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/)

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)
# Table of Contents

1. Executive Summary ........................................................................................................ 3  
   Key Conclusions ........................................................................................................... 3  
   Key Recommendations .................................................................................................. 4  

2. Background .................................................................................................................... 6  
   Meeting Objectives ........................................................................................................ 6  
   Post-seminar Expectations ............................................................................................. 6  
   Meeting Rationale .......................................................................................................... 6  
   Meeting Program .......................................................................................................... 7  
   Organizers .................................................................................................................... 7  

2. Session One .................................................................................................................... 9  
   Presentation by Dr. Khama O. Rogo: “AID Architecture and Health Outcomes in Africa: Focus on Family Planning” ................................................................. 9  
   Presentation by Ms. Rhonda Smith: “Uganda on the Move” ......................................... 14  
   Presentation by Dr. Claude Sekabaraga: “Financing of Reproductive Health in Rwanda: Contributions of Resource Tracking” ......................................................... 19  
   Presentation by Dr. Chisale Mhango: “Malawi: Population & Development: Progress through Family Planning” .............................................................. 22  

3. Session Two ................................................................................................................... 26  
   Statement by Hon. Rukia Chekamondo ........................................................................ 26  
   Statement by Dr. Sadia Chowdhury ............................................................................. 27  
   Statement by H.E. Adv. Bience Gawanas .................................................................... 28  
   Discussion ..................................................................................................................... 29  

4. Session Three ................................................................................................................ 33  
   Panel on “Donor Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?” ...................................... 33  
   Panel on “Ministerial Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?” ........................................... 37  
   Presentation by Dr. Kassa Tsegaya Kebede: “Re-Affirming Commitments to Achieve the Health-related MDGs/MDG 5b” ........................................................................... 42  

5. Closing Session .............................................................................................................. 44  
   Statement by Mr. Sangeet Harry Jooseery .................................................................. 44  
   Closing Statement by H.E. Adv. Bience Gawanas ....................................................... 44  

Appendix 2: List of Participants ....................................................................................... 48  
Appendix 3: Documents Available Online ....................................................................... 53

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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 (PPDA RO), 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

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\(^1\) http://www.fpconference2009.org/
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 intergovernmental 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/](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/](http://www.worldbank.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.”

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.

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

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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](http://ppdafrica.org/docs/FinancingHealthMDGs/rogo-e.pdf)


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. 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%. The

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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%). 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 planning. [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%.

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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%).

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 . . . You cannot see only through one eye . . . What are we waiting for?”

— Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group.
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, 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 MDG 5 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.

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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.

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://ppdfrica.org/docs/FinancingHealthMDGs smith-e.pdf
"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)

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.

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 than they actually have.”

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.
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.

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

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“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

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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](http://ppdafrica.org/docs/FinancingHealthMDGs/sek-e.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 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 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
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).

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 by 2015, (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.

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

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.”

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

“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
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. Biène Gawanas**

The next official statement was made by H.E. Adv. Biène 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 reaffirmed 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 it is 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. 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

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.

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.” 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, released two years ago, which made this case very clearly.

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

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“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

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.”\(^1\) 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

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.

“\textit{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.}”
\textit{-- 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 panelists: “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.”

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.”

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 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.”

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 the 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 it 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

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.”

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.

**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. 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);

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• 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.
“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 (PPD)

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.”

Closing Statement by H.E. Adv. Bience Gawanas

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda item</th>
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<tbody>
<tr>
<td>0930 – 0945</td>
<td>“AID Architecture and Health: Outcomes in Africa: Focus on Family Planning” by Dr. Khama O. Rogo, Senior Advisor, Health in Africa, World Bank Group</td>
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<tr>
<td>0945 – 1015</td>
<td>“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</td>
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<td>1015 – 1045</td>
<td>“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</td>
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<tr>
<td>1045 – 1115</td>
<td>“Presentation of RAPID model for Malawi” by Dr. Chisale Mhango, Director, Reproductive Health Unit, Ministry of Health, Malawi</td>
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<td>1115 – 1130</td>
<td>Break</td>
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<tr>
<td>1130 – 1300</td>
<td>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</td>
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<tr>
<td></td>
<td>Statement by Dr. Sadia Chowdhury, Coordinator, Reproductive and Child Health Programs, Population and Reproductive Health Capacity Building Program, World Bank</td>
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1300 – 1400 Group Photo and Lunch

