2009 Senior Policymakers' Seminar on "Financing the Health-Related Millennium Development Goals: Challenges and Opportunities" MEETING REPORT

Munyonyo Commonwealth Resort, Munyonyo, Kampala
16 November 2009

Hosted by Partners in Population and Development Africa Regional Office (PPD ARO), the African Union (AU), and the World Bank

Held at the 2009 International Conference on Family Planning: Research and Best Practices (http://www.fpconference2009.org/)

FAMILY Planning Health Wealth

With support from The Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health; The David and Lucile Packard Foundation (http://www.packard.org/); The William and Flora Hewlett Foundation; Venture Strategies for Health and Development; and the United Nations Population Fund (UNFPA)

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1. Executive Summary

The Senior Policymakers' Seminar on "Financing Health-related Millennium Development Goals: Challenges and Opportunities" brought together over 150 participants including ministers of finance, health, economic planning; senior policymakers from ministries of health, finance, and gender; representatives from president and vice president's offices; members of parliament, women leaders and knowledgeable civil society leaders from sub-Saharan Africa. Participants were drawn from 19 African countries, in addition to international participants from donor countries.

The meeting was held in Commonwealth Banqueting Hall at Munyonyo Commonwealth Resort on November 16, 2009 and was jointly organized by the Partners in Population and Development Africa Regional Office (PPD ARO), the African Union (AU) and the World Bank (WB). The meeting was held in conjunction with the International Conference on Family Planning Research and Best Practices in Kampala, Uganda, from 15-18 November 2009.

The meeting program revolved around four focused presentations and an informal discussion to facilitate learning and engagement by senior policymakers toward promising ends. The four presentation areas were directed toward advocating for:

- Understanding the linkages between population, poverty and health and the importance of policy levers for managing short and long term change in population dynamics;
- Prioritizing and integrating family planning in the poverty reduction strategy development process;
- Establishing the means for tracking resource flows, through national health accounts with reproductive health/family planning subaccounts and monitoring budgetary allocations at the national and sub-national levels; and
- Developing new leadership and increasing human resource capacity to implement population policies and high-quality family planning and reproductive health programs.

A number of key conclusions and recommendations emerged during the plenary discussion. These conclusions and recommendations were made in four key areas: family planning policy and advocacy, leadership, financing, and family planning strategies and programmes.

Key Conclusions

Family Planning Policy and Advocacy

- Family planning is essential to the achievement of all MDGs;
- Family planning is a "best buy" in today's financially strapped environment, with savings in other development areas of three (3) to thirty (30) times the original investment for family planning; and
- The MDG family planning strategy requires increasing contraceptive prevalence rate (CPR) by 1.5% a year, but African countries are lagging

Leadership

- Country leadership on family planning is critical—the desire for family planning comes from African women and families, so the leadership for family planning must also come from Africa

Financing

- There is a need for an additional ten (10) billion dollars for MDG5;
- Increasing budget support has led to government-owned programs and priorities, but this has resulted in family planning being left off of the agenda and without a separate budget line;
- Governments in Africa, on average, spend less than 10% of their total budget on health. This is significantly less than the Abuja target of 15%; and
- Donor and partner harmonization remains a problem, with fragmentation of resources and strategies

Family Planning Strategies and Programmes

- Underestimating the challenges and using ineffective strategies (such as separating maternal and child health from family planning and create vertical programs for HIV/AIDS)—has prevented Africa from success to date on health-related MDGs;
- The quality and availability of reproductive health services benefits from strong health systems and financing mechanisms (e.g. performance-based financing, community health insurance). Yet, specific interventions need earmarked resources (e.g., contraceptives, maternal and newborn medical equipment); and
- Some African countries have scaled up reproductive health interventions that increase community-based distribution of health services, including family planning (Rwanda-two community health workers in each village; Ethiopia's Health Extension Program-a community-based health programme with 32,000 salaried health extension workers)

Key Recommendations

Family Planning Policy and Advocacy

- Ensure that family planning is a key component of all national development strategies, including the poverty reduction strategy and action plan;
- Step up the pace of policy and program implementation;
- Regularly issue public statements supportive of family planning to mobilize both political and popular support; and
- Revitalize the Maputo Plan of Action through the momentum created by CARMMA

Leadership

- Improve stewardship (national and local leadership) and sector ownership on family planning/reproductive health;
- Increase funding for Population Secretariats, who are currently under-resourced; and
- Increase harmonization of programmes, with country-led leadership and donors/partners playing harmonized roles

Financing

- Increase funding through mobilization of global resources;
- Encourage "results-based financing" for family planning and reproductive health;
- Establish an enabling environment for effective public-private (e.g. IFC-Health in Africa);
- Ensure family planning is included in policies and basket funding;
- Ensure a separate budget line for family planning in country budgets;
- Support research to inform increased resource allocation from government and donors for FP/RH commodities (e.g. as in Rwanda's RHS);

- Increase government resources to health to realize the Abuja target of 15%;
- Improve efficiency in using the resources available;
- Create synergy between international, regional and national efforts in line with the framework of the Paris Declaration; and
- Improve planning and coordination

Family Planning Strategies and Programmes

- Reinforce the linkage between reproductive health and family planning services;
- Continue support for strengthening primary health care systems; and
- Increase budget allocations for contraceptives in national and district health budgets

2. Background

Worldwide, 200 million women would like to prevent an unplanned pregnancy but lack access to contraception. To address this alarming situation, an International Conference on Family Planning Research and Best Practices was held in Kampala, Uganda, 15-18 November 2009.[1]

Alongside other sessions conducted during the International Conference on Family Planning, Partners in Population and Development Africa Regional Office (PPD ARO), the African Union (AU) and the World Bank (WB) jointly organized a one day Senior Policymakers' Seminar on "Financing Health-related Millennium Development Goals: Challenges and Opportunities."

This important meeting, which brought together over 150 participants including Ministers of Finance, Health, Economic Planning, Members of Parliament, women leaders and knowledgeable civil society leaders in the sub-Saharan African region, was held at the Commonwealth Banqueting Hall, Munyonyo Commonwealth Resort on November 16, 2009.

Meeting Objectives

- To share and diffuse successful FP national experiences between countries from all regions;
- To increase commitment and mobilization of budgetary and other resources for FP programs; and
- To use a Voices-of-the-South model to develop ownership of FP programs.

Post-seminar Expectations

- National plans to implement new commitment to family planning;
- Monitoring of outcomes and achievements; and
- Expanded access to high-quality family planning services and sustainable national programs.

Meeting Rationale

There is a palpable rise in policy circles in recognizing again not only the importance of family planning as a health intervention but also an essential ingredient of development plans to capitalize on population age structures for economic productivity. With the 2006 Maputo Plan of Action[2] and Millennium Development Goal Target 5b[3] as landmark events in human development commitment, the majority of the African continent's leadership has begun to appreciate the linkages between population, health and development both at the macro and micro-levels. A high percentage of African families have mothers wanting to space or limit future births but unable to avail themselves of contraception. Clear and probable success stories have emerged, from Egypt

[1] http://www.fpconference2009.org/
[2] Maputo Plan of Action for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights: 2007-2010 (2006): *http://www.unfpa.org/africa/newdocs/maputo_eng.pdf* and summary brief at *http://ppdafrica.org/docs/maputo.pdf*
[3] United Nations Millennium Development Goals (2000): *http://www.un.org/millenniumgoals/* and summary brief at *http://ppdafrica.org/docs/RH-MDGs.pdf*

in the north, to Rwanda and Ethiopia in the east, to Malawi and Madagascar in the south, and to southwest Nigeria. Yet these advances are still relatively nascent and warrant thoughtful examination, open sharing, wider recognition, and reinforced commitment to secure continued progress.

Harnessing the voices of the South, the evidence base under formation, and the experiential wisdom of global policy leaders, this one-day seminar for high-level African development leaders sought to establish a community and agenda of action for universal access to family planning in Africa. One day of focused discourse may not launch a contraceptive revolution in Africa, but it may be a tipping point that can be enjoined by the efforts of others to accelerate commitment and resource mobilization.

Meeting Program

The program revolved around four focused presentations and a moderator led an informal discussion to facilitate learning and engagement by senior policymakers toward promising ends. The four presentation areas were directed toward advocating for:

- Understanding the linkages between population, poverty and health and the importance of policy levers for managing short and long term change in population dynamics;
- Prioritizing and integrating family planning in the poverty reduction strategy development process;
- Establishing the means for tracking resource flows, through national health accounts with reproductive health/family planning subaccounts and monitoring budgetary allocations at the national and sub-national levels; and
- Developing new leadership and increasing human resource capacity to implement population policies and high-quality family planning and reproductive health programs.

Following each thematic presentation, senior policymakers highlighted their direct personal experience with efforts in the area. This was followed by open discussion. Donors and senior policymakers next gave their perspectives on "National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?." Before closing, a session focused on concrete steps to advance family planning in countries willing to prioritize such investments.

Organizers

Partners in Population and Development (PPD) is a Southern-led, Southern-run inter-governmental organization of 24 developing countries, encompassing more than half the population of the entire globe. PPD was founded in 1995, to promote South-South cooperation in reproductive health and population and development. As part of the PPD global alliance, the Partners in Population and Development Africa Regional Office (PPD ARO) was opened in 2007 in Kampala, Uganda. The vision of the PPD ARO is "an African continent that meets its Reproductive Health needs, promotes the Population and Development agenda and thereby addresses poverty, through South-South Cooperation." Its mission is "to provide a platform for the promotion of and resource mobilization for Reproductive Health, Population and Development in Africa through three elements: 1) Policy dialogue 2) Networking and building strategic partnerships in the region and 3) Sharing of experiences and good practices. More information is available online at: http://www.ppdafrica.org.

The African Union (AU) has the vision to "build an integrated Africa, a prosperous and peaceful Africa, driven by its own citizens and representing a dynamic force in the international arena." The Social Affairs Portfolio of the AU Commission covers health, children, drug control, population, migration, labour and employment, sports and culture. More information is available at: http://www.africa-union.org/.

The World Bank is a vital source of financial and technical assistance to developing countries around the world. Its mission is to fight poverty with passion and professionalism for lasting results and to help people help themselves and their environment by providing resources, sharing knowledge, building capacity and forging partnerships in the public and private sectors. The World Bank provides low-interest loans, interest-free credits and grants to developing countries for a wide array of purposes that include investments in education, health, public administration, infrastructure, financial and private sector development, agriculture, and environmental and natural resource management. More information is online at: http://www.worldbank.org/

The meeting also received funding and technical support from The Bill and Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health (http://www.jhsph.edu/gatesinstitute/); The David and Lucile Packard Foundation (http://www.packard.org/); The William and Flora Hewlett Foundation (http://www.hewlett.org/); Venture Strategies for Health and Development (http://www.venturestrategies.org/); and the United Nations Population Fund (UNFPA) (http://www.unfpa.org/).

The co-operating organisations all contributed technically and financially to the meeting, locally hosted by PPD ARO.

The meeting programme is shown in Appendix 1 and the list of participants in Appendix 2. Documents and presentations available online are listed in Appendix 3.The meeting was rapporteured by PPD ARO and this report has been produced by PPD ARO in conjunction with the other organizing institutions.

2. Session One

Chaired by Hon. Rukia Chekamondo, Minister of State, Privatization, Uganda Ministry of Finance, Planning and Economic Development on behalf of Hon. Syda Bumba, Uganda's Minister of Finance, Planning and Economic Development; and Co-Chair: Hon. Dr. Richard Nduhura, Minister of State, General Duties, Uganda Ministry of Health on behalf of Hon. Dr. Stephen Mallinga, Uganda's Minister of Health

On behalf of all the organizing institutions, Dr. Jotham Musinguzi, Regional Director for Partners in Population and Development Africa Regional Office (PPD ARO), welcomed all of the participants and informed them that the official opening statements were postponed until the arrival of the chairs: Hon. Rukia Chekamondo, Minister of State, Privatization , Uganda Ministry of Finance, Planning and Economic Development and Co-Chair: Hon. Dr. Richard Nduhura, Minister of State, General Duties, Uganda Ministry of Health.

Presentation by Dr. Khama O. Rogo: "AID Architecture and Health Outcomes in Africa: Focus on Family Planning"

Dr. Musinguzi invited the first presenter, Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group to make a presentation on "AID Architecture and Health Outcomes in Africa: Focus on Family Planning."[4]

Dr. Rogo began by giving an overview of the history of thinking in development. From 1960s, the focus in Africa was on the concept of uhuru (Swahili for 'freedom'). A spotlight was placed on "eradicating poverty, ignorance, and disease." Dr. Khama O. Rogo then gave an overview of the Eight (8) UN Millennium Development Goals (MDGs) to be achieved by 2015.[5]

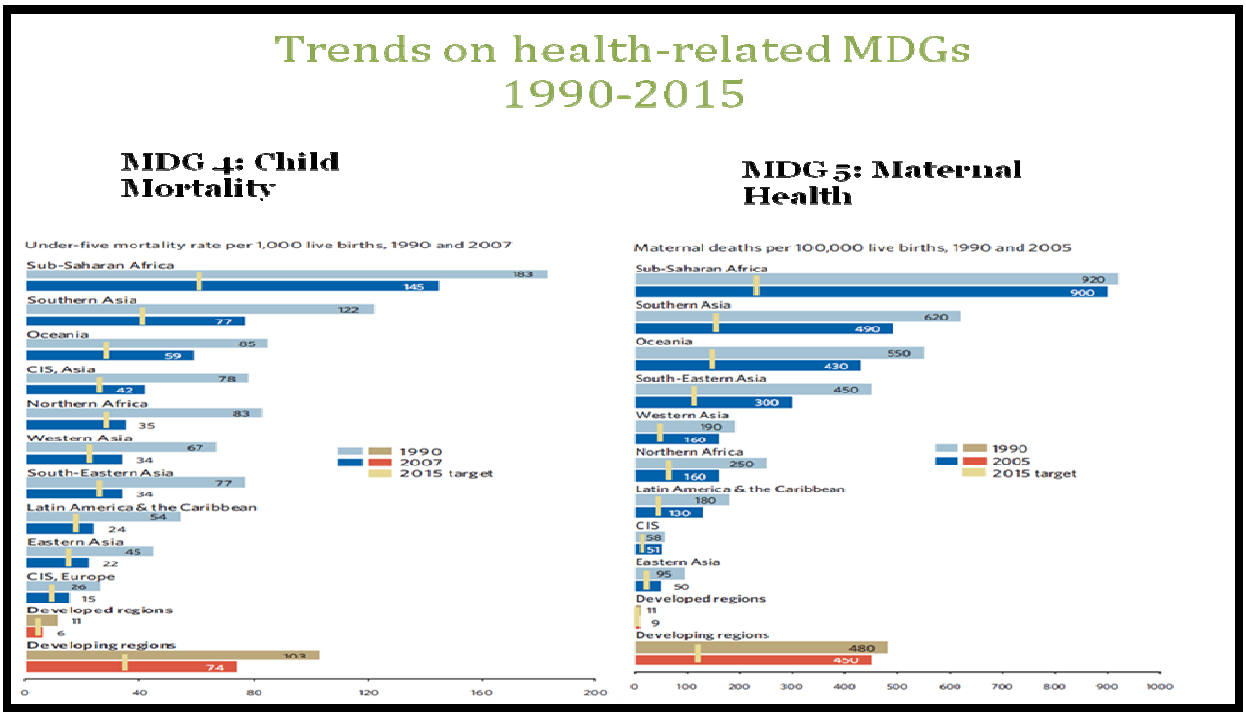
In his presentation, Dr. Rogo first addressed the issue of who pays for health services. There is an assumption that the public sector should be the focus of health systems, but most countries provide less than 10% of general budget towards health. Dr. Rogo stressed that the target of Abuja needs to be met, and linked this

[4] "AID Architecture and Health: Outcomes in Africa: Focus on Family Planning" by Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group
English: http://ppdafrica.org/docs/FinancingHealthMDGs/rogo-e.pdf

[5] 1. Eradicate extreme poverty and hunger; 2. Achieve universal primary education; 3. Promote gender equality and empower women; 4. Reduce child mortality; 5. Improve maternal health; 6. Combat HIV/AIDS, malaria and other diseases; 7. Ensure environmental sustainability; 8. Develop a global partnership for development. (http://www.un.org/millenniumgoals/)

promise to the Millennium Development Goals (MDGs) and promises of 1960s.

