Third African Region Partner Country Coordinators (PCC) Meeting
Hotel L'Ocean, Dakar, Senegal
Monday, 28 November 2011

MEETING REPORT

Organized by Partners in Population and Development Africa Regional Office (PPD ARO), with support from the William and Flora Hewlett Foundation

Partners in Population and Development
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On 28 November 2011, PPD ARO hosted the third African Region Partner Country Coordinators (PCC) Meeting at Hotel L'Ocean in Dakar, Senegal. Full presentations are available on the PPD ARO website, www.ppdafrica.org and links are available as an appendix to this report.

Session One: Opening Ceremony

Introductory remarks were made by **Dr. El Hadj Boubacar Samba Dankoko, the PCC for Senegal**. He welcomed all of the PCCs from the various countries in attendance as well as the Permanent Secretary of the Ministry of Health of Senegal, Hon. Mosa Mbaye. Dr. Dankoko introduced the topic and importance of the meeting before introducing the speakers.

After participants introduced themselves, **Dr. Jotham Musinguzi, the Regional Director for PPD ARO**, made some welcome remarks. He reminded participants of the importance working within the frameworks of the ICPD, the Maputo Plan of Action, and the Accra Agenda of Action. He stated that the group has been gathered to learn how other countries have been able to make progress, as well as to share in a South-South way and to learn from each other. He advised PCCs to take advantage of today's meeting, to learn what we have been able to do using South-South, such as through the National Task Forces working at the country level. He concluded by stating that "we at PPD ARO believe this is an important meeting which will help to enhance our work."

Dr. Harry Jooseery, the Executive Director of PPD, next made an address to the group. He said that the relentless work undertaken by PPD is shown in a compendium of practices of reproductive health which was launched in South Africa in October 2011. Dr. Jooseery stated that according to the PPD Strategic Business Plan of 2012-2014, the main guidelines for PPD are: improvements in RH commodity security in the member-countries, strengthening networks and partnerships, sustaining advocacy for favourable policy environment and resources provision for population and SRH, exchange of experiences and good practices between member countries and developing national capacity of the members to deliver quality SRH services '\';. He also noted that a conducive environment is important for PCCs for smooth running and country ownership. He then called on PCCs to strengthen South-South cooperation and to make inter-country cooperation a reality. He said that the strategic plan brings out the important guidelines and said that with those guidelines, PPD will make progress. He concluded by saying that the PCCs and other partners will always be in his heart forever and he thanked participants. He stated, "I feel that I have run PPD with honesty and sincerity, and have positioned PPD well at country, regional, and international levels. There is a stronger support and commitment of the 25 member countries. The yearly contribution for some countries has shifted from 20,000 to 40,000 and 40,000 to 80,000. . .I leave behind an exemplary staff in Bangladesh, Africa, New York, and China."

The opening address was made by the **Permanent Secretary of the Ministry of Health, Public Hygiene and Prevention of Senegal, Dr. Mosa Mbaye.** He noted the importance of this meeting and of PPD to promoting FP/RH globally. He apologized for the absence of Senegal at the PPD Board meeting and international forum, which was due to well-known constraints. He said that the PPD Strategic Plan is very useful and that Senegal is very keen on following the

recommendations of the meeting. He also noted the importance of FP/RH and population issues in light of the growing population which now stands at seven billion. On behalf of the minister and Ministry of Health in Senegal, he congratulated PPD's Executive Director for the efforts achieved while he was leading the institution and wished him success in his future endeavors. He concluded by wishing all an enjoyable stay and productive meeting while in Senegal.

Session Two: Highlights on PPD ARO achievements, PPD Strategic Business Plan, and FP/RH Continental Frameworks in Africa

Patrick Mugirwa, Programe Officer at PPD ARO, gave a presentation on "Highlights on PPD ARO Achievements." He noted that this is the same presentation that was made at the 2011 PPD PCC meeting in South Africa, so some of the PCCs will have already seen the presentation, but as a number of PCCs and past PCCs who are at this meeting in Dakar were not able to travel to South Africa, the presentation will be new to them. This presentation covered the work of PPD ARO from October 2010 to November 2011. After giving a brief background on the office, including its opening in 2007 and its mission, vision and objectives, he gave a summary of key achievements since establishment including developing parliamentary leadership for, and commitment to family planning and reproductive health in the region; creating champions for SRHR in Africa, including First Ladies, Cultural Leaders and Parliamentarians; helping strengthen accountability for the Maputo Plan of Action as continental framework for the achievement of the ICPD and MDGs targets; building strategic partnership with key institutions in the region (African Union, CAFS, APHRC, AFIDEP, SEAPACOH, EARHN, WARHN, SARHN, etc), and attracting many donors (Hewlett, Gates and Packard Foundations, UNFPA, DSW, IntraHealth, Women Deliver among others).

Between October 2010 and November 2011, under PPD Goal 1 (Strengthened South-South Cooperation in Population and Development), PPD ARO facilitated the second meeting of the Ugandan NTF on June 30, 2011 in Kampala, Uganda and organized a study tour of the Health Extension Programme (HEP) of Ethiopia for EARHN focal persons from August 30 – September 1. Under Goal 2 (Strengthened Capacities at Systems, Institutional and Individual Levels), PPD ARO organized a training of African PCCs in Web-based social networking and communication December 7 – 9, 2010 in Nairobi, Kenya and a capacity building on presentation using sub-Saharan Africa Rapid Model January 5 - 7, 2011 in Kampala, Uganda, and hosted a capacity building workshop on Spitfire for EARHN focal persons, July 19 – 21 in Nairobi, Kenya. Under Goal 3 (Strengthened Networks and Partnerships), PPD ARO attended the meetings for the Health Policy Project (HPP), Packard Foundation, Capacityplus Project, Advance Family Planning (AFP) Partners, STEP UP, Population Footprints, Reproductive Health Supplies Coalition Conference and the International Conference "Population, Development, and Family Planning in Francophone West Africa: The Urgency for Action." PPD ARO also continued cultivation of its Partnership with The African Union through attending various AU meetings at the ministerial and technical levels. PPD ARO also supported coordination meetings of the Eastern Africa Reproductive Health Network (EARHN) and Uganda's Parliamentary Forum on MDGs. Under Goal 4 (Improved Voluntary FP and other RH Services), PPD ARO held three workshops with Sector Heads and technical personnel in Mukono and Mayuge districts of Uganda in order to prioritize family planning in the planning and budgeting processes at the

district level and to pilot the intervention as south-south model intervention to be replicated in Uganda as well as in other PPD member and collaborating countries.