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
<table>
<thead>
<tr>
<th>Time</th>
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<tr>
<td>1515 – 1630</td>
<td>Discussion on “Ministerial Perspectives on National Policy and Resource Commitments to MDG 5b: What Are the Barriers and Solutions to Effective Aid?” Discussion</td>
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<tr>
<td>1630 – 1715</td>
<td>“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</td>
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<td></td>
<td><strong>Closing Session</strong></td>
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<tr>
<td>1715</td>
<td>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</td>
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<tr>
<td>1930</td>
<td>Dinner in Commonwealth Banqueting Hall</td>
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</table>
## Appendix 2: List of Participants

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Organization</th>
<th>Country</th>
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<tbody>
<tr>
<td>Dr. Adelaide Caruaiho</td>
<td>National Director of Public Health</td>
<td>MOH</td>
<td>Angola</td>
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<td>Dr. Anna Maria Rodriglaves Wok</td>
<td>Dinebot Finance</td>
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<td>Angola</td>
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<td>Dr. Gdelaide de al Fatuma DE CARVALHO</td>
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<td>MOH/PATHFINDER</td>
<td>Angola</td>
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<tr>
<td>Dr. Isilda Maria Simoes Neves</td>
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<td>MOH</td>
<td>Angola</td>
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<td>Dr. Maria Isabel Antonio NassocoLO neves</td>
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<td>Rene Drate</td>
<td>Director of Family Health</td>
<td>Ministry of Health</td>
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<td>Dr. Elise Quedraogo Diendere</td>
<td>Medecin</td>
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<td>Bukina Faso</td>
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<tr>
<td>Dr. Jeanetta Johnson</td>
<td>Deputy Director General</td>
<td>WAHO</td>
<td>Bukina Faso</td>
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<tr>
<td>Mrs. Delphine Bovoes</td>
<td>Delegate</td>
<td>Ministere Economic et finances</td>
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<tr>
<td>Mrs. WatoDelphine Barry Traore</td>
<td>Delegate</td>
<td>Ministry of Economics and Finance</td>
<td>Bukina Faso</td>
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<tr>
<td>Prof. Fru Fobuzshi AngwafO III</td>
<td>Secretary General</td>
<td>Ministry of Public Health</td>
<td>Cameroon</td>
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<tr>
<td>Dr. Frehiwot Berhane Defaye</td>
<td>Specialist M&amp;E Coordinator</td>
<td>IGAD</td>
<td>Ethiopia</td>
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<tr>
<td>Dr. Keseteberhan Admassu</td>
<td>Director General</td>
<td>Ministry of Health</td>
<td>Ethiopia</td>
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<tr>
<td>Dr. Mesrak Nadew Belatchew</td>
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<td>USAID</td>
<td>Ethiopia</td>
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<tr>
<td>Dr. Kassa Tsegaya Kebede</td>
<td>Senior Advisor Population, SRHR and Culture</td>
<td>African Union</td>
<td>Ethiopia</td>
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<tr>
<td>Mr. Alula Sebuatu Mesbena</td>
<td></td>
<td>Ministry of Finance</td>
<td>Ethiopia</td>
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<tr>
<td>Mr. Sahlu Haile</td>
<td>Regional Advisor</td>
<td>Packard Foundation</td>
<td>Ethiopia</td>
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<tr>
<td>Mrs. Bience Gawanas</td>
<td>Commissioner</td>
<td>African Union</td>
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<tr>
<td>Ms. Radia Mohammed Hassen</td>
<td>Director</td>
<td>Minister’s Office-Ministry of Women’s Affairs</td>
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<td>Premila Barlett</td>
<td>SR RH/FP Advisor</td>
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<td>Shaino Daba Hamusse</td>
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<td>M. Piune Jando’n</td>
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<td>Policy Office, French Ministry of Foreign Affairs</td>
<td>France</td>
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<tr>
<td>Dr. Elias Sory’n</td>
<td>Director-General</td>
<td>Ghana Health Services</td>
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<tr>
<td>Paul Sossa</td>
<td>Health Adviser</td>
<td>USAID</td>
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<tr>
<td>Dr. Claude Sekabaraga</td>
<td>Health Specialist</td>
<td>World Bank; Former Director of Policy Planning and Capacity Building Ministry of Health, Rwanda</td>
<td>Kenya</td>
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<tr>
<td>Dr. Bartrice Kigon</td>
<td>Head DRH</td>
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<td>Dr. Eliya Msiyaphazi Zulu</td>
<td>Director</td>
<td>African Institute for</td>
<td>Kenya</td>
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<td>Name</td>
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<td>29</td>
<td>Dr. Sheila Nyawira Macharia</td>
<td>Seniro Health manager</td>
<td>USAID</td>
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<td>30</td>
<td>Hon. Ali Mohamed Hussein</td>