Dr. Rogo reported that progress on the health-related MDGs has been slow, particularly in Africa. For MDG 1: Eradicate extreme poverty and hunger, "Sub-Saharan Africa counted 100 million more extremely poor people in 2005 than in 1990, and the poverty rate remained above 50 per cent" according to the 2009 UN Millennium Development Goals Report.[6] For MDG 6: Combat HIV/AIDS, malaria and other diseases, two-thirds of those living with HIV are in Sub-Saharan Africa, most of whom are women. And according to WHO, nearly one million people died of malaria in 2006; 95% of them lived in Sub-Saharan Africa, and the vast majority were children under five.



Dr. Rogo pointed to the lack of success in Africa on the health-related MDGs to three "tactical errors": underestimating the challenges; ineffective strategies; and over-reliance on old 'adversaries' for aid. The trends for reproductive and child health services have been to separate maternal and child health (MCH) from family planning (FP), integrate reproductive health services, and create vertical programs for HIV/AIDS. Trends for the policy environment have been that government leadership has remained stagnant with minimal change, donors have stronger voices, while consumers/communities have less voice. These trends have had significant impact on the sources of funding for health: governments in Africa, on average, spend less than 10% of their total budget on health. This is significantly less than the Abuja target of 15%.[7] The

[6] The Millennium Development Goals Report 2009 (2009): http://www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf

[7] The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001): http://www.un.org/ga/aids/pdf/abuja_declaration.pdf and the Abuja Call for Accelerated Action Towards Universal Access to HIV and AIDS, Tuberculosis and Malaria Services in Africa (2006): http://www.aumission-ny.org/documents/abuja_call.pdf

percentage of donor contributions has been variable, and private spending, in the form of in out-of-pocket expenditure has increased two to three fold, but it goes to the cure of disease and sickness, rather than to preventative healthcare.

Dr. Rogo said that aid falls into three categories: financial (soft loans, general grants, targeted grants and innovative financing), technical (short and long term), and goods (equipment, drugs and pharmaceuticals and infrastructure). But he said that there are significant sources that are alternatives to aid, such as government general expenditure (budgetary allocations, insurance, other, etc.) and private expenditure (out of pocket expenses)

In part, due to the structuring of aid, the trends in reproductive and child health have been to separate maternal and child health (MCH) from family planning (FP), integrate reproductive health services, and create vertical programs (HIV/AIDS) separate from MCH and FP. The trends in the policy environment have led to minimal change in government leadership, donors having stringer voices, and consumers and communities with less voice.

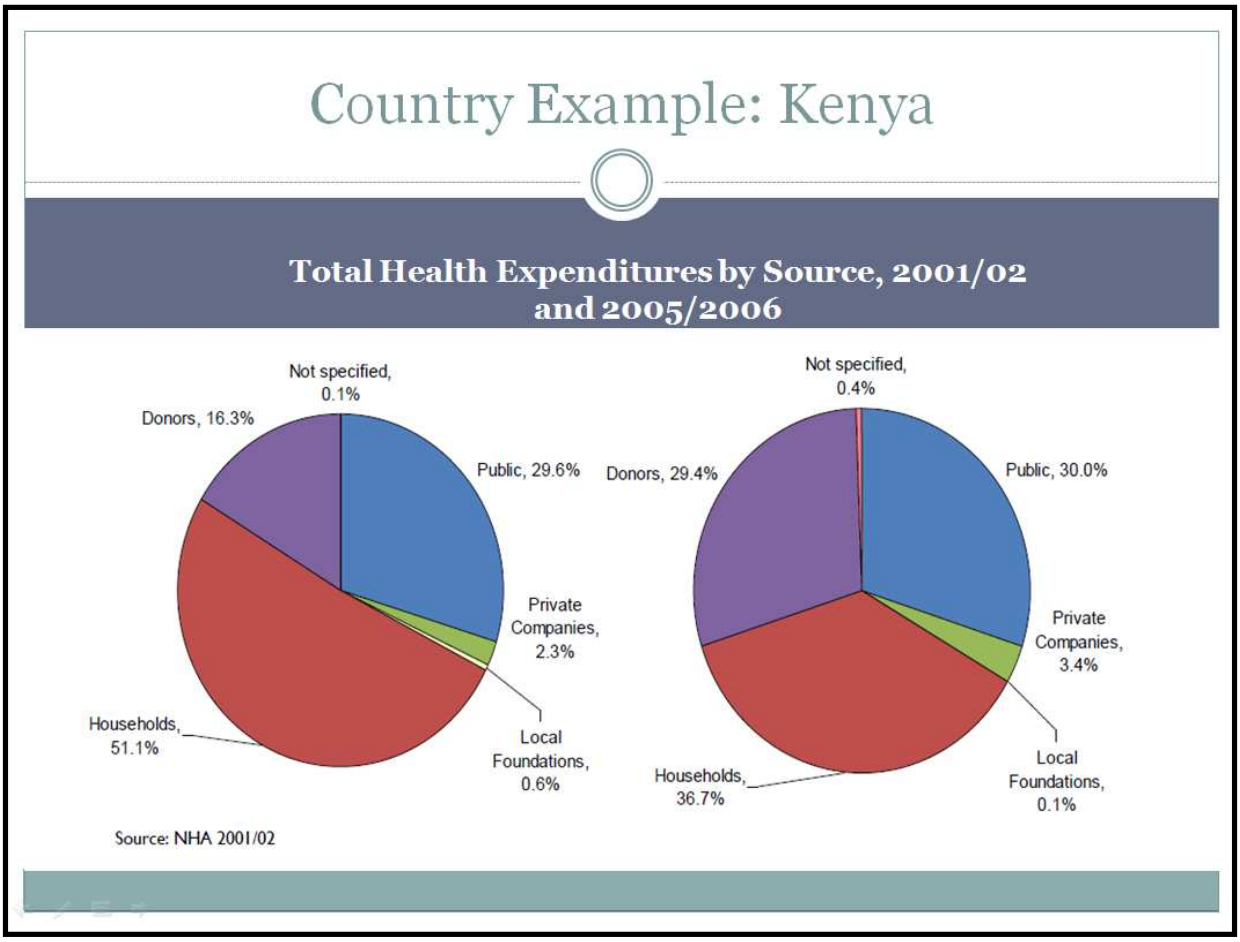
The first source of funding for health in Africa is African governments, which average less than 10% of the general total budget (falling short of the Abuja target of 15%).[8] Dr. Rogo stated that there is an assumption that the public sector should be the focus of our efforts, as most countries provide less than 10% of general budget. He called for the funding target of Abuja to be more clearly linked to MDGs and promises of 1960s.

According to Dr. Rogo, the second source of funding for health in Africa is donor contributions, yet this source is variable. Dr. Rogo said that "If we look at Africa-wide,. . . countries that are supportive of family planning tend to get more money for family planninf. [Yet] the biggest friends of Francophone Africa were never a friend of family planning. But in Anglophone Africa, the Dfids, the United States, have been friends [of family planning]. He stated that there are now "crossover countries such as Rwanda who have been able to attract funding for family planning through changing the politics of contribution for family planning. Yet, according to Dr. Rogo, "The way money flows remains an issue, [it] remains a challenge."

The third source of funding for health in Africa is private spending, which has been increasing two to three fold over time. Yet, this private out-of-pocket expenditure goes to cure disease and sickness, rather than to primary or preventative care.

Dr. Rogo next gave a country example of Kenya to illustrate the issue of funding for health and family planning in Africa. As shown in Figure 2, in Kenya, in 2005/2006, household out-of-pocket expenditures at 36.7% were the greatest source for health spending, followed by public sources at 30% and donors at 29.4%.

[8] "In 2001, in Abuja, Nigeria, Heads of States of the African Union (AU) member states committed to allocating at least 15% of annual government budgets to their health sectors." Regional Network for Equity in Health in east and southern Africa (EQUINET). (2008). "Meeting the promise: Progress on the Abuja commitment of 15% government funds to health." Policy Series No. 20. May 2008. EQUINET and the Health Economics Unit, University of Cape Town and Training and Research Support Centre http://www.equinetafrica.org/bibl/docs/POLBRF20Abuja.pdf



Dr. Rogo also explained how public providers make up 61% of the total health expenditures in women's health for 2005/2006, private providers are responsible for 30% of women's health expenditures, and other providers make up the remaining 9%. In Kenya according to the 2003 DHS, 71% of antenatal services are done in the public sector, 13% are private-sector, and 15% mission. Yet 59% of deliveries are done in the home, 26% in the public sector, 14% in the private sector. The majority of family planning services are carried out by the public sector (53%), private sector (34%), NGOs (10%) and other service providers (3%).

"Both the public and private sector have a role to play and need to be brought to the table . . . You cannot see only through one eye . . . What are we waiting for?"
-- Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group.

When looking at rural areas in Kenya, it is evident the role of private clinics is key; private clinics provide 15% of oral contraceptives and condoms and 48% of IUDS. Private providers in Kenya treat 47% of children with diarrhea; 33 % of the poorest and 30% of the poorer income groups use the private sector to access treatment for childhood diarrhea. Dr. Rogo asked the participants to ponder, "Where do people get the care? [And thus] how do you save lives?" "What does that mean in terms of programmes on the ground?" He argued that it matters in terms of where the support should go. He told participants that you must save lives through addressing where people seek care, and thus "both the public and private sector have a

role to play and need to be brought to the table."

From this example, Dr. Rogo drew the five following lessons/challenges: country leadership, donor coordination, government budget, out-of-pocket expenditure, and innovation in policy, strategy and financing.

Regarding country leadership, he said that we know clearly that Population Secretariats have been moving between the Ministry of Health and the Ministry of Finance and Planning. Yet, in terms of resourcing, the outcomes are unclear. He asked participants if this movement shows that money for population and health issues is really in the Ministry of Health. Regarding funding, he said that despite the Paris Declaration,[9] donor funding and harmonization remains a problem. More recently, "results-based financing has to come to family planning and reproductive health. Only then, can we focus and move from 2% to 4% to 5 %."

Dr. Khama O. Rogo asked the policymakers present to give an indication why health is financed in the single-digits, significantly below the Abuja target. Regarding public-private partnerships, Dr. Rogo stated, ""We have two eyes. Why would we want to look out of only one? You cannot see only through one eye. What are we waiting for?" Dr. Rogo then requested for governments to engage more strongly with the private sector.

Dr. Rogo concluded by giving five (5) key recommendations to the group, and asked the policymakers present to give an indication why health is financed in the single-digits, during the discussion:

1. Increase government resources, Abuja target must be realized;
2. Improve policies and strategies, country-led priorities are imperative;
3. Increase community participation in primary/preventive health;
4. Establish an enabling environment for effective public-private partnership (e.g. IFC-Health in Africa)
5. Improve stewardship (national and local leadership) and sector ownership

"Family planning is to maternal health is what immunization is to child health. If anyone feels and thinks that you can improve MDG5 without family planning, it is like saying MDG4 can improve without vaccination. That is how simple it is."
-- Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group.

In his concluding statement, Dr. Rogo urged the policymakers to "get in programs that focus on communities and individuals." He stated, "Your honourables, why is family planning important to discuss here? Imagine child health without immunization. We wouldn't consider a child health program without immunization. How can we think about women's health without family planning? Family planning is to maternal health is what immunization is to child health. If anyone feels and thinks that you can manage to improve MDG5 without family planning, then it is like saying MDG4 can improve without vaccination. That is how simple it is.

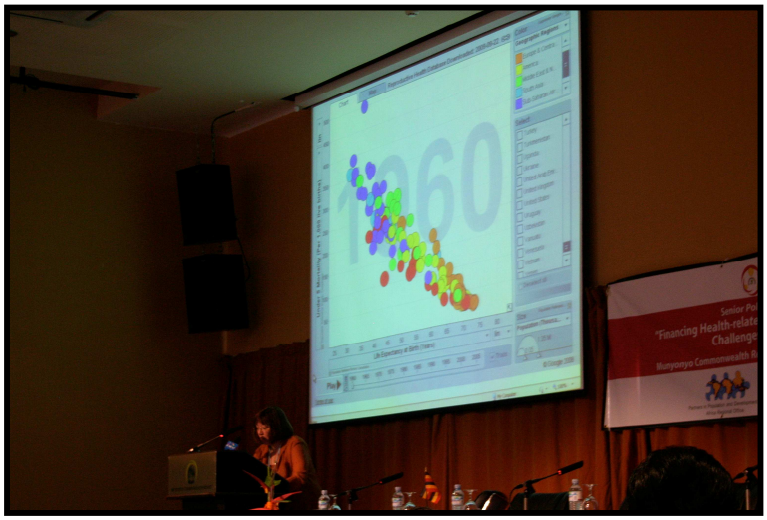
[9] Paris Declaration on Aid Effectiveness (2005): English: *http://www.oecd.org/dataoecd/11/41/34428351.pdf*
French: *http://www.oecd.org/dataoecd/53/38/34579826.pdf*

It is no longer a question of whether it is right or not. It is a question of whether we are willing to save the African mother. Family planning must, must be one of the first moves for every African government to improve maternal health. Let us hope that in the next five years we can all move contraceptive prevalence from very, very low single digits that we are seeing in our countries to double digits to the fifties and beyond."

This message was taken forward by many participants as a rallying cry at the closing session of the larger family planning conference on 18 November 2009. Dr. Ward Cates, President of Research at Family Health International, ended his presentation summarizing the "pearls" of the conference [10] with Dr. Rogo's quote and brought it forward in his discussion of the way forward from the conference and ICPD+15.[11]

Presentation by Ms. Rhonda Smith: "Uganda on the Move"

The second presentation, "Uganda on the Move"[12] was made by Ms. Rhonda Smith, Associate Vice President, International Programs and Director, ENGAGE Project at the Population Reference Bureau (PRB), on behalf of Dr. Jotham Musinguzi, Regional Director, Partners in Population and Development Africa Regional Office. Dr. Musinguzi introduced the presentation by stating that he has worked with Ms. Smith and other colleagues in Uganda to make this a Ugandan presentation, but it would be given by Ms. Smith on his behalf due to the use of new technologies.

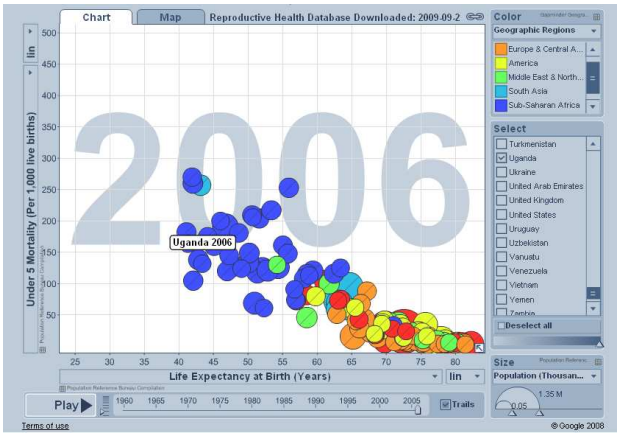


Ms. Smith began by giving an overview of Uganda's progress over the past 50 years: improved child survival, a higher national income, improved life expectancy, and higher rates of education. Using a technology called Trendalyzer, Ms. Smith first showed changes in child mortality and life expectancy.

