International Dialogue
Population and
Sustainable Development

October 21st 2004
GTZ-Haus
Reichpietschufer 20
10785 Berlin

Implementing the Millennium Development Goals

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Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH

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in cooperation with
SCHERING
making medicine work

Federal Ministry for Economic Cooperation and Development

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Schering AG would like to thank all the organizations and numerous participants who made this third International Dialogue Population and Sustainable Development a success. We would like to express our special thanks to Klemens van de Sand, who as the Commissioner for Millennium Development Goals within the Federal Ministry for Economic Cooperation and Development (BMZ), supported this meeting.

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SCHERING
making medicine work

Berlin, January 2005

Editorial

It was the third time that highly recognized experts met in Berlin to attend the International Dialogue Population and Sustainable Development – Implementing the Millenium Development Goals. The importance of this conference was emphasized by the presence of Ms Thoraya Obaid, Executive Director of the United Nations Population Fund (UNFPA), New York.

The main issue of the 3rd International Dialogue was focussed on the Millennium Development Goals. This was due to the fact, that the MDGs are worldwide recognized as the driving objectives to achieve a just world in balance between poor and rich.

In September 2000 Kofi Annan, UN Secretary General, announced the Millennium Development Goals (MDGs) as a start into the 21st century. Today numerous organizations focus their activities on the implementation of these goals. Three of the eight MDGs call for improvement in the health sector – reduction of child and maternal mortality, prevention of HIV/AIDS, tuberculosis and malaria – for equal opportunities for women, and for elementary education for all children until 2015.

During the International Dialogue – Population and Sustainable Development – Implementing the Millennium Development Goals - experts on development aid, and the initiators and supporters of the MDGs discussed their mutual concern for the successful implementation of these goals.

Education as the key to better prospects in life in development countries was realized as one of the crucial issues. It was discussed how education can be imparted and how it can be inbedded in particular cultural contexts.

The second key issue paid attention to the access to health services, medical care and contraceptives. 300 million couples – particularly in developing countries – know about the prevention of pregnancy but have no means to avoid them. Therefore access to medical services and contraceptives is indispensable.

All these discussions showed, from Schering's point of view, that there is still a lot to be done. Partnership with the privat sector, this was one of the results, is essential to fulfill the MDGs. Schering feels confirmed in continuing its social commitment.

We would like to thank all the participants, who made this conference a success. Special thanks to all distinguished speakers: Dr. Assia Brandrup Lukanow, Dr. Thoraya Obaid, Dr. Michael Hofmann, Dr. Dietrich Garlichs, Namtip Aksornkool, Flavien Nkondo, Samir Jarrar, Dr. Jörg F. Maas, Tewodros Melesse, Dr. Wolfgang Bichmann, Dr. Claus Janisch und Dr. Klemens van de Sand.

We also would like to express our gratitude to the organizations – German Foundation for World Population (DSW), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), International Planned Parenthood Federation (IPPF) Kreditanstalt für Wiederaufbau (KfW) and the Federal Ministry for Economic Cooperation and Development (BMZ) – who now for the third time renewed their partnership.

Holger Schumann
Leiter Social Healthcare Program,
Schering AG

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Dr. Sabine Grund
Journalist, Berlin

The third International Dialogue on Population and Sustainable Development focussed on the Millennium Development Goals (MDGs). The cooperating organizations were: Federal Ministry for Economic Cooperation and Development (BMZ), German Foundation for World Population (DSW), International Planned Parenthood Federation (IPPF), Kreditanstalt für Wiederaufbau (KfW), Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) and Schering AG. g+h communciation was the organizing agency. Gabriele Heuser, journalist with Radio Berlin Brandenburg (rbb), introduced the speakers and acted as facilitator for the discussions.

Two preceding conferences in Berlin during the past two years reported on regional perspectives and special projects from three continents and on the birth spacing initiative. This 2004 conference focussed on how to integrate reproductive health (RH) into the MDGs and on a new financial incentive structure to deal with the growing financing gap between needs and donor funding. The concept of RH includes maternal health, women's education/empowerment/equality and HIV/AIDS issues.

It appeared that three major issues dominated the discussions at this conference
- how to integrate RH issues into the MDGs politically,
- how to reach the main target group of poor, often illiterate women, with appropriately simple information and in culturally sensitive ways,
- how to narrow the financial gap between contraceptive and other medical supplies needed and the decreasing donor contributions.

MDGs and reproductive health (RH) – 10 years after the Cairo International Conference on Population and Development (ICPD)

The main issues were all touched by **Ulrich Köstlin,** Member of the Executive Board, Schering AG, in his opening address. He acknowledged the social responsibility of transnational corporations like Schering, as beneficiaries of globalization, in a world where 10 million children a year are dying before their fifth birthday. He elaborated on Schering's engagement, beginning with the support of family planning organizations in 1961. The medication distributed is the same sold anywhere in the world, only the packaging differs – in an attempt to prevent the product from returning to the commercial market. To reach the target group of the very poor, the company has gained experience in providing medical information leaflets for illiterate or semilliterate women. He also emphasized that Schering does not act out of pity but regards partner organizations as an equal and considers its engagement as a long-term investment in future customers. **Köstlin** stated that, "only what costs something is worth something". People are more disciplined in taking medication when they pay something for it.

In her presentation **Thoraya Obaid,** Executive Director of the United Nations Population Fund (UNFPA) took issue with the initiative suggested by some parliamentarians in Strasbourg to introduce an additional, ninth MDG on RH. She explicitly stressed that the field of RH may not have a goal of its own, rather it underpins the achievement of all eight MDGs. To officially add RH would require all governments to vote for that in the UN General Assembly. Various donors and developing countries agree that adding a ninth goal would not rally but splinter the efforts. Mainstreaming RH into the eight goals will give it sustainability, while having it as a vertical ninth goal would isolate it.

Obaid's main concern is that national governments understand the significance of RH for poverty reduction and include specific policy measures, relating to RH, into their national progress reports towards the MDG. To be effective, they have to itemize RH measures in the national budget. Thus achieving the MDG goals will only be possible when the goals of the ICPD, Cairo 1994 are also met. **Obaid** had some encouraging news regarding the national progress reports on MDGs. Africa has done best among the continents in including RH, a fact she ascribed to experience with the HIV/AIDS epidemic. Asked about (**Matthias Weiter,** BMZ) the role of civil society, **Obaid** added that countries like Yemen, Azerbaijan, Cambodia and others, which have included RH into their national reports, were supported by UN teams that helped the government reach a national consensus on the issue. The UN teams usually tried to get as much civil society involvement as possible.

Asked about her main wishes (**Klemens van de Sand,** BMZ) to the private medical firms, **Thoraya Obaid** mentioned

- that all people living with HIV/AIDS have access to anti-retroviral medication, including protecting infants from mother-to-child-transmission;
- that there is universal access to reproductive health services through the provision of quality and variety of contraceptives for the poorest of the poor;
- fast development of microbicides, a cream for women to protect themselves from HIV which is still in experimentation, and the speeding up of vaccines for HIV/AIDS.

The need for continuity in public programmes

Evina Ndo Engolo, parliamentarian from Cameroon, suggested groups like the Female Parliamentarians Network, the Association of Female Jurists, or the Association of Female Engineers as local partners for Schering in Cameroon. In response, **Ulrich Köstlin** stressed that his main wish for better cooperation with the public (sector) was to have reliable and long-term partners. The widespread stop-and-go mode of public programmes in developing countries brings disruption and discontinuity. That is destructive for efforts in family planning, and likely in the fight against HIV/AIDS. He cited his positive experience of cooperating with pro familia in Columbia, an organization that had been active consistently over 30 years, with great continuity in management. Such continuity is essential for birth-control products like a 5-year-implant for women. This product is very useful for some women, because they don´t have to remember taking the pill every day. But he also stated, that the product has to be removed after five years. But the firm has no data on what happens if it stays in the body longer. Yet the fairly simple

removal procedure requires a local partner institution with a sufficiently long time-frame. Before working with a new partner, Schering always asks: Is this a partner we can trust to be in business with for more than five years? Continuity and consistency of local partner organizations are the firm's most urgent request to the public sector.

Thoraya Obaid also underlined the need for more continuity. A UNFPA survey of 164 countries and their activities over ten years has indicated that the countries' greatest challenge lies in building a sufficient capacity of skilled people who will remain in their positions over a longer period of time. This is essential to deliver programmes and strengthen national institutions to maintain the programmes in place.

How to increase cultural sensitivity

Responding to a question (**Robert Zinser,** Rotary International) about the family planning activities of conservative non governmental organizations (NGOs), **Obaid** stressed that UNFPA is working with many conservative NGOs, whom the reality on the ground makes more active rather than conservative. Her dream would be to have a conference to showcase the work done by faith-based organizations and local cultural communities in reproductive health (RH) saving women's lives, and on HIV/AIDS. The results might be surprisingly positive to many international observers.

UNFPA's and the industry's idea (**Wolfgang Bichmann,** BMZ) of how to make contraceptive security work have to be discussed in light of cultural factors. Culturally ingrained practices like polygamy (**Teboho Kikine,** Lesotho Embassy) and the generally lower legal status of women are contradicting women´s empowerment. Does UNFPA support local civil society in changing attitudes in order to become able to reform the justice system? There is an enormous need for more programmes that will empower women (**Stella Regina Nakiwala,** DSW Uganda) so that they can support themselves out of poverty. Programmes have to look at women more holistically and take into account their daily living conditions.

