and related programmes;
2. Ensure allocation of increased resources for RH/FP programmes
3. Ensure accountability in public expenditures and track RH/FP resources;
4. Ensure a clear and separate budget line for family planning in national and sub national health budgets and ensure family planning is included in basket funding, where applicable including health insurance;

On Strategies and Programmes

1. Mobilize men to support reproductive health and family planning programmes
2. Participate in monitoring and evaluation of reproductive health and family planning programmes
3. Promote the sharing of innovative good practices between and among countries on the African continent through South-South cooperation

4. Support the drive against early marriages and teenage pregnancy and advocate for initiatives to keep the girl child in schools.

On Strengthening NEAPACOH

1. Network within the region with professionals, researchers and development partners in health, population and other development issues;
2. Enhance partnerships with civil society organizations;
3. Improve regular and ongoing communications and sharing of information through available technologies (e.g. email, website, blog, forum); and
4. Undertake resource mobilization activities to support the implementation of the NEAPACOH Strategic Plan and ensure sustainability of the Alliance;
5. Lobby for specific parliamentary committees on SDGs.

DETAILS OF THE MEETING COMMITMENTS CAN BE FOUND ON THE FOLLOWING LINK.

(http://www.ppdafrica.org/kampala-call-for-action/)

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LIST OF ACRONYMS

ACHEST	African Centre for Global Health and Social Transformation
AFIDEP	African Institute for Development Policy
AFP	Advance Family Planning
APHRC	African Population and Health Research Centre
CIP	Costed Implementation Plan
COMMAT	Common Wealth Medical Trust
CSOs	Civil Society Organizations
DD	Demographic Dividend
EAHPRO	East Africa Health Policy Research Organisation
FP	Family Planning
GDP	Gross Domestic Product
GoU	Government of Uganda
HW	Health Worker
ICPD	International Conference on Population and Development
IDRC	International Development Research Centre
IMCHA	Innovating for Maternal and Child Health in Africa
IMR	Infant Mortality Rate
LMICs	Low and Middle Income Countries
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
MPs	Members of Parliament
NDP	National Development Plan

NEAPACOH	Network of African Parliamentary Committees on Health
PC-EIDM	Parliamentary Caucus on Evidence Informed oversight and Decision Making.
P&D	Population and Development
PHC	Primary Health Care
PPD-ARO	Partners in Population and Development Africa Regional Office
RH	Reproductive Health
SRH	Sexual Reproductive Health
SSA	Sub Saharan Africa
SSC	South to South Cooperation
STEP UP	Strengthening Evidence for Programming on Uninteded Pregnancy
TBAs	Traditional Birth Attendants
TFR	Total Fertility Rate
UHMG	Uganda Health Marketing Group
UN	United Nations
UNFPA	United Nations Population Fund
UPE	Universal Primary Education
USAID	United States Agency for International Development
USE	Universal Secondary Education.
WHO	World Health Organization

1.0 INTRODUCTION

The health status of the people of Africa continues to be a matter of concern. The morbidity and mortality levels, especially of children and women remain unacceptably high. While governments in Africa have committed themselves to Sexual and Reproductive Health and Rights (SRHR) in international and regional agreements, implementation of these commitments at country level remains uneven. Yet frameworks like the ICPD PoA, the Maputo Plan of Action, an all-Africa continental framework that envisions universal access to SRHR including family planning (FP), and the Millennium Development Goals (MDGs) that recognize the importance of SRHR globally, would, if fully implemented, have uplifted the health status of women and children of the continent in a very fundamental way. Indeed a review of African countries progress in achieving the MDGs revealed that the health-related MDGs in particular (MDG 4 on reducing child mortality, MDG 5 on improving maternal health, and MDG 6 on combating HIV/AIDS, malaria and other diseases) remain unfinished business in the post-2015 development agenda.

The international community agreed to an ambitious new development framework "Sustainable Development Goals" (SDGs) that would end poverty by 2030 and universally promote shared economic prosperity, social development and environmental protection. The SDGs followed and expanded on the MDGs and were adopted at the UN in New York in September 2015. Considering that SRHR remains critically important for the sustainable development of the African continent, it is essential to continue positioning SRHR high on the continent's development agenda. For this to happen, SRHR including FP should be considered as an unfinished business requiring renewed vigor and determination in the post-2015 development agenda especially by policymakers. It is imperative that strong political will, national ownership and support is built and maintained in order to consolidate the gains made, complete the unfinished business and sustain momentum for the success of SDGs.

Successful implementation of SRHR including FP programs in Africa requires enhanced, pragmatic leadership and stewardship from African policymakers including Members of Parliament (MPs). The involvement of legislators is a strategic intervention that contributes to effective and sustained programs. It is important therefore to provide space for Members of Parliament, because of the unique nature of their roles, (legislation, budget appropriation and oversight) to understand the transition from the MDGs to the SDGs and what they need to do in the 2030 Agenda for Sustainable Development.

Building and strengthening capacities of policy makers makes them effective champions for SRHR.This will enhance the visibility of SRHR higher up on governments' agendas,

in addition to championing SRHR at national, regional and international levels. In addition, building capacities of policy makers and raising their awareness on issues of SRHR will make them become stronger advocates for SRHR and to effectively carry out their legislative, oversight, and budgetary appropriation function with SRHR lenses, as well as promoting good governance, to achieve health for all.

It is in this regard that every year, Partners in Population and Development, Africa Regional Office (PPD ARO) organizes high-level policy meetings for African parliamentarians who sit in the committees of health to promote south – south information exchange on best practices and identify areas of follow up action to advance the SRHR including FP agenda in the region. The meetings, organized under the auspices of the Network of Africa Parliamentary Committees on Health (NEAPACOH), focus on implementation of regional and international commitments including the ICPD PoA, the Maputo Plan of Action, the Millennium Development Goals (MDGs), and the FP2020 commitments, among others. The meetings also update parliamentarians on countries' progress on implementation of SRHR frameworks. In addition, the meetings provide a platform for building capacity and raising awareness of MPs on the interrelationships between SRHR and sustainable development, and emerging concepts like the Demographic Dividend, among others.

It is within this context that PPD ARO in partnership with NEAPACOH organized a two days high level policy advocacy meeting with parliamentarians from June 29 – 30, 2016, at Speke Resort, Munyonyo in Kampala, Uganda. This meeting was the eighth, in a series, that have been organized under the auspices of NEAPACOH. The meeting, whose theme was **"**From Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs): Challenges and Opportunities for Parliaments to enhance Reproductive Health/Family Planning", provided space for parliamentarians to understand the transition from the MDGs to the SDGs and what they need to do to build and sustain the momentum for political will for SRHR within the context of the SDGs.

1.1 Objectives of the meeting

The objectives of the meeting were to;

1. Assess progress made, challenges and lessons learned on achieving the country commitments made at the September 2014 NEAPACOH meeting
2. Have a common understanding of the challenges and opportunities for SRHR in the post-2015 development agenda
3. Share experiences and innovative practices on the implementation of RH including FP commitments in the 2030 Agenda for Sustainable Development

4. Enhance accountability, political leadership and stewardship for the implementation of RH/FP frameworks in the region in the context of the SDGs; and
5. Develop country-specific action plans for parliamentarians that promote RH/FP for implementation over the coming 12 months.

1.2. Participation

The meeting participants were from African countries' parliamentarians who chair and/ or are members of the Committees of Health and their Committee Clerks, as well as representatives of development partners, NGOs, Civil Society and other important stakeholders engaged in Family Planning, Reproductive Health and Maternal and Child Health programs. The participants were from Angola, Botswana, Burundi, Chad, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Senegal, South Sudan, Swaziland, The Gambia, Togo, Uganda, Zambia and Zimbabwe.

SESSION ONE

2.0 OPENING CEREMONY

The opening session was chaired by Hon. Paula Turyahikayo, MP from Uganda. Hon. Turyahikayo welcomed participants to the meeting. She informed participants that 18 countries were so far represented from all over Africa. She said the theme of the meeting was "From Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs): Challenges and Opportunities for Parliaments to enhance Reproductive Health/ Family Planning". She said the SDGs were 17 goals and 169 targets compared to MDGs that were 8 with 60 indicators.

Hon. Turyahikayo informed participants that most countries in Africa were not able to achieve MDGs and challenged them to work towards achieving SDGs. She said the meeting was providing an opportunity for African countries to chat a way to utilise the available opportunities specifically regarding SDG 3 targets and sub targets on maternal and child health.

She said 30 countries had been invited to the 2016 NEAPACOH meeting but only 18 were so far present and listed the countries represented in the meeting. She called upon delegates to use the meeting to share how to prepare to achieve the SDGs since they had unfinished business from MDGs. She invited Dr. Jotham Musinguzi to give his remarks.

2.1 Remarks by Dr. Jotham Musinguzi, Director General, NPC, Uganda.

Dr. Jotham Musinguzi expressed his pleasure for having been given the opportunity to address honorable members of parliament from across the African continent. He

thanked the Executive Director of Partners in Population and Development, Dr. Joe Thomas and the staff of PPD ARO for having worked tirelessly to ensure that the 2016 NEAPACOH meeting is a success. He thanked the Minister; Hon. Dr. Chris Baryomunsi for finding time to be in the meeting and to bring government commitment to Reproductive Health issues. He appreciated the collaboration of UNFPA, PPD ARO, STEP UP, IDRC through the IMCHA/EAHPRO initiative and AFIDEP that made the meeting successful. He noted that the last NEAPACOH meeting had been held in October 2014 but they were unable to hold one in 2015 but was sure the 2016 meeting would come up with commitments and resolutions that would bridge the gap.

Dr. Musinguzi informed participants that he has since transited from Partners in Population and Development Africa Regional Office to the National Population Council but was happy to participate in the meeting.

Dr. Musinguzi underscored the important role parliamentarians play in representing their people, legislation, budget appropriation and the general oversight of government business. He said that gives Members of Parliament a unique role to play in promotion of Maternal Health and population and development. He called upon Parliamentarians to continue promoting and advocating for population and development issues.

He reechoed the theme of the meeting and informed participants that he was going to work with them to understand the linkages between MDGs and SDGs. He informed participants that globally, government financing would evolve around SDGs. He said it was important to understand the SDGs, challenges, opportunities and lessons learnt. He said the meeting was a platform for a discussion between the technocrats and the Parliamentarians to identify the linkages between Millennium Development Goals and Sustainable Development Goals and the role Parliamentarians have to play to ensure achievement of SDGs by 2030.

Dr. Musinguzi informed participants that the NPC recognized the success of Uganda in achieving MDGs except that the performance on maternal health was not at its best. He said with the challenges known and lessons learnt, Uganda would continue to work hard. He said NPC associated with the meeting and wished participants fruitful deliberations.

2.2 Remarks by Dr. Joe Thomas, Executive Director, PPD

On behalf of PPD family of 26 member countries, Dr. Joe Thomas congratulated all the delegates upon making it to the conference both PPD member country delegates and non PPD member country delegates. He said PPD was established in 1994 at the International Conference on Population and Development (ICPD) as an inter-governmental organization for promoting South to South Cooperation in Population and Development.

He said PPD had its head office in Dhaka, Bangladesh, hosted by the Bangladesh Government with diplomatic privileges. He said PPD was a Permanent observer to the UN General Assembly in New York and a permanent observer to UN agencies in Geneva. He said PPD had regional offices in Kampala (ARO) and a programme office in Shanghai with a representation at UNESCAP in Bangkok.

Dr. Thomas informed participants that governance at PPD Board comprised of Cabinet Ministers/ Ministerial level; for Health, Population and Social Development in Member countries. He gave the mandate of PPD as promotion and establishment of South-South cooperation in RH, Population and Development and provide a global platform for

technical cooperation towards South-South cooperation (SSC) for RH, population and development.

He said in September 2015, UN member states agreed on 17 SDGs with 169 targets for the world's future by 2030. He said the SDGs have a unique nature of leaving nobody behind and focus on three prime focuses; universality; all are challenged to act; and transformation.

He said although there were differences between MDGs and SDGs, there were inter-linkages in wellbeing for all, which encompasses maternal mortality and child mortality, gender equality and global partnership.