[10] Cates, Ward, Family Health International. "What Did We Hear? What Do We Know? What Do We Do?" Presentation at International Conference on Family Planning, Kampala, Uganda November 18, 2009. Available online at: http://www.fhi.org/hld/kampala/documents/Cates.pdf and http://www.fpconference2009.org/media//DIR_169701/15f1ae857ca97193ffff8339ffffd524.pdf

[11] Cates, Ward. (2010). "ICPD+15: The Kampala Roadmap to Universal Access." 8 January 2010. Family Health International. http://www.globalhealthmagazine.com/guest_blog_top_stories/icpd15_kampala_roadmap

[12] "Uganda on the Move" by Ms. Rhonda Smith, Associate Vice President, International Programs and Director, ENGAGE Project at the Population Reference Bureau (PRB), on behalf of Dr. Jotham Musinguzi, Regional Director, Partners in Population and Development Africa Regional Office
Script in English: http://ppdafrica.org/docs/FinancingHealthMDGs/smith-e.pdf



On the left axis is the number of under 5 child deaths per 1000 live births, going from 0 to about 500, and on the bottom axis is life expectancy at birth (or the length of life in years) going from 25 up to 80. The countries are color-coded to the regions of the world. Starting with the red, we have East Asia and the Pacific. The orange is Europe and Central Asia,. The yellow is North and South America. The green is Middle East and North Africa. The light blue is South Asia. And the dark blue is sub-Saharan Africa, and these are clustered more towards the top left-hand corner with high child deaths and low life expectancy in 1960. And the countries clustered more in the bottom right hand corner have low child death rates and high life expectancy. The size of the bubble corresponds to the size of the country.

"When women can't decide how many children to have and when to have them, they're more likely to have many children, suffer from poor reproductive health, and it becomes harder for them to earn an income and meet the needs of their families."
-- Ms. Smith, Associate Vice President, International Programs and Director, ENGAGE Project at the Population Reference Bureau (PRB)

Uganda in 1960 had a child death rate of 224 and a life expectancy of about 44. That means about 22 percent of children died before the age of 5. Over time, from 1960 to 2006, child mortality reduced and life expectancy rose. In 2006, Uganda has 13 percent of children dying before reaching the age of 5 and an estimated life expectancy of about 50.

Uganda has also seen improvements in its economic growth. In 1982, Uganda had an average of $520 of purchasing power per person, which grew to about $1,500 in 2005, or almost three times the purchasing power per person today compared to two decades ago. However, although the overall national income per person has gone up, poverty levels shows that about one-third of Ugandans are living in poverty (less than $1.00 a day).

Ms. Smith argued that one way to make sure that Uganda's families are better off and that fewer people are living in poverty is to address the reproductive health needs of Uganda's women. Research on family planning has shown that it improves the health of women, boosts social and economic development, and contributes to reducing poverty. Women make up half of the labor force and more than three-quarters of employed women are currently working in agriculture.

Ms. Smith stated, "When women can't decide how many children to have and when to have them, they're more likely to have many children, suffer from poor reproductive health, and it

becomes harder for them to earn an income and meet the needs of their families. Recent surveys show that couples want to have smaller families today than their parents and grandparents. Our parents desired 6-7 children , but young couples today say that they only want 3-4 children. And women across the country report on average that they want two fewer children then they actually have."

"Uganda has one of the fastest growing populations in the world. Every year Uganda adds one million more people to the population."
-- Ms. Smith, Associate Vice President, International Programs and Director, ENGAGE Project at the Population Reference Bureau (PRB)

Ms. Smith then compared fertility trends in Uganda and Zimbabwe. In 1973, both countries had about seven births per woman. In the early 1970s, Zimbabwe's government strongly supported the country's family planning efforts. By 1980, Zimbabwe's family size began to decrease dramatically, owing to a strong community distribution program, making sure that women in rural areas could access contraceptives, and they had a population policy that supported family planning. Because of political commitment and investment, Zimbabwe has been able to bring family size down to about 3 births per woman. However, compared to Zimbabwe, Uganda's FP program has not made much progress in reducing family size over the decades with an average of between 6- 7 births per woman today.

"Because the number of births per woman in Uganda has remained so high, Uganda has one of the fastest growing populations in the world. Every year Uganda adds one million more people to the population."

After giving an overview of increased development in and around Kampala and land fragmentation and degradation in all areas of the country, Ms. Smith asked, "So are there any good things that can come out of this fast population growth? Like, will a fast population growth increase per capita GDP?" She argued that this is the case, "Only if you have a healthy workforce, enough jobs, educated workers, and modernized infrastructures in several sectors."

"The growing population means more people in need of social services. And that means more schools and expanded healthcare—and these are services that the government is going to have to provide. With so many people still living in poverty, access to food will also become even more of a challenge. All of this will put pressure on the government's budget and may crowd out other spending and investments, which could mean slower economic growth for the country. By managing the size of the population, Uganda can address these issues and contribute to economic development at the same time. And one place to start is by meeting the reproductive health needs of Uganda's women so they can better plan and space their children."

"According to the most recent national survey, only 18 percent of Ugandan women are using modern methods of family planning. However, almost twice that number—or about 2 in every 5 women —would like to space their next birth or stop having children altogether, but are not using any method of family planning. These women are considered to have an unmet need for family planning.

"If we could reduce maternal death and disabilities by 50 percent by 2013, that would result in an economic gain of 500 billion Ugandan shillings ($250 million USD)."
-- Ms. Smith, Associate Vice President, International Programs and Director, ENGAGE Project at the Population Reference Bureau (PRB)

One of the consequences of high unmet need is large numbers of unplanned pregnancies. And in Uganda, almost half of all pregnancies are unplanned, one of the highest percentages of unplanned pregnancies in sub-Saharan Africa. That means more than 850,000 women become pregnant every year without intending to have a child at that time.

Two consequences of unplanned pregnancies are:

- higher levels of fertility, which in turn leads to continued population growth, which as we mentioned earlier at the national level can strain the country's economic development.
- high-risk pregnancies (having babies too young, or too old, having too many, or too closely spaced), which can result in maternal injuries and deaths. At the household level, the loss of women means families continue to struggle, and the cycle of poverty continues. And at the national level, this loss of women means a loss of economic productivity for the country.

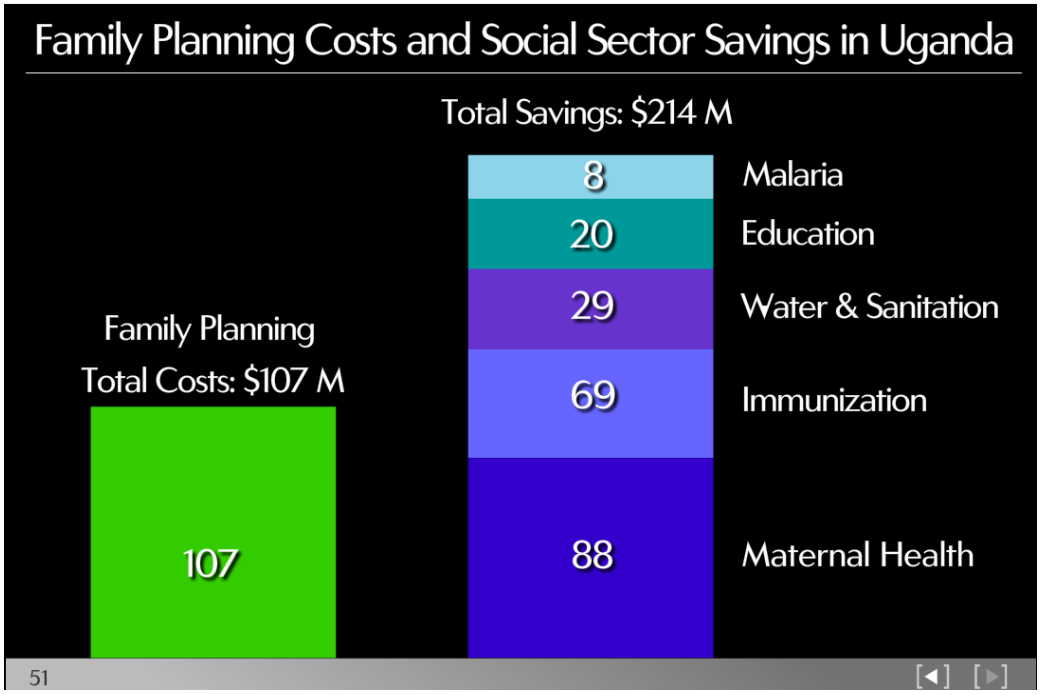
In Uganda, there are a total of about 1.4 million births every year and about 6,000 deaths related to pregnancy or childbearing. And for every 1 woman who dies from maternal causes, 20-30 women suffer short- and long- term disabilities. Economists found that there is a large impact of maternal death and disability on the national economy—between 2004 and 2013, if the situation remains the same, Uganda could lose the equivalent of 700 billion Uganda shillings (or $350 million USD) in lost productivity due to maternal deaths. During the same period, maternal disability could cost Uganda another 1.5 trillion Uganda shillings (or $750 million USD). However, if we could reduce maternal death and disabilities by 50 percent by 2013, that would result in an economic gain of 500 billion Ugandan shillings ($250 million USD). And it would also help us to achieve MDG 5, improving maternal health.

Ms. Smith then proposed family planning as a "best buy" in today's financially strapped environment. From 2007 to 2015, the additional family planning costs for meeting the unmet need would be about 107 million dollars, and that translates into total savings on costs related to maternal health, immunization, water and sanitation, education, and malaria of above $200 million dollars.

Ms. Smith said that as women have fewer and fewer children, gross national income per person increases. Uganda currently has between 6 and 7 children per woman and a gross national income of about $1400 per person. She also gave the example of Thailand, and argued that its economic success is in part "because women started having fewer children, and that set the stage for the country to better manage its population size." This kind of economic progress is not automatic; rather, it requires a series of investments:

- expanding family planning programs so women and couples can plan and space their children;

- Investing in health systems is also important to improve child survival and health in general;
- Improving educational enrolment is key—especially girls' enrolment; and
- Finally, it's crucial to stabilize economic conditions so more jobs can be created, making sure there are economic opportunities for young men and women.



Ms. Smith concluded by giving a set of recommendations: "In order for Uganda to make this kind of economic progress, it means stepping up the pace of its policy and program implementation." This means making every effort to:

- Ensure that family planning is a key component of all national development strategies including the poverty reduction strategy and action plan;
- Increasing budget allocations for contraceptives in national and district health budgets; and
- Regularly issuing public statements supportive of family planning to mobilize both political and popular support.

Ms. Smith then summarized her presentation, by stating that family planning can help Uganda have healthier women, break the cycle of poverty among Uganda's many families, and ensure women's full contribution to the nation's economy.

Presentation by Dr. Claude Sekabaraga: "Financing of Reproductive Health in Rwanda: Contributions of Resource Tracking"

The third presentation was on "Financing of Reproductive Health in Rwanda: Contributions of Resource Tracking." It was made by Dr. Claude Sekabaraga, MD, MPH, Former, Director of Policy Planning and Capacity Building Ministry of Health, Rwanda.[13]

Dr. Sekabaraga began by giving the reproductive health (RH) content of Rwanda. He showed an image of the high population impact by the third generation with a fertility rate of six children. Rwanda's performance on MDG 5 (reduction of maternal mortality) has improved and declined between 1990 and 2005. At 1990, the maternal mortality rate was 611 per 100,000 live births; in 2000 it peaked at 1071, by 2005 it reduced to 750; Rwanda's goal for 2015 is 153. Rwanda's performance on MDG4 (reduction of child mortality) has been much better. There has been a 35% reduction in under-5 mortality between 2005 and 2008, and performance is closer to being on track to the target for 2015.

Rwanda has had good success with family planning, and its modern contraceptive prevalence rate (CPR) has increased dramatically. In 1990, modern CPR was at 13%, in 2000 decreased to 4%, in 2005 the rate was 10%, but by 2008 the rate stands at 27%-- a 63% increase in two years.

"Modern CPR in Rwanda increased from 10% in 2005 to 27% in 2008, a 63% increase in two years."
-- Dr. Claude Sekabaraga, MD, MPH, Former, Director of Policy Planning and Capacity Building Ministry of Health, Rwanda

In Rwanda, reproductive health financing has changed in recent years. Reproductive health subaccount research studies were conducted in 2002 and 2006, before and following the introduction of major global health initiatives. These surveys provide a comprehensive picture of expenditures on health.

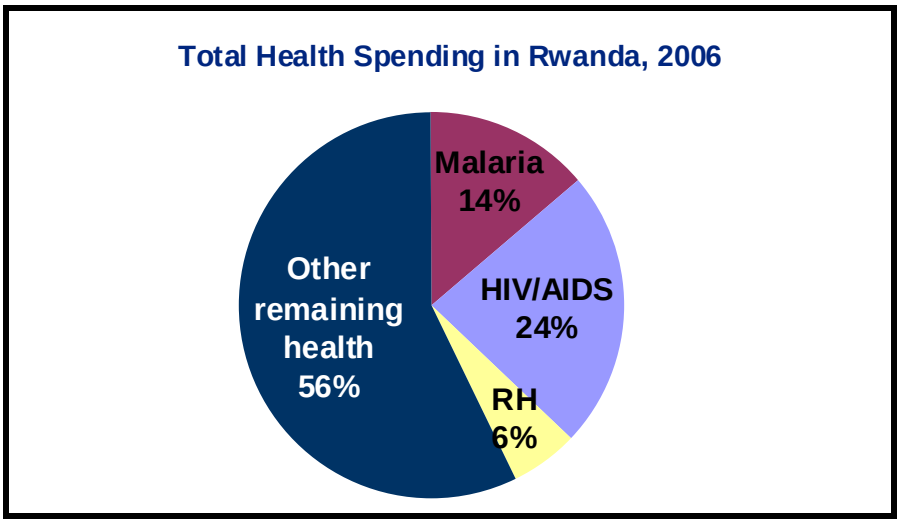
Between 2003 and 2006, per-capita spending rose from $20 to $34. Between 2002 and 2006, spending on reproductive health declined from 15.7% in 2002 to 6% in 2006 and spending on HIV/AIDS share has increased from 15% in 2002 (pre- Global Fund, PEPFAR period) to 24% in 2006. The share of donor funding spent on reproductive health has declined from 37% in 2002 to 8% in 2006. In

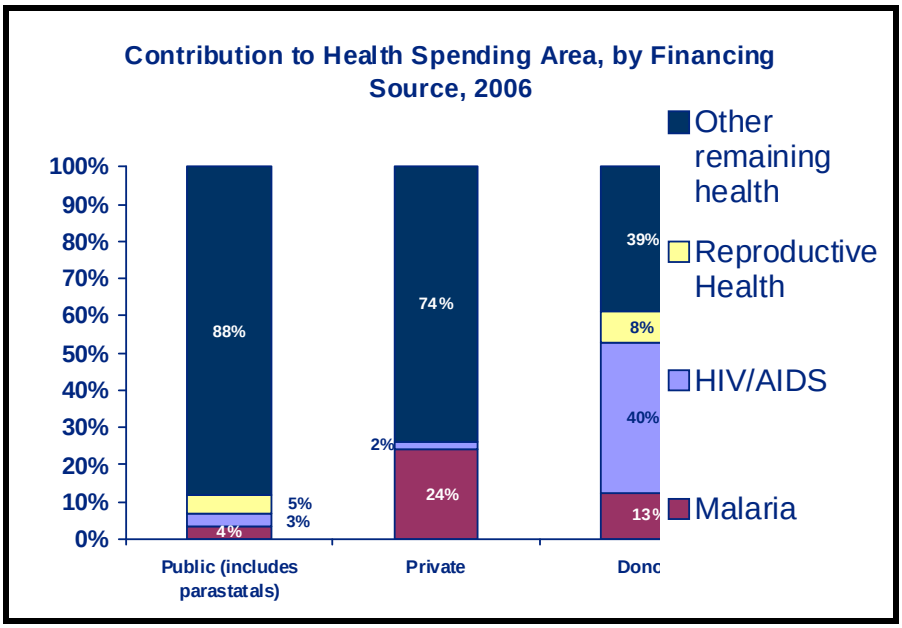
[13] "Financing of Reproductive Health in Rwanda: Contributions of Resource Tracking" by Claude Sekabaraga, MD, MPH, Former, Director of Policy Planning and Capacity Building Ministry of Health, Rwanda
English: http://ppdafrica.org/docs/FinancingHealthMDGs/sek-e.pdf
French: http://ppdafrica.org/docs/FinancingHealthMDGs/sek-f.pdf

2006, 5% of public spending is on reproductive health, compared to 1.2% in 2002. This has resulted in total reproductive health spending remaining relatively constant since 2002. In 2002, total spending for reproductive health was $16, 981,504 (in 2006 constant US$), and raised slightly to $19,334,787 in 2006 (in 2006 constant US$).