Mr. Mugirwa concluded by sharing a summary of funding to PPD ARO, including for programme and specific activities, as well as for core support from various donors and partners including the Hewlett Foundation, the Gates Foundation and Packard Foundation (AFP), Packard Foundation, USAID (Health Policy Project), UNFPA, Women Deliver, IntraHealth (CapacityPlus), and Marie Stoppes International.

The presentation "Highlights on PPD Strategic Business Plan and Its Operationalisation within Member Countries" was given by **Mr. Abdelylah Lakssir, International Programme Officer, PPD ARO**. Mr. Lakssir began by giving a summary of PPD's key areas of focus during 2012-2014, namely, improvements in RH commodity security in the member-countries, strengthening networks and partnerships, sustaining advocacy for favourable policy environment and resources provision for population and SRH, exchange of experiences and good practices between member countries and developing national capacity of the members to deliver quality SRH services. He then gave the vision, mission, and overarching guiding principles and values. The objectives of the strategic business plan (SBP) include:

1. To advocate for improved policy environment and resources mobilization for population and development and sexual and reproductive health;
2. To strengthen the health system delivery capacity and capacities of individuals and institutions to provide quality SRH Services;
3. To establish and strengthen strategic partnership with key development partners and international/regional agencies and existing networking with research and training institutions, NGOs, Media and other opinion makers for greater visibility of PPD as one of the leading global players in the population and SRH sector;
4. To strengthen institutional and human resources capacity of PPD Offices, PCC/Board Members Offices, Regional Networks, Partner Institutions and National Support Structures; and
5. To consolidate the achievements made so far, facilitate infrastructural development and expansion of constituencies for extended delivery of services.

Mr. Lakssir noted that all objectives are detailed with expected results and indicators of success (please see his presentation for details on results and indicators for each objective). He concluded by stating that translating the strategic business plan into reality requires commitment of all, foundation for sectoral plans, annual plans and periodic plans based on the strategic business plan, a mid-term review, a result-based performance framework and reporting.
The session was then opened to **questions, answers and general discussion**. The representative from Mali asked a question of how the strategic plan was costed. Mr. Lakssir said that this strategic plan was costed by objective and by result and Dr. Jooseery can answer more questions on the specifics of the SBP.

Another participant asked if PPD ARO strategic plan is separate from the PPD Secretariat strategic plan, which was developed in Bangladesh and presented in South Africa. Mr. Lakssir responded by stating that the plan is the same for PPD ARO. PPD ARO is guided by the strategic business plan of PPD global.

Dr. Betty Kyaddondo, the PCC for Uganda, congratulated the team that developed the strategic business plan, as there is close linkage to the work already going on at PPD ARO. She noted that it is very easy to link the strategic business plan to what Mr. Mugirwa presented on the work of PPD ARO. She stated that this close linkage will help guide the achievement of African continental frameworks such as Maputo and Abuja so that countries can learn from each other. She noted that this is especially as a number of countries in Africa are far from achieving the MDG targets.

Mr. Saikou JK Trawelly, the PCC for Gambia, stated that these meetings should be annual, as this forum allows us to share experiences and best practices and discuss how far we have gone in the various programs. He asked how the funding for PPD ARO is allocated, what activities are implemented by whom and when, stating that the PCCs are interested to know these things. He noted that the activities have been focused mainly in East Africa, such as for EARHN, and he stated that WARHN also has a strategic plan. He said that although activities that were outlined in that strategic plan, we do not know what has been done so far, although we have been having activities funded by UNFPA and IPPF in countries. He also asked about the parliamentarian's work, such as with SEAPACOH. He said that based on its stated mission, PPD ARO is more of a coordinating agency, and it should mobilize resources for countries. He concluded by recommending that as funds have been mobilized in our names, PPD ARO should do more information-sharing so that countries could put in requests for funds to be used within countries.

Dr. Musinguzi responded to some of the issues, stating that it is true that in the work PPD ARO has done so far, that our work in WARHN and SARHN has not been as strong as with EARHN. He noted that the real thing PPD ARO has done for WARHN is to support development of the strategic plan, as well as having taken time to improve it and put it in place. He noted that the PCC from Ghana can also say something about the status of the strategic plan. He noted that PPD ARO has not been as active in the other regions when compared to East Africa, and that this in part has been due to availability of funding. He also said that he agrees that some countries have done resource mobilization with CSOs as well as donors and that he congratulates the efforts there. Regarding First Ladies, he clarified by stating that PPD ARO did this work at the time of the AU meeting, PPD ARO was opportunistic in gathering First Ladies who were already there, and worked with them to let them know how to be involved in the field of FP/RH, as they previously had only been working on issues related to HIV/AIDS as a network. PPD ARO wanted to interest them to work more in maternal and infant health and was successful in that effort, as they agreed to expand their mandate. Dr. Musinguzi noted that working with First Ladies is difficult, as you cannot just call them to a meeting. He also agreed with the participant who noted that PPD ARO is too small to do everything, and stated that we have been able to have successes through working with partners within countries. He argued that PPD ARO should continue to concentrate on being a facilitator and enabler rather than a direct implementor.

Mr. Mugirwa, joined in, responding to some of the issues raised. He said that there are activities for countries to implement, and in those activities, PPD ARO coordinates but does not implement them. He also clarified that the parliamentarian meeting that met in 2009 in Nairobi was organized by the PPD Secretariat while PPD ARO has been working with SEAPACOH opportunistically since 2008, working with other partners such as EQUINET, APHRC, etc. He

stated that PPD ARO has also invited West African countries to the last SEAPACOH meeting so that they can start to move as well.