He said South to South Cooperation for Population and Development could contribute to positive changes in the following SDGs.

a) SDG, Goal 10, Reduce inequality within and among countries

b) SDG, Goal 3, Ensure healthy lives and promote well-being for all at all ages

c) SDG, Goal 5, Achieve gender equality and empower women and girls

d) SDG, Goal 17, Revitalize the global partnership for sustainable development

Dr. Joe Thomas, further told participants that during the 2012 London Summit on Family Planning, the leaders from around the world committed to a visionary goal of expanding access to voluntary, rights-based family planning programs to enable an additional 120 million women and girls in the world's poorest countries to use modern contraception by the year 2020. He said FP2020 had emerged as a unique platform for the global family planning community, a south-south collaborative space where countries identify needs and draw on the global knowledge base, where donors and partners connect, where agencies collaborate to align their priorities.

He further accentuated that the FP2020 partnership was committed to ensuring that the hope and the promise of the 2012 London Summit are fully realized. He said since then, the Governments, multilateral institutions, civil society organizations, foundations, and private sector partners were all collaborating to drive progress toward the realization of 2020 goal. He said by then, more than 36 out of 69 focus countries had pledged to the partnership for its realization.

Dr. Joe Thomas introduced Parliamentarians to the global strategy for women's, children's and adolescent health (2016-2030) which provided a roadmap for ending preventable deaths of women, children, and adolescents by 2030. He said the objectives of the global strategy were to survive (end preventable deaths), thrive (ensure health and wellbeing) and transform (expand enabling environment). He said those 3 strategies were also aligned with the SDGs particularly goal 3, 5 and 17.

He said with all the above strategies and commitments, the role of Governments and national leaders would be to own and drive the process to achieve national targets by developing investment and implementation plans, establishing one coherent system for monitoring and evaluation and ensuring accountability, and harnessing existing country-level multi-stakeholder engagement platforms. He said while the South to South cooperation would play an important role in country planning and implementation efforts through promotion of learning and sharing best practices, Parliamentarians needed to encourage collaboration around priority issues such as cross-border cooperation and regulations, knowledge and technology transfer and creation of transparency and mutual accountability among member countries for results, resources and rights.

He said SSC would play an important role in country planning and implementation efforts by promoting learning and sharing best practices, encouraging collaboration around priority issues such as cross-border cooperation and regulations, knowledge and technology transfer and creating transparency and mutual accountability among member countries for results, resources and rights.

Dr. Joe Thomas shared PPD's SSC intervention Framework and its alignment with SDGs. He gave PPD's intervention areas in respect to SDGs as; Advocacy and policy dialogue, Global health and population diplomacy, Capacity development and technical cooperation, Knowledge management and Partnerships and Relationships.

Dr. Joe Thomas informed participants that PPD works closely with the United Nations system, particularly platforms provided by the UN General Assembly for high-level policy engagement around sexual and reproductive health and rights, population and development, and the post 2015 Sustainable Development agenda. He gave the following way forward in strengthening the south to south cooperation.

a) National ownership and mutual accountability should form the basis of horizontal partnerships

b) Information and result management to be ensured

c) Ensuring north south cooperation and triangular cooperation

d) Strengthening regional exchange of knowledge and technology

e) Strengthening partnership among regional networks and parliamentary networks.

He concluded by inviting Parliamentarians to the PPD annual inter-ministerial meeting in Senegal on 26-30 November 2016 and wished all participants a very fruitful meeting.

2.3 Remarks by Dr. Eliya Zulu, Executive Director, AFIDEP

Dr. Eliya Zulu was glad to be part of the 8th NEAPACOH meeting that takes stock of what African parliamentary committee members on health have achieved and plan for the future prospects.

He informed participants that the African Institute for Development Policy (AFIDEP) aims at promotion of evidence based decision making through generation of data, translating it and making it simpler for decision makers. He introduced the team from AFIDEP and said AFIDEP works with decision makers to strengthen their capacity of translation of evidence.

Dr. Zulu noted that several parliaments in Africa make decisions that are not backed by evidence. He said this was due to lack of access to evidence and awareness that it exists. He said AFIDEP had taken over the role of addressing that bottleneck through conducting trainings for parliamentary technical staff so that they can support MPs better and that had already been done in Kenya and Malawi. He said AFIDEP was in the process of accessing the performance of NEAPACOH since its inception regarding what NEAPACOH was trying to achieve and what could be done differently. He said that interviews would be undertaken to access the impact of NEAPACOH and how countries were learning from each other.

Dr. Zulu informed participants that the major shift from MDGs to SDGs would create shriving populations since SDGs were more robust including accidents, health financing and communicable diseases. He said health financing would become a fundamental pillar in Government budgets and ignoring investment in health would affect all SDGs.

He called upon participants to continue illustrating how non achievement of the health related goals would affect the entire SDG framework. He said AFIDEP was happy to be part of NEAPACOH and to put up a study to document the achievements of NEAPACOH. He called upon Parliamentarians to document country achievements through NEAPACOH. On behalf of AFIDEP, Dr. Zulu wished all participants a wonderful meeting.

2.4. Remarks by Ms. Miranda Tabifor, UNFPA Uganda Representative a.i

Ms. Tabifor was honored to speak on behalf of UNFPA at the 2016 NEAPACOH meeting. She congratulated newly elected members of parliament who had just joined NEAPACOH. She commended the partnership and the work of NEAPACOH on the MDGs using the platform to advocate for reproductive health and family planning, especially on issues of budget allocation, passing supportive legislations, providing oversight functions on resources allocated and policy advocacy and mobilizing the population for maternal and child health services and other development programmes.

Ms. Tabifor informed participants that the theme for this 2016 NEAPACOH meeting was stemming from the September 2015 United Nations member states meeting where 17 Sustainable Development Goals were developed to build on progress made at the end of the implementation of the MDGs.

She said among the many voices that helped shape the SDGs were the parliamentarians, the representatives of the people. She said the overarching aim of the involvement of Parliamentarians was to engender inclusiveness as well as ensure that the goals respond to the needs and reflect the aspirations of the people. She said that was done having in mind the critical role parliament would have to play in the realizations of these goals through law making, oversight and representation.

She noted that country ownership and community mobilization, national policy and government accountability would be essential to ensure that the targets are met.

She stated that the SDGs were an opportunity to advance the unfinished agenda of the MDGs number 3, 4, 5 and 6. She said in most of the NEAPACOH countries, there was not enough progress on indicators related to health, specifically MDG 3, MDG 4, MDG 5 and MDG 6. She however noted that over all, there were important victories for recognition of sexual and reproductive health and rights with SDGs especially 3 and 5.

Ms. Tabifor alluded to the fact that the 2016 NEAPACOH meeting was very historic since it was the first of its kind since the UN General Assembly adopted the 2030 Agenda for sustainable development with a set of 17 Sustainable Development Goals (SDGs) and 169 targets and over 300 indicators. She also noted that several NEAPACOH countries such as Benin, Central African Republic, Chad, Comoros, DR Congo, Djibouti, Niger and Uganda had concluded political elections that had brought

new members of NEAPACOH on board. She noted that those two developments would therefore shape the agenda of the networks and the future of the nations.

Ms. Tabifor advised legislators to be ambitious since SDGs were special in a way because they were global rather than MDGs that were African oriented in order to achieve the set goals, targets and indicators. She emphasized the need to transform the world, overcome the tyranny of poverty in every part of the world, in every individual's life and heal and secure the planet and promote equity by 2030.

She said inequity in the world was quite huge and it impeded on the quality of maternal health care. She noted that most complications women face while giving birth reflect broader health care constraints, as well as wider challenges facing women and girls, such as poverty, gender inequality, lack of schooling, child marriage and teenage pregnancies, all of which impede the well-being of women and girls.

She said the other aspect which was prominent within the MDGs and was again prominent with the SDGs is human rights. Ms. Tabifor believed that one cannot have development without human rights. She said if people are respected, then progress will be made. She said SDGs bring the perspective that every country has the responsibility of mobilizing domestic resources to finance their development agenda. She said NEAPACOH could be the champion that bridges commitments and actions within individual countries.

She said the SDGs go ahead to emphasize the role of every citizen and set forth a plan of action for people, the planet and prosperity and seek to strengthen universal peace in larger freedom, a reason for everyone to take action to make sure that it happens.

Ms. Tabifor stressed that in order to achieve the SDGs, the role of parliamentarians cannot be over emphasized and the following could be done by parliamentarians to contribute to the achievement of the SDGs.

1. Formulation of new laws that can accelerate progress in achieving SDGs.
2. Advocate for increased funding for women's, children's and adolescents health including sexual and reproductive health and family planning through scrutinization of the national budget, including oversight function on funds allocated.
3. Education and generation of interest of people in constituencies about SDGs so that they are understood by everyone, engaging leaders at all levels on key issues and demanding for accountability in terms of service delivery and creating mechanisms to routinely track the country's commitments and performance on maternal and child health.

She concluded by acknowledging the supportive roles parliamentarians give to women's health, gender and empowerment in Africa. On behalf of the UN, she pledged

continuous engagement in the new journey of transforming the world by 2030 for people, for the planet and prosperity and ensuring that every pregnancy is wanted, every child birth is safe and every young person's potential is fulfilled.

2.5 Remarks by Hon. Blessing Chebundo, Chair, NEAPACOH

Hon. Chebundo said he was greatly honored to speak at the 8th NEAPACOH conference. He congratulated Members of Parliament who had recently been elected and welcomed them to the Network of African Parliamentary Committees on Health. He said the main goal of NEAPACOH was to build a constant collaboration of MPs on health through constant networking, sharing best practices and identifying solutions for health challenges in Africa. He took participants through a historical background of NEAPACOH.

He envisaged a relationship that would involve MPs on one hand and development partners on the other in the quest for healthy lives in Africa. He said NEAPACOH would look through the lens of policy formulation to ensure adherence to international agreements and general improvement of people's livelihoods.

He thanked PPD ARO for the continued support to NEAPACOH, particularly Dr. Jotham Musinguzi, for holding the hand of the committee in its early days and showing them the direction, and Mr. Patrick Mugirwa, who runs around doing NEAPACOH work. He introduced the NEAPACOH executive committee. He was grateful to the leadership of Partners in Population and Development, UN family and other partners including the Government of Uganda for the support and the collaboration to NEAPACOH since 2008. He informed the participants that the Government of Uganda had offered to host NEAPACOH offices in the parliament of Uganda.

Hon. Chebundo underscored the relevance of the theme of the 2016 NEAPACOH meeting which looked at the transition from MDGs to SDGs and the impact on Reproductive Health and Family Planning. He said the theme cut out the role parliamentarians have to play to achieve SDGs. He noted that MDGs failed to achieve their targets due to lack of a robust mechanism to monitor implementation. He said governments around the globe would continuously bank on their MPs to achieve SDGs

since there was no international organization to enforce their implementation and called on MPs to develop a legal framework at country level to achieve SDGs. He also encouraged MPs to demand from their Governments annual SDGs implementation reports.

He implored participants to use the two days conference fully for the benefit of their countries. He hoped that the fruits of the meeting will be realized by communities that different participants represented.

2.6 Opening Remarks by Hon. Dr. Chris Baryomunsi, Minister of State for Housing, Uganda

Hon. Dr. Chris Baryomunsi welcomed African parliamentarians to Kampala. He was delighted that the theme of the meeting was cognizant with the UN SDGs that were aimed at ending poverty and improving quality of life. He noted that MDGs basically aimed at developing countries but SDGs were encompassing all countries around the globe.

The Hon. Dr. Baryomunsi gave a brief history of population and development organizations around the world, saying that by the late 1950s and early 1960s, there was a realization that there is need to look at the challenges of a rapidly growing population. He said the First World Population Conference organized by the United Nations was held in Rome Italy in 1954 to exchange scientific information on population variables, their determinants and their consequences. The Second World Population Conference was organized in 1965 by the International Union for the Scientific Study of Population (IUSSP) and the United Nations; most of the participants were experts in the field. He said that the focus at that international meeting was on the analysis of fertility as part of a policy for development planning. After the meeting, the UN established UNFPA in 1969 to monitor population growth around the world and examine the relationship between population and development.

Dr. Baryomunsi said the UN realized that nothing can be achieved without the political leadership of countries and therefore organized the third world population conference in Bucharest, Romania, from 19 to 30 August 1974. He said that Conference, the first of

an intergovernmental nature, was attended by representatives of 135 countries. The debate focused on the relationship between population issues and development. The next international conference on population was held in 1984 in Mexico City.