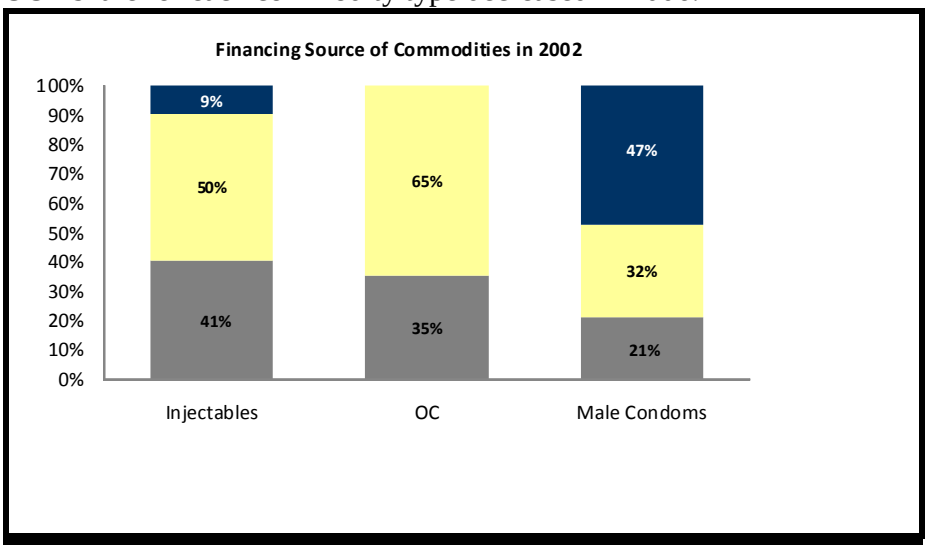
Public management of reproductive health funds declined from 51.7% in 2002 to 26% in 2006, while donor management increased from 0.2% to 19.1% and private sources (including NGOs) increased from 38% to 45.5%.

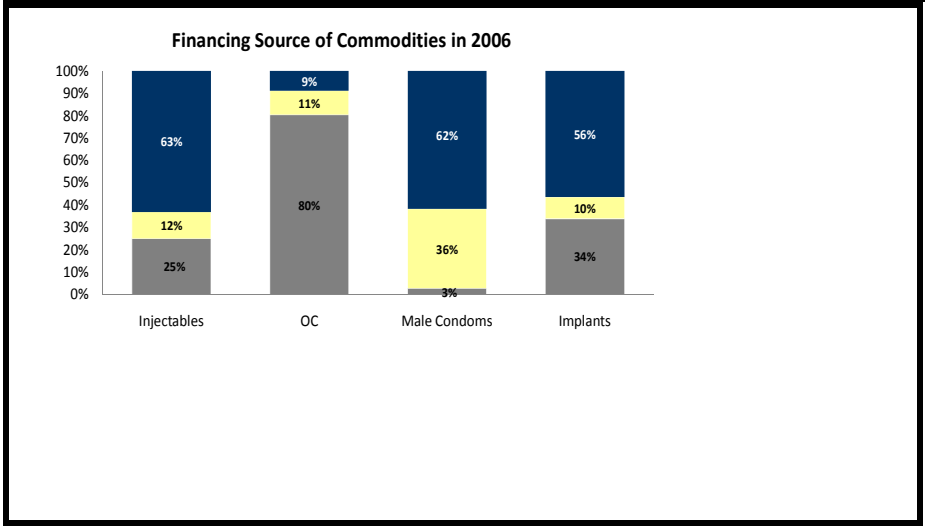
In 2006, the majority of reproductive health expenditures were for maternal health (73%), followed by family planning at 22% (and other reproductive health at 5%). Maternal health expenditures were highest for delivery care.

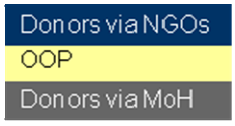




Rwanda has also used the data to compare the financing sources for commodities in 2002 and 2006. Donated products managed by NGOS accounted for the largest share of expenditures for each contraceptive commodity type (except for oral contraceptives) in 2006. Compared to 2002, OOP share for each commodity type decreased in 2006.







The government of Rwanda has used the 2006 RHS data for decision-making, such as in the planning process. Beginning in 2008, family planning and reproductive health were treated as a specific budget program. The 2009-2012 health sector strategic plan identified family planning and reproductive health as a strategic program in recognition of its priority in the national government and donor budgets.

"The RHS contributed to the [Rwandan] government's decision to provide $5,000,000 for RH (a 10% increase) for contraceptive procurement in 2009."
-- Dr. Claude Sekabaraga, MD, MPH, Former, Director of Policy Planning and Capacity Building Ministry of Health, Rwanda

The 2006 RHS data has also been used to inform resource allocation. The RHS contributed to the government's decision to provide $5,000,000 for RH (a 10% increase) for contraceptive procurement in 2009. The government used the data to advocate with donors to mobilize one million USD for contraceptives in health sector budget support in 2008. And the government of Rwanda used the data to secure Global Fund support for RH of US$2.4 million in contraceptive assistance provided over three years.

Dr. Sekabaraga concluded by arguing that reproductive health is key to achieving the MDGs and that the quality and availability of RH services benefits from strong health systems and financing mechanisms (e.g. performance-based financing, community health insurance). Yet, specific interventions need earmarked resources (e.g., contraceptives, maternal and newborn medical equipment). Beginning in 2008, a dedicated budget program and specific resource allocation in Rwanda reflected strong increases national government support for RH. Yet, the need for reproductive health remains high and whether the needs are met surely will impact success in accelerating achievement of the MDGs.

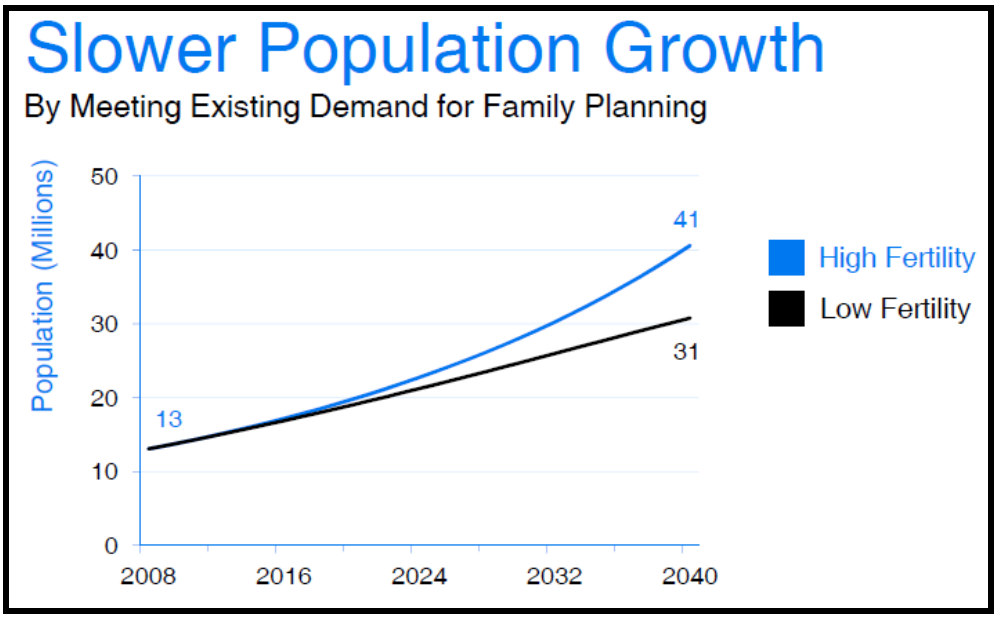
Presentation by Dr. Chisale Mhango: "Malawi: Population & Development: Progress through Family Planning"

The fourth presentation was made by Dr. Chisale Mhango, Director, Reproductive Health Services, Ministry of Health, Malawi[14] and was titled "Malawi: Population & Development: Progress through Family Planning." Dr. Mhango began by stating Malawi's National 2020 Vision: "Malawi will be secure, democratically mature, environmentally sustainable, self-reliant with equal opportunities for and active participation by all, having social services, vibrant cultural and religious values and a technologically driven middle-income economy." To reach this vision, Malawi's growth and development strategy focuses on poverty reduction through sustainable economic growth.

[14] "Presentation of RAPID model for Malawi" by Dr. Chisale Mhango, Director, Reproductive Health Unit, Ministry of Health, Malawi. Online in English: http://ppdafrica.org/docs/FinancingHealthMDGs/mhango-e.pdf and French: http://ppdafrica.org/docs/FinancingHealthMDGs/mhango-f.pdf

"How can we pack 41 million people in a small country like Malawi?"
-- Dr. Chisale Mhango, Director, Reproductive Health Services, Ministry of Health, Malawi

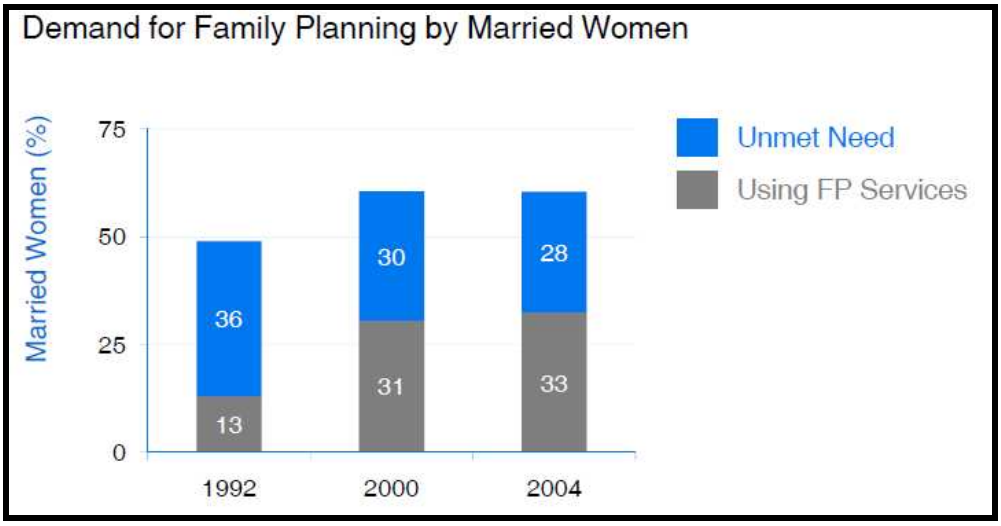
Yet, according to Dr. Mhango, population will affect Malawi's economic growth and social development in the coming decades. There are 13 million people (2008) in the country, with 52% population under 18. Current fertility is six births per woman and 35% teens 15-19 bear children. HIV prevalence in the country is 12%. At the current fertility rate, the population will triple by 2040. In 2040, there will be 40.6 million people, from 13.1 million in 2008. Dr. Mhango asked "How can we pack 41 million people in a small country like Malawi?" Yet, if the total fertility rate (TFR) in Malawi was reduced from 6 to 3, there would be 10 million less people in 2040 (41 vs 31 million people).



Contraceptive use in Malawi is low. Many women want to delay or limit births, but are not using contraceptives. As such, 2 in 5 births are unintended or arrive too soon. The unmet need for FP in Malawi is 28%, one of the highest unmet needs in Africa. Between 2004-2006, Malawi raised modern CPR from 28 to 38%. But in 2004, the CPR was 28% for modern methods and an additional 13% was traditional methods. So the raise for CPR between 2004 and 2006, was really just a conversion of women who were ready to use the services, but previously did not have access to modern methods.

The effects of meeting the existing demand for family planning has a strong impact across development sectors: education, health, agriculture, and economy and the labor force. For education, fewer students due to low fertility means that more resources are available per child. With high fertility by 2040, there will be 8.7 million primary students, and with low fertility, there will be 5.5 million primary students. These students require classrooms—with high fertility, Malawi will need 13,950 primary schools by 2040, and 8,824 with low fertility. Less population pressure will lead to better education. More resources will be available for training and incentives to keep teachers in rural areas, more resources for classrooms and educational

material, and smaller classrooms and better learning environments. Less population pressure will also help with the achievement for MDG 2 (Universal primary education).



"If fertility is not reduced, Malawi will have to create 4 million new jobs for young people by 2040" -- Dr. Chisale Mhango, Director, Reproductive Health Services, Ministry of Health, Malawi

For health, there are critical shortages of human resources and inadequate infrastructure for universal access to health care. The cumulative savings in health expenditures in Malawi between 2008 and 2040 if fertility declines would be $1.8 billion, as compared to constant fertility.

For agriculture, with a higher population, there is less land per holder (land fragmentation) as land holdings are divided among more family members. This means that there is lower productivity from small farms and less food security and less food per person.

Higher population leads to overuse, overexploitation, soil erosion, deforestation, less soil fertility, and environmental degradation. Currently (2008), there are 533 people per square kilometre of land, With high fertility, there will be 1,657 people per square kilometre of land by 2040, and with low fertility, there will be 1,256 people per square kilometre of land. With lower fertility, there will be less pressure on environmental resources, which will help Malawi to modernize, fertilize for higher yields, improve family nutrition, reduce environmental degradation, thus making progress on MDG 1 (Eradicate extreme poverty and hunger) and MDG 7 (Ensure environmental sustainability).

Regarding employment, more youth requires more jobs. With high fertility, 4 million more youth would need jobs by 2040. With less population pressure, Malawi would have a better economy, with more funding for social sector (education and health), greater disposable family income, lower youth unemployment and greater stability, thus making progress on MDG 1 (Eradicate extreme poverty and hunger).

"The cumulative savings in health expenditures with declining fertility in Malawi between 2008 and 2040 would be $1.8 billion"
-- Dr. Chisale Mhango, Director, Reproductive Health Services, Ministry of Health, Malawi

Dr. Mhango argued that policymakers must act now, as the cost of inaction increases with time. The key **issues** are:

- High population growth
- Unbalanced age distribution (half below age 18)
- 41% of births are unintended or ill-timed
- 28% of married women want to avoid or delay pregnancy but don't use contraception

The **opportunities** are:

- Contraceptive use is established in the culture
- 33% of married women already use contraceptives
- Potential for increased use is large

There is also **readiness** in Malawi:

- Political will is present
- Service networks are established and developing
- Development partners very sympathetic to Malawi's population development agenda.