Mr. Lakssir then said that PPD ARO is not selective. For example, in East Africa, PPD ARO has been opportunistic as the organization has received funding from donors who have focus in East Africa. He noted that some West African countries have been able to be incorporated into some of these activities. He said that there is not yet any funding for WARHN, but that PPD ARO has been working with the PCC for Ghana to try to see how to move and implement the strategic plan. ,

Dr. El Hadj Boubacar Samba Dankoko, the PCC for Senegal acknowledged and congratulated PPD ARO staff on the good reporting back from the PPD Board meeting in Pretoria, South Africa. He noted that when he was in Indonesia, he said that in the framework of the strategic plan, it would be desirable to get in touch with regional organizations because we are all coming from regions with a number of breakthroughs. Regarding West Africa, he noted that it would be very useful if PPD deals with partners such as WAHO, as it is doing excellent work in the region working with First Ladies. He noted that the health and population departments and the highest ranking officials in countries are structured and focused on the sub-regional bodies. He said that there is a wealth of information on WAHO's website, and that creating a partnership with them is of the essence, "Otherwise, we are missing out and trying to reinvent the wheel [and] we miss out on resources." He also asked if these documents and presentations on the screen are available in French so they can be shared.

Dr. Musinguzi agreed that WAHO is an important regional group we should work with. He said that PPD ARO and PPD Secretariat sometimes do not have good contacts with all of the regional bodies. He said that when PPD ARO works with WARHN, that WAHO should also be included. But he noted that with population issues, other organizations in addition to health organizations also need to be included.

Mr. Lakssir added that WAHO was involved during the process of developing the strategic plan for WARHN, and they made a presentation at the meeting. He said that during the meeting of SEAPACOH in Kampala in 2009, PPD ARO invited the WAHO Director to attend the meeting but unfortunately, there was no response and the director later apologized for that. Mr. Lakssir concluded by stating that for all presentations, he will make sure that they are translated and posted on the website so that PCCs can download them rather than printing.

Dr. Rachidi Lahsen, representing the PCC for Morocco, stated that Morocco's First Lady is traveling around the world sensitizing on cancer. He also noted that Morocco is the chair of the Executive Council of the WHO. Morocco has also been working with MPs around the world. He noted that the work of francophone countries is not reflected in the reports of PPD.

Dr. Musinguzi said that we do not always know about all issues, so PCCs need to inform us of partnerships at meeting and though other methods such as email communications.

Mr. Lakssir said that to clarify, PPD ARO has not been inviting First Ladies to meetings, but that PPD ARO is opportunistic in our approach, so the organization works with existing networks

such as OAFLA. PPD ARO worked with the AU to expose OAFLA to broader issues of health. He stated that Morocco is not an AU member, for the reasons that the PCC for Morocco knows better than he does. He again noted that the role of PPD is not to convene, but to work with existing networks. He said that the reports of PPD cannot be blamed, as countries need to actively participate in meetings and report on what they have done. This need had been shared with member countries at meeting. The PPD Secretariat can work with the PCCs to help them communicate. The PCCs need to take responsibility to share information about their countries' work.

The former PCC for Morocco, Dr. Mohamed Abou-Ouakil, said that each PCC is responsible for drafting reports on country activities. This report should also go beyond what is related to work with PPD. He noted that Morocco has done some missions to support other countries. He requested that PCCs get back to that information-sharing status with yearly reports. He noted that in the past, there were both country profile and reports, with various skills and structures noted. This means that on such occasions, PPD partners can share information. He thanked PPD ARO for helping PCCs to meet in Dakar, Senegal. He concluded by re-iterating that just as in the past, all countries need to report annually.

Dr. Musinguzi said that presentations of country work are very useful for sharing, and that PPD wants PCCs to take credit and share information, "We as PPD are not taking credit for everything, we expose you to what others are doing, and then you can do the work in your countries. We want to recognize the work done by you."

The representative from South Africa, Ms. Bongiwe Dumezweni-Ntakuiuba, noted that when partners report on activities, reports should not only focus on activities, but also answer the so-what question as it drives us to focus on outcomes. She noted that in Mr. Mugirwa's presentation, some of that issue was highlighted, but that it can be highlighted stronger. Her second point was that the sexual reproductive health work needs an explicit gender analysis, as PPD's partners are advocates of gender-equality work, so this analysis should be "in your face."

Dr. Musinguzi responded by stating that a focus on outcomes is essential, particularly as donors are demanding this outcome information, as well. He said that a discussion of outcomes and how partners can get there will happen later in the meeting. He agreed that gender is one of PPD's values, so the point of the representative from South Africa was well-taken.

Mr. Fathi Ben Messaoud, the former PCC from Tunisia, spoke next. He said that they are very happy to be with the team of PPD ARO and with Dr. Jooseery. He said this is an area where he has been involved in since the inception of PPD. The first observation he shared was on Mr. Mugirwa's presentation on the activities of PPD ARO; he noted the significant progress and leap forward by the PPD ARO in its work. He noted that the office started with $20,000 and due to the extraordinary effort made by the office, it has grown significantly. He applauded Dr. Musinguzi, who has made our organization enjoy glamour and also very active with many activities that have been done by the office since its inception. He noted that his colleagues from Morocco made an important point. He noted that North African countries have not been as involved with PPD ARO's work. He said that it may be due to political reasons and because of the distance and language barrier. He noted that Morocco, Tunisia and Egypt are all also part of

MENA as well as African continental organizations, yet unfortunately, "our attendance is not what it could have been." He stated that PPD ARO has yet to be to Tunisia. He said that those in Tunisia would be happy to have PPD ARO visit and that such a visit would also be a value-addition. He noted that since the inception of PPD, members have worked in conjunction on priorities including the MDGs. He called on those present to start brainstorming today, as PPD is not only about RH, it is about poverty, democracy, CSOs, NGOs and youth. He concluded by suggesting that all of these issues be put on the agenda for discussion in order to support the urgent and real needs of the African continent.

Dr. Musingzui agreed with Mr. Ben Messaoud stating that there can be a lot of countries can benefit from increased collaboration and that PPD needs to put sharing between countries as a priority.

The PCC for Ghana, Ms. Esther Cofie, said that there is a strong link between SRHR and population. She noted that a meeting in Ghana was held to develop a strategic plan for WARHN, with the participation of WAHO. She also noted that the strategic plan for WARHN has been translated into French, and has also been updated. She said that the issue now is to get the other countries in West Africa on board and starting to implement the strategic plan. She also requested that PPD help mobilize resources in order for implementation of the strategic plan to start.

Dr. Musinguzi agreed with Ms. Cofie's comments, and stated that PPD needs to help mobilize resources in order to help WARHN to move.

The representative of PCC from Mali, Mr. Toure Mountaga, said that the current conference being held in Dakar is wonderful opportunity for PPD to make headway. He noted that even if PPD partners are not in big numbers, PPD ARO should not underestimate itself. He requested that PPD ARO give directions on the approach to PCCs and countries, "you cannot dictate, but you can provide some priorities for us to be effective."