The Fifth International Conference on Population and Development was held from 5 to 13 September 1994 under the auspices of the United Nations. More than 180 States participated in this event, at which a new programme of Action was adopted as a guide for national and international action in the area of population and development for the next 20 years. This new programme of Action placed emphasis on the indissoluble relationship between population and development and focused on meeting the needs of individuals within the framework of universally recognized human rights standards instead of merely meeting demographic goals. The adoption of this programme marked a new phase of commitment and determination to effectively integrate population issues into socio-economic development proposals and to achieve a better quality of life for all individuals, including those of future generations.

Hon. Baryomunsi noted with dismay that despite commitments made during the ICPD, Africa's leaders did not fully embrace them, thus a delay in implementation and continuous poor population indicators in the African continent. He said to counter poor indicators, a millennium summit of the United Nations was held in 2000 and all the 189 United Nations member states at the time and at least 23 international organizations, committed to help achieve the eight Millennium Development Goals by 2015:

He noted that reviews on ICPD@20 and MDGs indicated progress in some areas but a lot of work was yet to be done by parliamentarians and political leaders in Africa. He said some countries took the decision for a demographic transition early for example the Asian Tigers but Africa was still grappling with high fertility that still drives population growth rate. He therefore called upon MPs to work towards turning the youth bulge in several African countries into a productive workforce that is skilled. He said many African youth were unemployed and that escalates to high dependencies and rebellions.

The Honorable Minister informed parliamentarians that a lot of frameworks had been put in place that empowered them to drive policies to reduce the TFR. He said commitments made in the FP2020 London summit could give them an edge in increasing the health budget.

He was optimistic that as parliamentarians in the term that was transiting from MDGs to SDGs, they would be able to leave a legacy. This would be through scrutinization of laws that affect maternal health, child mortality and family planning, championing population and development issues and increasing budget allocation to the health sector. He advised that SDGs were multi-dimensional and multi-layered and should therefore be handled at a multi-sectoral level.

He concluded by thanking Partners in Population and Development for the financial and technical support rendered to NEAPACOH and pledged that the Government of Uganda would continue to give priority to issues that affect population and development. He then declared the meeting officially open.

SESSION TWO

3.0 FROM THE MDGS TO SDGS: CHALLENGES AND OPPORTUNITIES FOR RH/FP

This session was chaired by Hon. Dr. Michael Bukenya; a Member of Parliament from Uganda who has practiced medicine for over 17 years. Hon. Bukenya informed participants that he was glad that after working for a while at implementation level, he was then at the policy level. He invited Dr. Jotham Musinguzi to make his presentation.

3.1 The MDGs and successor SDGs: The interface by Dr. Jotham Musinguzi, Director General, NPC, Uganda

Dr. Musinguzi said his work had been made easier by the previous speakers and was sure those to come after him would touch on the same subject. He reminded

Parliamentarians their roles of legislation, oversight and budget appropriation. He took participants through MDGs and told them that the bench mark for MDGs was 1990. He went on to give the MDG targets by 2015.

He then took participants through the SDGs, noting that the language for SDGs was different: with words ***like for all and everywhere***. He

went on to point out the achievements of MDGs on health as:

- HIV, tuberculosis and malaria targets (halting and reversing the global epidemic) have been met.
- Child mortality decreased by 53% – a great achievement, but falling short of the 67% target.
- Deaths related to pregnancy and childbirth (maternal mortality) have fallen by more than 40%, impressive but short of the 75% target.
- The target for drinking water has been met, with 91% of the global population using an improved drinking water source, compared to 76% in 1990
- Between 1990 and 2015, the global prevalence of underweight among children aged less than 5 declined from 25% to 14%, nearly reaching the target of a 50% reduction.

Dr. Musinguzi shared some success factors for the MDGs. He said the MDGs were few in number and had fewer targets; they were time-bound, measurable and easy to communicate. He said they were widely accepted as a measure of progress in the developing world and had investments in measurement systems to track progress and enhance accountability.

He said the limitations of MDGs; included failure to meet several targets (e.g. child and maternal mortality, sanitation), variable progress between countries, notably in African region and those affected by conflict, focus on aggregate rather than equitable achievement. They also contributed to strong vertical health and disease programs and ignored health systems strengthening.

Dr. Musinguzi informed participants that their leaders had been requested to report to the General Assembly every year and said it impressive seeing the President of Uganda report on MDGs.

He said Sustainable development is about using resources more efficiently, in order for society to reduce not only its impact on the environment, but also on the economy, whilst improving social impacts both locally and globally to ensure a fairer and more sustainable future.

He said the SDGs were on people's basic needs, covering both the rich and the poor. He gave three elements of sustainable development as social, economic and environmental. He said all the three elements were required in order to achieve sustainable development and an impact on one element will usually have a knock on effect for the other two elements.

Dr. Musinguzi then gave the general features and differences between MDGs and SDGs. He said MDGs were about a limited set of human development targets: specifically targeted at developing countries, with developed countries as partners. SDGs are "integrated and indivisible, global and universally applicable": SDGs were applicable to all countries and about addressing the needs of the poor or otherwise disadvantaged groups wherever they may live (not just in poor countries).

He said the SDG are ‘‘unprecedented in scope and significance’’. The SDGs cover the economic, environmental and social pillars of sustainable development with a strong focus on equity. The wide range of SDGs more closely reflects the range of issues with which a government has to contend in reality-People, Planet, Prosperity, Peace and Partnership.

Dr. Musinguzi concluded his presentation by summarizing what SDGs address as:

1. Poverty, 2. Food security and nutrition, 3. Health**,** 4. Education, 5. Gender equality, 6. Water and sanitation, 7. Energy, 8. Economic growth and employment, 9. Infrastructure, industrialization, innovation, 10. Equity, 11. Cities, 12. Consumption and production, 13. Climate change, 14. Oceans, seas and marine resources, 15. Ecosystems, 16. Peaceful and inclusive societies, 17. Means of implementation.

3.2 Achievements of the MDGs: Reflections on the performance of African Countries and implications for SDGs by Ms. Roselline Achola, NPO-FP, UNFPA

Ms. Achola said her task was simple because the previous speakers had alluded to what she wanted to talk about. She concentrated on maternal health and family planning.

She started her presentation with the global and Sub Saharan African population to enable participants appreciate the need for family planning.

She said the population globally was 7.4 billion, with 949 million people living in Sub Saharan Africa (SSA). She informed participants that in SSA, there were 211 million women in reproductive age and the youth (10-24 years) population was 303 million.

Ms. Achola said maternal survival significantly improved since the adoption of MDGs, MMR dropped by 45% between 1990 – 2015 but women in developing countries continued to die in big numbers (over 14 times higher than developed regions) due to pregnancy related complications. She was sad to note that maternal deaths in Sub-Saharan Africa (SSA) and Asia account for 86% of all deaths globally.

Ms. Achola enumerated the achievements of MDGs in the previous 15 years on MH/FP with specific emphasis on MDG 5.

Ms. Achola compared the global changes with changes in SSA. She said MMR fell globally from 380 to 210 per 100,000 live births while in SSA; it fell from 990 to 510 per 100,000 live births. She said skilled attendance increased from 59% to 71% while in SSA, it increased from 43% to 52%.

Regarding contraceptive use, Ms. Achola said the global increase was from 55 to 64% while in SSA, it increased from 13% to 28% noting that it was still low. On unmet need for FP, she said globally, it reduced from 15% to 12% but in SSA, it was still at 24%.

She said globally, 64% of women were receiving the recommended 4 ANC care visits while in SSA, only 49% of women were receiving the recommended 4 ANC care visits. Ms. Achola said globally, adolescent birth rate reduced from 59/1,000 to 51/1,000 births but in SSA, they only reduced from 123/1,000 to 116/1,000 births. She said generally, progress on MH had been slow for most SSA countries.

Ms. Achola informed participants that contraceptive use was still low with a high unmet need in some countries. She gave some countries with the unmet need for FP, like Zimbabwe with 12.8%, Swaziland 13%, Malawi 19.4%, Namibia 17.5%, Uganda 34%, Kenya 18.6% and Burundi 32.4%. She said adolescent birth rate was also still high in Sub Saharan Africa.

She informed Parliamentarians that they had an unfinished agenda, regarding MH/FP, saying MMR fell short of the global goal and targets and there was inequality in access to SRH information and services evidenced by high unmet need and low CPR.

Ms. Achola told Parliamentarians that adolescent childbearing was still high in SSA, saying that pregnancy complications were the leading cause of death among women aged 15-19 years. She said in Sub-Saharan Africa, this was high at 116 per 1,000 adolescent girls in 2015 down from 123 per 1,000 in 1990. She said this has harmful consequences for health of girls and baby and denies the girl child opportunity of fulfilling her potential e.g. school drop has implications on socio-economic outcomes of women.

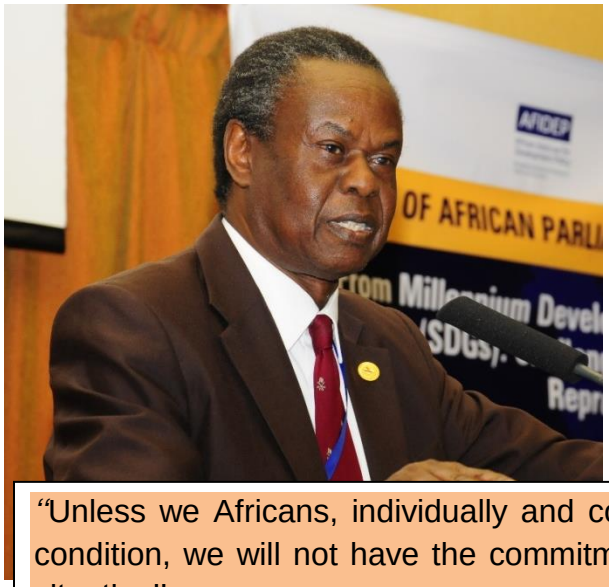
Ms. Achola listed a number of tasks ahead for countries, and called upon Parliamentarians to ensure they play their role for their countries to achieve. These included:

- Improve financing of the health sector, health insurance (15% of Government of which 25% should go to RH)
- Innovations to reduce MMR and improve CPR
- Strengthen health systems
- Strengthen health information systems for improved monitoring of the SDGs
- Increased involvement of MPs in planning & prioritizing game changers
- Reduce proportion of girls getting married by age 18 years & teenage pregnancy which lead to school drop outs
- Follow up & ensure implementation of commitments at all levels
- Ensure increased HRH particularly midwives because of their crucial role in MH/FP in most SSA.
- Countries to contribute for RHCS especially FP commodities as it is unfunded priority in most African countries
- Support policies like task sharing for MH/FP
- Invest in young people to harness DD

Ms. Achola concluded by noting that UNFPA was committed to ensuring that every pregnancy is wanted, every child birth is safe and every young person's potential is fulfilled.

3.3 Leadership and Stewardship for SDGs in the 2030 Agenda for Sustainable Development. The role of Parliamentarians in enhancing South-South collaboration by Prof. Francis Omaswa, Executive Director, ACHEST

Prof. Omaswa thanked the organisers of the meeting for inviting him to make a presentation. He said the health of the people was a precondition for productive life. He informed participants that the right to life means the right to health which means right to responsive health system. He called upon participants to reject "God has called her/him" complacency attitude, which led to poor quality of life, poverty, dignity, social justice and equity. He said the connected globalized world has knowledge and resources but lacks the will.



He said a study on major causes and effects of household poverty in Uganda was conducted and poor health and diseases were identified as the major causes of household poverty.

Prof. Omaswa said Africa had 11% of the world's population but half of the world's burden of maternal and child deaths, 85% of malaria cases, 67% of AIDS cases and 26% of underweight children. He said due to an increasing epidemic of non- communicable diseases, Africa was faced with a double burden of disease. He said Africa had the highest disease burden, yet the lowest level of financing on health. He noted that:

> "Unless we Africans, individually and collectively feel the pain and the shame of our condition, we will not have the commitment to take the needed actions to correct our situation''.

Referring to the health for all principle, developed in 1978 and reaffirmed in 2008, Prof. Omaswa said,

"The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries."

He informed participants that the people have a right and duty to participate individually and collectively in the planning and implementation of their health care. He said primary health care is essential health care and should be made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development". He re-echoed his message that;

> "Health is made at home and only repaired in health facilities when it breaks down. Be clean, eat well, and do not share accommodation with animals. This is a message from the Director General of Health Services" (Omaswa 1999- 2005).