"Family planning facilitates the achievement of all of the MDG targets"
-- Dr. Chisale Mhango, Director, Reproductive Health Services, Ministry of Health, Malawi

Dr. Mhango concluded by stressing the arguments for how family planning facilitates the achievement of the MDG targets:

1. Eradicate extreme poverty and hunger (MDG1):
Targets: (a) Halve, the proportion of people whose income is less than $1 a day, and (b) who suffer from hunger between 1990 and 2015

- FP improves maternal health, thereby increasing women's productivity, and reduces dependency level at both family & national levels

2. Achieve universal primary education (MDG2):
Target: Ensure that, by 2015, children, boys and girls alike, will be able to complete primary schooling

- FP reduces the number of children that have to be provided with education & makes the target manageable

3. Promote gender equality and empower women (MDG3):
Target: Eliminate gender disparity in primary and secondary education preferably by 2005 and in all levels of education no later than 2015

- When a family has too many children parents tend to educate sons only – promoting gender inequality

4. Reduce child mortality (MDG4)

Targets: (a) Reduce by two thirds, the under-five mortality rate 1990 by2015, (b) 100 % measles immunization of 1 year old children

- The fewer the number of children the better the care, the more the food, the lower child mortality. There will be savings on vaccines

5. Improve maternal health (MDG5)
Targets: (a) Reduce by three quarters the maternal mortality ratio 1990 by 2015

- Family planning reduces exposure to risk of pregnancy related death
- The fewer the births, the more likely we can cope with provision of skilled attendance at births

6. Combat HIV/AIDS, malaria, and other diseases (MDG6)
Targets: (a) By 2015 halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases

- Condom use in family planning protects against HIV infection
- The fewer the children the more likely the target to provide U5C with ITNs can be achieved

7. Ensure environmental sustainability (MDG7)
Targets (a) Reduce by half the proportion of people without sustainable access to safe drinking water and sanitation

- Family planning reduces the number of people that have to be provided with safe water and good sanitation

8. Develop Global Development Partnership (MDG8) [Goal calls for increasing access to essential drugs on a sustainable basis]

- The savings realised from family planning will assist to increase availability of essential drugs on a sustainable basis.

After Dr. Mhango concluded his presentation there was a short break before the next session started with statements by Uganda's Minister of Finance, the World Bank and the African Union.

3. Session Two

Statement by Hon. Rukia Chekamondo

The session opened with a statement by Hon. Rukia Chekamondo, Minister of State, Privatization, Uganda Ministry of Finance, Planning and Economic Development on behalf of Hon. Syda Bumba, Uganda's Minister of Finance, Planning and Economic Development.[15] Hon. Chekamondo welcomed the participants to Uganda, and stressed the importance of the MDGs as a development framework. "The unique value in the Millennium Development Goals lies in the fact that they are time-bound, measurable and internationally

[15] Statement by Hon. Rukia Chekamondo, Minister of State, Privatization, Uganda Ministry of Finance, Planning and Economic Development, on behalf of Hon. Syda Bumba, Uganda's Minister of Finance, Planning and Economic Development. English: http://ppdafrica.org/docs/FinancingHealthMDGs/chekamondo-e.pdf

In Uganda "we need to do a lot more on MDG 5 if we are to achieve our target by 2015. Some of the bottlenecks have been identified and I am aware that for example in Uganda, both the weak health system and inadequate human resources for health are contributing factors"
-- Hon. Rukia Chekamondo, Minister of State, Privatization, Uganda Ministry of Finance, Planning and Economic Development

agreed. As tools, they show that we know where to go, and that we have the means to get there - if the political will exists and if we can allocate the necessary resources and address all barriers to achieve them."

Hon. Chekamondo continued by stating that progress of MDG 5—maternal health—has been particularly slow: "I am fully aware that for example in the case of Uganda, we need to do a lot more on MDG 5 if we are to achieve our target by 2015. Some of the bottlenecks have been identified and I am aware that for example in Uganda, both the weak health system and inadequate human resources for health are contributing factors." Hon. Chekamondo concluded by stating that development must be country- and region-specific, and must involve partnership with all stakeholders.

Statement by Dr. Sadia Chowdhury

The second statement of the session was made by Dr. Sadia Chowdhury, Coordinator, Reproductive and Child Health Programs, Population and Reproductive Health Capacity Building Program at the World Bank. Dr. Chowdhury began by stating that it was a great pleasure for the World Bank to be involved in the re-focusing of reproductive health and family planning in development. She said that the World Bank, in 2007, together with partners, began work to refocus on health systems strengthening and multi-sector approaches, particularly for reproductive health outcomes, specifically in Africa and South Asia. Dr. Chowdhury said that the World Bank's mandate in this area is critical. The World Bank is currently preparing a specific action plan on reproductive health for 2010-2015 and requested that participants at the meeting give input before the action plan is taken to the World Bank Board in the first quarter of 2010.

Dr. Chowdhury said that the World Bank wants to help countries address high fertility, manage pregnancies and reduce sexually transmitted infections. "But being the [World] Bank, we want to leverage our advantage to get partners into reproductive health issues, including financing for reproductive health. We want to work with our country partners to strengthen country health systems to improve reproductive health outcomes. We want to use our work in the countries to promote high-level policy dialogue on reproductive health at the global and national level."

"We want to leverage our advantage to get partners into reproductive health issues, including financing for reproductive health. We want to work with our country partners to strengthen country health systems to improve reproductive health outcomes."
-- Dr. Sadia Chowdhury, Coordinator, Reproductive and Child Health Programs, Population and Reproductive Health Capacity Building Program at the World Bank

Dr. Chowdhury concluded by stating that the World Bank wants to consult with partners to better understand what they can do better than what they have done before. She said that no one

country can work alone by itself, and thus, “we have to work with our partners in development, we have to work with our country partners.”

Statement by H.E. Adv. Bience Gawanas

The next official statement was made by H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union. H.E. Adv. Gawanas began by noting that this conference is taking place a few weeks after the 15-year review of the International Conference on Population and Development (ICPD+15), which took place in Addis Ababa, Ethiopia, from 19 to 23 October 2009. The Steering Committee for this review was co-chaired by H.E. Adv. Gawanas and Mrs. Lalia Ben Barka of the Economic Commission of Africa (ECA), with the support of UNFPA. The Conference reviewed progress made in the implementation of the Programmes of Action of the ICPD over the last decade and a half and adopted an outcome document in which African countries, development partners and the civil society re-affirmed their commitments made 15 years ago. H.E. Adv. Gawanas noted that the key issues of the ICPD were also articulated in the Maputo Plan of Action of the African Union, adopted in 2007.

H.E. Adv. Gawanas said that “Over the last five years, and guided by the Africa Health Strategy and in particular by the Maputo Plan of Action mentioned above, the AU Commission has been mobilizing political will among Member States, international and regional partners as well as communities. Repositioning Family Planning into reproductive and primary health programmes was one of the main outcome areas of the Maputo Plan of Action. The rationale for this was the realization that is it hardly possible to reduce maternal and child mortality without increasing access to affordable, acceptable and accessible family planning services. It was also a realization that providing family planning services could not be achieved without strengthening primary health care services and the entire health care system, as exemplified in the Africa Health Strategy of the African Union.”

H.E. Adv. Gawanas stated that although there has been remarkable progress made by many of African countries in addressing issues related to reproductive, maternal and child health and family planning, “the challenges still remain.” She said that unmet need, leading to unplanned pregnancies and high maternal mortality, has significant impact beyond the dismal statistics. “The fact that about ten or so women die by the time I finish this statement, means that hundreds and thousands of families and communities are made to suffer the loss of loved ones, who in many cases are the producers and primary caregivers at the family level. In economic terms, the tragic death of a mother costs much more than the cost of her treatment and, in fact, much more than the cost of the family planning services, had society been able to pay for it.”

We need to support "country-led plans, country-led actions, rather than supporting countries on the basis on the basis of what others think they need. Many plans, interventions have been unsuccessful . . . because countries, the communities, and the women themselves do not own development. Let us support countries, let us support them based on the needs and priorities that they define."
-- H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union

H.E. Adv. Gawanas then spoke about the African Union's Campaign to Reduce Maternal Mortality in Africa (CARMMA), which has a slogan of "Africa Cares: No Woman Should Die While Giving Life." H.E. Adv. Gawanas said that when she was approached, some months ago, by PPD Africa and the Gates Foundation to co-sponsor the high-level meeting on family planning, she did not hesitate to lend the African Union's support "because I was firmly convinced that this was an important opportunity for the African Union to demonstrate leadership and mobilize support for concrete action in this area."

H.E. Adv. Gawanas said that the leadership of the African Union has put the promotion of maternal and child health at the top on its agenda, as this subject has been part of the AU's agenda during a series of Summits since January 2008. Maternal and child health also has been decided to be the major theme of the July 2010 AU Summit to be held in Kampala, Uganda. As part of the preparation for the Summit, the AU Commission is in the process of reviewing the implementation status of the Maputo Plan of Action, particularly the targets and indicators on maternal and child mortality, access to reproductive health services, unmet family planning needs, incidence of unsafe abortion, and integration of HIV/AIDS services into reproductive health programmes, among others. H.E. Adv. Gawanas then requested that participants provide input into the various events of the African Union on the review of the Maputo Plan of Action and help generate useful recommendations on the way forward after the Summit.

H.E. Adv. Gawanas concluded by stating that we need to support "country-led plans, country-led actions, rather than supporting countries on the basis on the basis of what others think they need. Many plans, interventions have been unsuccessful because of ownership. [They have been] unsuccessful, because countries, the communities, and the women themselves do not own development. Let us support countries, let us support them based on the needs and priorities that they define."

Discussion

The chair then invited countries to make contributions related to the presentations and the issues they covered. Dr. Keseteberhan Admassu, Director General, Federal Ministry of Health, Ethiopia, said that Ethiopia has made significant progress on

MDGs 4, 5, and 6. He said that one significant step was Ethiopia's Health Extension Program (HEP). It is a community-based health programme with 32,000 health extension workers (HEWs). All of the health extension workers are women, who have been trained for one year, and they work at the household level. The health extension workers have responsibilities in family health, communicable diseases, hygiene and sanitation, and they also provide health education. The government of Ethiopia has shown their commitment to the program through providing a salary for all of the health extension workers. The programme started in 2005, and has already been able to achieve higher coverage for primary health care in the country. In addition, the government has focused on bringing donors and development partners into partnership with the government in the program, "There is harmonization so donors and partners can contribute."

Ethiopia has also been working on health commodity security to prevent stockouts. He said that the government aims to address unmet need for family planning; "despite progress, unmet need is still too high." They have also been working to have family planning methods, including injectables distributed by the health extension workers in order to reach more people. Community access with the health extension workers is very high. Ethiopia is now in the second wave of implementation for the program. He said that in a few months, more publications on this program will be released, as "we see great potential in this program."

Ethiopia has also made significant progress in the expansion of health centers. The government committed to universal access to health centers for all people. That meant that Ethiopia needs to have 3,200 health centers and in 2005, they had only 500. "Now, we are almost there; we currently have 2,374 health centers." These centers were constructed using Global Fund for HIV, TB, and Malaria money. "We fought, so that people could benefit from the funds." He also said that Ethiopia has been making progress in a number of areas related to reproductive health and family planning, including training midwives, improving Health Information Systems in the country, so that data from the health center goes to the district and to the central Information Management System in the Ministry of Health.

Dr. Elias Sory, Director-General, Ghana Health Services stressed that African governments "cannot continue to depend on donors. How can we get our African leaders to recognize that this is the way to go?" He also said that regarding contraceptive security, there is a gap of about $30 million. He said that, like as encouraged in an earlier presentation, we have to work on developing public-private partnerships, and also do use social marketing, as well as develop access at the community level through community groups.

Dr. Bellington Vwalika, Head, Obstetrics and

"Our countries must put more resources to assure political engagement and sustainability of reproductive health. We must recognize the support of finances remains important. I must remind us that with our weak resources, we are confronting high populations [that demand that we] treat, educate, put in place infrastructure and jobs for youth to assure the security of our population."
-- Dr. Daff, Senegal

Gynecology, University of Zambia, said that the prevalence of long-term methods has been improving in the country and that this was a best practice that other countries can learn from.

Dr. Abosede Remilekun Adeniran, Deputy Director RH/FP, Department of Family Health, Nigeria, said that they have been focusing on commodities. In particular, Nigeria has started a program for community-based injectables.

Dr. Daff, Senegal, said that based on what has been said, and with the different strategic plans of African countries, we can see that the challenges remain practically the same. We have the responsibility in our governments. She said that the four presentations have put the finger on the problem. In particular, the financing of health and financing for family planning, remains a strategy to achieve the MDGs, as the last presenter has shown. "Our countries must put more resources to assure political engagement and sustainability of reproductive health. We must recognize the support of finances remains important. I must remind us that with our weak resources, we are confronting high populations [that demand that we] treat, educate, put in place infrastructure and jobs for youth to assure the security of our population." She said that it is good that partners intervene and support Senegal in programmes for advocacy. She thanked USAID and other partners like the Gates Foundation. She said that there is a need for research to allow other partners to intervene, and to have reinforcing institutions. The UN tries to close the gap where others have not covered. Yet, as recognized by the first presenter, our francophone countries remain poorly assisted. "My concern is not to transfer resources from Anglophone [countries], but we need resources everywhere. We need many resources to attain the objectives we have fixed ourselves." She said that countries can learn from each other and transfer strategies, such community based injectables provision. She said that Senegal's president committed to reach the MDGs, and that he proposed that we take care of the women whose needs are not met. About 800,000 to one million women in Senegal has unmet need for contraceptives. She said that for sustainability, we need to work on adolescents. We have 45% youth below 15 years of age. She said that opportunities to provide contraception should be taken advantage of "On the occasion that there is an abortion, we should propose a contraception [method]." She re-iterated that the issues in countries are the same, across both Anglophone and Francophone countries.

Hon. Fanta Mathini, a parliamentarian from Mali spoke next. The delegate stated that the Abuja commitment was signed by African Heads of State. Thus, “we need to allocate a budget to ensure that budgets are allocated to health at 15%.” There needs to be a budget line for contraceptives. The representative said that in Mali, UNFPA is buying contraceptive products, yet family planning should be like HIV/AIDS and malaria, and be elevated in order to reduce child and maternal mortality, as the challenges and strategies are known.

Hon. Jessica Eriyo, Member of Parliament and Minister of State for Environment, Uganda said that she represents a district in Uganda that has been disturbed by wars and conflict. She said that women and children are more vulnerable in these conflicts. Also, in Uganda, land is becoming more scarce. She asked participants to “imagine a woman who has just delivered, and she has no one to assist her and she has to walk many miles to get firewood, and she has to get water . . . imagine the infant of this woman.” She said that there are so many of these issues, when women fetch water from unclean sources, there are serious health implications, yet an easy solution is available, and “women should be assisted to collect clean water from her rooftop.” She also noted the issue of sanitation in schools—and the need for separate bathrooms in schools, because girls drop out because of this issue. She also noted that in Uganda, the issue of fuel is critical, because people use wood for cooking, as they do not have access to modern energy and light. She said that she and others in Parliament and in Government are addressing these issues to reduce the burden on women. She noted a number of Parliamentary Committees in Uganda and regionally, which address gender, health, and environmental issues and asked participants to address these critical issues in their countries by working together.

Hon. Jerolinmek Piah, Assistant Minister for Planning and Administration, Ministry of Gender and Development, Liberia, spoke next. He said that the seminar is important to Liberia, due to its histocial situation of experiencing war for many years. He said that as a country, they are moving forward, and are committed to the MDGs and development, but they are facing many challenges realted to health and development in the country. The population of the country has grown, but without accompanying expansion of social services, due to the war. The most recent Demographic and Health Survey pointed to the many problems in the country, and Liberia is looking to build on other countries experiences of programmes for maternal and child health in order to reach the MDGs.

Before the short break, Dr. Jotham Musinguzi, Regional Director, Partners in Population and Development Africa Regional Office (PPD ARO), re-capped a number of key points made in the presentations and discussions, and asked “Is it possible that family planning can be embraced to

be a major solution to maternal health?" He stressed the critical link made by Dr. Rogo, when he stated that "Family planning is to maternal health is what immunization is to child health. If anyone feels and thinks that you can improve MDG5 without family planning, it is like saying MDG4 can improve without vaccination. That is how simple it is."

4. Session Three

Panel on "Donor Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?"