On the notion of contraceptive security **Ulrich Köstlin** argued that most pharmaceutical products are so light-weight and inexpensive to transport that they could be provided from any manufacturing spot. The problem of contraceptive security lies not with purchases or manufacturing. It depends on a reliable local distribution network and an adequate storage that ensures that supplies are continuously available at any time and location when needed. This is a matter of education and development of the skills to manage distribution.

Thoraya Obaid disagreed on the question of purchasing power, there have been 49 poor countries with a delivery gap in contraceptives – and the Dutch government has come up with the money. Yet she emphasized that countries can´t always rely on donors, they need to work on the segmentation of their market, determining who can pay and who cannot yet pay. Second, and following the same logic of increasing coverage of costs by the receiving side, the ministry of health has to include a budget item for contraceptives to prove the commitment of the country. That amount has to grow successively and eventually cover domestic needs. In Nicaragua it has meant that for the first year the

country provided 20 per cent and donors contributed 80 per cent after two years the ratio will be 40 to 60 per cent and further increasing for the Nicaraguan side. Third, the issue of RH is included in Poverty Reduction Strategy Papers (PRSP), thus contraceptives ought to be included in budgets established under PRSPs. Fourth, European donors give budget support, for instance to Senegal, and the country decides how to use it. Obaid observed that contraceptives were needed in the country, but the EU money was not spent on them. So it might be helpful if EU donors earmarked money for RH purposes in their budget support. **Obaid** agreed with **Köstlin** on the need to improve distribution and storage of contraceptives. There is a loss of products due to corruption and the leakage of contraceptives to the commercial market. But there is also a severe lack of availability, when Uganda receives three condoms per man and year, despite its high AIDS infection rate.

As for the traditional practices, **Obaid** conceded that NGOs and development actors have to ask self-critically: What have we been doing wrong in the past 50 years? Women are still not empowered enough, and the situation is becoming worse. These questions can´t be resolved by verbal reference to human rights. For long times, there has been a lack of sensitivity to the contexts of the countries, to understanding cultural taboos and dealing with them constructively. UNFPA has begun a training programme on gender taboos, supported by Germany. In one sad example in Africa, an HIV-positive woman was refusing not to nurse her baby. If she didn´t nurse, her mother would know she is infected. So, she had to choose, either killing/infecting her baby or exposing herself. Understanding the context, and getting the affected people to identify positive elements in their context to improve their situation, is what is needed.

According to **Obaid**, the persistence of female genital mutilation (FGM), for instance in Egypt, proves that despite all the money invested over 50 years development actors have failed in major ways. There is something wrong in how we were approaching it, we have to look and empower cultures and faiths and motivate them to deal with these issues. Similarly, we have failed in the economic empowerment of adolescents and women, which is very important to poverty reduction and central to the Millennium Development Goals.

Towards a new type of partnership

In his presentation **Michael Hofmann** (BMZ) stressed the significance of the MDGs in integrating the recommendations of all major UN conferences during the 1990s. The need for a new type of partnership between industrial and developing countries was introduced at the subsequent Monterrey conference.

The German financial contribution has been declining, due to severe budget problems nationally. In light of financial shortfalls, the MDG 8 concerning a new partnership gains added significance.

Hofmann also stated, that the style of cooperation has to change. The Poverty Reduction Strategy Papers (PRSPs) are vital documents, reflecting a paradigm shift towards ownership clearly being with the developing country. Accordingly, donors should move from

a project towards a programme and, progressively, towards a budget approach. That means Germany can´t earmark its funds towards any goals anymore, like it was possible under the project approach. If Germany wants to collaborate with specific countries in the field of RH, this might reduce the partner countries to those who are willing to enter into cooperation in that field. Alternatively, German money for RH could be given to NGOs, but that would mean to forego the opportunity to press countries towards structural changes. **Hofmann** emphasized the need for such an element of intervention as a ´harsh policy dialogue´ with some governments. An example are discussions surrounding the Arab Human Development Report. In that region, one could compromise by avoiding the term "reproductive health" and instead talk about the prospects and freedom of the people, and the empowerment of women in particular.

The meaning of the term "coherence" (**Assia Brandrup-Lukanow,** GTZ) needs to be considered in various contexts. **Hofmann** mentioned that the Programme of Action 2015, that the Chancellor requested, was compiled and agreed upon by the whole Cabinet. Thus all relevant ministries had to cooperate.

But in demanding more coherence, **Hofmann** reminded the audience that we all have to be aware that people´s ability to deal with complexity is limited. So there is need to find tools to remind people of the various aspects they have to consider. A focus on complementarity (**Claudia Radeke,** KfW) may be useful here. If major international donors concentrate on AIDS, German funds could be focussed on family planning. But most of all, a change of attitude is needed among NGOs (especially German ones), that supplies of condoms and pills are not free of charge, that people should pay in accordance with their financial means. And countries have to take responsibility for their projects. Donors should move towards programme support but they still should monitor the use of funds.

Education and public awareness

The sensitive nature of sex education was shown in the movie "When African Women Talk Sexuality" (by Le Groupe Amos, DR Congo 2002). A group of Kongolese women was to be taught by a local teacher about sex. The video showed how uninformed this women are and how they are at a loss of words.

The movie introduced the Plenary Session I on education. **Dietrich Garlichs** (UNICEF Germany) emphasized that education is important for all children, a focus on girls mainly is less adequate than it might have been some years ago. The gap of school attendance between boys and girls has narrowed in recent years, but girls still drop out earlier and there are regional disparities. A lower educational level for girls means early marriage and more children. Every additional year of a girl´s schooling reduces the mortality rate for her children by five to six per cent; and reduced mortality is essential to reducing the population growth rate. In addition, it is estimated that two thirds of young women in Africa don´t know how to protect themselves against AIDS. So this fact is another argument for education.

One major impediment to education is school fees: They were abolished in Kenya last year, and 1.5 million more children showed up for school. Female teachers are important

for girls. Also separate sanitary facilities. Education is the strategic MDG to promote and achieve the others, like poverty alleviation, health, water and sanitation, and gender issues. UNICEF did originally focus on girls´ education because there was a major gap. But since the gap has nearly closed, what matters most is education of a sufficient quality, for girls and boys. UNICEF decided to leave Afghanistan when the Taliban banned girls from schools, that was a political decision based on principle. But generally, education is equally important for all children.

Namtip Aksornkool (UNESCO Paris) from Thailand introduced her programme, "Africans Write For Africans", on AIDS education. She mentioned that literacy is often taken for granted, but is absent in parts of the population. In Swaziland one in three people is AIDS-infected, in Botswana and Zimbabwe one in four, and in South Africa it is one in ten. In 2001, the Saturdays in Swaziland were reserved for funerals, today there are daily funerals. 80 per cent of the infections occur in sexual relations. The question had arisen in the UN system, why after 10 years of efforts, there still was so little progress, why people did not change their behavior. It turned out that the educational material on AIDS was unsuited, not relevant to people´s daily lives, too technical and not culturally adequate. Thus stakeholders in respective countries were brought together to develop new materials: teachers, literacy workers, police/law enforcement officers, traditional healers, other health workers, religious leaders and the media. They are sensitized to gender issues (including traditional songs and dances) and informed about AIDS-related questions. That includes fighting against myths, such as that sex with very young girls can cure from AIDS, a widespread belief. The stereotype of macho men has to be broken. Men are taught to take responsibility to avoid infection for themselves and their families. Local people develop their own information materials on AIDS (supported by UNESCO), using culturally adequate ways to represent the lessons. This creates a greater chance that the message will reach the relevant target groups.

The economic and health crisis in various African societies implies that major family relations are disrupted. Aunts, who are usually preparing girls for marriage, are no longer around to teach the young girls/adolescents about sexuality. **Flavien Nkondo** (GTZ) from Cameroon found out that in his country this leads to early pregnancies and girls dropping out of school and sometimes even becoming social outcasts. This problem occurs at all levels of society, often the fathers of the fetus abandon the underage mother, and her parents can´t deal with the consequences. Therefore, a programme was developed to teach younger women about sex, so that they pass on their knowledge to their surroundings as "aunties". These trained aunties go to schools, they act as confidants of pregnant girls, in case even counselling them on a safe abortion if they really want that, or on how to deal with the pregnancy and stay in school. So far, 2700 aunties have been trained, there is more demand. Rwanda and Nigeria want to take up this program, and it will be included in the public investment budget of Cameroon. In the school where it began, there were 60 cases of pregnancy in primary school, after six months there was only one case.

Samir Jarrar (Arab Resource Collective, Lebanon) reported that one in five people in the Arab world lives on less than two dollars a day, while the region also has some of the

wealthiest countries. The variations are enormous in wealth and education. The original Islamic teaching demanded that every believer seek education, primarily to read the Quran for themselves. Today the female half of the population is largely excluded from the development of the region. On the positive side, more than 95 per cent of an age cohort receive primary education, most kids are in co-ed classes, more girls are going to school. Yet what is really needed is a change in the paradigm of education, the quality of education is too low as the curricula have not been adapted to the requirements of the present. Religion is not an obstacle in principle, but poorly trained religious teachers are. The highest rate of illiteracy is among women over 60 years. School fees are still a problem in some regions of the Arab world.