<td>MP</td>
<td>Kenya National Assembly</td>
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<td>31</td>
<td>Hon. David Ekwee Ethuro</td>
<td>MP</td>
<td>Kenya National Assembly</td>
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<td>32</td>
<td>Hon. Robert Onsare Monda</td>
<td>Chair, Health committee</td>
<td>Kenya National Assembly</td>
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<td>33</td>
<td>Mr. Stephen Wainana</td>
<td>Economic Planning Secretary</td>
<td>Ministry of Planning</td>
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<td>Mr. Tewooddros Melesse</td>
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<td>Mrs. Yego Eunice Kigen</td>
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<td>Hon. Jerolimmek M. Piah</td>
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<td>Ministry of Gender and development</td>
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<td>39</td>
<td>Hon. William Twehway</td>
<td>Assistant Minister</td>
<td>Ministry of Education</td>
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<td>40</td>
<td>Mr. Edwin Power Gaye</td>
<td>MP</td>
<td>House of Representatives</td>
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<td>41</td>
<td>Mrs. Patricia Kamara</td>
<td>Assistant Minister</td>
<td>Min. of Gender and Development</td>
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<td>Dr. Chisale Mhango</td>
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<td>43</td>
<td>Hon. Mwanza Patrick</td>
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<td>Lilly Memory Baaruda-Maliko</td>
<td>Deputy Team Leader (HPN)</td>
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<td>Mihowa Lingalireni</td>
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<td>Office of the Vice President</td>
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<td>46</td>
<td>Mr. Athanase Nzokirishaka</td>
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<td>UNFPA</td>
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<td>47</td>
<td>Mr. Maxwell Mkumba</td>
<td>International Affairs Advisor</td>
<td>Office of the vice President</td>
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<td>48</td>
<td>Mrs . Olive Mutema</td>
<td>Policy Advisor</td>
<td>Futures Group International</td>
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<td>Mrs. Fannie Kachale</td>
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<td>Mrs. Olive Mtema</td>
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<td>51</td>
<td>Mrs. Winnie Chilemba</td>
<td>Nurse/Midwife Lecturer</td>
<td>Unversity of Malawi</td>
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<td>52</td>
<td>Ms. Grace Gondwe</td>
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<td>Ministry of Development Planning &amp; Cooperation</td>
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<td>Ms. Juliana Lunguzi</td>
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<td>Ms. Mihowa Lingalireni</td>
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<td>Office of Vice President, Malawi</td>
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<td>Hon. Fanta Mathini</td>
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<td>Assemblee Nationale</td>
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<td>Mr. Joosery Harry</td>
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<td>Dr. Mojisula Odeku</td>
<td>Project Director</td>
<td>JHU/CCP NURHI</td>
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<td>61</td>
<td>Hon. Sudatu Sani</td>
<td>Committee Chairman Chair of the Parliamentary Committee on MDGs</td>
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<td>Ken Uchechukwu Okoro</td>
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<td>Mr. Abdullahi Mawada</td>
<td>Snr. Program Manager</td>
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<td>Mrs. Igharo Elizabeth Egbibhalu</td>
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<td>Public Health, John snow, Inc./USAID/Deliver Project</td>
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<td>Mrs. Salako Adebusola Abidomi</td>
<td>Chief Nursing Officer</td>
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<td>Ms. Ifeoma Ofili</td>
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<td>Abdullahi Maiwada</td>
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<td>Veronique Chikwaka</td>
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<td>74</td>
<td>Prof. Aloys Nguma Monganza</td>
<td>President of Congolese Society of Obstetrician/Gynecologists</td>
<td>Obstetrics/Gynecologist (Scogo)</td>
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<td>Congolese Society of Obstetric and Gynaecology (SCOGO)</td>
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<td>Dr. Bacor Nyamadu Daff</td>
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<td>81</td>
<td>Mr. Bunmi Makinwa</td>
<td>Director, Africa Regional Office</td>
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<td>Dr. Michael Mbizvo</td>
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<td>83</td>
<td>Ms. Sarah Jonson</td>
<td>Technical Officer</td>
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<td>84</td>
<td>Mr. Omara Yussuf Mzee</td>
<td>Deputy Minister</td>
<td>Ministry of finance</td>
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<td>85</td>
<td>Mrs. Florence Maridadi Mwairi</td>
<td>Assistant Director</td>
<td>President’s Office</td>
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<td>86</td>
<td>Ms. Mwanaidi Mahiza</td>
<td>IT Manager</td>
<td>National bureau of statistics</td>