Moderator: Dr. Musimbi Kanyoro, Director, Population Program, Packard Foundation
Panelists: Dr. Sadia Chowdhury, World Bank; Mr. Bunmi Makinwa, UNFPA; Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation; Mr. Scott Radloff, USAID; Mr. Tony Daly, DfID

The panel was opened by Dr. Musimbi Kanyoro, Director, Population Program, Packard Foundation, who gave a short introduction to the Packard Foundation, whose experience is strongest in Ethiopia and Nigeria in Africa. She briefly introduced the panelists, before posing the first question to Mr. Bunmi Makinwa, UNFPA and Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation: "Family Planning has been on the agenda of governments for some time. Do you feel there is a renewed attention and commitment to family planning at this time and to what extent do you think MDG-5 serves as a galvanizing framework? As a donor what do you see as the opportunity for this moment and what stands in your way to fully utilize this moment?"

Mr. Bunmi Makinwa, UNFPA, began by stating that family planning "is about humans, it is about life." He said that the present opportunities can help to bring on board more people in a way that will ensure greater well-being of people. He said that there is increased talk about gender and community. This creates greater opportunities to work together at the country level and regional level. He said that this increased collaboration is a new direction that the United Nations is going: "One UN." He said that the UN is working to "come together to support governments, to support countries to bring together our comparative advantages."

Dr. Musimbi Kanyoro asked Mr. Makinwa to discuss the areas of comparative advantage. Mr. Bunmi Makinwa, said that for UNFPA, the comparative advantage is in the years of experience in commodity security, and that gender is also an area of understanding for UNFPA.

Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation, said that he felt there is a renewed commitment. He told a story of how he was contacted by the Gates Foundation to develop a five-year strategy. He advised them that they should frame the strategy in context of the MDGs. But the response he received five years ago was that the MDGs is a foreign concept in the U.S. Now, the Gates Foundation President has said that everything that the Gates Foundation does in global health must be measured in terms of how we contribute to the health-related MDGs. Mr. Rimon said that this is a quite a shift in 5-years. He said that the MDGs will be difficult, if not impossible to achieve without concentrated effort—and that there is a lot of evidence for that, such as the U.K. All-Party Parliamentary Group on Population, Development and Reproductive Health's report,[16] released two years ago, which made this case very clearly.

"If southern voices do not own the issue [of family planning], we cannot sustain this. Family planning must be owned by countries themselves."
-- Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation

Mr. Rimon said that the trend, as he see it, is that "We are not there yet." He said that there are multiple communities that need to work together to address this issue—the population community is one place, but the rights community is another, and then they bicker among themselves. There is strength in unity. This pulling together has been the experience in advocacy of HIV/AIDS and malaria. Unity is important for advocacy. A second trend Mr. Rimon noted was the downward trend for reproductive health since ICPD. He said that this trend may have been reversed recently, but the remaining question is 'Will that be sustained?' There have been record increases in funding for reproductive health from the U.S. He said that based on the statistics from the past year, the funding has increased remarkably to the extent that he did not believe the statistics at first. The third issue Mr. Rimon addressed was "if there is more money and resources, are they better spent?" He said that "more money better spent may help solve our problems." He said that another barrier to family planning worldwide was "If southern voices do not own the issue [of family planning], we cannot sustain this. Family planning must be owned by countries themselves."

Dr. Musimbi Kanyoro, addressed the second question to Mr. John May, World Bank; Mr. Scott Radloff, USAID; and Mr. Tony Daly, DfID: "What are your observations concerning financing MDG-5b (universal access to contraceptives)? How much money do we need? Are country

[16] Report of Hearings by the All-Party Parliamentary Group on Population, Development and Reproductive Health. "Return of the Population Growth Factor." January 2007. http://www.appg-popdevrh.org.uk/Publications/Population%20Hearings/APPG%20Report%20-%20Return%20of%20the%20Population%20Factor.pdf

governments making the ask specifically for MDG-5b and are donors responding? With the opportunities for more resources, how do we address 'more money, better spent?'"

Mr. Scott Radloff, USAID, began by stating that the resources needed to meet unmet need were estimated in the report "Adding it Up."[17] According to 2003 estimates, the amount being spent by donors and host countries is US $7.1 billion. Addressing unmet need would require an additional US $3.9 billion. He said that if you look at Africa, for every user, there may be two women with unmet need. The need in Africa may be more than 50%. The annual increase in modern contraceptive prevalence is 0.5% and unmet need in Africa averages 20-30%. At this rate, it will take 30 years to address unmet need. Based on this information, there are clearly not enough resources going into contraceptives. Mr. Radloff, said that there have been funding changes under U.S. President Obama. Even before President Obama took office, USAID has been shifting resources from more mature programs, and graduating programs in Latin America and Europe in order to double resources to Africa. Those shifted resources were then focused on about ten countries. Many countries have shown success, more than 0.5% increase in modern contraceptive prevalence per year—in those countries, it has been closer to 1-2% increase per year. Countries in Africa such as Ethiopia, Zambia, Malawi, Madagascar, and Rwanda have shown higher use of contraceptives. And Tanzania and Uganda have shown progress, at a rate closer to 1% increase per year. President Obama allocated an $80 million increase for FY 2009. The FY 2010 budget is in Congress, but Mr. Radloff said that it looks like an additional $60-80 million.

Mr. Scott Radloff, USAID, said that when countries request more resources, it usually has to do with contraceptives, because when there is no product, there is no program." Many countries will have stock-outs, but stock-outs are partly an aspect of success. With increased contraceptive prevalence rates, the need for commodities increases every year. It is good to get requests for resources, but it is not good that it is not planned." Mr. Radloff said that commodity approaches are also necessary to address unmet need. He said that if you look at unmet need, among rural, poor populations, the unmet need is higher that urban and educated sections of the population. He also said that community-based approaches are important and that private-public partnerships and social marketing are innovative models worth looking at.

Dr. Musimbi Kanyoro asked Mr. Radloff why USAID has a limited focus on only 10 countries in Africa. He responded by saying that USAID is looking at country focus and is hoping to expand beyond 13 countries, 10 of which are in Africa.

Dr. Musimbi Kanyoro asked Mr. Anthony Daly, DFID, to also speak about other European donors. Mr. Daly began by giving a broad overview on European financing. He said that, for example, "in Uganda, we know that for every $1 spent on family planning, more than $3 are saved in other development areas. We know the contribution of family planning is great." Yet family planning has been crowded out by the tremendous resources for HIV/AIDS. As of 2005, there was a reduction in family planning funding, but that may be changing, despite the negative impact of the current global economic crisis. The G8 recently re-committed themselves to honouring their commitment to MDG5, and for the first time, there is a mechanism in place to

[17] The Alan Guttmacher Institute and UNFPA. 2003. "Adding It Up: The Benefits of Investing in Sexual and Reproductive Health Care" http://www.guttmacher.org/pubs/addingitup.pdf

monitor the funding at the global level. He said that this new mechanism has made many in the field hopeful. Recently, at the UN General assembly, more than $5 billion dollars of new money was pledged to MDG 4 and 5. The US government increase in this area is also very encouraging. Donor coordination will really provide the focus we need for family planning assistance. Mr. Daly said that there is potential for more funding—particularly from sources that are less traditional.

Dr. Sadia Chowdhury, World Bank, responded next. She said that U.K. Prime Minister Gordon Brown and the World Bank set up a task force with the responsibility to identify what is required to achieve MDG5, in particular to examine the current financing and the remaining financing gap. The working groups are looking at overseas development assistance (ODA) and domestic financing of family planning. They found that maternal health was not on the radar and that there is often no separate budget line. The costing found that there is a need for an additional 10 billion dollars. She said that it is increasingly important for the private sector to come in and become a major player.

"It is our failure as people who implement, if we are not able to catch onto the changes happening. We have moved from stand-alone programs then to ICPD to comprehensive, then to general budgetary support. We have a focus on family planning, but not on the outcome. This makes it our failing . . . it is the global failing. Health systems strengthening is not necessarily bad."
-- Dr. Sadia Chowdhury, World Bank

Dr. Musimbi Kanyoro said that the three major categories of donor—bilateral, multilateral, and private foundation—are all represented here at this meeting. She then asked a third question to all of the panellists: "With increased attention to integrated services and health systems strengthening, what steps can be taken to ensure that family planning is not lost?"

Mr. Jose (Oying) Rimon II, Bill and Melinda Gates Foundation, said that the answer is different, depending on the definition of health systems used. There is supposed to be increases in budget support, SWAps, and consistent with the Paris Declaration on Aid Effectiveness, the governments are to decide what their priorities are. Mr. Rimon said that "Systems are put in place and family planning is taken off [the agenda]. . . Family planning and reproductive health are not taken as high priority." Mr. Rimon said that the Gates Foundation invested in civil society groups in order to influence the process. In Europe, the system is hard to understand, and it is very difficult on part of NGOs to access funds or influence the process. The Gates Foundation made a small investment to train NGOs to influence the process. The result of that program was that for every $1 million invested in trying to influence the process, they were able to generate $40 million in projects in countries." The Gates Foundation is making more investments, to have better leverage. The goal of the Foundation is to leverage resources at a 50- to-1 ratio.

Dr. Sadia Chowdhury, World Bank, said that people are "focusing on health systems strengthening because health service delivery mechanisms have not matured." Community-based services have done well. But we have to strengthen systems and not sacrifice any programme that has done well. Globally, three large organizations are coming together—the Global Alliance

for Vaccines and Immunisation (GAVI), The Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank—on one platform to ensure overall health systems strengthening and prevent fragmentation. One reason is to improve MDG5 outcomes. "It is our failure as people who implement, if we are not able to catch onto the changes happening. We have moved from stand-alone programs then to ICPD to comprehensive, then to general budgetary support. We have a focus on family planning, but not on the outcome. This makes it our failing . . . it is the global failing. Health systems strengthening is not necessarily bad." Dr. Chowdhury emphasized that improving outcomes is most important.

Dr. Musimbi Kanyoro then asked for responses from governments on the posed questions, to bring the group to a richer discussion.

Panel on "Ministerial Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?"

Hon. Dr. Richard Nduhura, Minister of State for Health, Uganda, said that the attitudes of people are changing, in large part due to education. Better-educated mothers are accessing family planning, but education is still not as accessible as it needs to be: "This will only work when there are enough resources for everyone to go to school and stay for some time." When people are better educated, they appreciate family planning more. In Uganda, when HIV/AIDS was higher, it was more difficult to talk about family planning, as children were dying; now, the situation has improved and the messages of family planning are easier to communicate. Hon. Dr. Nduhura said that everything hinges on resources and thus it is very welcome that we have development partners expressing that resources are available. He said that the government must also contribute to the budget, and development partners can help fill in areas where resources are lacking. He called for greater discussion of the issues, and that the government should be able to set the priorities for programmes and where funds should be allocated.

Tanzania's Deputy Minister of Finance, Hon. Omar Yussuf Mzee, spoke next. He said that going back to 1970s and 1980s, Tanzania started very well, as far as family planning is concerned. In the 1970s, the fertility rate was nearly 8 children per women. They tried to reduce the figure to 5. When HIV became an issue, most of the donors in Tanzania decided to reduce contribution to family planning and make allocations to HIV/AIDS. The Tanzanian government "couldn't put what was required for family planning." Awareness of family planning is nearly 80%, but usage is near 20%. He said that the reason for this was that they left the issue of family planning to women and did not involve men and religious leaders. A high percentage of Tanzanians are Muslim and it was a mistake not to involve them. Now Tanzania is trying to involve men and religious leaders to advocate for family planning. Hon. Omar Yussuf Mzee said that he wants to ensure that the Government of Tanzania is committed to reproductive health. "Most of farmers are women in Tanzania and they are the ones who feed the households." Thus, the economy of Tanzania is dependent upon women's health and economic production. He concluded by stating that "We believe family planning and reproductive health are very important."

The Minister of State, Finance, Uganda, Hon. Rukiya Chekamondo, spoke next. She said that when issues are raised, they are directed to the Minister of Finance. In Uganda, women have 30% of parliamentary offices and they have been aggressive on maternal health. The Senior Minister of Finance Planning and Economic Development in Uganda, Hon. Syda Bumba, is a woman and she is serious on increasing funding for maternal health. Hon. Chekamondo said that the different sectors guide the Ministry of Finance and that her office's "responsibility is to mobilize resources from our basket and the basket of partners." She said that she will be guided by this seminar, and promised that there is an opportunity, and that the Ministry of Finance in Uganda will work to channel resources to family planning. They will also ask development partners to give us a hand. She said that "Uganda will succeed on MDG5 because everyone is working on it. Nobody can handle everything alone, we have to join hands and come out with solutions together. The Ministry of Finance in Uganda will have to join hands with other African governments and also work at the local level to mobilize support."

"Do we need money to convince our society that women's lives are of value? Family planning is none other than women saying, I want to have a voice, I want to make decisions over my own life and my own future."
-- H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union

"Uganda will succeed on MDG5 because everyone is working on it. Nobody can handle everything alone, we have to join hands and come out with solutions together. The Ministry of Finance in Uganda will have to join hands with other African governments and also work at the local level to mobilize support."
-- Hon. Rukiya Chekamondo, Minister of State, Finance, Uganda

H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union, responded next. She asked, "does commitment automatically translate into money?" She said that the commitment, as shown through increased resources for family planning, is back. She said that the question of whether the movement has properly dealt with debates in the field. She reminded others of the couple yesterday, whose story was told in the opening plenary of the meeting. H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union, asked "Who determines the unmet need? Is it at the point that the person says 'I want to use FP. I want to reduce having children. Or is the unmet need determined by how many contraceptives we have?" She said that a critical linkage is between knowledge and usage. The cost of raising awareness is a separate issue from having contraceptives that are going unused because of a lack of awareness and education. She said that everybody is talking about resources for better health care facilities and similar measures. She continued by asking, "I asked the question, do we need money to convince our society that women's lives are of value? Family planning is none other than women saying, I want to have a voice, I want to make decisions over my own life and my own future." She said that resources are not just about money, but also need to take the need for human resources into account.

H.E. Adv. Gawanas continued by stating that resources must also be mobilized domestically, within countries. "Contraceptives are not something that you start and finish. It is about

sustainability." She reminded participants that greater efficiency in using the resources available is critical. She said that another part of the problem is the large number of actors in the field leads to fragmentation of resources and strategies. She called for better planning and coordination in the field. She said "I heard that the UN is working as one. . . . If we can achieve the UN as working as one, then we have achieved a great deal." She said that she is happy with the renewed focus on family planning. But she asked if the "renewed attention on family planning is really, really about saving the lives of women?" She asked if it was a fad, or politically correct, or if the real goal is save the lives of our women and children.

Hon. Dr. Robert Monda, Chair of Committee on Health, Kenya, spoke next. He said that population growth in Kenya is still high, at 3%. As of the census in August there are 4.6 children per woman. They feel that it is still very high. Family planning contraceptive use had stagnated, but now it has increased to 46% in 2008 according to the Kenya Demographic and Health Survey (DHS). There is an inadequate supply of contraceptives in the country and family planning services are in high demand. Kenya also has a constraint in human resource capacity implementation. To address some of these issues, Kenya has put in place family planning logistics working groups. A new community strategy is in place. A third intervention is to work to have greater equity in health service provision. In Kenya's current budget, there are now 20 health workers per constituency to address the issue of health equity. Each constituency is to create a model health care center. He continued by stating that Parliamentarians in Kenya have networks to address family planning issues and that they are also addressing reproductive health issues in campaigns. There is a media network on population and development. The Kenya Parliament has partners that assist them, including the private sector and NGOs. He said that this is a critical issue because "family planning affects all humanity." And as such, he and other Parliamentarians in Kenya have made an effort to ensure to address these issues.