It was discussed that the running costs of an education system should not be covered by donors, since education has to be owned by the countries themselves (**Garlichs,** UNICEF). That could also mean that donors should not engage in funding primary education at all; but where countries need temporary help, donors might step in with support. In many countries the decision makers don´t know anything about the conditions in public schools, which they and their kids never attended. **Klemens van de Sand** (BMZ) weighed in quoting Jeffrey Sachs, who recommends that countries have to invest upfront in primary education to make an economic take-off possible. So should donors refuse funding for education even if countries demonstrate political will and good governance but just lack the means at the moment? According to **Jarrar**, one major problem for the reorganization of the educational system remains that those few who are educated teachers spend a lot of time writing reports for donors, while there is a lack of effective teachers to do the daily work. A good teacher can improve a curriculum, but a good curriculum does not help if there are only unqualified teachers. The educated Arabs spread around the world, they need incentives to return and work in the region. The primary problem may not be money, and there is abuse of donated funds. A different incentive structure is urgently required for educated people to work in the region instead of going abroad. **Garlichs** agreed that much more donor money will not be available, as long as some countries spend more on the military than on health and education together.

Medical supplies under a new partnership

A devastating funding situation was painted by **Jörg F. Maas** (DSW): In 1992 the funding needed to supply means of contraception was US$ 222 million, while donors contributed US$ 82 million. For 2000 the donor contribution had increased to US$ 200 million while the projected need was US$ 811 million. Four donor organizations have joined efforts in a supply initiative to improve the coordination of their efforts and use available funding most effectively. Added complications result from a lack of storage facilities and weak distribution systems. Better overall donor coordination could close around a third of the funding gap with efficiency improvements. And donors should take up the task of improving the distribution systems so that supplies available in the countries actually reach the consumers.

On average, African goverments spend between three and nine per cent of the budget on health, including the donor component, according to **Tewodros Melesse** (IPPF in

Nairobi). Kenya today is down to spending US$ 3.5 per person and year for health. This does not take into account the segmentation within society. The rich can fly to Europe and get every treatment they want. The middle class might get subsidized or free medical service from some NGO. Yet the poor are left out, over 50 per cent of the population live in rural areas and few will have access to services or money to pay for them. This situation cannot be overcome with increased donor contributions, there are other options. First and foremost, governments have to prove that they are serious about health, they have to allocate funds for contraceptives in the national budget. This has to be complemented by capacity building for forecasting needs and better regional distribution.

Whoever is able to pay for contraceptives should do so. Only those who cannot pay, should be assisted or even get them for free. But there has to be a strategy of evaluating income, making more people pay. Services provided should be competitive with the private medical practice. Once this new type of service is established, in fact even with a concessionary loan from development banks, the clinics will attract this cateogry of the population. The income derived for these clinics will not only make them self-sufficient but help them to subsidize services to underserved populations and community based activities.

The redefinition of partnership between North and South should include NGOs. Donors ought to require accountability also for institutional input: Is their support perpetuating dependency or improving local capacities? What about the internal brain drain, away from public service to foreign NGOs that offer higher salaries? This is not sustainable. On the part of the receiving countries, there is a tendency to set up NGOs (supposedly non-profit) which are really consultancies. In some countries the legal framework has not been updated since the 1930s. Corruption exists not only in the public sectors, NGOs are not free from it. Transparency should apply to the civil society and the private sector as well. The need for a longer-term commitment mentioned by Schering is a mutual one, countries would like to have that with donors and the private sector. **Melesse** stressed the need for a much more open and sincere dialogue between the donors and national governments, and among the donors themselves, to avoid unnecessary competition and potential abuse of funds. This has to come from the countries in the South, they have to be determined to improve the situation by setting their priorities.

Wolfgang Bichmann (KfW) underlined the dramatic population growth in the coming years with 96 per cent of it in the developing countries. There has been a drastic increase in family planning since the Cairo conference but, due to population growth, by 2015 the amount of US$ 1.8 billion would be needed for contraceptives. The funding gap will not be closed by donor money. More efficient use of funds as well as government budget allocations are ways towards reducing the gap. Part of the problem is that in some countries RH is thought of as a global public good that donors have to make available.

There are five possibilities to close the funding gap:
- user fees for all who are able to pay, subsidies only for the very poor,
- increased community financing schemes by NGOs, a mixture of pre-payment and user fees,
- expanded private sector participation and thus more cost efficiency by 10 to 15 per

cent: market segmentation, less administrative and legal barriers for private providers, incentives for private service provision (i.e. tax deductions),
- expanded social protection, social security mechanisms that include RH,
- innovative new financing mechanisms like those currently being developed for immunization programmes ("contraceptive independence initiative").

German development cooperation in reproductive health should collaborate more intensely with the private sector. In partnership with other organizations and donors, it should use the financing experience and comparative advantages of Germany as one of the big contraceptive donors. And if an opportunity arises, one should participate in the preparation and structuring of a global supply fund to bridge the existing financial gap.

Restructuring financial support

Claus Janisch (KfW) focussed on the need for innovative mechanisms to actually implement the MDGs, as called for in the title of the conference. External donors provide 40 per cent or more of the health budget of at least 30 developing countries, and foreign aid plays a significant role in another 30 countries. Government and NGO donors pursue two objectives:
- to subsidize selected essential needs, and
- to encourage changes (in technology, management or economic structures) judged beneficial to low-income groups.

Treating tuberculosis, testing for HIV, or contraceptive services are either not affordable to people living on two dollars a day, or they involve a preventive care that people struggling to survive the next day may not choose to invest in.

In cooperation with India, it had become evident to KfW that 80 per cent of rural health services in that country were delivered by the private sector. This led to the question of efficient allocation of German donor resources, which hardly rely on the private sector. Currently, most assistance is given as input support or supply-side subsidies. Grants are made to governments or local NGOs to cover costs of implementing a programme. These inputs can be infrastructure, commodities, teaching etc. Input-based assistance is also budget support, which was mentioned this morning. This input-based assistance has dominated in family planning and reproductive health (RH), and the results since the Cairo conference have been disappointing.

In contrast, output-based assistance (OBA) agrees on a unit cost for specific essential output. Then it pays the cost directly or offers a subsidy to low-income groups through coupons/vouchers with or without co-payment from the client, a system that is also called demand-side subsidies. KfW assumes that in selected circumstances, output-based funding has advantages over input-based assistance. OBA payments to providers resemble commercial transactions, such as paying for a haircut.

Under OBA, external donors and national governments subsidize selected items of essential health services for poor target groups. Payment occurs either by issuing coupons or vouchers with cash value for services to patients, or as direct payment to providers without vouchers. These payments can be combined with a variety of govern-

mental and private insurance schemes. A small co-payment from low-income clients may be required.

OBA has a number of logistical advantages:
- encouraging efficiency and quality in services;
- enabling donors to target external resources (co-payments);
- a more efficient model of project management for the donor agency. OBA permits funds to be disbursed rapidly, without the distortions of input-based assistance;
- the ability to expend rapidly, even more important in confronting HIV/AIDS.

KfW supports a voucher system in Kenya, where a sex worker buys a voucher for a small amount, which covers STD diagnosis and treatment. In the first week of the programme, one woman was selling 250 vouchers, and the women buyers later called to thank her for this efficient service. Similar voucher programmes are planned for safe delivery, sterilization, diagnosis and treatment of child pneumonia etc..

The clients buy the voucher and go to any accredited service provider; they are free to choose their doctor. That will reward those doctors who provide a good service, who open their clinics later in the evening or early in the morning – in contrast to government institutions that traditionally close at five o´clock and during the weekend. A private management agency reimburses the service providers quickly after receiving the vouchers. That agency conducts internal monitoring and evaluation, claims and payment, accreditation and marketing distribution of the vouchers. The poor use of resources denies services to many in need. All policy statements speak about the grass-roots beneficiaries, thus it is high time to include them in reaching the MDGs. OBA is a mechanism to empower the clients/patients by giving them the money (in the form of vouchers). **Janisch** stressed that it is time to concentrate on the beneficiaries, not on the bureaucrats, as we have done in the past.

The discussion of the prior presentations focussed on how to improve involvement of the private sector. **Lutz Schaffran** (Schering, Family Planning international) described how UNFPA orders supplies from Schering, which would normally take six months to produce and ship. UNFPA usually wants products delivered immediately, but they are unable to give estimates half a year in advance of how much they need. So for 30 years Schering has made its own planning for UNFPA and stores the products in its warehouse, with a risk that they will not be able to sell all of them. He contrasted that IPPF, always notifies Schering of its annual demand one year in advance.

Bichmann emphasized the need to define more clearly what we understand by public-private partnership (PPP). Health ministries could be regulating bodies, but sometimes they also employ nurses and deliver health services. There needs to be more clarity in the structures. An improved partnership could be the new financing mechanisms for immunization programmes that are currently being developed.

The services of faith-based organizations in Africa should be better integrated into international efforts. These organizations each define what type of services are compatible with their value system, that simply has to be taken into account when choosing cooperating partners. The German goverment usually tries to include such faith-based partners in its programmes (**Janisch**).