He said according to WHO, "social determinants of health were the conditions in which people are born, grow, live, work, and age". He said there was need for partnership of individuals, health system and government. He gave the responsibility of each as;

- ***Individuals*** *have the primary responsibility for maintaining their own health.*

Prof. Omaswa said;

"Until and unless in each and every county, there is a critical mass of individuals and institutions that work with their respective governments as both support and accountability agents, it will not be possible to create and sustain enabling environment to quality improvements"

- ***Health systems*** *are responsible for providing the information (health literacy) and facilitating behaviors (enabling laws regulations) that individuals need to achieve their best health.*
- ***Government*** *is responsible for ensuring that the conditions and systems exist that allow people to be as healthy as they can be. (access to the healthy food, clean water, ?adequate housing, education)*

He emphasized the need for health care and health promotion noting that the pressures to society and governments to pay more attention to repairing and restoring lost and broken individual and community health were stronger than those to promote and protect existing health. He illustrated this by noting that an epidemic in one country puts the whole world on alert. He said the drama of providing health care is the more visible face of the health system receiving more attention and more resources than health promotion.

He called upon Parliamentarians to embed health in governance. He said at its best, the routine governance of society should be the foundation of the health system by ensuring that laws, regulations and good practice are complied with by all. He said the job description of the village or community administrator as the very first frontline health worker was to ensure that homesteads are hygienic, mothers attend ante natal clinics, children are immunized, the nearest health facility has required personnel and supplies, the referral system is in place, the correct food crops are grown and stored properly, all children are going to school, the rural road network is maintained, law and order is enforced, etc.

To ensure quality assurance of health services, Prof. Omaswa recommended the following;

- Strong regulatory bodies
- Strict and independent accreditation
- Strong professional associations
- Supportive supervision
- Educated demand
- Self-assessment

Prof. Omaswa concluded his presentation by looking at the role of Parliamentarians, noting that in;

- Politics– they should make; follow up and follow through with political commitments (CARMMA, AU Summit, IPU Resolutions, etc.); champion and advocate for MNCH agenda, etc.
- Policies – they should make supportive legislations/policies and follow up on their implementation (on health, education, women empowerment, etc.).
- Purse – they need to do budget appropriation/other financing options for health sector
- Publics – they should mobilize the population for services, health prevention, etc.
- "Policing" – they should monitor performance/accountability – political commitments; financial and programme results. He said wide gaps exist between commitments and deliveries; between policies and executions.

Discussion

1. **During the presentation, you said our health system concentrates on malaria. Why doesn't our system look at issues of infrastructure, financing and information sharing?**
   Many countries have concentrated on malaria because it is the biggest killer and has many a lot of effects. It for examples takes the productive time, increases fertility rates since couples want to produce more children to take care of those who are likely to die due to malaria, increases government spending on treatment and it leads to dependency issues.
2. **There is need to share the good practices for peer learning. Zimbabwe has achieved 10% unmet need for FP but it is not being talked about.**
   It is good to share what your country has done for people to learn from you. When an example is given on a country, members need to learn from it.
3. **What is the suitable age for a lady to get married?**
   Legally, different countries have different consent age. For Uganda, it is 18 years. For many countries in Africa, it is 18 years. Our concern is that many girls are married off before they are 18 and many are forced. Science has proved that women below 20 years have complications and their children during child birth. Beyond 35 years, women tend to have complications. We need to try and fight early marriages.
4. **Why are Africans always behind? We have the resources but we seem to keep at the bottom. What do we need to do?**
   It is the mind-set. Stop tolerating the intolerable. When you look at the commitments made by our leaders at the International meetings, you realise that colonialism, slavery and donors are leading the way. We need to lead the development of our

countries.

5. **If people have given you the mandate, why do you continue to speak as advocates not implementers? What is the problem?**
   Parliamentarians need to stop blaming others and do what they should do. What Parliamentarians should do is right implementation.
6. **Who is responsible for ensuring that the available resources serve people the right way?**
   Many times resources are not used to serve people. For example, we have had cholera outbreaks in our communities and people are taken to health facilities for treatment but after treatment, people are sent back to the very conditions that resulted into cholera.
7. **We are not doing much to create demand for FP. Commodities are not readily accessible to where women need them.**
   A lot has been done to create demand for FP except we still have issues with infrastructure. The distribution by National Medical Stores is based on the push system which sometimes brings challenges especially at the lower level health facilities. To address that in Uganda, there is an alternative distribution strategy, through Uganda Health Marketing Group.

SESSION THREE

4.0. THE USE OF RESEARCH EVIDENCE FOR DEVELOPMENT IN AFRICA

4.1. Innovating for Maternal and Child Health in Africa (IMCHA): Strengthening the relevance and timeliness of research to improve maternal, newborn and child health outcomes in Africa by Dr. Pamela Juma, APHRC

Dr. Pamela Juma informed participants that every day, nearly 800 women across the globe die due to complications during pregnancy and childbirth and 29,000 children under 5 die from preventable causes. She said that there was progress made in MDGs but there was a huge unfinished agenda to ensure improved MCH. She said there were various challenges to be addressed in SDGs.

She said partners were generating research that can make a difference and gave the IMCHA Goal as; to improve maternal,

newborn and child health outcomes by strengthening health systems. She said this would be achieved by providing data for evidence in decision making. She said there were research teams in some countries of Africa to ensure this data is generated.

She said the design of the project involved two inter-related program components;

– Implementation Research Teams (IRTs)

– Health Policy and Research Organizations (HPRO)

She said Western Africa had 7 Implementation Research Teams (IRTs). There were 2 in Mali + Burkina, Faso, 3 in Nigeria, and 1 in Senegal + Benin*. In Eastern Africa, there were 13 IRTs; 2 in Ethiopia, 2 in Malawi, 1 in Mozambique, 6 in Tanzania, 1 in South Sudan + Uganda + Sierra Leone + Liberia + Uganda.

Dr. Juma informed participants that the goals of the implementation research teams were to;

- Generate evidence on interventions and their effective implementation and/or scale-up to improve health and health equity outcomes.
- Address health systems challenges and strengthen health systems using primary health care as an entry point in the targeted countries.
- Generate new knowledge about how interventions work, for whom, and under what conditions.

She said the ITRs thematic research areas were high impact community based maternal, newborn and child health interventions, like the effect of different training approaches and incentive mechanisms on community health workers and the effect of various mobile-based solutions for community education and improving health information systems on maternal health. She said other ITRs thematic research areas were quality improvement models at facility level and costing of various health interventions.

She said the goal of Health Policy and Research Organizations was to;

- Facilitate uptake of evidence emerging from the IRTs and other relevant studies
- Build coherence and facilitate mutual learning across the IMCHA program
- Strengthen individual and institutional capacities in implementation research and research use

She gave the goal of the EA HPRO as to improve translation of research evidence and learning into practice for effective policy and programmatic MNCH interventions. She said the objectives of the EA HPRO were;

- National: Identify and maximize opportunities for policy change for MNCH issues in the five countries.
- Regional: Build consensus for MNCH issues to drive policy outreach at national and regional levels.
- Institutional: Strengthen the capacity of IRTs for long-term and systematic engagement with decision makers in their respective countries for more effective uptake of the evidence they generate.

She pointed out that the strategy was to recognize maternal new born and child health as a top priority in health planning, address MNCH policy and program issues focusing on equity, gender and health systems factors and realising that equity is important for MNCH programs. She said WHO defines health equity as "Absence of unfair and avoidable health differences among social groups".

She called upon Parliamentarians to consider whether the poorest and most vulnerable populations have access to MNCH services, how a woman who lives 3 hours away from the nearest health facility seeks treatment for her sick child, how an unemployed family raises enough money to pay the expensive medical bills and how a family possesses the knowledge that they need to seek medical care for their child while designing MNCH programs.

She informed participants that gender is important for MNCH programs, saying social norms surrounding gender influence decision-making and access to resources and mothers' access services.

Dr Pamela Juma concluded on the note that a mother's status influences the child's health. More than half of the reductions in the number of underweight children between 1970 and 1995 were due to improvements in the mother's status and education level (Smith and Haddad in 2000).

She gave the conducive health system factors as; governance, information, financing, service delivery, human resources, medicines and technologies.

4.2 Moving research evidence to policy and programme practice: The role of Parliamentarians in enabling increased utilization of data and research in decision making within government and the legislature, by Dr. Rose Oronje, Director, Science Communications & Evidence Uptake, AFIDEP

Dr. Oronje started her presentation by defining what evidence is. She said it was the body of facts or information about an issue. She said it has to be true or validated or proven and

excludes false or untrue information or claims.

She informed participants that evidence is a crucial ingredient for effective delivery of parliament's core functions but unfortunately, evidence is not always used in parliament debates & decision-making for many reasons. She gave some examples of crucial evidence for delivery of parliament functions as; annual government performance or monitoring and evaluation reports, budget analyses (critical review of budget estimates vis-à-vis priority development issues), annual reports of government expenditure, regular statistical reports for different sectors, regular constituency-level reports on development and other issues and research reports on key development issues.

Dr. Oronje said AFIDEP study in Kenya and Malawi parliaments in 2014 revealed that decision-makers rate the importance of research and data use very highly. However, most of them feel that prioritization of research and data use is low at institutional level because budget allocation to support application of research evidence and data is low.

She gave other reasons for non-use of evidence by Parliamentarians as inadequate staffing and skills in research and data use, lack of supportive infrastructure, evidence is not readily available to MPs, low interest in use of evidence among MPs and politics and interests of Parliamentarians.

She told participants that there were some ongoing efforts to address these challenges. She said Parliaments had put in place library and information departments/units, research units and adoption of technology, but often libraries weren't functioning effectively to support MPs due to poor staffing, no access to online information resources, few researchers and researchers and clerks supporting committees lack requisite skills to effectively find evidence, assess its quality and package it appropriately for MPs.

She said AFIDEP had started a training program for parliament staff on effective evidence use. She said it was a comprehensive course on evidence-informed decision-making (EIDM) and had been implemented in Kenya and Malawi to build capacity of parliament staff in effective evidence searches, assessing, synthesizing and packaging evidence for MPs. She said before the NEAPACOH meeting of 2016, AFIDEP and partners had conducted a workshop on EIDM for 16 parliament staff from 10 countries in the previous 2 days on where and how to find evidence relevant for parliament, how to assess its quality

and how to synthesize and package it appropriately for MPs.

She listed the specific actions can MPs can undertake to enable increased focus on evidence in their Parliaments. They included the following.

- Enact laws or seek implementation of laws that require government to share performance information to enable oversight.
- Establish/strengthen links with the monitoring and evaluation departments which helps to access to regular performance data to inform oversight.
- Establish formal links with research institutions and introduce regular forums where emerging research on urgent development issues is discussed.
- Advocate for increased resource allocation to research generation and use.
- Introduce orientation sessions for new MPs on evidence use in parliamentary processes.
- Engage parliamentary service commissions on the need for resources to revive parliamentary library – qualified, experienced librarians, introduce subscriptions to relevant online resources, reliable internet connectivity and adoption of online platforms that enable real-time sharing of information between MPs and technical staff, increase numbers of researchers supporting MPs and facilitate regular training for technical staff (committee clerks and researchers) on effective ways of finding evidence, assessing its quality, synthesizing and packaging it appropriately for MPs.

She was of the view that the task of country delegates in a particular year's country commitments, was making a commitment to at least one feasible action to be undertaken in the following year to enable an increased focus on evidence use in parliament. She concluded her presentation by calling upon country delegations to comment on the status of evidence use in their respective parliaments.

Experience on use of evidence in decision making

1. **What is the status of evidence use in your parliament?**
   Parliaments always make reference. Every contribution in parliament is based on evidence.
2. **What is the institution's position on building the capacity of committees of health?**
   We always train staff who support Parliamentarians but also train Parliamentarians to package evidence. We do analysis of evidence and share with Parliamentarians, so that they translate the existing policies into policies.
3. **How do you achieve that link to enable Parliamentarians access evidence? You need to put in resources to support Parliamentarians.**

In 2014, Kenya employed 30 researchers. Parliamentarians can also support funding to their technical staff through Parliamentary Service Commission.