The PCC for Tunisa, Mr. Adnene Ben haj Aissa, agreed that partner countries should always keep the practice of drafting reports. He noted that every year, information can be sent, but not always necessarily presented in meetings, but that the ED can provide a summary of all of the reports. He also said he would like to have the next PCC meeting for Africa held in Tunisia in 2012, as the last meeting was held in Tunisia in 2002.

Next, Dr. Jooseery said that the strategic business plan (SBP) has been developed in consultation with all stakeholders. The SBP has goals, objectives, expected results, and activities related to each objective. Each activity has been costed with a budget. This budget was developed in consideration of current costs and the outgoing SBP's budget. As of September 2011, the resource mobilization of the existing business plan is 95%, and by December it will reach 100%. He noted that the two SBPs are in line with the broader strategic plan for PPD. He also agreed that PPD needs to ensure that country work is well-documented. He said that each country should have an annual report, yet only Ghana, Tunisia, Morocco and Indonesia have submitted reports on the PPD SBP for work done in 2011. He also stated, "We need to also think about the quality of network, of partnership we are having. It is not that we do not create, actually, we

[can] create network[s]. Morocco is welcome to join [the] network of First Ladies." He noted that PPD has reported on activities performed, but that it better needs to show outputs and outcomes. He noted that documenting outcomes is an area where PPD is weak, "We need to document further and ensure that whatever we are doing has an impact at the higher level. We have all these declarations for PPD meetings-- where have we failed? We need to know the outcome[s] at the national levels. This is where we have not done well." He then noted that participants have been given two important documents—the new PPD by-laws that were updated in November 2011 as well as a new booklet, "South-South Cooperation: A Pathway for Development" which defines South-South cooperation and tells PPD members how to build it and utilize the comparative advantages of PPD.

The third presentation on "FP/RH African Continental Frameworks: Maputo Plan of Action and Abuja Declaration: Key Frameworks for the Achievement of the ICPD and MDG Goals" was made by **Mr. Abdelylah Lakssir, International Programme Officer, PPD ARO**.

He began by introducing the Maputo Plan of Action, which is a continental policy framework on Sexual Reproductive Health and Rights (SRHR) adopted in 2006 by Africa Union Summit to accelerate and improve sexual and reproductive health and rights in Africa. It was extended to 2015 by the Africa Union Summit in Kampala, July 2010 and is vital to the achievement of the goals of the ICPD, and the MDGs, particularly MDG four and five. Within the first cycle of life of the MPoA, major milestones were attained, including several countries developing maternal and newborn health roadmaps, significant progress in scaling up linkages between SRH and HIV/AIDS, expanded access to FP services and laws to protect women against violence and criminalizing harmful practices against women were passed. However, progress in term of implementation varies between countries. Mr. Lakssir stated that the implementation of the Maputo Plan of Action must be supported by all parties, for example, the African Union should continue its advocacy role, conduct resource mobilization, monitoring and evaluation, and dissemination of best practices; Regional Economic Communities need to provide technical support to countries, advocate for increased resources, harmonize implementation, monitor progress, and share best practices; countries should incorporate all action areas of the Maputo Plan of Action into current national strategies and roadmaps, members of parliaments must play their legislative, representative, budget appropriation, and oversight roles and partners, including NGOs and CSOs and other development partners, need to align their financial and technical assistance and cooperation plans with national and regional needs.

Mr. Lakssir then discussed the Abuja Declaration, which was generated from a special summit of Heads of State of Africa held in Abuja from 26-27 April 2001 to address the exceptional challenges of HIV/AIDS, tuberculosis and other related infectious diseases. At this meeting, African governments committed to allocating at least 15% of their annual government budgets to the health sector. They also called upon donor countries to meet their commitment of devoting 0.7% of GNP as Official Development Assistance (ODA) and cancel African external debt in order to allow increased investment in the social sector. Since 2001, few countries have made progress in increasing their domestic funding towards the Abuja target. the AU reports that six (6) AU member states have met the 15% target—Rwanda (18.8%), Botswana (17.8%), Niger (17.8%), Malawi (17.1%), Zambia (16.4%), and Burkina Faso (15.8%). And according to the WHO, only eight (8) countries in Africa are on track to meet the Millennium Development Goals

(MDGs)— Algeria, Cape Verde, Egypt, Eritrea, Madagascar, Rwanda, Seychelles, and Tunisia—and most African countries are achieving less than 50% of the gains required to reach the goals by 2015. The AU reports that government health spending in sub-Saharan Africa currently averages US$25-27 per capita, yet 32 of the 53 AU member states invest less than $20. The result of this funding shortfall from both domestic and donor resources means than most African countries are not yet on track to achieve the health MDGs. He noted that Abuja's implementation can be supported by both African countries and donor countries. African countries need to monitor/evaluate and report regularly on progress towards the Abuja target in national and regional meetings; set out open and transparent policies on how domestic funding for health is sourced, spent, monitored and accounted for; promote South-South collaboration through exchange of best practices and expertise to improve the efficiency of the health system and Increase domestic spending for health but not at the expense of reductions in spending on other social services. Ministers of health and finance can enhance governance of ODA that flows into their country for health. Donor countries need to increase their ODA to the target of 0.7% of gross national product (GNP) to developing countries in line with the national and regional priorities of recipient countries.

Mr. Lakssir concluded by stating that, "Universal access to family planning and reproductive health services is critical for the achievement of MDG5 and essential to the other MDGs. The Maputo Plan of Action and the Abuja commitment are the vehicles in Africa for their attainment. It is time to refocus our efforts on ensuring their implementation."

After Mr. Lakssir concluded, Dr. Musinguzi added that the specific issue noted in the presentation ("Ministers of health and finance can enhance governance of ODA that flows into their country for health") is an issue that PPD ARO and partners will be working on during a meeting on Wednesday 30th . He noted that these ministers are critical for making the difference and that for the Wednesday meeting, PPD ARO has brought a group of African countries to discuss issues related to the demographic dividend and support for FP/RH and population issues and all PCCs are invited to observe the meeting. He noted that both donors and ministers will be talking at this meeting.

Ms. Bongiwe Dumezweni-Ntakuiuba, the representative from South Africa, added that the role of PPD should be outlined in the role of stakeholders in Mr. Lakssir's presentation.