Acceptability of contraceptives could be improved through better marketing. The proper branding of condoms will make them attractive, even turn them into a fashionable product. That is a cultural issue which has to be taken more seriously. Also condom application has to be explained in the local language (**Ingar Brueggemann**). Reservations were expressed about implants, especially for illiterate women, as this could be the opposite of empowerment. One has to make sure that women understand what kind of product they are using, and that they really want that. On the other hand, the voucher concept just presented is a very creative idea, local NGOs could be involved, they could take responsibility and support the wider use of such creative instruments (**Namtip Aksornkool**). **Janisch** replied that the first voucher project was very small, now other donors like the World Bank and the Department of International Development (DIFID) are seeking cooperation on that with KfW.

The issue of outdated laws and customs in Africa was raised again. Traditionally, men decide when to have sex and whether to use a condom. There is a new law proposed to guarantee equality in marriage, but that is not yet passed and may well be discarded by the next government. Are donors involved in strengthening the legislative framework, so that laws are reformed and respected by future governments? To this **Tewodros Melesse** replied that politicians always act on short-term logic; thus it is the task of professional bodies and civil society to defend laws or demand their reform.

Melesse was asked about his perspective on OBA (output-based assistance): This appeared to strengthen the demand side, not just economically but politically to hold governments accountable (**Klemens van de Sand**). He first stated that there should be more programmes with mutual accountability of governments and donors to each other, where governments cover a growing part of costs at a yearly increasing rate. There is such predictability in the actions of corporations, the same should apply for the behavior of governments. **Melesse** confirmed that vouchers are a good innovation. Yet he cautioned that health is not a profitable business and thus needs public sector involvement, because there are people in all countries who can´t pay all or part of the cost. The positive effect of the voucher system is to challenge health providers to be more efficient and competitive in order to earn enough vouchers. Both for health care financing and as a cost-efficiency measurement, a competition of different providers is an excellent initiative.

Wolfgang Bichmann added that this voucher system is not an invention of KfW. There had been a meeting this summer, and a presenter had asked whether the fact that so little had improved over the years was an indicator of wrong approaches. New economic approaches are pointed out to donors by creative organizations like IPPF and the Aga Khan Foundation. When more funding is not feasible, one has to think about new approaches, and there are many pilot experiments with OBA worldwide that have to be taken up and pursued.

Closing summary and reflections by Klemens van de Sand (BMZ)

Klemens van de Sand was the speaker to give the closing summary. He realized six major crucial points, which were discussed during this conference.

1. The MDGs are results that define what has to be achieved - not what has to be done and how. Reproductive health (RH) is essential for reaching all MDGs. There is no need for a ninth MDG, both because RH is already implied in the MDGs and for the political reasons stated by Thoraya Obaid.

2. MDGs are to be achieved at the national level, therefore national strategies and actors matter for RH. And national strategies are developed by national governments that have to develop not just any strategies but credible ones. That means, these governments put their own resources into the appropriate strategic fields. Even if resources are limited, there is scope to reshuffle the budget, for example from military to health expenditures. National strategies have to be owned by governments, and they are fundable from external sources when the developing countries´ governments, as mentioned by Tewodros Melesse, put their house in order before going to the donors. That has to be highlighted again.

3. It has to be admitted that Germany did not live up to the promises made in Cairo. But the most important implication for donors is that reliable funds are essential. Stop-and-go policy has to be put an end. Sustainability in the field of reproductive health and education requires long-term engagement; a three-year programme does not make a lasting difference.

4. The MDGs cannot be achieved without the private sector: It was important to hear this morning that the private sector acknowledges its social responsibilities. There certainly is scope for reducing prices of medical supplies, though not below profitability. There is also need for more research on medicine, for example in microbicides for women.

5. On funding, the first question is where more money should come from. A very interesting example was the OBA approach by KfW, that can be combined with external funding. This and other options to mobilize internal funding have to be used.
   The second issue is the use of funds. Running costs, salaries of teachers/health workers etc.. Funding should only be a last option in cases where governments have done everything else possible to mobilize their own resources.
   Third, we need to look at quality of output. It is not enough that children go to school, they have to learn something. It is not enough that you put up health centres if there is no medicine and are no health workers. MDGs are misinterpreted when they are seen only as measurable in numbers. Capacity, quality and institutions matter, that is where investment is needed and has to be combined with donor funding for infrastructure.

6. Institutions in all fields of development are really important, and they have to be accountable. There is no purely technical approach to health or education, the institutional setup and governance structures have to be taken into account. Thus GTZ has to be very much a political institution, living up to the very core of its goal, namely building capacity.

Welcome Address

Dr. Assia Brandrup-Lukanow

Director of the Division for Health, Education and Social Protection, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), Eschborn

I would like to welcome the distinguished representatives of UNFPA, UNICEF and UNESCO, and of the German Ministry for Economic Cooperation and Development, Excellencies from the embassies, ladies and gentlemen, dear colleagues:

It is my pleasure to welcome you to the third "International Dialogue on Population and Sustainable Development" which will focus on the Millennium Development Goals. We are pleased to host this meeting on behalf of the coorganizers, the German Ministry of Economic Cooperation and Development, the Schering Corporation, the German Foundation for World Population, the International Planned Parenthood Federation, the Kreditanstalt für Wiederaufbau and the GTZ.

This is a "private-public-UN-bilateral-governmental-non-governmental" cooperation. I don't know if you have had a chance to see the small flyer, which announced today's meeting, and how the logos hardly fitted around the paper of the flyer.

I think this is an implementation of the Millennium Development Goals – Eight Partnerships, and we hope that these partnerships will carry us further together. Today, we will discuss how to take the Cairo Agenda into the commitment to the Millennium Development Goals, and which role our respective organizations can play in working towards the achievement.

In addition to a more in-depth view of the UNFPA report, we will have the opportunity to go into more detail on the important role of the private sector, both in research and development, as well as with respect to corporate citizenship and corporate social responsibility.

We will hear the perspective on the implications of Cairo for German Development Cooperation today. We will then look particularly at the role that the education of girls plays, and the continued need to improve the access to medical service, medical supply, and contraception. We hope that by the end of the day, we will be able to come up with some answers for action and joint priorities.

I would like to take this opportunity to thank two people who have helped us in coming together today and who have put tremendous effort into communicating with all the different organizations, and these are Annette Hornung and Rhan Gunderlach of g+h communications. Thank you very much for all the work you have done in preparing this meeting.

And without further ado, I would like to introduce the speakers of this morning's session. Ms **Thoraya Obaid** is the Executive Director of the United Nations Population Fund. She

has joined the UNFPA in 1999 as Director for Arab States and Europe. Prior to that, she was a member of the United Nations Strategic Framework Mission to Afghanistan. In 1996, Ms Obaid chaired the Inter-agency Task Force on Gender in Amman. She was also a member of the International Women's Advisory Panel and of the Regional Programme Advisory Panel, of the International Planned Parenthood Federation IPPF. She was particularly involved in women's issues in the Arab States. From 1983 until 1990 she was a member of the editorial board of the Journal of Arab Women and a member of the Working Group for formulating the Arab Strategy for Social Development sponsored by the League of Arab States. Ms Obaid comes from Saudi Arabia and was the first Saudi woman to receive a Saudi government scholarship to study in the United States, and she has particular experience in crossing cultures and in inter-cultural communication.

Mr **Ulrich Köstlin** is a member of the Board of Executive Directors of the Schering AG and is in charge of marketing and sales, supply chain and environment for Europe and Africa. Before, he has worked in various positions in the pharmaceutical industry, such as the General Manager of Infarma in Quito, Ecuador, and in the USA as General Manager for Diagnostic Imaging and Member of the Executive Committee of Berlex Laboratories. Mr Köstlin holds a doctorate in law and brings us today the perspective of the private industry.

And Mr **Michael Hofmann,** is since 1999 Director General of the Department Global and Sectoral Policies, of the Multilateral and European Cooperation at the Federal Ministry for Economic Cooperation and Development. From 1979 until 1980, he was the assistant of the president of the Brandt-Commission. He worked at the research institute of the Friedrich-Ebert-Foundation and as a researcher at the German Development Institute DIE. From 1988 until 1992, Mr Hofmann was an advisor of the former German Chancellor Willy Brandt, and he was in charge of the office of the Social Democratic Party leaders Björn Engholm and Rudolf Scharping. He is a member of the German United Nations Association, the Society for International Development and the advisory board of the German Foundation for Development and Peace.

Opening Address

Dr. Ulrich Köstlin
Member of the Executive Board, Schering AG, Berlin

Family Planning – Schering's Commitment to Corporate Citizenship

There is much talk today about globalization—about the one world, which grows ever smaller and more interdependent. Companies like ours are constantly challenged to take a position on global issues. Transnational companies, in particular, are seen as the beneficiaries of globalization. We are reminded that, in a world in which every fifth person still lives on less than one dollar a day, in which 130 million children still do not go to school, in which ten million children a year die before their fifth birthday—in such a world, we are told, we should not work purely to maximize our profits. We must not only take a position but take responsibility.

As a representative of Schering, and as a human being, I can only agree. Corporations nowadays have to manage a very complex network in the system of stakeholders. There are the shareholders, the customers, the employees and the public in general. I believe, that we have to act according to the doctrine of sustainability, not only today, but also in the medium and long run. This requires from us responsible behaviour. The fact that Schering has helped to organize this particular conference is just one expression of our sense of responsibility and the stance we take.