4. **Most of the information gathered is informal, for example from constituencies. Committees visit health facilities to get information.**
5. **Ethiopia developed an ICT centre and it has internet.** *Parliamentarians utilise the ICT centre to get information. Ethiopia also built a modern library with books from researchers. There has also been capacity building for Parliamentarians to enable them use computers.*

Discussion

1. **Do these orientations have an effect on the health sector and what lessons have you learnt from these implications?**
   We started implementing this project in 2015. We have no results yet, we are still analysing the data. To strengthen linkage with executives, in the design of the project, the teams included the decision maker from MoH. When stakeholder meetings are held, they are organised by executives. One lesson learnt is that many partners are implementing our interventions. We need to learn from them for example UNICEF and World Vision.
2. **Are there any specific reasons why countries like Tanzania have 6 research teams while other countries have none?**
   Initially, we had planned to have 10 research teams in West Africa and 10 in East Africa due to limited funding. But the selection was based on competitive call for proposals. Teams were selected according to the quality of their proposals. Some countries did not submit any proposal at all.
3. **In your presentation you said about 800 women were dying daily due to maternal causes. Have you done any research on abortion as a measure to reduce maternal mortality?**
   The 800 talked about are global daily occurrences, but half of them are happening in Africa. In Kenya, there is a report on abortion in health facilities. On legalising abortion, some countries allow it on medical conditions especially where the life of the mother is in danger.
4. **The studies/researches have just started.** *We are looking at how we can improve it especially looking at community health extension workers. We want to test homes to have their own incomes through community health promoters. We want to see what happens after 5 years.*
5. **What causes all these maternal deaths? Are there qualified health workers to do the job?**
   Most of the causes of maternal mortality are preventable. Some women die at home while others die at health facilities. The causes include traditional practices that hinder women from accessing health services, including the decision to go to the health facility being taken by men. Others are lack of knowledge of the danger signs

during pregnancy; lack of transport to the health facility, poor road network, insecurity on the roads, long distance to the health facility, lack of qualified staff or inadequate supplies at the health facility. In some cases, the qualified staff lack the necessary equipment and supplies to save the lives of mothers.

6. **Why do you target 5 years as a control? Isn't it a long period to generate evidence? Why not look at 6 months and give results so that it is rolled out?**
   Evidence generation does not take 5 years. 5 tears is the time of the project. Implementation research approach is being used and evidence is given from time to time. We have a lot to learn from Tanzania, Ethiopia and Malawi.
7. **Can't we, in Africa establish a centre for certification of academic credentials for medical practitioners to avoid quack medical practitioners who want to practice from other countries?**
   That is a good proposal but it needs to be carefully studied before it is implemented.

SESSION FOUR

5.0. ENHANCING THE DEMOGRAPHIC DIVIDEND FOR SOCIO-ECONOMIC TRANSFORMATION IN AFRICA.

5.1 Maximising the role of adolescents in enhancing the Demographic Dividend in Africa: What does the evidence show? By Ms. Violet Murunga, Senior Knowledge Translation Officer, AFIDEP

Ms. Murunga said WHO defines young people as between 10 and 24 years old and of the

1.1 billion people in Africa, 3 out of 10 (350 million) were young people and the number was projected to almost triple by 2100 to 906 million. She said that a huge population of young people has a potential to accelerate socio-economic development when they transition into the working age population, but, they have to be healthy, skilled and gainfully employed. If not, this will be a liability and lead to political instability, violence and crime as seen with the Arab Spring.

She said education is not only necessary to secure a skilled and productive population but also linked to good health. She said many African governments had made some progress as evidenced by substantial increase in the proportion of children attending primary school and modest improvement in literacy rates,

but challenges persist as primary school dropout rates remain high particularly among girls, tertiary institutions were unable to absorb secondary school graduates and mismatch between education curricula and the job market.

She noted that African governments had already committed to address youth health and development challenges. She said that many of them were signatories to 1994 ICPD, Education for All, 2015 MDGs, the 2030 SDGs, FP2020, AU Agenda 2063, AU Maputo Plan of Action and Ministerial Commitment on Comprehensive Sexuality Education (CSE) in East and Southern Africa (ESA).

Ms. Murunga said the National development and health policies including specific youth policies and youth sexual and reproductive health (SRH) policies and legislation, but progress on many fronts was slow. She said her presentation focused on status of education and youth SRH indicators. She affirmed that African countries lagged far behind Asian tigers on secondary and tertiary education enrolment rates. She called upon Parliamentarians to reform education system to focus on innovation, skills development, science and technology and entrepreneurship.

She informed participants that keeping girls in school and providing comprehensive sexuality education was key to empowerment of youth and future generation of women.

Regarding young people's health status, Ms. Murunga said they were sexually active and experimenting with drugs and substance abuse and negative attitudes and limited or lack of access to information and services puts them at risk of a range of issues including STIs, HIV, unintended pregnancy and complications or death related to pregnancy, childbirth and unsafe abortion.

She said teenage pregnancy was highest in West, Middle and parts of Southern Africa and keeping girls in school could reduce teenage marriages, pregnancy and childbearing especially in West, Middle, and East Africa. She informed participants that most adolescents who are sexually active have an unmet need for contraceptives while others were using alcohol and drugs and not much data existed on drug and substance abuse.

A national survey in Kenya showed that 8% of adolescents aged 10-14 and 19% adolescents aged 15-17 have ever used alcohol and 13% of adolescents aged 10-14 and 17% of adolescents aged 15-17 have ever used a drug other than alcohol.

Sub-Saharan Africa hosts the largest share of HIV deaths among young people and 2.1 million adolescents aged 10-19 living with HIV - nearly all (85%) were located in Africa in 2012. She said majority (about 1.3 million) were in Eastern and Southern Africa and 390,000 in the West and Central Africa. She revealed that there were about 300,000 new HIV infections among adolescents – 13% of all new infections - 830 adolescents were infected with HIV everyday of 2012.

She called upon Parliamentarians to champion; all children going to school and quality education such that no child is left behind, girl education and ending child marriage, improving access to comprehensive sexual and reproductive health services including access to contraceptives and safe abortion services for those who need them in line with national policy. She asked them to champion development or implementation of CSE, push for more resources allocated to these issues, more attention to be placed on drugs and substance abuse and investments in strengthening routine data systems to collect data on adolescent health.

Referring to the role of legislation, Ms. Murunga called upon Parliamentarians to check the extent to which laws protect children, provision of universal secondary education, reforms of secondary education to address unemployment and putting in place laws to address unsafe abortion.

On oversight, Ms. Murunga called upon Parliamentarians to hold governments accountable for implementation of global and national policy and legal frameworks including SDGs; AU Agenda 2063; FP2020; Education for All; National education and SRH policies and legal frameworks.

5.2 Enhancing the Demographic Dividend for Socio-Economic Transformation in Africa: The Role of Parliamentarians, by Dr. Eliya Msiyaphazi Zulu, Executive Director, AFIDEP

Dr. Zulu started his presentation with a big question, ‘‘Will the Post-2015 development agenda mark a turning point in optimizing the value of the most important resource (people) for the realization of long term socioeconomic development goals for African countries?’’

He said 68% of the African Population was under age 30 and by 2030 this number would slightly decline to 58% and wondered what that meant for SDGs. He told participants that there was need to concentrate on children and youth because the numbers were with young people, saying close to 31% of Africa’s population was aged 10-24, and 68% under age 30 then.

Dr. Zulu said youth can be critical agents for positive socioeconomic change if appropriate investments are made to unleash their power to innovate and become productive citizens. He said poor health and socioeconomic investments in young people determine life-long economic and general development contribution and outcomes. He noted that youth can be a development liability (if uneducated, unskilled, unhealthy, and without job opportunities)

and can sometimes be agents of social unrest if they are without hope and disillusioned by the world economic and political order.

He said birth rates had fallen remarkably in the previous fifty years in all regions except in Africa. He said that in 1960s, African countries were comparable to East Asian countries, with high fertility and low per capita GDP. By 1980, rapid fertility decline was underway in most East Asian countries while little change was noted in Africa. He said by 1990, per capita GDP increased substantially in countries with fewer than 3 children per woman and by 2000, the differences were becoming more pronounced.

Dr. Zulu informed participants that by 2010, fertility had not declined much in the majority of African countries, while income levels in lower fertility countries had soared. Decline in fertility led to a structure with more working age adults relative to children in Malaysia, while high child dependency remained in Uganda. He gave an example of Tanzania and Malaysia's age structures which differ remarkably due to differences in birth rates.

Dr. Zulu informed participants that the Demographic Dividend is the economic benefit arising from a significant increase in the ratio of working-age adults relative to young dependents. He said the first step is to accelerate fertility decline, which opens the window of opportunity for growth by creating an age structure dominated by working age youth and adults. To earn a sizable demographic dividend, Dr. Zulu said, countries should make simultaneous investment in education; empowerment of women and youth; economic reforms to create ample jobs; and efficient public institutions.

He said the demographic dividend is time-bound and happens once in a population's history. He said the bigger labour-force provided an impetus for accelerated economic growth in South Korea, but this will turn into high old age dependency in due course.

He alluded to regional commitments to harness the DD in Africa, including;

- AU Agenda 2063; saying one of the objectives of the Agenda is to unleash the full potential of the youth and women to boost socioeconomic development
- The 2013 Sixth Joint AUC and UNECA Conference of African Ministers of Finance, Planning and Economic Development in Abidjan
- 2013 Addis Ababa Declaration on ICPD Beyond 2014: "Harnessing the Demographic Dividend – The future we want for Africa".
- 2017 African Union Summit Theme – "Demographic Dividend and Youth Development"

He said Uganda can earn a DD of $3,843 by 2040 if it simultaneously invests in family planning, education, empowerment of women and health, job oriented economic growth

and governance. He said African countries can harness massive demographic dividends if they implement the right policies in an integrated manner.

Dr. Zulu enumerated some of the challenges and opportunities for harnessing the demographic dividend. These included the following.

- Prioritize family planning and address all barriers of access and use of contraception to eliminate unplanned pregnancies and reduce fertility.
- Step up efforts in reducing child mortality to facilitate fertility decline.
- Reform education systems to focus on innovation, skills development, science and technology and entrepreneurship (transformative education).
- African countries should reform economies to create more quality jobs and enhance innovation and productivity of the informal sector.

He said countries should diversity economies and invest in sectors with high job multiplier effects. He emphasized mmodernization of agriculture and enhancing value-addition industries, capitalizing on growth of ITC sector to develop service sector, enhancing economic infrastructure including energy, transportation and communication to reduce the costs of doing business and attract domestic and foreign investment and enhancing productivity of the informal sector and support graduation from small to medium sized enterprises.

He told Parliamentarians that they had a big role to play in promoting DD agenda. He said they needed to;

- Add a strong voice to DD programme and roadmap development processes by making sure the people's voices are loud and clear.
- Prioritization of social development sectors and not only about economic infrastructure.
- Champion family planning, empowerment of women, and education transformation.
- Oversight on programme implementation and accountability in use of public resources.
- Champion evidence-informed decision-making.
- Support efforts to strengthen local capacity in evidence generation, knowledge translation and use and advocacy.

He said the time to act was then and strategic youth development and job creation should be at the center of the SDG agenda.

Discussion

1. **We may not do much if our economies does not improve. Dr. Zulu said our governments tend to look at quick fixes.**
   But not because we don't know these issues but there are many challenges. For example, Uganda has prioritised infrastructural development. This is important for a woman who is in labour and moving to the nearest health facility. Talk about power, it is important for industrialisation. There is growth of factories in our constituencies, employing more people. We therefore need integrated development if we are to harness the demographic dividend.
2. **Regarding the demographic dividend, we need to give information to those who make decisions, for example the president.** *To save our resources, Parliamentarians should deal with accountability issues. They should fight corruption. Are schools developing our children using the resources at their disposal? The DD is more about the mindset. We need to focus on quality with the little resources we have.*
3. **What should Uganda do to address challenges to attaining the demographic dividend?**
   Uganda is doing the right thing. Uganda is actually showcased as one country on track. The president is focusing on human capital development. There is need to reduce fertility in order to create a youth bulge.
4. **We need to reach a point as Africans where we talk of eradication of poverty.** *We need to own the DD as countries.*
5. **It is true, investing in young people will accelerate harnessing the DD, but we need to be ready to accept the consequences of this investment.** *It is right young people need SE e.g. RH, FP and youth friendly services. If we trigger sexual arousal among youth, we should be responsible for the outcomes. We know compliance among young people is limited. If we introduce them to early sex, they lose identity. We need to be careful about the kind of investment we make among young people. We need to engage more into economic investment rather than social aspects*. **We need to define and limit CSE.** *CSE has an element of age appropriate information. Each age group has its own package. It is CSE because it looks at other issues. It doesn't encourage young people to do abnormal things. We need to stop our children, if not, help them.*
6. **What do you attribute high school dropout rates especially from primary to Secondary level in our countries to?**
   In some parts of our countries, there are no secondary schools nearby. Poverty limits many people from sending their children to secondary schools that are far away. In the case of girl children, early marriages and limited value for education have been the main challenges. Teenage pregnancy, lack of sanitary facilities and stigmatisation in case a girl became pregnant, delivered and decided to go back to school have contributed to school dropout rates for girls.
7. **How do we make a balance if we are to invest in young people? China began with a one child policy, but now has reversed it and is encouraging 2 or 3. Those who**

have produced more children are also suffering.
It is not about how many children, but about supporting families to have the number of children they want. If the health system is okay, and people are skilled, in a friendly economic environment, you will not struggle with families regarding the number of children to produce. Families will regulate fertility themselves.