The representative of PCC from Egypt, Mr. Osama Refaat Sherif, added that PPD ARO is helping member countries exchange expertise and knowledge. He stated that after 18 years or more as PPD, it is time for the member countries to communicate together to develop one standard FP/RH and poverty alleviation plan for population-development sustainability. He stated that, "countries need to work together to have one standard to work from."

Dr. Abou-Ouakil, the former PCC from Morocco, stated that PCCs could act as ambassadors of our institutions and PPD at the meeting. He stated that in order to make sure the issues more forward and are implemented through the watchdog role of the organization, and that efficiencies are realized from North to South. He argued that PCCs need to have technical training in advocacy and communication within their countries and also for meetings like the one we are having today in order to express voice for the ideas of the organization, as this will contribute to

the attainment of our objectives. PPD at Dhaka and the PPD ARO should devote some time to tell PCCs about the challenges of working in countries and how PCCs can help PPD to attain their objectives as well as the MDGs and the implementation of the strategic plan at the national level.

Dr. Jooseery commented on the Maputo PoA; he stated that it is an Africa-friendly ICPD. He said that it is meant to work on ICPD goals but with an African touch. He said that when it was being discussed in 2007, that it was ensured that the fifth objective of Maputo is South-South cooperation. He noted that unfortunately, this issue has not been given enough attention and important. He also agreed that financing for Maputo has not been adequate, preventing achievement of the goal. He stated that commitment from the North is necessary in order to achieve our goals.

Session Three: Country Experiences on the Implementation of Maputo and Abuja, and National Task Forces (NTFs)

In this session, presentations on Maputo and Abuja were made by representatives of member countries.

Dr. Betty Kyaddondo, PCC for Uganda, made the first presentation. She began by noting that Uganda has a maternal health roadmap, which is a tool for mobilizing resources and broadening responsibility beyond the Ministry of Health and donors. It has three central objectives: improving ANC and EmOC services, promoting health-seeking behavior, and ensuring the availability of family planning information and services. A total of 16 billion shillings ($8 million) is required annually, according to the costing figures for the plan. Achievements in Uganda include: the continental frameworks have been domesticated and popularized; strengthened partnerships and harmony between relevant MOH, MOFPED, MOES, MOLG, MOGLSD) CSOs, Members of Parliament and the media; population, family planning, maternal and child health are priority focus interventions in the NDP; improved community mobilization and empowerment through the Village Health Teams; renewed interest to cover Reproductive Health issues in the media; increased Government and donor funding for Health and specifically for FP and improved clarity and inclusion of stakeholders in the accountability mechanisms. Lessons learnt include: that artnerships vital in successful programmes; district political leadership is cardinal; more time is needed around ASRH and focused ANC, SAB and post natal care; lots of IEC materials are required to empower communities; the role of RH/FP Champions is essential to highlighting FP and MCH issues through the media; and programmes integrating health and economic empowerment are more successful and sustainable. Challenges include: policies and programmes have not been sufficiently implemented in order to reach the service delivery goals; lack of information needed to understand and monitor trends in RH and family planning funding, gauge levels of commitment, identify potential funding gaps, and advocate for increased government funding; community mobilization doesn't match service delivery; local governments play a key role in allocating resources within a decentralized system, but RH and FP are not usually viewed as a priority area at the district level; implementation of SRH and family planning programmes at the district level is hampered inadequate resources; and although the media still publishes negative articles, most health reporters have a positive attitude towards

FP. She also noted a number of recommendations to address the challenges present, and gave figures on the financing for reproductive health commodities against actual expenditures.

Dr. Kyaddondo then noted that Uganda's National Task Force has met three times. The first meeting was in October 2010 to increase the visibility of South-South cooperation in P&D. During the meeting, key stakeholders to constitute the NTF were identified. The second meeting held on June 30, 2011 brought together the NTF to agree on advocacy issues (Adolescent fertility and RHCS). At the third meeting, stakeholders agreed to address the following issues: strengthen MOH and MOES collaboration to ensure girls don't get pregnant in school, enforce the school health programme, address boys and men's role in reducing adolescent fertility, and follow up on National Health Accounts to track resources (where is the money coming from, where is it going and what is it doing?).

Mr. Adenene Ben Haj Aissa, the PCC for Tunisia, made the next presentation. He said that Tunisia's family planning program took off in 1966, with fundamentals of addressing gender and education. There was political commitment of the first president of the republic. He next spoke of activities undertaken since ICPD in 1994. Public health and service delivery has been improved, with a large variety of contraceptives available. Resources have been increased; 75% used to be donor-funded, but as early as the 1990s, the government took over. Currently, 92% is funded by the government. Donors provide 40% of resources. Mobile clinics are also available for service provision. There are 22 operational clinics where a wide range of services are available. CPR is high, with a national average of 60.2. Tunisia is working to reduce maternal death ratio. Tunisia is also making efforts to improve prevention of HIV/AIDS and other STIs. Special joint efforts with NGOs since 1995 have been made by Tunisia to address the special needs of youth and adolescents, in order to sensitize and counsel this population. There are also programmes to prevent gender violence. Tunisia has also done a number of South-South activities as well as triangular cooperation including South-North-South. Tunisia has worked with Mali and Mauritania, and soon will work in Niger. These programmes are supported by Northern donors. Tunisia also has a number of documents on its South-South cooperation programmes that can be shared with other participants. A NTF was set up in Tunisia, and meetings including NGOs were convened in 2008. Lessons learned include: since January 14, Tunisia found that there are glaring discrepancies between constituencies in distribution of resources (including in terms of human and financial resources and infrastructure). Before January 14, a rosy picture was painted but now regional discrepancies are visible. Decentralization and empowerment of decentralized regions is also important. Donor coordination is also important. And that we should do more with less resources

Dr. El Hadj Boubacar Samba Dankoko, the PCC for Senegal, began by noting that he is the vice-chair of the Executive Committee of the MoH and the coordinator for WAHO in Senegal. Senegal has developed an integrated package of services at all levels of the health system. Monitoring tools are reviewed and updated to ensure follow-up of issues. Senegal has also been conducting community mobilization through women leaders to increase the level of knowledge on diseases such as HIV, malaria and also talk about family planning and encourage delivery at health centres. Constraints include many actors and lack of clear coordination mechanisms. He also noted that programs are also mainly donor-driven in Senegal. The recommendations he made are to match interventions with the community needs, improve coordination of interventions, and advocate for an inclusive approach. Regarding FP, Senegal has a budget line

for contraceptive security and there is political commitment to increase funding. There is also a communication strategy for FP. Achievements include regular updating of policies and guidelines, development of a RHCS strategy and social marketing of FP products. Under repositioning of family planning, there has been increase of various FP method use. Abortion is risky and done in unsafe situations. Senegal has started a program to build obstetric centres to prevent women from having to travel such long distances to deliver safely. Caesarian sections and regular deliveries are free of charge to women. Contraceptive security has also been improved in Senegal, and quality of supplies is monitored by a lab. The budget for health is Senegal is 10.4% and there is a Presidential directive to meet 15% by 2015.