This is the third International Dialogue on Population and Sustainable Development. This year the conference takes place under the motto "Implementing The Millennium Development Goals." The link between Population and Sustainable Development on the one hand, and the Millennium Development Goals on the other hand, is very clear. In front of this particular audience I will not expand on this further. But I want to emphasize that we, as a company, with health as our core business, can only support the fact that three of the Millennium Development Goals focus on health. Goal five speaks of the improvement of maternal health, and that naturally includes management of fertility and reduction in the birth rate. It is clear that Schering sees this as an important target. Aside from religious and social pressures, it is often just a lack of information and of money, which prevents women from exercising their choice and from actively planning their families.

Almost entirely out of the public eye, Schering supports projects run by family planning organizations. The first projects started back in 1961 in India and in Colombia, where I have worked myself and have had many intense contacts with the organizations there. Their aim was to supply even the poorest of the poor with contraceptives. Since then, our activities have grown continuously. Schering has so far realized family planning projects in over 120 countries, often together with the UNFPA and the World Health Organisation (WHO). In other words, we've made contraceptives available at cost price, without taking

a profit. We've supplied contraceptives at cost price to governmental organizations such as the Kreditanstalt für Wiederaufbau (KfW), the Department for International Development (DFID) or the European Union, as well as to international organizations such as the WHO. They then distribute these products free to family planning organizations. There is no difference in the quality of the products from those we sell in industrialized markets, such as our home market in Germany. And this, by the way, is a very important point because we do not want to encourage any re-flow of these types of products into the commercial market. The packaging is different, and – a very important point – the information leaflet is designed in a different way. Here, such leaflets are filled with tiny print; in countries where we can't assume that everyone can read, the information leaflets may include pictogrammes. In that way, women who can't read can still understand how they have to take the pill and what precautions they have to take.

In addition, on the basis of market studies in many countries of Asia, Latin America and Africa, we make medication available to middle class women at a price they can afford, which means with lower profit margins for Schering, so-called social marketing programmes. Our aim is to increase both the availability and the acceptance of contraceptives among women of this class. We fix a price that is enough to make it a commercial transaction but which is within reach for a lower middle-class income. We've discovered that people take medication in a more disciplined manner if they have to pay for it. The rule seems to apply: only what costs something is worth something. So, one of the contributions to this globalized world is a broader choice for women through a differentiated price policy for our products and the fact that we make a wide range of products available.

Some people might now be asking themselves: why does Schering sacrifice commercial profit? What does Schering get out of it?

It's an open secret that companies want to make profits, and Schering is no exception. But that doesn’t have to be a contradiction between company ethics and competitive profits. Experience shows that ethical behaviour can bring increases in cost and reductions in turnover and profits, at least in the short term. It would be unrealistic, even dishonest, to deny this. But successful companies do not only consider short-term profit. And this is particularly true when giving up short-term profit is, in effect, an investment in the future.

Ernst Ulrich von Weizsäcker said, and I quote: “Concerning oneself with business ethics in the long term is not a waste of scarce resources. Properly understood, it is in a company's long term self-interest and becomes part of a company's rational policy.”

For Schering, our contribution to family planning is not only ethical behaviour but makes business sense. We believe in the need for birth control for many years to come. Broadening information and choice for women in all countries and under all conditions will also favour the long-term development of the commercial markets. And it is these markets which allow us to amortize our substantial investments in Research and Development, this year alone around one billion Euros, and return a profit to our shareholders.

Once more: Schering's commitment to this conference, and naturally Schering's commitment in the fields of family planning, reproductive health and sexual health, combine social responsibility with healthy commercial interest. It's not a “good-will” action, and certainly not a gesture of pity. As we understand it, social commitment means treating your partner as an equal. Our partner organizations define their needs and we help them, because we have the means to do so and because, as representatives of the rich half of the world, we feel we have a responsibility to do so.

Finally, let me express a wish. I hope that the impulses that emerge from this conference will be taken up at the forthcoming UN conference, which will evaluate where we are five years after defining the Millennium Development Goals.

Keynote Address

Dr. Thoraya Obaid
Executive Director, United Nations Population Fund (UNFPA), New York

An Overview

Status quo – new insights – new challenges ? Is sexual health rightly consolidated under the Millennium Development Goals (MDGs)?

I would like to thank Schering for being socially responsible as a private sector company. As you know, the whole issue of responsibility of the private sector was an initiative of the Secretary-General, and we appreciate initiatives like those of Schering. I would like to thank all those that have sponsored this meeting, and I am very happy to be with you today.

I have just come from Strasbourg, from the second International Parliamentarians' Conference, where more than 130 parliamentarians adopted recommendations to strengthen the implementation of the ICPD Programme of Action. Actually one specific recommendation for parliamentarians is, to strive, to convince governments to include a ninth goal on universal access to reproductive health in the 2005 review of the Millennium Development Goals.

Before that, I was at UN Headquarters in New York attending the General Assembly's commemoration of the ICPD 10th anniversary. Minister after Minister and Ambassador after Ambassador, actually 65 countries, affirmed their commitment to build a better world and reaffirmed their commitment to the ICPD.

Such policy deliberations and declarations are important. But sometimes we must remind ourselves of what we are actually trying to achieve, and for whom. Our focus should always be on people.

I am at this meeting today in the hope that a woman in Mali will not die on a donkey cart on the way to a health clinic. I come in the hope that a girl in Bangladesh will be able to attend school and not be forced into early marriage. I come in the hope that a young man in Colombia will have guidance to respect women and girls and be a supportive partner. I come in the hope that a mother of ten in the slums of Nairobi can protect herself and her children against HIV/AIDS. I come in the hope that a young couple in the grips of poverty who want to plan and space their children are able to do so. And I come in the hope that a girl in Eastern Congo can be safe from rape.

Reproductive health and the linkage to the Millennium Development Goals

I have been asked this question: Is sexual and reproductive health rightly consolidated under the MDGs? My answer is: You know that there is no specific goal for reproductive health among the eight goals, but the goal itself informs and underpins the achievement of all the eight Millennium Development Goals. It's like the UN Secretary-General Kofi Annan has wisely stated, and I quote him: "The Millennium Development Goals, particularly the eradication of extreme poverty and hunger cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts to promote women's rights, and greater investment in education and health, including reproductive health and family planning."

The international consensus was reached in Cairo at the 1994 ICPD on the goal to achieve universal access to reproductive health services by 2015. Reproductive health is a broad concept that encompasses long established rights and understandings. The ICPD Programme of Action says that reproductive health includes sexual health and it implies that people are able to have a safe and satisfying sex life free from coercion, discrimination and violence, and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Reproductive health services also include:

- family planning,
- safe motherhood including antenatal, postnatal and delivery services, including emergency obstetric care, and
- the protection, prevention, treatment and care of sexually transmitted infections, including HIV/AIDS.

The international understanding of reproductive health recognizes the centrality of gender equality, women's empowerment, universal education, voluntary choice, and male involvement and responsibility.

Spelling out the concept of reproductive health – with its focus on maternal health, women's education, empowerment and equality, and HIV/AIDS – there is no doubt that the Millennium Development Goals are part and parcel of the reproductive health agenda and vice versa.

The ICPD Goals and Millennium Development Goals – agreement on fundamentals

In fact, the achievement of all eight of the Millennium Development Goals will be determined by the achievement of the ICPD goals. The ICPD agenda is comprehensive and far-reaching. It focusses on:

- poverty reduction and environmental sustainability,
- development cooperation and partnership between civil society, governments and the private sector,
- reducing maternal and child mortality,
- reducing the spread of HIV/AIDS,

- improving access to essential medicines, including contraceptives and other reproductive health supplies, and
- involving beneficiaries – including women, young people and persons affected by HIV/AIDS in the design, implementation and evaluation of reproductive health programmes.

Each of the Regional Conferences or Meetings, held in 2003 and 2004 as part of the ICPD ten-year review, has affirmed the strong linkages between the ICPD and Millennium Development Goals. And an increasing number of countries are including reproductive health in their national development and poverty reduction plans and Millennium Development Goals' reports. The latest scientific and technical evidence concludes that reproductive health and rights are clearly linked with poverty reduction, and the achievement of the MDGs. The World Bank includes reproductive health indicators in its poverty assessments because economists understand that access to reproductive health is key to development and poverty reduction.

The Millennium Project Task Force on gender and the one on child and maternal health state strongly that reproductive health and rights must be part of the essential strategies to achieve the Millennium Development Goals, and in particular Goal 3 on gender equality and the empowerment of women, and Goal 5 on maternal health. That is why UNFPA is catalyzing and supporting efforts to ensure that reproductive health and rights are an integral part of MDG processes and frameworks at the national and international levels.

Together we need to look ahead and plan strategically on how to ensure that at the September 2005 five-year review of the Millennium Declaration, the linking of ICPD and MDGs is recognized and recorded in the official documents of the 2005 Summit.

We are working with partners to ensure that universal access to reproductive health is reflected in the targets and indicators of the relevant MDGs. We are working to ensure that the indicators list for monitoring MDGs is revised to include indicators on universal access to reproductive health. We are working to ensure that the strategies to achieve the Millennium Development Goals include adequate reference to reproductive health and related interventions. We are also encouraging member states to include in their national reports on the MDGs information on progress in the area of reproductive health. And we are supporting efforts to integrate ICPD goals and issues into national poverty reduction strategies such as PRSPs, and in sector-wide policies (SWAPs).