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<td>87</td>
<td>Ms. Sauda Kassim Msemo</td>
<td>Principal Economist</td>
<td>Ministry of Finance and Economic Affairs</td>
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<td>88</td>
<td>Dr. Josee Yawa Djugubo Apetsianyi</td>
<td>MD, MPH</td>
<td>Ministry of Health</td>
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<td>Dr. Tchiguiri K. Kassouta N’ tapi</td>
<td>Medecin</td>
<td>Government Ministry of Health</td>
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<td>90</td>
<td>Dr. Yawa Djugbe Josee</td>
<td>Medecin</td>
<td>Ministre Sante</td>
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<td>Dr. Fred Kakongoro Muhumuza</td>
<td>Economic Advisor</td>
<td>Ministry of Finance</td>
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<td>92</td>
<td>Dr. Aine Byabashaija Aloysious</td>
<td>National Program Coordinator</td>
<td>Venture Strategies innovations</td>
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<td>93</td>
<td>Dr. Betty Nakazzi Kyaddondo</td>
<td>Head, FHD</td>
<td>POPSEC</td>
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<td>94</td>
<td>Dr. John B Kabera</td>
<td>Consultant</td>
<td>Futures Group</td>
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<td>Dr. Jotham Musinguzi</td>
<td>Regional Director</td>
<td>PPD-ARO</td>
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<td>96</td>
<td>Hon. Baba Diri</td>
<td>MP</td>
<td>Parliament of Uganda</td>
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<td>97</td>
<td>Hon. Jessica Eriyo</td>
<td>Minister</td>
<td>Ministry of Water &amp; Environment</td>
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<td>Hon. Rukiya Chekamondo Kulany</td>
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<td>MoFPED</td>
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<td>Mr. Abdelylah Lakssir</td>
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<td>Mr. Charles Zirarema</td>
<td>Ag. Director</td>
<td>Population Secretariat</td>
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<td>Mr. Francis Tukwasibwe</td>
<td>Programme Officer</td>
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<td>102</td>
<td>Mr. Hannington Burunde</td>
<td>Head Communications</td>
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<td>Mr. Isah Mbuga</td>
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<td>Mr. James Kotzsch</td>
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<td>Mr. Nuwamanya John</td>
<td>Foreign Service Officer</td>
<td>Ministry of Foreign Affairs</td>
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<td>Ms. Diana Nambatyaa</td>
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<td>Ms. Janet Jackson</td>
<td>Representative</td>
<td>UNFPA</td>
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<td>110</td>
<td>Ms. Josephine Byekwaso</td>
<td>Bilingual secretary</td>
<td>Uganda</td>
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<td>Ms. Kangabe Edith</td>
<td>Ag. Head Policy and Planning</td>
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<td>112</td>
<td>Hon. Baroness Jenny Tonge</td>
<td>Member of Parliament</td>
<td>UK</td>
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<td>113</td>
<td>Mr. Anthony Daly</td>
<td>Regional Maternal Health Advisor</td>
<td>DFID, East Africa</td>
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<td>Dr. Don Lauro</td>
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<td>6HTech</td>
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<td>115</td>
<td>Dr. Eduara Bos</td>
<td>Lead, Population Specialist</td>
<td>World Bank</td>
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<td>116</td>
<td>Dr. Matha Campbell Martha</td>
<td>President</td>
<td>Venture Strategies for Health</td>
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<td>Dr. Michael Klag</td>
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<td>118</td>
<td>Dr. Sadia Afroze Chowdhory</td>
<td>Coordinator RH</td>
<td>World Bank</td>
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<td>119</td>
<td>Dr. Scott Radcoff</td>
<td>Director, Office of POP&amp;RH</td>
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<td>Dr. Werner Haug</td>
<td>Director</td>
<td>UNFPA</td>
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<td>121</td>
<td>Dr. Williard Cates</td>
<td>President, Research</td>
<td>Family Health International</td>
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<td>Scott Radloff</td>
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<td>Dr. Bellington Vwalika</td>
<td>Head, Obstetrics and Gynecology</td>
<td>University of Zambia</td>
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Appendix 3: Documents Available Online

**Agenda in English:** [http://ppdafrica.org/docs/FinancingHealthMDGs/agenda-e.pdf](http://ppdafrica.org/docs/FinancingHealthMDGs/agenda-e.pdf)

**Agenda in French:** [http://ppdafrica.org/docs/FinancingHealthMDGs/agenda-f.pdf](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](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](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](http://ppdafrica.org/docs/FinancingHealthMDGs/sek-e.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](http://ppdafrica.org/docs/FinancingHealthMDGs/mhango-e.pdf)

French: [http://ppdafrica.org/docs/FinancingHealthMDGs/mhango-f.pdf](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](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](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](http://ppdafrica.org/docs/FinancingHealthMDGs/jooseery-e.pdf)