Hon. Saudatu Sani, Member of Parliament, Nigeria and the Chair of the Parliamentary Committee on MDGs was the next to speak. Hon Sani said that sometimes people look at development the way it should be done. People bring a project to a country, they are often doing it in a straightjacket format. When partners come, they come with initiative to change things, do not consider culture. Hon. Sani said that the Parliament is essential to involve in programs in the country. The Parliament wants to fund programs for MDG5, and wants to increase the budgetary allocation. Hon. Sani said that the word family planning is not acceptable to everyone, but if the words "maternal mortality: or "saving the lives of women and children" are used, money is available. In Nigeria, "we have leaders campaigning to reduce maternal mortality. But because of stigma, family planning cannot be used [as a term]. The initiative is good, but the name is bad.

Who are you planning for?" Hon. Sani asked partners to make Ministers and Parliament in Nigeria accountable, and to engage with the government. "Nigeria has committed about one billion dollars for MDGs from the government, in addition to what donors are bringing into country."

Professor Fru Fobuzshi Angwafo III, the Secretary General of the Ministry of Public Health, Cameroon spoke next, and began by saying that the questions being raised about family planning are linked to child survival. "If we agree to move ahead for family planning, it has to be linked to child survival." When people are sick, families are reluctant to contribute to health care, yet they will die otherwise. But people can be educated to invest in the health of relatives. The representative also addressed the issue of financing for health systems strengthening and pointed out the problem in harmonization with the increase in the number of interventions and the transformation from part- to full-time health workers, as an example of a practical issue that needs to be better addressed.

The next representative to speak, Dr. Rene Darate, was from Benin. Dr. Darate made a case for family planning as central for the reduction of maternal mortality in Benin. Benin has a population of eight million people and a population growth rate of 3.5%. At this rate, in 20 years Benin will have 16 million people. The maternal mortality rate is 375, with figures from the 2006 Demographic Health Survey. Fertility is at 3.6 children per woman and life expectancy is 50 yrs. Considering these challenges, Benin created a roadmap with family planning as a central component. Universal access to health was also defined in this strategy, including free cesareans for women. Benin hopes to achieve the MDGs, but problems of sanitary structures and human resources also exist. To improve FP, there is a commodity security strategy with increased funding for commodities every year. They are working to increase distribution of commodities in communities. This has all been possible because of a positive legal environment, with parliament creating laws for women to be informed on various methods, as well as a law against female genital mutilation (FGM). Dr. Darate also recognized the role of partners in Benin, including UNFPA, WB,, USAID and other partners support to reposition FP. National budget is at 8% for health this year, which is not sufficient. They have proposed that health be allocated 15% for 2010. The National Assembly is putting together a law for the budget, so that the share for reproductive health in the budget will increase. Dr. Darate concluded by stating that Benin hopes to keep improving, as all actors are aware of the problems and the need to act.

Dr. Eugen Rwabuneza Mwinura, Ministry of Health, Rwanda, spoke next. He said that Rwanda has committed themselves for financing family planning, but that they still have a long way to go. The fertility rate, currently at 5.5 children per woman is high, and maternal mortality is also

high. Rwanda is actively strengthening community-based distribution in the country, with two community health workers in each village. They are currently doing training and scale-up. In Rwanda, there is community work once a month, where people work on the roads, bridges, etc, They also use one hour of this time to sensitize the community on issues such as family planning. Family planning is a big priority in Rwanda. To address problems of accessibility, they are trying to construct secondary health posts. Regarding male involvement, Rwanda is trying to sensitize men, as men think contraceptives are for women, not for men. Another barrier in Rwanda is faith-based organizations (FBOs). 40% of health facilities are run by faith-based organizations, mainly Roman Catholic organizations, so they only tell people about natural methods, which have higher failure rates. Rwanda is trying to create more awareness. Dr. Mwinura concluded by stating "Let us try to unite in struggle for the MDGs. If we strengthen our unity, we will be able to get there by 2015."

"We can't hide behind cultural arguments. It is our people who want to control their fertility."
-- Dr. Eliya Zulu, Director, African Institute for Development Policy

Dr. Eliya Zulu, Director, African Institute for Development Policy, spoke next. He said that he wanted to speak as a practitioner in the field, and to speak as a fellow African about some issues we are grappling with, such as "Is this renewed energy really about women's lives?" He said that he wanted to emphasize the importance of family planning to be seen as health issue. "It is a win-win. We've seen all the evidence here for women, children and families. But men also benefit from family planning. It empowers women. At family level, and also at the national level. We cannot achieve our development goals without family planning."

Dr. Zulu said that, in the past politicians did not want to touch family planning because of concept that people in Africa want to have many children. People were thinking that family planning was a western agenda to limit the number of Africans. Dr. Zulu continued, "We can't hide behind cultural arguments. It is our people who want to control their fertility."

He said that is was also important to pay attention to the issue of population growth, as it is very critical. Countries in Africa have high population densities. In Kenya, if the stall in Kenya was going to be sustained, the projection would be revised from 54 million people by 2050 to 80 million people. "Health is important, but we have to think about the numbers. . . We are struggling to feed our people." People ask the question and say that China and India are doing well with large populations. But the difference is that their population is a high quality population, but if you have illiterate people, it is going to be catastrophic. "But we have to take action. We have to keep momentum." He argued for increased investments in research in order to demonstrate the arguments that the Ministry of Finance need in order to be convinced. He said that countries in Africa can learn from each other. Countries like Ethiopia and Malawi have

increased their CPR dramatically in two years, yet in Northern Nigeria, contraceptive prevalence is still 5%. “We need to challenge researchers, as policymakers to give evidence. We don't have to continue to reinvent the wheel. There are best practices we can learn from.” He also said that regarding the issue of fragmentation and having too many players also applies to research and that researchers have to start consolidating their efforts. Dr. Zulu concluded by saying that “the international community is ready to help us. But we have to lead ourselves. We have to make family planning universally accessible to each and every woman and man who wants to use it.”

“Donors are really willing to listen to what the governments say. And we can see that governments are committed to supporting reproductive health in Africa.”
-- Dr. Musimbi Kanyoro, Director, Population Program, Packard Foundation

Dr. Musimbi Kanyoro, Director, Population Program, Packard Foundation, was the final speaker during this portion of the discussion. She said that a commitment to family planning is going to require the commitment of public-private partnerships. “When thinking of financing, we will have to think of not just commodities, but think of the funding that goes towards awareness, funding that goes to health systems and structures, and that is sustainable for a long time.” She said that the Ministers of Finance have to depend on what the Ministry of Health asks for in the budget. She concluded by stating that from her observations having facilitated the donors panel, that “Donors are really willing to listen to what the governments say. And we can see that governments are committed to supporting reproductive health in Africa.”

Presentation by Dr. Kassa Tsegaya Kebede: “Re-Affirming Commitments to Achieve the Health-related MDGs/MDG 5b”

The final presentation was made by Dr. Kassa Tsegaya Kebede, Senior Advisor Population, SRHR and Culture, African Union, on behalf of H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union.[18] Dr. Kebede began by stating that MDG5, has a target of 5A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio, and the related indicators are the maternal mortality ratio and proportion of births attended by skilled health personnel. The target 5B is: Achieve, by 2015, universal access to reproductive health. Related indicators include: contraceptive prevalence rate, adolescent birth rate, antenatal care coverage (at least one visit and at least four visits), and unmet need for family planning.

Dr. Kebede said that there were a number of general observations on the status of MDG5, based on the WHO Report 2008:

- The high risk of dying in pregnancy or childbirth continues unabated in most of Saharan Africa and Southern Asia countries;
- Little progress has been made in saving mothers’ lives (maternal deaths per 100,000 live births);

[18] “Re-Affirming Commitments to Achieve the Health-related MDGs/MDG 5b” by Dr. Kassa Tsegaya Kebede, Senior Advisor Population, SRHR and Culture, African Union, on behalf of H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union. Online in English: http://ppdafrica.org/docs/FinancingHealthMDGs/commitments-e.pdf

- Skilled health workers at delivery are key to improving outcomes;
- Antenatal care is on the rise everywhere;
- Adolescent fertility is declining slowly; and
- An unmet need for family planning undermines achievement of several other goals.

Dr. Kebede continued, by stating that the commitments have been re-affirmed at the continental level through the adoption of continental policies and strategies, putting maternal and child health on top on continental agenda, and recurrent calls for action/commitments.

Continental policies and strategies that have been adopted include: the Maputo Plan of Action (2006), the Africa Health Strategy (2007), the Pharmaceutical Manufacturing Plan (PMP) for Africa (2007), the Plan of Action for Prevention of Violence (2007), and the launch of CARMMA at continental and national levels since May 2009. To put maternal and child health on top on continental agenda, there have been subsequent African Union summit debates and decisions since 2005 and the landmark decision to make "maternal and child health" the major theme of the 2010 African Union Summit. Recurrent calls for action/commitments include: the Addis Ababa Call for Action on Task Shifting for Maternal Survival (July 2009) and the ICPD+15 Outcome document, Oct 2009.

At the global level, commitments have been re-affirmed through The Global Campaign on Health Related MDGs (4, 5, 6), the Commitment Document of the IPCI (October 2009), and the White Ribbon Alliance Movement for Maternal Health.

Despite these renewed commitments, Dr. Kebede said that there needs to be a stronger push to move beyond commitment and into concrete action. Specifically, Dr. Kebede called for participants and partners to take **seven steps to move beyond commitments**:

1. Need for concrete actions at national and local levels;
2. Need for mobilization of domestic as well as global resources;
3. Increased support for strengthening primary health care systems;
4. Need for revitalizing the Maputo Plan of Action through the Momentum created by CARMMA;
5. Need for updated and harmonized data on maternal and child health indicators;
6. Need for reinforcing the linkage between reproductive health and family planning services; and
7. Creating synergy between international, regional and national efforts in the framework of the Paris Declaration.

"It is my hope that by 2015 we will no longer need to talk of being ashamed of what is happening on our continent, we should be able to say that we have achieved the MDGs. I am confident that we can do it. And even if we cannot do it, we have to do it, because we know the objective of the MDGs."
-- H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union

5. Closing Session

Hon. Dr. Richard Nduhura, Minister of State for Health, on behalf of Hon. Dr. Stephen Mallinga, Uganda's Minister of Health, said that the day's meeting was productive and informative and wished all of the participants a good stay in Uganda.

Statement by Mr. Sangeet Harry Jooseery

Mr. Sangeet Harry Jooseery, Executive Director, Partners in Population and Development (PPD) made the next statement.[19] He said that the way a health care system is financed is a key determinant of the health and well-being of a population. "People in developing countries pay a high proportion of their health cost out of their own pockets. While in Germany 11% of all medical expenses are borne by households, in developing countries, 90% of health expenses are borne by households." He said that external donor funding for family planning has suffered between 1995 and 2005, and "the financial downturn aggravates the situation." He said that official development assistance overall has also fallen short of the 0.7% pledged. He continued by saying that "Developing countries, especially those most vulnerable in sub-Saharan Africa need assistance from the North to redress its health system." He also said that developing countries have the potential and capacity to trace their own future and pointed to countries such as Brazil, India, and China who have developed strong economies and others such as Indonesia, Thailand and South Africa that are emerging. He continued, stating, "I am happy to note that a new South-South ODA is emerging. Let us synergize our efforts, share our expertise, experiences and knowledge among ourselves, promote South-South cooperation and move forward positively to meet [the] ICPD [Programme of Action] and [the] MDGs. What we need is more commitment, ownership, and engagement from ourselves [to] translate policy into actions in line with the Paris Declaration and the Accra Agenda for Action." He said that reproductive health services should be free all around the world. He concluded by stating that "We welcome the financial recovery. We cannot and should not talk of a health recovery. Health is a right and cannot be lost and regained."

"What we need is more commitment, ownership, and engagement from ourselves [to] translate policy into actions in line with the Paris Declaration and the Accra Agenda for Action."
-- Mr. Sangeet Harry Jooseery, Executive Director, Partners in Population and Development

Closing Statement by H.E. Adv. Bience Gawanas

H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union, formally closed

[19] "Statement at the Senior Policymakers' Seminar on "Financing Health-related Millennium Development Goals: Challenges and Opportunities" by Mr. Sangeet Harry Jooseery, Executive Director, Partners in Population and Development (PPD). English: http://ppdafrica.org/docs/FinancingHealthMDGs/jooseery-e.pdf

the meeting with a statement. She began by stating that “when you are the last speaker, you have the choice to repeat, or say that everything has been said.” She said that although everything has been said, she wanted to make one final statement. She said that when we meet, we make recommendations. She said that “Having listened to what countries are doing, it provides a golden opportunity to not repeat the mistakes of others.” She said that nothing is impossible if there is will and commitment to do it. She said it is her hope that by 2015, “we will no longer need to talk of being ashamed of what is happening on our continent, we should be able to say that we have achieved the MDGs. I am confident that we can do it. And even if we cannot do it, we have to do it, because we know the objective of the MDGs.”

H.E. Adv. Gawanas called for greater links between research and policymaking. She appealed for all participants to support CARMMA, and to remember the slogan, "Africa cares, no woman should die, while giving life." She corrected the impression that the 2010 AU Summit is only on maternal and child health—she said that it is a normal AU Summit, but will have an additional two to three hour debate on maternal and child health. But the Summit will provide an opportunity for other actions to take place, and for a report to be presented to the Heads of State that family planning is back as central to development. She concluded by declaring the seminar officially closed.

Appendix 1: Meeting Programme

Senior Policymakers' Seminar on "Financing Health-related Millennium Development Goals: Challenges and Opportunities"
Monday, 16 November 2009
Commonwealth Banqueting Hall, Munyonyo Conference Center, Kampala, Uganda
AGENDA

Chair: Hon. Rukiya Chekamondo, Minister of State, Finance, Uganda, on behalf of Hon. Syda Bumba, Uganda's Minister of Finance, Planning and Economic Development
Co-Chair: Hon. Dr. Richard Nduhura, Minister of State for Health, on behalf of Hon. Dr. Stephen Mallinga, Uganda's Minister of Health

Time	Agenda item
	Opening Session
0930 – 0945	"AID Architecture and Health: Outcomes in Africa: Focus on Family Planning" by Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group
0945 – 1015	"Uganda on the Move" by Ms. Rhonda Smith, PRB, on behalf of Dr. Jotham Musinguzi, Regional Director, Partners in Population and Development Africa Regional Office
1015 – 1045	"Financing of Reproductive Health in Rwanda: Contributions of Resource Tracking" by Claude Sekabaraga, MD, MPH, Former, Director of Policy Planning and Capacity Building Ministry of Health, Rwanda
1045 – 1115	"Presentation of RAPID model for Malawi" by Dr. Chisale Mhango, Director, Reproductive Health Unit, Ministry of Health, Malawi
1115 – 1130	**Break**
	Session Two
1130 – 1300	Statement by Hon. Rukia Chekamondo, Minister of State, Privatization, Uganda Ministry of Finance, Planning and Economic Development on behalf of Hon. Syda Bumba, Uganda's Minister of Finance, Planning and Economic Development Statement by Dr. Sadia Chowdhury, Coordinator, Reproductive and Child Health Programs, Population and Reproductive Health Capacity Building Program, World Bank Statement by H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union Discussion
1300 – 1400	**Group Photo and Lunch**
	Session Three
1400 – 1500	Panel on "Donor Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?" Moderator: Dr. Musimbi Kanyoro, Packard Foundation Panelists: Dr. Sadia Chowdhury, World Bank; Mr. Bunmi Makinwa, UNFPA; Mr. Jose (Oying) Rimon II, Gates Foundation; Mr. Scott Radloff, USAID; Mr. Tony Daly, DfID

	Discussion
1515 – 1630	Panel on "Ministerial Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?" Discussion
1630 – 1715	"Re-Affirming Commitments to Achieve the Health-related MDGs/MDG 5b" by Dr. Kassa Tsegaya Kebede, Senior Advisor Population, SRHR and Culture, African Union, on behalf of H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union
	Closing Session
1715	Closing Statement by Mr. Harry Jooseery, Executive Director, Partners in Population and Development Closing Statement by H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union
1930	**Dinner in Commonwealth Banqueting Hall**