Before I close, I will give you just a bird's eye of where we are in terms of the national reports on the Millennium Development Goals and ICPD. They vary from one country to another in terms of detail and depth. There are 66 national Millennium Development Goal reports published up to date. 28 or 40 per cent have good textual coverage of reproductive health, and 15 even have reproductive health as an explicit goal or a separate chapter. About 70 per cent of them include contraceptive preference rate data in either the text or table, and is therefore the most widely used indicator for reproductive health. 28 out of the 66 discuss adolescent reproductive health.

If we look by regions, Africa has done the best in terms of the national reports on the Millennium Development Goals. It is the strongest, with 80 per cent of the reports in

Africa including contraceptive preference rates in the discussion, 30 per cent with good reproductive health coverage, and 45 per cent addressed adolescent reproductive health. And of course, this is a link with the whole issue of the HIV/AIDS epidemic.

The second strong region is Europe and the countries in transition, which has the highest percentage of reproductive health coverage and also adolescent coverage, 50 per cent of the reports from Europe and the CIS include reproductive health issues for young people.

The examples from Asia and Middle East/North Africa were somewhat similar in terms of the measure of overall reproductive health coverage, with about one third only having good coverage. However, both regions have relatively fewer parts that addressed adolescents and reproductive health. But both Asia and Middle East/North Africa were relatively explicit about the reproductive health goal or target. Latin America, by contrast, was the poorest in terms of this kind of coverage, even though it is most active in the area of reproductive health and family planning.

I thought this bird's eye view will give you a sense of the variety of the national reports that have come in. I would like to conclude by saying that today, obstetric complications are the leading cause of death among women and babies in the developing world. Women in Africa face a 1 in 16 chance of dying during pregnancy and childbirth. And every minute, 10 people are newly infected with HIV. I repeat, every minute - as we are speaking right now - 10 people are newly infected with HIV, mostly young people, and mostly young married women. The vast majority of these infections are sexually transmitted. All over the world, the poorest people have the least access to information and services.

Sexual and reproductive health must be addressed if we are to eradicate poverty and to achieve the Millennium Development Goals, especially the goals related to gender, maternal health, and HIV and AIDS.

Keynote Address

Dr. Michael Hofmann
Director-General, Global Sectoral Policies, Multilateral and European Cooperation, Federal Ministry for Economic Cooperation and Development (BMZ), Germany

German Commitment

Global Partnership – 10 Years after the Conference on Polulation and Development in Cairo

Let me first pass on greetings from our Minister. Many things have already been said, so I will try to focus on some aspects.

The Cairo Conference marked a threshold, but it was necessary that we had the Millennium Declaration at the Millennium Summit that brought together the recommendations of the various international conferences held in the nineties. It gave a new impetus to the international community bringing together the right to development, eradication of extreme poverty, maintaining of peace and security, sustainability as an overarching goal, democracy, strengthening the rule of law, basic human rights and human freedoms. All this is compiled in the Millennium Declaration. What is also very important is that a new type of interrelationship between industrial and developing countries was introduced at the Monterrey Summit.

German Development Assistance and the MDGs

How did we mainstream the Millennium Development Goals into German development assistance? We were instructed by our Chancellor to write a Programme of Action 2015, focussing on halving poverty by 2015. Soon after the Millennium Summit, in April 2001, we were able to present this Programme. It was not just a programme or an action plan of the development ministry, allowing others to say: What has it got to do with me? Instead, it was adopted by the whole Cabinet. It was an exercise in coherence or, to put it more modestly, it was an exercise in reducing incoherence. We had to work together with the different ministries and see who should be involved in which way in this action programme, indicating what would be Germany's contribution to achieving the Millennium Development Goals.

The Action Programme certainly contained the principles of gender equality and protection against gender-specific violence. In addition we enshrined five specific basic social services in our Action Programme. They are:

1. support for social sectoral reform programmes, particularly in the fields of education and health,
2. fighting HIV/AIDS,

3. access for young women and men to family planning facilities,
4. access to vital medication,
5. the development of social security systems.

It was very clear that we had to interlink the different sectors. That had already been the logic of the Cairo Programme of Action in 1994: to link health and reproductive health in particular with a country's overall and sectoral development. We highlighted this issue in our position paper on sexual and reproductive health, where we also try to identify where the connections to other sectoral policies are.

Through our sexual and reproductive health projects, we are supporting our cooperation countries in the following key areas:

- realizing sexual and reproductive rights, including measures to eliminate violence and genital mutilation,
- educating and informing the public on health matters so as to enable them to make their own decisions and act responsibly,
- opening up access to family planning services,
- caring for girls and women during pregnancy and childbirth,
- preventing and treating sexually transmitted diseases, including HIV/AIDS.

These are the elements that we try to focus on in the kind of programmes that we implement.

Public Private Partnership

It is absolutely clear that if you want to achieve this, you need to follow the principles of public private partnership. We are most grateful that it was already mentioned that this conference is a good indication of what public private partnership means: bringing together actors from the public and the private side.

For instance, the distribution of subsidized condoms and contraceptives by private and public suppliers has proved useful in efforts to fight HIV/AIDS and promote family planning. HIV/AIDS programmes need to be linked up more closely to health services and related to family planning and mothers' health, as these provide a gateway for expanding HIV/AIDS prevention and treatment. Within social marketing programmes, broad-impact information campaigns have to be conducted by private distribution structures, service providers and international non-governmental organizations, bringing the different actors together in a country-specific approach.

Education

There is also a very close linkage between the issue of reproductive health and the education sector, in particular what Ms Obaid referred to before. The conveying of specific information and skills, for instance what protection a condom offers, how it is used, what the real purpose of a condom is, is vital to the success of family planning programmes.

Moreover, it is well known that better educated parents often have fewer and healthier children with better prospects for the future, what is, without doubt, of tremendous impor-

tance. Other areas, such as the creation and development of social security systems or the consideration of population trends in development planning, are equally important for the success of sexual and reproductive health efforts. Furthermore, we should not forget that promoting sexual and reproductive health is also a means of achieving other development goals related to poverty reduction. This interlinkage has to be clearly seen.

Cairo plus 10

Access to a range of family planning methods and the right to sexual self-determination are vital prerequisites for sexual and reproductive health, as agreed on in 1994 at the International Conference on Population and Development in Cairo and expressed in the Programme. Where do we stand ten years after the Conference?

Let me do what donors always do, which is to present to you what we have done; though I'll try to be very brief and also self-critical at the same time.

From 1994 to 2003, the German government provided total funding of over €1 billion for the implementation of the Cairo Programme. Most of this support has been channelled through our bilateral projects in the developing countries. Since Cairo, support has been provided for over 150 projects dealing with population-related measures and reproductive health services. Today, the German government is supporting national reproductive health programmes in 46 countries as well as eight regional programmes.

What is also clear is that we promised more in Cairo. We are all aware of that. We promised more in Cairo but we have not been able to achieve enough in the subsequent years. This applies also to the ups and downs of our contribution to the United Nations Population Fund. It has been an uphill battle just to maintain it and to get back to what we had achieved in the early nineties, since during the nineties we ran into financial problems.

And that does unfortunately also apply to our contribution to the WHO and other organizations. We cannot shy away from the fact that what we are able to achieve in this context is closely related to overall budget constraints. This refers to our capabilities to mobilize funds to support our bilateral programmes or multilateral institutions.

When I talk about the international level, I could not and should never forget, Ms Brueggemann, the tremendous role and activities of the International Planned Parenthood Federation, which we have been supporting for many years, and for good reason. And even the recent evaluation of the UNFPA and the International Planned Parenthood Federation programmes clearly indicates that it is important that we support these institutions. Though - as we all know, everything can be improved. The evaluation also showed that there is scope for improvement with respect to these institutions and also with respect to our own activities in this field.

I am most grateful that the German Chancellor only recently underlined the importance we attach to sexual and reproductive health by signing the World Leaders' Statement to support the International Conference on Population and Development. We will also work towards support for further financial commitments.

MDGoal 8

Let me try to put the activities on sexual and reproductive health in a broader picture. I would like to mention Millennium Development Goal 8 in particular – "developing a global partnership for development" - because not only in Goals 3 to 6 there is a direct link to reproductive health.

An enabling environment that allows developing countries to prosper is of importance. We need to achieve a point at which developing countries can earn their own money as a result of improved trade opportunities, thus providing their finance ministers with the kind of revenues that are necessary to put reproductive health in a regular budget.

In this regard we also have to take into consideration the efforts in terms of achieving fairer terms of trade, dismantling agricultural subsidies and granting debt relief. Ultimately, debt relief means freeing up resources that would otherwise be used for servicing debt so that they can be used directly for the developing countries' budgets.

On the topic of trade, you will see a clear link to the subject of reproductive health when you look at the World Trade Organization's Agreement on Trade-Related Aspects of Intellectual Property Rights, TRIPS. We have now reached an agreement granting developing countries improved access to affordable drugs under the TRIPS Agreement. The previous rules meant compulsory licensing, which ultimately implied that only those countries that produce drugs were in a good position. Now we have a situation in which all those countries that are not in a position to produce these drugs are able to import affordable generic drugs produced by third countries. I think this clearly shows that the activities and the efforts surrounding Millenium Development Goal 8 are of tremendous importance.