Dr. Rachidi Lahsen, the PCC for Morocco, began his presentation by noting that Morocco has made significant progress with increased access to health care and including eliminating user fees to make services free at government health centers. Morocco has had decreases in maternal mortality and increases in the contraceptive prevalence rate. Gender-based violence is also something that Morocco is fighting against, with a strategy and work including a guide and other ICE materials. He also mentioned that Morocco made significant progress in term of enhancing access to FP/RH services through the improvement of the availability and the quality of those services. Morocco also put in place a monitoring system of maternal and neonatal deaths throughout the country and national and sub-national committees are supporting this initiative. He also presented some FR/RH indictors that testify that the country in on truck to achieve the MDGs, especially MDG 5.He added that like other countries, Moroccan is experiencing youth social, cultural, economic and health dynamic and change, which require an appropriate institutional framework and multidimensional intervention . in this regard the Ministry of Health has developed and implemented a National Youth-Friendly Strategy to promote the health of youth and adolescents.
Regarding the MDG6 he mentioned that Morocco was able to put in place a comprehensive and well structured strategy to response to the HIV / AIDS, supported by a National Strategic Plan, a strong political commitment and a strong involvement of civil society organisations.
HIV prevalence remains very low (<1%).
In his presentation he highlighted that the Fight against tuberculosis is considered by the Ministry of Health in Morocco as a priority health intervention and that since 1991, the DOTS strategy has been adopted and successfully implemented.
Regarding the Malaria situation he shared that the year 2010 was marked by the granting to the country by the WHO, the certificate of disposal of autochthonous malaria.
Since 2005, no indigenous case or active transmission of malaria were recorded in the country.
In 2010, the epidemiological situation of indigenous malaria remained similar to previous years with ZERO cases of autochthonous malaria.

He concluded by stating that despite the efforts and achievements, a number of challenges remain, which include bridging the gap between the rural and urban areas, more improved quality of services, strengthening the monitoring and evaluation of health programs and enhancing the availability of qualified staff at health facilities.

Mr. Toure Mountaga, the representative of the PCC for Mali, noted that due to the lack of time, he will not be able to give his presentation, but a report in MS Word on the work of Mali is available for participants to read.

The **PCC for Ghana, Ms. Esther Cofie**, began by noting that the presentation she will make was prepared by the Population Council in Ghana, but that they were unable to work with the Ministry of Health to include their input. Ms. Cofie gave statistics for the country, and noted that the general policy environment in the country is based on and incorporates regional and international frameworks. National policies include: National Policies – National Population Policy, 1994, Reproductive Health Policy and Standards, (Revised, 2003) Repositioning Family Planning, 2006-2010 Millennium Acceleration Framework, 2010, National HIV & AIDS Strategic Plan 2011-2015, Roadmap for Maternal and New Born Health, 2008, and the Emergency Obstetric and Neonatal Care Needs Assessment, 2010. CPR is Ghana has gone backwards from 2003 to 2008, so in order to increase the visibility of family planning, Population Council celebrated a national family planning week. Little data is available on unsafe abortion, but there is PAC undertaken by the MoH. There is a lot of activity in maternal and child health and access to services has been increasing. Resources for SRHR have increased, and Ghana's national health insurance system includes maternal health care. The Population Council is also lobbying for the national health insurance system to include contraceptives for free. Ghana faces a number of challenges, including inadequate implementation and monitoring of programmes; resource constraints; cultural and religious constraints; leadership constraints; huge gap between awareness and practice; misconceptions and barriers to FP maybe fertility related, opposition to use, lack of knowledge; women's ability to access RH service is hampered by religious and cultural beliefs; low uptake of HTC partly due to stigma and discrimination against those testing positive; lack of adequate trained health workers and high staff turn over; info on availability of PMTCT not well disseminated; and inability to site CHPS compounds in all rural areas. She also noted a number of recommendations that the country can work on in order to meet these challenges. These recommendations include: effective implementation and regular monitoring of plans and programmes and sharing of reports; strong leadership for SRHR programmes at different levels; strengthen partnership between stakeholders in SRHR in the public and private sectors; strengthen strategies to overcome misconceptions about FP; and training and continuous capacity building for service providers. Regarding Abuja, between 14.5 in 2004 and 16.43 in 2010 of Ghana's national budget goes to health, but there is no specific budget line item for FP. In addition, her presentation included a lot of detail on specific indicators for Maputo and her presentation can be accessed online for full details.

Mr. Saikou JK Trawelly, PCC for the Gambia, made the next presentation on the work and achievements of the Gambia. Access to safe motherhood and child survival services have been improved with training of doctors, nurses and midwives and provision of equipment for emergency maternal and newborn child health (EMNCH) care nationwide, providing basic and comprehensive emergency obstetric care (BEmOC and CEmOC) on a 24 hour basis and the revision of The National RH Policy 2007-2014 to incorporate emerging issues. The president has also made a pronouncement that there will be free maternal care for all Gambian women. Achievements include: reduction of referrals due to maternal and RH emergencies; reported cases of incidences of malaria in pregnancy have reduced through focused ante natal care newborn child health (EMNCH) care nationwide; access to skilled attendance at birth; with