8. **We need to do something about our education. We need to include our indigenous values in our education curriculum.**
   African families were very important in bringing up children. We also need to strengthen the technical institutions. In Kenya, for example, many technical institutions have been turned into universities which leave many young people without skills.
9. **Lesotho has a challenge of HIV with HIV prevalence rate among married men and women aged 15-49 being 25%. How can we win the war against HIV?**
   Look out for the hot spots, to get who to target. Generate more in-depth data at local levels to get the drivers of HIV incidence and prevalence.
10. **What did Asians do to get where they are that we can copy?**
    There is an opportunity for us to do something. The Asians lowered their fertility and invested in other sectors of the economy like education, economic reforms to create jobs, governance for accountability and improved health.
11. **We are talking more about young people in relation to harnessing the DD. What is the role of older people in attaining the DD?**
    Older people can be champions. The president of Malawi is almost 75 years but has been appointed by the UN as a champion.
12. **Why do you only worry about young dependants not older dependants?** *Each country has its own population issues. Besides when people work and have no many child dependants, they save and may not be dependants in their old age.*

SESSION FIVE

6.0 SRH/FP ADVOCACY LANDSCAPE IN THE 2030 AGENDA FOR SUSTAINABLE DEVELOPMENT

6.1 New advocacy opportunities for SRH/FP in the context of the SDGs in the 2030 Agenda for Sustainable Development, by Ms. Marianne Haslegrave, Director, COMMAT

Ms. Marianne Haslegrave the Director of the Commonwealth Medical Trust, made a presentation illustrating the new advocacy opportunities for SRH/FP in the context of the SDGs. She made a recap on Health and SRH/FP in the 2030 Agenda for Sustainable Development, saying it started with the development of SDGs in 2014.

She informed participants that SRH was included in the SDGs and pointed out how health and the health-related SDGs that include SRH. She pointed out goal 3. Ensure healthy lives and promote well-being for all at all ages. She gave some of the SRH issues under goal 3, including;

- Reduce the global maternal mortality ratio to less than 70 per 100,000 live births.
- End preventable deaths of new born and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.
- End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- Reduce by one third, premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well- being. Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
- By 2020, halve the number of global deaths and injuries from road traffic accidents
- Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
- Substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

She said the 2030 agenda also has a declaration that talks about the Demographic Dividend, means of implementation and global partnerships. She said the SDGs bring everybody together, they are universal and call on everybody's involvement.

Ms. Haslegrave informed participants that other opportunities for reviewing and follow up on SRH/FP existed. She said the WHA has a strong role of reviewing progress of SDGs. She pointed out the resolution which was to be passed by World Health Assembly (WHA) in 2017 on the 2030 Agenda, which included important paragraphs on role of WHO and WHA in reviewing progress at least every two years. She called on participants to know what indicators they needed for their countries, saying the international indicators would be used by the Secretary General of the United Nations to monitor progress.

She said other possibilities existed, including through Commission on Population and Development and Commission on the Status of Women.

She noted that to promote physical and mental health and well-being, and to extend life expectancy for all, countries must achieve universal health coverage and access to quality health care. She said no one must be left behind since the UN committed to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030.

She said the United Nations were committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education.

She said prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development had been included in the SDGs and hoped that would improve the lives of Africans.

Discussion

1. **As African countries, we may have to make choices. Do we allow our children to die from malaria while we chase priorities under SDG 3?**
   Countries can't do everything at the same time. You will make priorities of what goals and when. The whole process is country led. Countries need to decide what they want to do and how to do it. Malaria is not a problem in the United Kingdom, but United Kingdom can fight malaria in India.

2. **We are making assumptions that all Members of Parliament understand the global agendas, which is not the case. Is there a way an orientation for Parliamentarians can be organized?**
   As MPs, you need to ask questions so as to be informed. It is important that you and your staff know what these issues are. Ask CSOs, UNFPA, WHO, etc. CSOs want to see that goals are implemented and they need partners.
3. **There are a number of challenges faced by Parliamentarians. The MPs from the ruling party find themselves bound by the party caucus and have to approve what government brings and this limits their capacity to do what is right.**
   MPs are accountable to the people and should aim at doing what benefits the people they represent as much as possible. Parliamentarians don't need to depend on the executive. They should ensure nothing compromises their role of legislation, oversight and budget appropriation.

4. **MPs were worried that many times African leaders append their signatures on declarations but do nothing to implement them. The most significant is**

universal health coverage which has not taken off in most of the African countries.

Parliamentarians have the power to ensure service delivery. They should be held responsible. MPs should continue lobbing for universal health coverage which will go a long way in improving health conditions in different countries.

5. **There are a number of viruses and other diseases on the African continent. How do we protect ourselves from these viruses or epidemics?**

   Research is being undertaken by the WHO to curb disease outbreaks in Africa. Some of the diseases arise from cultural norms and lack of vigilance in the health centres. Many of these diseases are preventable. Sadly, for some diseases, no cure has been found yet. You need to however get to prepare for any eventualities.

6. **How do you compare Africa and Western countries in terms of implementation of MDGs?**

   Most African countries did not achieve MDGs but have the opportunity to improve through implementing SDGs.

DAY TWO

SESSION SIX

7.0 COUNTRY ACHIEVEMENTS AND LESSONS LEARNED IN IMPLEMENTATION OF COMMITMENTS OF NEAPACOH MEETING OF OCTOBER 2014 AND COUNTRY ACTION PLANS FOR 2016-2017.

7.1 Setting the stage: Country progress, achievements and challenges regarding implementation of the NEAPACOH 2014 commitments

7.1.1 Malawi commitments

Malawi, during the 2014 NEAPACOH meeting had committed to achieve four advocacy objectives:

- To have Ministry of Health increase funding to Family Planning from K60 Million upwards by July, 2015
- To have Ministry of Health increase facilities providing youth friendly services by 10% by July 2015.
- To have Members of Parliament pass a bill that raise marriage age from 15 to 18 years by July 2015.

- To have the capacity of the health committee strengthened in use of evidence based research in its oversight function

The advocacy efforts result in the following;

- In February, 2015, Malawi Parliament passed the Marriage, Family Relations and Divorce Bill. This raised the marriage age to 18 years. The President assented to it in April, 2015. We now have an ACT.
- Family Planning allocation was increased from MK60 Million in 2014 to MK70 Million in 2015 and now it has been revised to MK 75 Million.
- The Health Committee capacity in the use of evidence is strengthened by a number of interactions with the think tanks such as AFIDEP and Health Policy Palladium).
- The facilities providing youth friendly health services have increased by 8% by May 2016.

Major Lessons Learnt

- The NEAPACOH commitments are the commitments by the whole health committee not just the team that attends NEAPACOH meetings.
- Support from Development partners and Civil Society Organizations helped the Parliamentarians to achieve the commitments.
- Support from PPD ARO secretariat also raised the momentum among the Health Committee members

Challenges

- The Committee did not have funding to invite Ministry of Finance and Ministry of Health to a Round Table Meeting together. It relied on the donors (HPP and Jesus Cares Ministries) to finance the meetings. This limited the number of meetings held.
- The funding made the committee to visit the rural health Centres close to Lilongwe the capital city. There is need for the committee to have funding for the implementation of the commitments.

7.1.2 Burundi commitment

Burundi had committed to promote reproductive health by advocating for an increased budget. The achievements so far were;

1. Increased approval of family planning programmes.
2. Sensitized men on vasectomy and 97 men underwent vasectomy in 2015.
3. CPR was raised from 34.3% in 2014 to 37.4% in 2015.
4. Rate of delivery at health centers increased.
5. Increased the health budget from 11.5% to 14%

6. The Burundi Government has developed a strategic plan aimed at lowering the Total Fertility Rate from 6 to 2 by 2025
7. Promoted sex education among the youth.

The challenges the Parliamentarians faced during implementation included the following;

1. 22% of health centres in Burundi are religious based and therefore do not offer family planning.
2. High rate of unemployment among the youth.

7.1.3 Ethiopia commitments

Ethiopia had committed to; Increase the budget allocation for FP/RH commodities by 5% in the FY 2015/16 and Ensure Integration of AYRH services in 25% of public youth centers and 50% public university clinics by FY 2015/16.

He informed participants that;

1. Women caucus and associate members were actively participating on the RHS issue and sense of ownership were developed.
2. Community mobilization on SRH was carried out in respective constituencies
3. Increased budget allocation to Reproductive Health by 5%
4. Members of parliament had out reaches where they discussed with their constituents, donated blood and discussed with Hospital administration and Directors.

The challenges they faced were;

1. Resource Scarcity to fulfill all the demand in the sector.
2. Weak participation of the private sector on FP commodity financing.

7.1.4 Ghana commitment

Ghana had committed to improve Family Planning service delivery by ensuring that MoH trains 500 Community Based Nurses to deliver Family Planning services.

Achievements.

1. Ghana’s Parliament included in the National Health Insurance Law a provision to enable the Minister to make funds available from the Health Insurance Fund for family planning.
2. Ghana expanded the training of two categories of community health nurses namely: Diploma Community Health Nurses (DCHN), and Certificate Community Health Nurses (CCHN) in order to realise the FP 2020 goals.

3. A total of 4714 community health nurses were trained in 2014/2015 financial year.

7.1.5 Kenya commitments

The Kenya delegation made a number of commitments at the 2014 NEAPACOH meeting. These included the following.

1. Secure increased funds for Family Planning Commodities and services in order to increase Contraceptive Prevalence Rate (CPR) from 46% to 56% (2015)
2. Increase the general health budget towards the Abuja Target.
3. Increase the budget for family planning
4. Increase the number of youth empowerment centres**.**

The achievements since 2014 were highlighted as;

1. CPR increased to 53%
2. Budget allocation to the health sector increased by 19%
3. Increased budget on family planning.
4. The youth empowerment programmes were allocated Kshs. 24 Billion in the 2015/2016 budget.
5. The Committee on Health is working to ensure incorporation of the health aspect, including Family Planning, in the youth targeted programmes.

7.1.6 South Sudan commitments

1. Conduct National KAPs baseline.
2. Organize RH sensitization workshop for National legislature and Executive.
3. Organize a National Family Planning conference

Accomplishment.

1. National KAP Study on FP was conducted in 2015
2. Sensitization on national parliamentarian on RH with emphasis on Maternal Death Surveillance and Response (MDSR) was conducted on 2nd March 2016.
3. Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), African Child Right instrument have been ratified by the Parliament and Women & Child Rights are incorporated in transitional constitution (2011)
4. National Family Planning conference to be held in August 2016.

It was noted that several activities in health including increase in budget allocation had not been done due to civil wars.

7.1.7 Swaziland commitments

- Strengthening the health Committee

- Draft Parliamentary Reports from the Health Ministry which focuses mostly on the issues of FP/RH
- Create partnership increase with the Civil Society
- Champion in Family Planning, in public statements in constituencies and parliamentary debates
- Increase in general health budget towards the Abuja declaration
- Strengthen the health system

Accomplishments

1. Members were engaged through workshops to fully capacitate them on issues of Reproductive Health. The Ministry of Health also engaged the Members in their activities as part of increasing the FP/RH knowledge and basic understanding of what it entails.
2. Rallies piloted by the Health Ministry were conducted, and members of Parliament on the Health Portfolio Committee were invited to be part of the Rallies.
3. Civil Society Organizations have formed groups in the constituencies that will help to advocate on the aspects of FP/ RH issues. Rural Health Motivators were also engaged and through the help of the Clinics under Health Ministry.
4. Swaziland has made great strides in increasing the General Health budget towards the Abuja Declaration to 12%.