During the "Major Event" in 2005 we will review what has been achieved since 2000. You can be assured that anyone who tries to say that the importance of reproductive health should not be mentioned in any of the reports must be aware that the Europeans have a different view. We will express this view in our reporting to be published by the end of the year. We will reflect on our activities with respect to reproductive health and point out why we think it is important that we do so with a view to Millennium Development Goals 3 to 6 and, as I said, also take into account the importance of Goal 8 in achieving progress in this area.

This brings me to what is, I must honestly say, a problematic area, which is also enshrined in Goal 8, namely the new kind of partnership that we are looking for. The new kind of partnership is not only calling on us to at last achieve the 0.7 goal. We know that we are behind on this goal, but we have the Barcelona Commitments of the European Union , and the German government is firmly sticking to achieve at least 0.33 by the year 2006 as a milestone towards the 0.7 we are striving for.

But it is also clear that the style of our cooperation has to change, and that also poses a problem. Since the debt relief initiative for highly indebted poor countries, we have the poverty reduction strategies, also beyond these countries; all IDA (International Development Association) countries will prepare respective reports. We regard the poverty

reduction strategy papers as vital documents and than the ownership for the strategies should be with the developing country. We as donors should gradually move away from a project approach heading for a programme approach and towards a budget approach. This approach does not render the possibility of earmarking our activities as we did in the old-style project-based cooperation. And it is hardly compatible with the process of sectoral concentration we presently apply in our bilateral cooperation. Rather do the approaches imply an intense dialogue between us as donors and our partner countries – a dialogue on development strategies, on sectoral concepts and on the inclusion of major development goals as those related to reproductive health.

It will be a harsh political dialogue in several places, and we should be aware that there is an element of intervention, and I am not shying away from saying: yes, it has to be done in certain cases.

Only recently we had a very good discussion about the Arab Human Development Report. The authors and those at the forefront of this endeavour recommended: Focus on women. Focus on the empowerment of women. Take into account reproductive health issues. It is obvious: if you talk with representatives of this region, you cannot only talk about oil. We should not avoid a dialogue on the issues we talk about today. Reproductive health might be a very technical term but in the end it means: What prospects do people have? What freedoms? What are the individual rights and freedoms of people? And it is clear that it refers especially to the empowerment of women.

Plenary Session I

The importance of educating girls and women in particular

Dr. Dietrich Garlichs

Executive Director, German Committee for United Nations Children`s Fund (UNICEF), Germany

Only with better education for all children, we will achieve progress in the fight against poverty, exploitation and HIV/AIDS. I emphasize: **better** education and **all** children. **Better** education because often children are in school but do not get a good education. And **all** children because it certainly concerns girls, but boys as well.

Let's face the current situation: 120 million children of school age do not go to school. 54 per cent of these are girls. In the nineties, the percentage of girls not attending school was higher. So it seems, we have achieved some improvement. I want to make clear that I am not talking about enrollment. Because we know that girls tend to drop out of school earlier than boys, I am talking about attendance. Certainly, that still does not say anything about the quality of teaching. And we also know, that in secondary schools girls lag behind even more.

No schooling or little schooling is bad for all children, but it is particularly bad for girls for several reasons. Just to mention a few:

- **early marriage and pregnancies:** We know that women without education or little education have more children than educated women.
- **the risk to get infected with HIV/AIDS** is greater if you have not gone to school;
- **the social status** of girls and women who got no education or little education is much lower.
- **The risk of malnutrition, exploitation and violence** is much greater.

All these are serious effects, often becoming a question of live and death. Taking the example of HIV/AIDS, it is estimated that two thirds of the young women in Africa do not know how to protect themselves from an HIV/AIDS-infection. This is very much related to education and information. In some countries, the infection rate is five to six times higher for girls than for boys. This is an incredible difference, which can only be reduced with better education for girls.

There is an interdependence between education, child mortality and population development. It is estimated that every additional school year for a girl reduces the child mortality rate by five to ten per cent. Reducing the child mortality rate is, as we know, an important contributing factor to slowing down population growth. And as already mentioned: Women with education have fewer children, they have their children later, they can space their births. Just one example: In Guatemala, women without education have seven children (on average); women with completed primary education have four children (on average).

Another subject: economics. We know that education is a very good investment. The World Bank states that in particular education in girls is highly profitable, probably the most profitable investment in a society. Japan and other countries in South-East Asia have impressivley demonstrated how education for girls can effectively push the economy.

When education is so important and so profitable, what can we do to improve the situation? I am convinced that in the long term the best strategy will be that we improve the social status of girls and women, but this is a complicated and long-term strategy. However, there are also short-term pragmatic interventions which have proven successful. For example: tearing down financial barriers like school fees. Many families just cannot afford to send their kids to school. And if families have to select among their children, it is the girls who have to stay home. Early last year, Kenya abolished school fees, and all of a sudden 1.3 million children more showed up in school. We have similar examples from other countries.

Often it is not only a matter of finances. Female teachers are important to attract girls to school. Water and sanitation are also important, especially when girls get older. They have to have separate latrines, otherwise parents are afraid to send their girls to school.

We also have to consider what kind of education we are talking about. It is important to teach life skills, so that students and their parents and the community feel that students learn relevant things in school. The curriculum has also to appeal to the community leaders, religious leaders and parents. They must be convinced that it is important to get girls and boys into school.

My general conclusion is that though education is only one of the eight Millennium Development Goals, it is the most important one. I think it is the strategic goal in order to achieve or at least to promote the other goals. And to achieve the Millennium Development Goal on education is not so unrealistic. Of course, there are financial problems. The World Bank has estimated that till 2015, an additional 60 billion US$ is needed. That may sound much, but if you compare that sum with other budget items, it is not so much: it is what the Iraq war has cost the USA, not including the other countries that participated; or it is the annual expense of occupation of Iraq. If the political will is there, one can mobilize these resources.

I like to finish with a story about Monica. Monica is a girl in Southern Sudan. She is ten years old, and she lives in an area that is probably one of the toughest places for girls to grow up in the world. In Southern Sudan, about one per cent of the girls complete primary education, while about five per cent of the boys do. In Southern Sudan, a region as big as France, it is more likely that a child dies before it turns five than that it ever goes to school. In this tough place UNICEF is engaged in promoting small village schools. The people build the schools themselves. They are very motivated. We just deliver some material and technical advice. Monica goes to one of these village schools, and she is very proud of it. My UNICEF colleague asked her what she wanted to become after school. She responded that she would like to become the director of the banks in Southern Sudan. Well, so far there is one bank in the region, another one is just being established.

I liked that very much, because it shows how ambitious she is and how her horizon widened already by going to school. For me, she is a symbol of how important education is and what difference education can make.

I think we need many Monicas in many countries, but it is our job to give these children the chance to develop their potential, to develop their ambitions, and to make them aware of their rights. Because it is a right all countries have signed in the Convention on the Rights of the Child: A quality primary education free of charge.

Flavien Nkondo
Anthropologist, Deutsche Gesellschaft für
Technische Zusammenarbeit (GTZ), Cameroon

As we have heard already, girls tend more to drop out of school than boys. There are several reasons for that. One reason is early pregnancy. Pregnant girls are considered to be outcast by the society as well as by their families. Often they are abandoned by the genitor of the child. They suffer social and economic consequences. They are forced to leave school.

Let me present some figures: In Cameroon most adolescents will start having sex at the age of eleven, and the first pregnancy occurs at the age of thirteen. 30 per cent of the adolescent girls get pregnant. 38 per cent of them will drop out, stop school definitely. 44 per cent lose years of schooling. On average they drop out for two or three years. So more than one third of the girls who are pregnant will just stop going to school.

In 50 per cent of the cases, the genitor of the child was the first sexual partner. It's not like parents normaly think, that their daughter is pregnant, because she has too much sex. The genitors come from all social backgrounds, they are students or civil servants or businessmen. 42 per cent of these genitors do not care for the child, they just disappear, which poses a lot of problems, because the child is left without birth certificate and the young mothers have no financial help.

Now let me introduce you our project, which we developed with the help of InWEnt, Internationale Weiterbildung und Entwicklung gGmbH (Capacity Building International, Germany). The preliminary idea was, that traditionally, in most of the African communities, the aunts were the ones who prepared the girls for marriage. But with the economic disorder and organization, the aunts are no longer around. So our approach was to creat a sort of aunts, called "Aunties" for the adolescents to guide them on sexuality.

Now, where do these Aunties intervene? They are trained to work on themselves. The major goal is to help to avoid adolescent pregnancies. They are operating in their immediate surroundings. They are talking to their brothers and sisters, cousins and nephews and so on. They are talking about sex. They are teaching to bridge the gap of information.

For example: they are going to school to try to talk to students about hygiene, sexuality, prevention of early pregnancies, and so on. They do not only teach girls, but also boys. They also give testimony on what happened to them as teenage mothers, and they also counsel other adolescents in difficult situations, like those who are sexually active and those who are pregnant.