timely access to effective emergency obstetric care in the event of a complication. In addition, almost all the service delivery points are now offering at least four RH services (ANC, FP, infant welfare service and labour and delivery, and blood transfusion) and the RHCS logistics management tools were reviewed and updated in order to improve the Logistics Management Information System and capacity of health personnel has been built to do forecasting of RH commodities. Improved access to HIV Prevention and youth-friendly information and services at all levels has been through the creation of youth-friendly centres, increased uptake of VCT services. Constraints in the Gambia include: inadequacy of resources (financial, material and human) reduced the amount of programme inputs, geographical coverage and efficiency of service delivery, structural barriers (cultural denial and resistance), low socio-economic and political status of females, poor road networks impact negatively on the hospital referral system leading to delays that are responsible for high maternal morbidity and mortality, high staff attrition rates due to low morale and poor remunerations, lack of data has made decision making and policy formulation difficult and difficulties in mobility at community level for health supervisors. Lessons learned include: use of traditional communicators to disseminate messages on maternal and child health, increased male involvement in maternal and child health issues had led to marked reduction of mothers dying of ante-partum or post-partum haemorrhage and early decision-making in seeking help when obstetrical problems emerge. He then made a number of recommendations for the Gambia, which include: to establish a comprehensive programme of data for development, diversification of funding sources, intensification of capacity building of health personnel and facilities, and creation of incentives for health workers. He also noted that in Gambia, we have a "terminal working group," rather than a named "National Task Force." The working group has quarterly meetings, and annual meetings which visit intervention areas. One of the key advocacy opportunities is World Population Day. This group has also mobilized resources for the DHS and for the 2013 Population and Housing Census. At the Indonesia Board meeting, Gambia met with partners to get assistance and are now writing the bilateral assistance documents. South-South is also included in the 7th cycle of UNFPA assistance in Gambia.

The representative of the **PCC for Egypt, Mr. Osama Refaat,** gave an overview of Egypt's progress on ICPD and MDGs, including detailed statistical information and trend data. Egypt's population policy has changed over time according to conditions faced, and has moved from health approach to development approach. There is a broad Strategic Population Plan 2002 – 2017 and an updated Strategic Population Policy 2007 – 2012, with prime objective of targeting 2.1 children per family in 2017. Egypt has achieved the recommendations for reductions in the maternal mortality rate. The current MMR is 55 per 100,000. There have been improvements in a number of MDG areas. Egypt also conducted a third survey study on the financial expenditures versus the population development and stabilization programs and policies in Egypt for the years 2009 and 2010. This study will help with modifications to the strategy after the revolution of 25 January 2011. In comparison to other middle-income countries, Egypt has high out-of-pocket expenditures and government spending is low relative to other middle-income countries.

Mr. Refaat noted that PPD has supported the Ministry of Health and Population, the National Population Council to Develop a national task force to promote RH, Population and Development through the National South Support Structure of Egypt. The goals of the task force are to: enhance the collaboration with partners in population and development (South-South

cooperation) and to successfully continue the achievement of ICPD, 1994 plan of action and the MDGs. They have held two meetings, and have conducted activities including revising the objectives of NTFSS and its relation to the partners in population and development, presenting the proposed scholarships from the participated organizations, enhancing the role of the NPC in supporting the activities of Egypt and PPD, encouraging the fund raising agencies to participate and support the NTFSS member organizations and developing of an action plan and evaluating system for the NTFSS. More than 21 ministries work together on the NTF in Egypt. He concluded by stating that Egypt looks forward to establishing the new strategy in the next three months after parliamentary elections in order to try to reach 2.1 TFR by the end of 2017.

The last t presentation was made by **Dr. Lucien Toko, the PCC for Benin**. He said that Benin is going to mainstream the cost of family planning in the national health scheme. One goal of CARMMA is to reduce 75% of maternal mortality. He also noted that advocates want spending on the health sector to shift from 10-15%. He argued that Benin needs better community involvement and the involvement of traditional leaders in order to complement the work of the government. CARMMA was launched in September 2010 in Benin. He said that the maternal roadmap involves CSOs, donors, the private sector and government. He noted that 9% of the national budget goes to the Ministry of Health, and with advocacy, partners hope to increase the budget to 15% by 2015 as anticipated by Abuja. Benin's MoH has a budget line for contraceptives but no budget line for RH commodities; he said that this item is so small that we cannot tell you the exact percentage. He also identified difficulties faced due to a lack of human and financial resources, cultural taboos, and weaknesses in monitoring and evaluation. He concluded by giving a number of recommendations that will help Benin move forward to advance FP/RH nationally. Benin has a NTF that has met and has drafted a framework for the implementation of the roadmap.

Dr. Jooseery wrapped up the presentations very well by giving a summary of the significant work that has been going on in countries.

Mr. Ben Messaoud noted that the indicators shown do not always show the impact, for example, there may be high levels of spending on health, but not results. He also agree with South Africa's refusal to make a presentation, due to the time constraints. He said that PPD should be named Partners in Population and Health and said that it is high time to review our own stra. He concluded by arguing that we cannot just use the health sector, but that the health sector needs to be mainstreamed with many other development programs in order to improve the status of the community.

Dr. Musinguzi said that it is true that the targets for the MDGs are high, yet some countries are moving towards the targets. He said that when setting targets, you set them high even if you know it will be almost impossible to achieve them. He noted that these targets and standards are set not only to compare and report, but that Presidents personally were reporting on how countries were doing in their forums, "This peer pressure is good for our development." Dr. Musinguzi concluded by stating that, "for example on Abuja, some countries are not achieving 15%, if you have a big economy, you may not need 15%, 10% is good, but for a country with a small economy, 15% [of the country's budget to the health sector] is not enough."

Dr. Abou-Ouakil, the former PCC for Morocco, said that when you look at indicators, the indicators are not based on the same approaches, as some countries use national surveys, and there are different survey methods between countries. There are blatant differences. He noted that the exercise in sharing and comparing data across countries is important, but that partners need to share information and just indicate the source. He concluded, noting that despite difference, surveys are validated with demographers, and that some are even validated in America by a specialized institution.

Dr. Rachidi Lahsen, the PCC for Morocco, noted the recent elections in Morocco and said that there will be a new strategy that will be released in 2012. He said that all political parties have promised better health, employment and reformed education.

Mr. Toko Lucien, the PCC for Benin, asked for a definition for tripartate cooperation, as Morocco mentioned it earlier.

Dr. Abou-Ouakil, the former PCC for Morocco, answered by stating that an example of tripartite partnership in Morocco was with JICA. Countries wanted to share the example of Morocco in emergency obstetric and neonatal services. Training was done in Morocco and Japan and many African countries participated. He work was with medical doctors and nurses. Funding was provided by JICA and the training and the internship was provided by Morocco; the trainees were from other African countries. Also, in another project, nurses from African countries were trained with funding from the Islamic Development Bank while the site and trainers were Moroccan nationals. GTZ also did the same as a donor.