7.1.8 Uganda commitment

The Ugandan delegation in 2014 committed to establish a National Health Insurance (NHI) scheme that includes family planning.

Accomplishments

1. Members of parliament who sit on the health committee in 2014 held a bench marking exercise with Israel.

2. Members of Parliament who are champions of Maternal and Child Health also held bench marking exercises with the health department of South Africa on how they initiated the national Health Insurance Scheme.

3. The members also held dialogue meetings with fellow members of parliament from Ghana, Ethiopia and Rwanda and shared experiences on how they can come up with a law on the NHI.

4. Members of parliament also held a dialogue with ministry of health on the status of the NHI bill, and were informed that the bill is with the ministry of Finance, Planning and Economic Development and awaiting a Certificate of Financial Implication.

Challenges.

The recent parliamentary and presidential elections affected expedition of the process of enacting the National Health Insurance Scheme.

7.1.9 Zimbabwe commitments

- Doubling the FP budget line from 1.7% to 3%.
- Removal of FP user fee by 2013.
- Reduce unmet need for FP from 13% to 6.5% by 2020
- Sensitization of law makers on FP and RH.

Accomplishments.

- The FP budget has increased by 2%
- Unmet need dropped to 10%
- Capacity building sessions for legislators have been held by Zimbabwe National Family Planning Council.

Challenges

- Inadequate domestic funding for the project hence donor dependence.
- Lack of access to SRHS by the youth because of age of consent.
- Cultural and religious barriers for women to access FP

7.2 Addressing RH/FP issues by countries that never attended the 2014 NEAPACOH meeting

Several countries did not attend the 2014 NEAPACOH meeting and so did not have any commitments to report on. However, they shared their best practices in health, especially reproductive health and family planning.

7.2.1 Angola

- Conducted the first population and housing census in 2014.
- The country worked towards reducing MMR from 460 in 2010 to 350 by 2015. They were advocating for increased funding for health to 15%.
- HIV prevalence had reduced to 2%
- They were addressing taboos that hinder intake of FP services
- They were promoting the education of the girl child to retain them in school.

Challenges

- Cultural hindrances that take family planning as a taboo.

Way forward

- Continuous sensitization of community members by MPs and other stakeholders.

7.2.2 Botswana

- Started HIV test, counselling and treatment for pregnant women. All HIV positive people are put on free ART
- The country was working towards increasing youth friendly services

7.2.3 Chad

- The country adopted a law on RH and developed the National Policy on Population and Development.
- The country provides free medical care for the HIV positive people. Infected children and women are freely taken care of by government 100%
- Prioritized health infrastructure in the National Development Plan. They planned to build health centres in all provinces

7.2.4 Gambia

- A ban on child marriages was being implemented.
- The country was working towards reducing unwanted pregnancies.

7.2.5 Lesotho

- The Education Act of 2010 provides free primary education for
- Dialogue between the executive, the legislators and technical officers on health has been done to improve healthcare.
- There is a challenge of high HIV prevalence rate at 25%

7.2.6 Namibia

- Namibia partnered with UNFPA to achieve MDGs 4,5 and 6 and had done the same to achieve SDGs.
- Parliamentarians had lobbied for direct funding from government
- SRH issues were top on the government agenda.
- Increased capacity building and awareness creation in RH
- A committee for rural women parliamentarians was created to ensure achievement of MDG 5
- The National Budget has included the Demographic Dividend and protection of the girl child.
- Compulsory free primary education has been introduced.

7.2.7 Senegal

- A law on health policy has been drawn to allow the drawing of health policies.
- Increased investments for adolescents by putting in place youth centres
- The country was working towards complete eradication of HIV. Senegal has the lowest HIV prevalence in Africa.
- RH is integrated in the school curriculum e.g. in the modules
- Universal coverage of health programmes in Senegal was at 80%
- There is need for new sensitisation issues.
- MPs need to be helped to understand RH issues better.

7.2.8 Togo

- Togo was working towards having improved health infrastructure
- In 2014, Parliamentarians worked with Ministry of Finance to increase the budget for RH/FP
- The government has created an institution responsible for statistics.
- MPs have been trained in their roles, however the trainings are limited

7.2.9 Zambia

- Parliamentarians have conducted outreaches aimed at addressing the myths and misconceptions about uptake of RH services including FP.

Recommendations

1. There is need for African countries to put in place measures to help the un-educated youth to contribute to the economy.
2. We need to bring young people to participate in decision making.
3. African Union should set up a centre for certifying and accrediting medical professionals to ensure quality and standardization in all African countries.

8.0 PRESENTATION OF COUNTRY COMMITMENTS FOR 2016/17

Each country made a commitment during the 2016 NEAPACOH meeting, which would be implemented in the next one year. The country commitments were later presented by Ms. Eva Nakimuli as given below.

8.1 Angola: To ensure integration of FP services in all the sanitary units up to the community level

8.2 Botswana: Advocate for investments in the young people with a focus on education, health, skilling and job creation to enhance the demographic dividend.

8.3 Burundi:

a) Accelerate advocacy calls for legislation on Reproductive Health and Family Planning.
b) Disseminate the law on Gender Based Violence (GBV) which includes incrimination of early marriages, women's economic discrimination and extramarital affairs.
c) Foresee long-term Demographic Dividend benefits that will accrue from tracking the development and equipping of at least one technical school per Commune.

8.4 Chad: Ensure broad dissemination of the three laws regarding RH/FP;

a) Law number 29 on child marriage
b) Law number 6 on Reproductive Health

c) Law number 19 on the protection of people living with HIV AIDS

8.5 Ethiopia:

a. Create awareness for parliamentary committees of budgeting and finance and social affairs standing committee on the transition from MDGs to SDGs and identify goals which were not accomplished in MDGs and prioritize them in SDGs
b. Sustain advocacy oversight and budgeting for FP/RH

8.6 Ghana: Advocate for investments in the young people with a focus on education, health, skilling, job creation to enhance the demographic dividend.

8.7 Kenya: Amend the NHIF Act to provide for universal health care

8.8 Lesotho:

a. To convince the MoH to introduce the EGCG complex and injectable /capsule that reduces the binding of HIV cells to body cells
b. Increase and take a lead on rising health concerns when addressing constituency issues and play an oversight role to ensure achievement of SDGs

8.9 Malawi: To ensure MoH distributes the contraceptives procured by the 57M Kwacha and increase use of FP commodities.

8.10 Namibia: To review the existing SRH policies in a view to increase access to SRH services among young people.

8.11 Nigeria: The clerk present could not commit himself on behalf of the MPs who were not able to attend.

8.12 Swaziland: To improve access to FP/SRH services by adolescents in Swaziland

8.13 Senegal: Promote sustained involvement of parliamentarians in supporting and implementing laws and policies passed by the Senegalese government on Reproductive Health and Family Planning.

8.14 South Sudan: Sensitize national and sub national parliamentarians and other political leaders on SRH/FP, SDGs and DD issues.

8.15 The Gambia: To increase funding to conduct a rigorous campaign and mass sensitization on the passed Women's Bill 2016 banning the practice of FGM

8.16 Togo:

a. Improvement of the rate of assisted deliveries by skilled personnel from 65% in 2013 to 75% in 2017.
b. Increase the rate of women using contraceptives from 25% in 2013 to 55% in 2017.

8.17 Uganda: Establish a National Health Insurance Scheme that includes FP

- Engage H.E The President to take a political decision on the NHI
- Consider the NHI as an issue of national importance on the floor of parliament

8.18 **Zambia:** To increase the budget for FP from the current levels of allocation by 50%.

8.19 **Zimbabwe:** Fast track and have indicators to monitor progress against SDG 3.

9.0 PRESENTATION AND ADOPTION OF NEAPACOH RESOLUTIONS BY ZACCH AKINYEMI, EXECUTIVE DIRECTOR, PACE

KAMPALA CALL FOR ACTION

A meeting of the Network of African Committees on Health (NEAPACOH) held at Speke Resort Munyonyo, Kampala, Uganda, June 29-30, 2016, gathered members of Parliamentary Committees responsible for health from **19** countries, as well as a representatives of development partners, NGOs, Civil Society and other stakeholders engaged in Family Planning, Reproductive Health and Maternal and Child Health to promote information exchange, facilitate policy dialogue and identify key areas of follow up action to advance reproductive health and family planning on the continent.

The meeting was organized under the auspices of NEAPACOH. The theme of the meeting was “From Millennium Development Goals (MDGs) to Sustainable Development Goals (SDGs): Challenges and Opportunities for Parliaments to enhance Reproductive Health/ Family Planning”.

The meeting was hosted by Parliament of Uganda and Partners in Population and Development Africa Regional Office (PPD ARO) with support from partners namely National Population Council (NPC) Secretariat of Uganda; United Nations Population Fund (UNFPA);African Institute for Development Policy (AFIDEP); International Planned Parenthood Africa Regional Office (IPPFARO); East Africa Health Policy Research Organization (EAHPRO); Strengthening Evidence for Programming on Unintended Pregnancies (STEP UP); Programme for Accessible health, Communication and Education (PACE) and Mariestopes International Uganda (MSIU). Participants were

drawn from Parliaments of Angola, Botswana, Burundi, Chad, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Namibia, Nigeria, Senegal, South Sudan, Swaziland, The Gambia, Togo, Uganda, Zambia and Zimbabwe.

The participants to the NEAPACOH meeting:

Noted that sexual reproductive health and rights (SRHR) and family planning (FP) remain critically important for the sustainable development of the African continent and hence observed that it is essential to continue positioning them high on the continent's development agenda;

Further noted that SRH including FP should be considered as an unfinished business requiring renewed vigour and determination in the 2030 Agenda for Sustainable Development;

Noted the predominantly young population of African Countries and the role of RH/FP to harnessing the Demographic Dividend in our countries.

Recognized that in order to successfully implement the 2030 Agenda for Sustainable Development and the International Conference on Population and Development (ICPD) beyond 2014 Framework of Action and achieve mutual success, the African continent should deepen South-South cooperation and support stakeholders, including civil society and the private sector to play a greater role in building effective multi-stakeholder partnerships to complement national development efforts;

Further recognized that population dynamics, sexual and reproductive health and gender equality are at the core of sustainable development, and that deepening South-South cooperation in this field will contribute to the health and well-being of all people;

Noted that the resources allocated for better reproductive health in African countries are not adequate to achieve the desired development;

Recognized the MDGs successor SDGs adopted by the international community at the UN in September 2015 aimed at ending poverty by 2030 as well as to universally promote shared economic prosperity, social development and environmental protection.

Further recognized the role of parliamentarians be it, representation, legislation, appropriation and oversight for better utilization of public resources;

Appreciate the crucial role of research and evidence in the delivery of parliamentary core functions;

And hereby adopt the Kampala Call for Action on June 30, 2016 based on sustainable development as the core principle. The Kampala Call for Action, which aims to accelerate and outline key actions to further promote SRH & FP, gender equality , population and development for the next five years, recommends the following:

On Leadership

1. Promote good governance and accountability in all matters of health;
2. Continue providing leadership and stewardship on policy, legislation and budgetary oversight for reproductive health and family planning
3. Champion and undertake actions that enable increased use of evidence in decision making
4. Ensure that FP and population issues are integrated into national development strategies, including the poverty reduction strategies and action plans
5. Promote and support RH/FP activities in the constituencies
6. Foster general awareness on population issues at all levels in the country

On legislation:

1. Initiate debate and pass bills that support RH/FP programmes
2. Support laws that operationalize task sharing for improved service delivery of RH/FP issues
3. Ensure the inclusion of FP and RH components in the national health insurance
4. Support implementation, oversight and monitoring of global commitments such as Every Woman Every Child; FP2020; Life Saving Commodities that are geared at addressing improvements in the lives of mothers and children
5. Institute studies to ensure existing laws facilitate for achievements of SDGs, and where necessary advocate for relevant new laws.