Appendix 2: List of Participants

	Name	Designation	Organization	Country
1	Dr. Adelaide Caruaiho	National Director of Public Health	MOH	Angola
2	Dr. Anna Maria Rodrilaves Wok	Dinect Finance	Ugovenn	Angola
3	Dr. Gdelaide de al Fatuma DE CARVALHO		MOH/PATHFINDER	Angola
4	Dr. Isilda Maria Simoes Neves		MOH	Angola
5	Dr. Maria Isabel Antonio Nassocolo neves		SES -USAID	Angola
6	Rene Drate	Director of Family Health	Ministry of Health	Benin
7	Dr. Elise Quedraogo Diendere	Medecin	Ministere de la Sante	Bukina Faso
8	Dr. Jeanetta Johnson	Deputy Director General	WAHO	Bukina Faso
9	Mrs. Delphine Bovoes	Delegate	Ministere Economic et finances	Bukina Faso
10	Mrs. WatoDelphine Barry Traore	Delegate	Ministry of Eco nomics and Finance	Bukina Faso
11	Prof. Fru Fobuzshi Angwafo III	Secretary General	Ministry of Public Health	Cameroon
12	Dr. Frehiwot Berhane Defaye	Specialist M&E Coordinator	IGAD	Ethiopia
13	Dr. Keseteberhan Admassu	Director General	Ministry of Health	Ethiopia
14	Dr. Mesrak Nadew Belatchew		USAID	Ethiopia
15	Dr. Kassa Tsegaya Kebede	Senior Advisor Population, SRHR and Culture	African Union	Ethiopia
16	Mr. Alula Sebuatu Mesbena		Ministry of Finance	Ethiopia
17	Mr. Sahlu Haile	Regional Advisor	Packard Foundation	Ethiopia
18	Mrs. Bience Gawanas	Commissioner	African Union	Ethiopia
19	Ms. Radia Mohammed Hassen	Director	Minister's Office-Ministry of Women's Affairs	Ethiopia
20	Premila Barlett	SR RH/FP Advisor	USAID	Ethiopia
21	Shaino Daba Hamusse		Oromisa Repionol Health bureau	Ethiopia
22	M. Piune Jando"n		Policy Office, French Ministry of Foreign Affairs	France
23	Dr. Elias Sory	Director-General	Ghana Health Services	Ghana
24	Monsiuer Paul heidon slans Sossa		USAID/WEST Africa	Ghana
25	Paul Sossa	Health Adviser	USAID	Ghana
26	Dr. Claude Sekabaraga	Health Specialist	World Bank; Former Director of Policy Planning and Capacity Building Ministry of Health, Rwanda	Kenya
27	Dr. Bartrice Kigon	Head DRH	MODIS	Kenya
28	Dr. Eliya Msiyaphazi Zulu	Director	African Institute for	Kenya

			Development Policy	
29	Dr. Sheila Nyawira Macharia	Seniro Health manager	USAID	Kenya
30	Hon. Ali Mohamed Hussein	MP	Kenya National Assembly	Kenya
31	Hon. David Ekwee Ethuro	MP	Kenya National Assembly	Kenya
32	Hon. Robert Onsare Monda	Chair, Health committee	Kenya National Assembly	Kenya
33	Mr. Stephen Wainana	Economic Planning Secretary	Ministry of Planning	Kenya
34	Mr. Tewoodros Melesse	Regional Director	IPPF	Kenya
35	Mrs. Muya	Country Director	International Health	Kenya
36	Mrs. Yego Eunice Kigen	Chief Finance Officer	Min. of Finance	Kenya
37	Hon. Njoki susan Ndungu	Chairperson	CLICK	Kenya
38	Hon. Jerolinmek M. Piah	Assistant Minister for Planning & Adm	Ministry of Gender and development	Liberia
39	Hon. William Twehway	Assistant Minister	Ministry of Education	Liberia
40	Mr. Edwin Power Gaye	MP	House of Representatives	Liberia
41	Mrs. Patricia Kamara	Assistant Minister	Min. of Gender and Development	Liberia
42	Dr. Chisale Mhango	Director, Reproductive Health Services	Ministry of Health	Malawi
43	Hon. Mwanza Patrick		National Assembly	Malawi
44	Lilly Memory Baaruda-Maliko	Deputy Team Leader (HPN)	USAID	Malawi
45	Mihowa Lingalireni	Special Adivisor	Office of the Vice President	Malawi
46	Mr. Athanase Nzokirishaka	Representative	UNFPA	Malawi
47	Mr. Maxwell Mkumba	International Affairs Advisor	Office of the vice President	Malawi
48	Mrs . Olive Mutema	Policy Advisor	Futures Group International	Malawi
49	Mrs. Fannie Kachale	Deputy Director	Ministry of Health	Malawi
50	Mrs. Olive Mtema	Policy Specialist	Futures Group	Malawi
51	Mrs. Winnie Chilemba	Nurse/Midwife Lecturer	Universtiy of Malawi	Malawi
52	Ms. Grace Gondwe	Economist	Ministry of Development Planning & Cooperation	Malawi
53	Ms. Juliana Lunguzi	Programme Officer	UNFPA	Malawi
54	Ms. Lilly Menory	Deputy Team Leaders (HPN)	USAID	Malawi
55	Ms. Mihowa Lingalireni	Special Advisor to Vice President	Office of Vice President, Malawi	Malawi
56	Paul Lackson Zakaria Chibingu		National Assembly	Malawi
57	Dr. Binta Keita	Director, Reproductive Health	Ministere dela Sante DNS/DSR	Mali
58	Hon. Fanta Mathini	Parlementaire	Assemblee Nationale	Mali
59	Mr. Jooseery Harry	Executive Director	PPD	Mauritius
60	Dr. Mojisula Odeku	Project Director	JHU/CCP NURHI	Nigeria
61	Hon. Sudatu Sani	Committee Chairman Chair of the Parliamentary Committee on MDGs	National Assembly	Nigeria
62	Ken Uchechukwu Okoro		PRHP-OAU	Nigeria
63	Mr. Abdullahi Mawada	Snr. Program Manager	USAID	Nigeria

64	Mr. Kayode Olusola Ajao	Ile Ife	Obafemi Awolowo University	Nigeria
65	Mrs. Igharo Elizabeth Egbibhalu	Associate Director	Public Health, John snow, Inc./USAID/Deliver Project	Nigeria
66	Mrs. Salako Adebusola Abidomi	Chief Nursing Officer	Federal Ministry of Health	Nigeria
67	Ms. Ifeoma Ofili	Committee Clerk	National Assembly, Abuja	Nigeria
68	Abdullahi Maiwada		USAID	Nigeria
69	Dr. Abosede Remilekun Adeniran	Deputy Director RH/FP	Department of Family Health	Nigeria
70	Veronique Chikwaka	Conseillere du nimstre, Diretrice a Conseillere en charge de venfant	nimistere du genre,dela fanille a de l' enfant	Republique Democratique ou Congo
71	Dr. Thibaut N. Mukaba	-	USAID	Republique Democratique ou Congo
72	Hon. Katumwa Vicky Mukalay	Depute	Assemblee Nationale	Republique Democratique ou Congo
73	Ms. Adrienne Binwana	Director	Service Nati Femme	Republique Democratique ou Congo
74	Prof. Aloys Nguma Monganza	President of Congolese Society of Obstetrician/Gynecologists	Obstetrics/Gynecologist (Scogo)	Republique Democratique ou Congo
75	Professor Aloise Nguma Monganza	President	Congolese Society of Obstetric and Gynaecology (SCOGO)	Republique Democratique ou Congo
76	Dr. Eugen Rwabuneza Mwinura	In-charge FP	Ministry of Health	Rwanda
77	Mr. Eric Kagame	Maternal Health Specialist	USAID	Rwanda
78	Dr. Bocas Daff		MOH	Senegal
79	Dr. Elhadji Amadou Mbow	-	USAID	Senegal
80	Dr. Bacor Nyamadu Daff	Chef de Division dila santi de la Reproduction	MSP	Seneral
81	Mr. Bunmi Makinwa	Director, Africa Regional Office	UNFPA	South Africa
82	Dr. Michael Mbizvo	Director a.i	WHO	Switzerland
83	Ms. Sarah Jonson	Technical Officer	WHO	Switzerland
84	Mr. Omara Yussuf Mzee	Deputy Minister	Ministry of finance	Tanzania
85	Mrs. Florence Maridadi Mwairi	Assistant Director	President's Office	Tanzania
86	Ms. Mwanaidi Mahiza	IT Manager	National bureau of statistics	Tanzania
87	Ms. Sauda Kassim Msemo	Principal Economist	Ministry of Finance and Economic Affairs	Tanzania
88	Dr. Josee Yawa Djatugbo Apetsianyi	MD, MPH	Ministry of Health	Togo
89	Dr. Tchiguiri K. Kassouta N'tapi	Medecin	Government Ministry of Health	Togo
90	Dr. Yawa Djatugbe Josee	Medecin	Ministre Sante	Togo

	Aptsiany			
91	Dr. Fred Kakongoro Muhumuza	Economic Advisor	Ministry of Finance	Uganda
92	Dr. Aine Byabashaija Aloysious	National Prgram Coordinator	Venture Strategies innovations	Uganda
93	Dr. Betty Nakazzi Kyaddondo	Head, FHD	POPSEC	Uganda
94	Dr. John B Kabera	Consultant	Futures Group	Uganda
95	Dr. Jotham Musinguzi	Regional Director	PPD-ARO	Uganda
96	Hon. Baba Diri	MP	Parliament of Uganda	Uganda
97	Hon. Jessica Eriyo	Minister	Ministry of Water & Environment	Uganda
98	Hon. Rukiya Chekamondo Kulany	Minister	MoFPED	Uganda
99	Mr. Abdelylah Lakssir	IPO	PPD ARO	Uganda
100	Mr. Charles Zirarema	Ag. Director	Population Secretariat	Uganda
101	Mr. Francis Tukwasibwe	Programme Officer	UNFPA	Uganda
102	Mr. Hannington Burunde	Head Communictions	POPSEC	Uganda
103	Mr. Isah Mbuga	NPO	POPSEC	Uganda
104	Mr. James Kotzsch	Country Director	DSW	Uganda
105	Mr. Nuwamanya John	Foreign Service Officer	Ministry of Foreign Affairs	Uganda
106	Mr. Patrick Mugirwa	Programme Officer	PPD-ARO	Uganda
107	Mr. Twaha Matata	Foreign Service Officer	Ministry of Foreign Affairs	Uganda
108	Ms. Diana Nambatya	Associate Program Officer	PPD ARO	Uganda
109	Ms. Janet Jackson	Representative	UNFPA	Uganda
110	Ms. Josephine Byekwaso	Bilingual secretary	Uganda	Uganda
111	Ms. Kangabe Edith	Ag. Head Policy and Planning	POPSEC	Uganda
112	Hon. Baroness Jenny Tonge	Member of Parliament	UK	UK
113	Mr. Anthony Daly	Regional Maternal Health Advisor	DFID, East Africa	UK
114	Dr. Don Lauro	Consultant	6HTech	USA
115	Dr. Eduara Bos	Lead, Population Specaialist	World Bank	USA
116	Dr. Matha Campbell Martha Madison	President	Venture Strategies for Health Development	USA
117	Dr. Michael Klag		JH Bloomberg SPH	USA
118	Dr. Sadia Afroze Chowdhory	Coordinator RH	World Bank	USA
119	Dr. Scott Radcoff	Director, Office of POP&RH	USAID	USA
120	Dr. Werner Haug	Director	UNFPA	USA
121	Dr. Williard Cates	President, Research	Family Health International	USA
122	Elizabeth Lule	Manager	World Bank	USA
123	Mr. Jay Gribble	Presenter	PRB	USA
124	Mr. Jose Rimon II	Policy & Advocacy	Bill and Melinda Gates Foundation	USA
125	Mrs Alexandra Todd Lippock		USAID	USA
126	Mrs. Ishrat Zafar Husain	Senior Health Advisor	USAID	USA
127	Mrs. Monica Kerrigan	-	Gates Foundation	USA
128	Mrs. Susan Olson		US State Dept	USA
129	Ms. Anne Woodworth	-	MSH	USA

130	Ms. Barbara Seligman		ABT ASSOC	USA
131	Ms. Carmen Coles	-	USAID	USA
132	Ms. Elise Walsh Boos	-	Makerere	USA
133	Ms. Helena Choi		Hewlett Foundation	USA
134	Ms. Nichole Zlatunich	Consultant	Hewlett Foundation/ PPD ARO	USA
135	Ms. Nicole Gray		Hewlett Foundation	USA
136	Ms. Peggy Clark	Vice President	Aspen Institute	USA
137	Ms. Rhonda Smith	Presenter	PRB	USA
138	Ms. Rosann Wisman Rosann	Director Ministerial Leadership International	Aspen Institute	USA
139	Ms. Sadra Jordan		USAID	USA
140	Ms. Sarah Clark, PhD	Vice President and Centre Director	Futures Group	USA
141	Ms. Susan Reier	Technical Officer	WHO, Geneva	USA
142	Ms. Valerie De Fillipo	Vice President	ABT Associates	USA
143	Prof. Duff Gillespie		John Hophin University	USA
144	Scott Radloff	Director, Office of Population and RH	USAID	USA
145	Ms. Marrisa Pine Ifeakey	Presenter	PRB	USA
146	Dr. Bellington Vwalika	Head, Obstetrics and Gynecology	University of Zambia	Zambia

Appendix 3: Documents Available Online

Agenda in English: http://ppdafrica.org/docs/FinancingHealthMDGs/agenda-e.pdf
Agenda in French: http://ppdafrica.org/docs/FinancingHealthMDGs/agenda-f.pdf

Full presentations

"AID Architecture and Health: Outcomes in Africa: Focus on Family Planning" by Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group
English: http://ppdafrica.org/docs/FinancingHealthMDGs/rogo-e.pdf

"Uganda on the Move" by Ms. Rhonda Smith, Associate Vice President, International Programs and Director, ENGAGE Project at the Population Reference Bureau (PRB), on behalf of Dr. Jotham Musinguzi, Regional Director, Partners in Population and Development Africa Regional Office
Script in English: http://ppdafrica.org/docs/FinancingHealthMDGs/smith-e.pdf

"Financing of Reproductive Health in Rwanda: Contributions of Resource Tracking" by Claude Sekabaraga, MD, MPH, Former, Director of Policy Planning and Capacity Building Ministry of Health, Rwanda
English: http://ppdafrica.org/docs/FinancingHealthMDGs/sek-e.pdf
French: http://ppdafrica.org/docs/FinancingHealthMDGs/sek-f.pdf

"Presentation of RAPID model for Malawi" by Dr. Chisale Mhango, Director, Reproductive Health Unit, Ministry of Health, Malawi
English: http://ppdafrica.org/docs/FinancingHealthMDGs/mhango-e.pdf
French: http://ppdafrica.org/docs/FinancingHealthMDGs/mhango-f.pdf

"Re-Affirming Commitments to Achieve the Health-related MDGs/MDG 5b" by Dr. Kassa Tsegaya Kebede, Senior Advisor Population, SRHR and Culture, African Union, on behalf of H.E. Adv. Bience Gawanas, Commissioner for Social Affairs, African Union
English: http://ppdafrica.org/docs/FinancingHealthMDGs/commitments-e.pdf

Statements

Statement by Hon. Rukia Chekamondo, Minister of State, Privatization, Uganda Ministry of Finance, Planning and Economic Development, on behalf of Hon. Syda Bumba, Uganda's Minister of Finance, Planning and Economic Development
English: http://ppdafrica.org/docs/FinancingHealthMDGs/chekamondo-e.pdf

Statement by Mr. Sangeet Harry Jooseery, Executive Director, Partners in Population and Development (PPD). English: http://ppdafrica.org/docs/FinancingHealthMDGs/jooseery-e.pdf