Mr. Ben Haj Aissa Adenene, the PCC for Tunisia, also spoke about tripartiate partnership, stating that all the partners benefit, and that there is cost-savings.

The representative for South Africa, **Ms. Bongiwe Dumezweni-Ntakuiuba**, noted that sustainable programs are often talked about, but she asked what we mean when we say "sustainability." She asked, "what is sustainability? what are we sustaining? What makes some programs sustainable?" She also said that this issue needs to be linked to how we protect the gains we have made in times of crisis. She noted that population and development discussions are about sustainability. She requested that this be something to reflect on in our next discussions.

The former PCC of Morocco, **Dr. Abou-Ouakil**, said that after the ICPD PoA, there has been the MDGs. He said that the MDGs are to serve the purpose to say that these are development indicators, not just health indicators. He said that this means that all stakeholders should work on that and reach the objective of health as part of development.

The PCC of Ghana, **Ms. Esther Cofie**, related to point raised by South Africa representative. She said that every country has a national development strategy to make sure that everything planned is sustained and not separated, as that is the way to make an impact.

Dr. Betty Kyaddondo, the PCC of Uganda, spoke in more detail about one of the lessons learnt in Uganda. She said that what they were previously doing wrong was not linking health to

broader issues of development, "We emphasized on mobilizing communities for health, such as for maternal health, but now we are mobilizing communities more broadly, and including mobilizing for economic health. Programs using VHTs give health education, educate on growing food, how to get some income. This way when communities access health care, they cannot complain they have no money for transport, [if you mobilize more broadly], you know that the women will have some money for transport for antenatal care and delivery." Communities are using market strategies for health, they forget about the free services, but often services are not really truly free. She noted that now with community mobilization in Uganda, "we now give a comprehensive package, so it is more sustainable."

Closing Remarks were made by **Dr. Harry Jooseery,** Executive Director, PPD. He stated that the group present covered a range of issues in depth, linking MDGs, Maputo, etc. with PPD's new strategic business plan. He noted that the group heard from nine countries and that "we have heard that countries have all made a lot of progress. We have seen that it is important to put more emphasis in a number of areas, including health system strengthening and monitoring and evaluation." He also noted the presence and useful contributions of veteran PCCs, whch have heped the discussions. He then noted that the ICPD addressed some issues only in passing and that there are emerging issues that need to be addressed, such as climate change in the context of sustainable development, nutrition and food security. He concluded by thanking the PCCs for their support through his tenure at PPD, stating that "it has been a formidable experience for me. The journey from 2006 to 2011 has been a very pleasurable journey. My dear brothers and sisters, you have been behind me, I am sure you will be behind me in the future. Thank you very much for your everything."

Dr. Musinguzi, spoke next, thanking all participants for their participation. He also noted the leadership of Mr. Lakssir and also Dr. El Hadj Boubacar Samba Dankoko, the PCC for Senegal, who also provided significant leadership and in-country support. He thanked past PCCs for their attendance at this meeting, Dr. Abou-Ouakil and Mr. Fethi Ben Messaoud , of Morocco and Tunisia, respectively, for their continued work for PPD and on behalf of PPD's shared issues. To conclude the meeting, Mr. Lakssir and Dr. Musinguzi presented Dr. Abou-Ouakil and Mr. Ben Messaoud , plaques commemorating their contribution to PPD and to South-South cooperation more broadly. They then presented Dr. Jooseery with an African statue representing the continued needs of African women for improved health and more generally, for population and development globally, as a departure gift.

Documents from the Third African Region Partner Country Coordinators (PCC) Meeting in Dakar, Senegal on 28 November 2011

Meeting Programme (English): http://ppdafrica.org/docs/PCC2011/programme-e.pdf

Meeting Programme (French): http://ppdafrica.org/docs/PCC2011/programme-f.pdf

Photographs: https://picasaweb.google.com/PPDAfricaRegionalOffice/PCC2011

List of Participants: http://ppdafrica.org/docs/PCC2011/px.pdf

Report (English): http://ppdafrica.org/docs/PCC2011/report-e.pdf

Policy Briefs: http://ppdafrica.org/index.php/en/programs/policydialog/policy-briefs

Session Two: Highlights on PPD ARO achievements, PPD Strategic Business Plan, and FP/RH Continental Frameworks in Africa
Mr. Patrick Mugirwa, Programe Officer, PPD ARO, "Highlights on PPD ARO Achievements": http://ppdafrica.org/docs/PCC2011/mugirwa-AROachievements.pdf

Mr. Abdelylah Lakssir, International Programme Officer, PPD ARO, "Highlights on PPD Strategic Business Plan and Its Operationalisation within Member Countries": http://ppdafrica.org/docs/PCC2011/lakssir-SBP.pdf

Mr. Abdelylah Lakssir, International Programme Officer, PPD ARO, "FP/RH African Continental Frameworks: Maputo Plan of Action and Abuja Declaration: Key Frameworks for the Achievement of the ICPD and MDG Goals": http://ppdafrica.org/docs/PCC2011/lakssir-maputo-abuja.pdf

Session Three: Country Experiences on the Implementation of Maputo and Abuja, and National Task Forces (NTFs)
Presentations on Maputo, Abuja, and National Task Forces (NTFs) were made by Representatives of Member Countries:
Uganda: http://ppdafrica.org/docs/PCC2011/uganda.pdf
Tunisia: http://ppdafrica.org/docs/PCC2011/tunisia.pdf
Senegal: http://ppdafrica.org/docs/PCC2011/senegal.pdf
Morocco: http://ppdafrica.org/docs/PCC2011/morocco.pdf
Mali: http://ppdafrica.org/docs/PCC2011/mali.pdf
Ghana: http://ppdafrica.org/docs/PCC2011/ghana.pdf
Gambia: http://ppdafrica.org/docs/PCC2011/gambia.pdf
Egypt (Population Programme Achievements): http://ppdafrica.org/docs/PCC2011/egypt-pop.pdf
Egypt (National Task Force): http://ppdafrica.org/docs/PCC2011/egypt-ntf.pdf

Benin: http://ppdafrica.org/docs/PCC2011/benin.pdf