On Advocacy

1. Promote FP as essential to the achievement of all SDGs, especially SDG 3 and SDG5, in partnership with civil society organizations and the media;
2. Regularly issue public statements supportive of RH/FP to mobilize both political and popular support;
3. Lobby for inclusion of RH/FP activities in government priorities and keep them high on the agenda
4. Advocate for investments in the young people with a focus on education, health, skilling, job creation to enhance the demographic dividend.
5. Advocate for investments in the extraction and proper management of Natural resources to address challenges revealed by demographic surveys and other studies.

On Financing

1. Advocate for increased government resources to health sector including RH/FP and related programmes;
2. Ensure allocation of increased resources for RH/FP programmes

3. Ensure accountability in public expenditures and track RH/FP resources;
4. Ensure a clear and separate budget line for family planning in national and sub national health budgets and ensure family planning is included in basket funding, where applicable including health insurance;

On Strategies and Programmes

1. Mobilize men to support reproductive health and family planning programmes
2. Participate in monitoring and evaluation of reproductive health and family planning programmes
3. Promote the sharing of innovative good practices between and among countries on the African continent through South-South cooperation
4. Support the drive against early marriages and teenage pregnancy and advocate for initiatives to keep the girl child in schools.

On Strengthening NEAPACOH

1. Network within the region with professionals, researchers and development partners in health, population and other development issues;
2. Enhance partnerships with civil society organizations;
3. Improve regular and ongoing communications and sharing of information through available technologies (e.g. email, website, blog, forum); and
4. Undertake resource mobilization activities to support the implementation of the NEAPACOH Strategic Plan and ensure sustainability of the Alliance;
5. Lobby for specific parliamentary committees on SDGs.

-End –

10.0 CLOSING CEREMONY

The closing session was chaired by Hon. Mangole Gilbert, a Member of Parliament from Botswana. He thanked the participants for participating in the meeting. He commended the commitment exhibited by participants through all sessions and believed that since different delegates had shared their experiences, there was a lot of learning from each other. He said that was one way of addressing common challenges affecting African countries. He said just as the meeting started with opening remarks, the meeting would end with closing remarks. He invited Dr. Jotham Musinguzi, the

Director General, National Population Council of Uganda to give his closing remarks.

10.1 Remarks by Dr. Jotham Musinguzi

Dr. Musinguzi informed participants that he would be brief because of time. He thanked the Parliamentarians for the vibrant sessions in the previous two days. He said it was extremely encouraging to see Parliamentarians working together.

He said the 2016 NEAPACOH meeting had the biggest number of participants from the Francophone countries and called upon them to keep attending because the challenges African countries face are closely related. Dr. Musinguzi underscored the role of Parliamentarians, saying they were very important in the transition from MDGs to SDGs. Using the example of Malawi, which, after attending the 2014 NEAPOACOH meeting committed to enact a law on increasing the age of marriage from 15 to 18 and increase the budget for FP, and two years later they are reporting achievements, he called upon participants to implement the commitments they had made. He said countries like Ghana, Ethiopia, Rwanda and Uganda had made a difference in funding and policy.

Dr. Musinguzi informed Parliamentarians that their work would make a difference in the lives of the people that elected them. He encouraged them to be bold and courageous, saying people of Africa deserved more and Parliamentarians have the power to make a difference.

He pledged to work hard to ensure Parliamentarians the technical support they need. He thanked the organisers of the meeting and the hotel for the job well done, and wished all participants safe journey to their homes.

10.2 Remarks by Dr. Joe Thomas, Executive Director, PPD

Dr. Thomas congratulated delegates from the 19 countries that attended upon completion of a two-day intensive meeting. He believed they had achieved a lot. He informed participants that the key to sustainable development was leaving no one behind, and called upon members to ensure they work towards keeping everyone healthy.

He thanked the organisers of the meeting for inviting him to be part of the meeting. He informed participants that PPD would transmit the information and commitments made through their website.

Dr. Thomas said that they would want to take PPD further. He said PPD ARO had 14 countries and would want to see the number of countries increasing. He said the deliberations of the 2016 NEAPACOH meeting were very good and he would like to see those deliberations come up in the PPD meetings. He called upon participants to utilize the information shared during the meeting to advocate for improved FP services.

He said the meeting was one step towards keeping the African population healthy. He thanked all organisers and funders of the meeting, and wished participants the best as they improve the lives of their people.

10.3 Remarks by Hon. Dr. Blessing Chebundo, Chairperson NEAPACOH

Hon. Dr. Chebundo thanked participants for their commitment in the previous two days of the meeting. He said he observed participants sit unselfishly from morning to evening, a gesture that they were committed to improving the lives of their people.

He observed that some members had been attending NEAPACOH for the last 8 years to improve the lives of the people. He said he was challenged by the zeal of Parliamentarians and saluted them for their dedication.

He said the meeting had discussed RH/FP issues in light of SDGs. NEAPACOH and PPD ARO and other partners had made it easy and would ensure implementation of the commitments and the resolutions made.

Dr. Chebundo noted that people were at the centre of development and as representatives of the people, Parliamentarians must implement SDGs. He called upon Parliamentarians to translate SDGs into national laws. He said the major role of parliament is legislation and oversight and it is in the process of making things that the

Parliamentarians perform their roles. He called upon participants to invest in the solution and not to be part of the problem.

Dr. Chebundo said the meeting had taken stock of what was done in 2014/15 and also shared what was to be implemented in the following one year. He called upon participants to continue interfacing with the Executive leaders. He asked them to step their feet and say ‘‘this will work or will not work.’’

He informed participants that after the closing ceremony, executive members of NEAPACOH would meet to transact business. He invited the members to return after lunch for the business meeting.

He told participants to guard the initiatives they have already started. He thanked PPD ARO and NPC- the organisers of the meeting - for their hard work. He thanked PPD and said through Parliamentarians, the world would see a lot of changes. He thanked the facilitators

He appreciated PPD ARO for continuously organizing the meetings where such important ideas are shared. He called upon participants to advocate for various committees to join NEAPACOH. He asked members to ensure the discussions of the meeting were used in their countries because there was a lot to learn. He recommended that NEAPACOH meetings should involve finance ministries of various countries.

10.4 Closing Remarks by Hon. Jovah Kamateeka, MP, Uganda

Hon. Kamateeka, on behalf of the Speaker of Parliament of Uganda, welcomed all participants to Uganda. She thanked the participants for their commitment in the previous two days to improve the lives of the people they represent. She thanked Hon. Kadaga for being an ardent supporter of women and people’s rights. She said Hon. Kadaga was a champion of maternal and child health and had proposed that all committees of parliament should use gender and human rights checklists in their business.

She said with the proposal, all business of Parliament would be human rights compliant and human rights responsive. She said she would ensure HC IIs have maternity wards and advocate for sufficient funding for recruitment of health workers, especially

midwives. She underscored the importance of training VHTs saying, the above would form a foundation for the NHIS that the country was advocating for.

Hon. Kamateeka appreciated the President of Uganda and the NRM government but also the heads of states for allowing members to attend the NEAPACOH meeting of 2016. She called upon Parliamentarians to work towards increasing the budget for FP.

She thanked the organizers of the meeting for inviting her to close the meeting of the Network of African Parliamentary Committees of Health (NEAPACOH). She welcomed participants from the different countries to attend the meeting. She welcomed Members of Parliament who came all the way from the countries of Botswana, Burundi, Chad, The Gambia, Ghana, Kenya, Malawi, Namibia, Nigeria, Senegal, South Sudan, Swaziland, Togo, Zambia and Zimbabwe. She noted that Angola, Cote d'Ivoire, Ethiopia, Mozambique, Rwanda, South Africa, Mali and Mauritius were invited to the meeting but couldn't make it due to other scheduled programmes. She thanked other distinguished participants for finding time out of their busy schedules to attend the meeting.

She said that the meeting was the eighth in a series of regional parliamentary meetings that were held annually under the auspices of NEAPACOH. She informed participants that she had had the opportunity of presiding either at the opening or closing of some of the previous NEAPACOH meetings. She said the organization of meetings of that magnitude, no doubt, requires determination, commitment, a lot of resources, expertise and experiences. She thanked PPD ARO and partners for the support that they extended to the NEAPACOH Secretariat to regularly and consistently organize those meetings.

Hon. Kamateeka informed participants that they had come to the end of a two days meeting of intensive deliberations, during which, she had no doubt, that knowledge was shared, new information was exchanged, programmes were debated, and lessons were learnt. She said the meeting was organised, first and foremost, as a follow-up to similar meetings that had been held since 2008, but also in order for the parliamentarians to have a reflection about their roles to repositioning reproductive health and family planning in their respective countries in the context of a new global agenda that was ushered in following the end of the Millennium Development Goals (MDGs) and the birth

of the Sustainable Development Goals (SDGs) in September 2015. Hon. Kamateeka said the main objectives of the meeting, therefore, had been to provide an opportunity to review progress, share experiences and lessons learnt over the past years on the implementation of country reproductive health and family planning commitments made during the past NEAPACOH meetings. She said in addition, the meeting had been held in order to provide space for parliamentarians to understand the transition from the MDGs to the SDGs and what they needed to do to build and sustain the momentum and political will for reproductive health and family planning within the of context of the SDGs. She hoped participants accorded themselves time for deeper discussion and were able to come up with workable recommendations around those objectives. She took note of the presence of the intelligentsia, from various disciplines in the meeting, and believed they had done a commendable job.

Hon. Kamateeka said from the programme for the meeting, she noted that topics around MDGs and SDGs were given space for presentations and discussions. She believed participants were going to leave the meeting with a clearer understanding of the interface between MDGs and SDGs and what their additional roles will be as they transit from MDGs to SGDs. She said the experiences from different countries that had been shared should give participants a sense of shared and common challenges. She called upon participants to build on what they learnt from the meeting, to identify, develop and implement joint programmes to address shared problems.

She said participants were then able to talk about the relationship between the MDGs and the successor SDGs. They were able to talk about African countries' achievements on the MDGs and the implications for SDGs. They were able to talk about how they could create stronger leadership and stewardship for implementation of SDGs in the 2030 Agenda for Sustainable Development as well as the role of Parliamentarians in enhancing South – South collaboration and able to talk about people, their communities and the challenges facing them in a manner that puts faces to numbers.

She asked Members of Parliament whether they had asserted themselves, and were satisfied with the representative, legislative, budget appropriation and oversight roles they had played and would continue to play. She said all participants should leave the

meeting with a better understanding of how better they could play their roles, and of the challenges at hand in their next round of tasks. She was happy to note that participants had been able to come up with resolutions and country action points which should be binding to all those who participated in their framing, discussion and adoption.

Hon. Kamateeka thanked all those who worked together to have the meeting successful. She recognised the successful partnership by NPC Uganda, PPD ARO, UNFPA, AFIDEP, STEP UP, HPRO, and PACE in organising the meeting. She encouraged similar partnerships to be forged in other programmes. She congratulated the staff of PPD ARO and NPC Secretariat who worked hard to ensure a successful meeting. She wished everybody a safe journey home and hoped to see them again soon.

10.5 Vote of thanks by Hon. Tchaboure Aime Gogue, MP, Togo

Hon. Tchaboure thanked the organisers of the meeting that acted as a conduit for translation from the MDGs to the SDGs thinking. He said the NEAPACOH meeting was a great success due to the commitment of the organisers and also the participants.

He thanked His Excellence Yoweri Kaguta Museveni, the president of Uganda for his leadership and support for RH/FP. He said the President was actively involved in health activities, and that was why Uganda was on track to realizing the health commitments in the SDGs.

On behalf of the NEAPACOH, he thanked the guest of honour, Rt. Hon. Speaker of Parliament of Uganda, represented by Hon. Jovah Kamateeka, for commitment towards women empowerment and health issues. He thanked all Ugandans for their hospitality and the Parliamentarians for their contribution during organization of the meeting.

Hon. Tchaboure thanked and congratulated the organizing committee of the 2016 NEAPACOH meeting upon holding a successful meeting, that had not only come up with the country commitments but also the Kampala resolution on RH/FP. He said the

theme of the meeting showed that there were challenges and opportunities for the development of Africa. He informed participants that the meeting offered an opportunity for delegates to share experiences and action plans from 2014-2015. He appreciated the importance of strategic partnerships that existed among African countries and believed that was the way to go.

He thanked the delegations from the 19 African countries that attended the high level 2016 NEAPACOH meeting and wished all participants safe journeys to their homes.