But the adolescents can also call for the Aunties. These Aunties are also trained to react when girls are afraid that they might be pregnant. They have emergency pills that can be

provided to them. Even in remote areas, they have these pills available. They can give them 72 hours after the act. After this time period, they can help the adolescent to test if she is really pregnant. In the case she is pregnant, she receives advice. If she wants an abortion, the Aunty will still advice her where to go and how to do it. By law, abortion is forbidden in Cameroon. But there are also voices, which say, that from time to time you really have to by-pass the system, organize things so that people have access to what they need. If the adolescent wants to continue the pregnancy, the Aunty advices her what to do, will help her to talk to her parents early. I emphasize “early”. Because most parents learn only after eight months that their daughter is pregnant and she does not have access to antenatal care. So it is important that there are Aunties around, they talk to the girls and tell them to go to antenatal care, to take vaccinations, to do the HIV screening, so that they have access to AIDS prevention. Also after birth, they advice the girls so that the child has a birth certificate. They take care that the girls go to the hospital for child care. They teach them to feed and educate their child, and they encourage the mothers to go back to school.

A special issue are rapes. Normally, when girls are raped, or there are cases of sexual abuse, the families will negotiate with the genitor. They go and beg the rapist to give some money to take her to the hospital and so on. Now, these Aunties have decided that they will not do that any more, there is no negotiation with the rapist. They instead report the case to the police, and they will put him in a very difficult situation. So they do not only give health advices but also try to build up awareness against abuse. They are part of women-empowerment-programme.

Aunties associations exist now in 33 localities in Cameroon, and we have about 2700 girls who are trained as Aunties. There is a bigger demand for this programme, Rwanda and Niger want to replicate it. I think the big achievement is, that the Minister of Women’s Affairs has adopted this approach, and they have planned to train more Aunties in 2005. It will be included in the public investment budget. Just to show you how immediate success is: In the place where we started, there were 60 cases of pregnancy in primary school, after six months, we have only one case of pregnancy, so it is very effective.

Samir A. Jarrar
Chairman, Board of Trustees,
The Arab Resource Collective, Lebanon

In the morning session, Mr Hofmann suggested that when the Arab world is mentioned, “oil” comes to mind as well as “Islam” and “tradition”. The variances in the Arab region are great. We have one of the wealthiest economies in the world with a per capita of over US$ 20,000, and we have one fifth of the population living on less than two dollars a day. This is true not only in the economic sense, but also at all levels of development.

The Arab educational system is embedded in a rich cultural, intellectual, and educational heritage that dates back to the founding of Islam in the 7th century AD. This tradition is based on expending human resources and energy on the search for knowledge. Arabs led the world in many areas of knowledge for over a thousand years, after translating and building upon the great treaties of the Greeks, Persians, Eastern and other civilizations.

Islam placed a very high premium on education. The prophet Mohammad considered it “the duty of every Muslim man and woman to seek knowledge… and to seek education from cradle to grave” (see Massialas and Jarrar, 1991). These sayings reveal two very essential principles of modern education, namely, equity in education by making it available and obligatory for every male and female, as well as making education a life-long pursuit, something we are trying to inculcate in our times.

So from the beginning, the mosque became the place of worship and the first school in Islam. Here Moslems would meet to study and memorize the holy Koraan. Discussion groups known as circles or “Halakat” emerged, laying the foundation for religious sciences and the mosque-college-system where adults would meet with the learned scholars (Faqih) and spend time studying. Once an individual masters the material presented he/she is licensed by the Faqih. Individual differences were attended to - a modern concept we are - trying to achieve in our educational practices. A parallel system was developed when the need for educating the youth emerged. So the Koraanic schools or the “kuttabs” were established. These schools highlighted oral learning and independent study.

Public education in the Arab region started picking up momentum after the creation of the independent states since the late 1940s. The region made significant gains at all levels of education. The last decade witnessed significant progress in school access and retention (see figure 1). Following are some observations:

Overall participation in Early childhood care and education is low with gross enrolment ratios in the majority of countries falling under 20 per cent. Efforts towards achieving good quality of health, care, education and development of young children are underway.

Figure 1

Arab States: selected education indicators, 2001

Countries	Total Population (thousands)	Compulsory education (age group)	Adult Literacy rate (%)		Pre-primary education		Primary education						Secondary education		Tertiary education		Total public expenditure on education as % of GNP	EFA Development Index (EDI)
			Total	GPI	GER (%) Total	GPI	NER (%) Total	GPI in GER	Survival rate to grade 5 (%)	% of female teachers	% of trained teachers	Pupil/ teacher ratio	GER (%) Total	GPI	GER (%) Total	GPI		
Algeria	30746	6-16	68,9	0,76	4,2	1,00	95,1	0,93	96,0	47,9	97,1	27,6	71,6	1,08	-	-	-	0,87
Bahrain	693	-	88,5	0,92	34,9	0,95	91,0	0,99	99,1	75,8	-	16,4	95,0	1,09	-	-	*3,1*	0,93
Djibouti	681	6-15	-	-	0,5	1,02	34,0	0,76	87,7	29,9	-	34,4	19,6	0,62	1,2	0,85	-	0,65
Egypt	69124	6-13	55,6	0,65	12,8	0,94	90,3	0,94	98,9	53,3	-	22,5	88,1	0,93	-	-	-	0,82
Iraq	23860	6-11	-	-	**5,5**	**0,99**	**90,5**	**0,82**	***65,5***	**72,5**	**100,0**	**21,4**	**38,3**	**0,62**	14,1	0,54	-	-
Jordan	5183	6-16	90,9	0,90	31,0	0,92	91,3	1,00	-	63,2	-	20,0	86,3	1,02	31	1,02	4,6	0,94
Kuwait	2353	6-14	82,9	0,96	73,5	0,99	84,6	0,99	.	79,4	-	13,6	85,2	1,06	-	-	-	0,90
Lebanon	3537	6-12	-	-	73,9	0,99	89,8	0,96	94,0	86,5	14,9	16,8	77,4	1,10	44,7	1,14	2,8	0,90
Libyan Arab Jamahiriya	5340	6-15	81,7	0,77	7,8	0,96	-	1,00	-	-	-	**8,4**	104,8	1,06	58,1	1,09	-	-
Mauritania	2724	6-14	41,2	0,61	-	-	66,7	0,96	54,7	25,6	-	39,1	21,7	0,76	3,2	0,28	**3,6**	0,60
Morocco	29585	6-14	50,7	0,61	59,7	0,58	88,4	0,89	83,7	42,1	-	28,3	*40,9*	*0,81*	10,3	0,81	5,2	0,75
Oman	2688	-	74,4	0,80	5,2	0,87	74,5	0,98	96,2	58,5	99,8	23,4	78,5	0,98	7,5	1,68	4,4	0,84
Palestine (PAT)	3310	6-15	-	-	31,1	0,94	95,1	1,01	.	*53,9*	-	*31,0*	84,9	1,06	30,6	0,98	-	-
Qatar	591	6-17	84,2	0,97	31,7	0,99	94,5	0,96	-	82,0	-	12,4	90,2	1,05	23,3	2,69	-	0,91
Saudi Arabia	22829	6-11	77,9	0,83	4,9	0,93	58,9	0,97	94,0	48,8	-	12,3	69,2	0,89	22	1,50	-	0,80
Sudan	32151	6-13	59,9	0,69	19,6	0,99	-	0,85	***84,1***	-	-	-	32,0	-	-	-	-	-
Syrian Arab Republic	16968	6-12	82,9	0,82	9,8	0,91	97,5	0,93	92,4	67,7	95,6	24,0	44,6	0,90	-	-	4,2	0,90
Tunisia	9624	6-16	73,2	0,76	19,8	0,98	96,9	0,96	95,5	50,0	-	21,9	79,1	1,04	23,2	-	*7,2*	0,89
United Arab Emirates	2879	6-11	77,3	1,07	70,8	1,00	80,8	0,96	97,5	76,2	-	15,3	79,4	1,06	-	-	-	0,88
Yemen	18651	6-14	49,0	0,41	0,4	0,92	*67,1*	0,66	**86,0**	-	-	-	*46,3*	*0,42*	**11,1**	**0,28**	10,6	0,63
Arab States	283518	-	62,2	0,69	19,6	0,99	81,1	0,89	94,0	58,5	-	21,7	63,7	0,90	22	1,50	-	-
Developing countries	4863977	-	76,4	0,83	35,0	0,95	82,5	0,92	83,3	61,4	-	28,1	56,6	0,89	11,3	1,28	4,2	-
World	6134038	-	81,7	0,88	48,6	1,02	84,0	0,93	-	73,1	-	22,4	63,7	0,92	23,2	-	4,5	-

Source: UNESCO Institute for Statistics; EFA Global Monitoring Report 2005, Statistical annex.
(Data for 1998-2000)

In 2001, net enrolment ratios at the primary level reached 81 per cent, showing a commendable growth of over 17 per cent between 1999 and 2000, in spite the fact that close to 7.5 million children are still out of school at the primary level (60 per cent of them are girls). The interesting observation, however, is that boys repeated more than girls. This reveals the fact that once girls have access to primary education, they do better than boys.

At the secondary level, the region witnessed an increase in enrolment ratios from below 50 per cent in 1999 to around 65 per cent by 2001. Strong gains were witnessed in girls' education at this level. In Tunisia, girls' enrolment outnumbered boys at the secondary cycle.

Participation at the tertiary level grew by 80 per cent; gross enrolments grew from 12 per cent to 22 per cent during the last decade of the century. Gender disparities vary widely. Women are enrolled in traditional fields; i.e. education, humanities, social sciences and health related programmes.

Literacy is one of the major problems in the region with one of the lowest literacy rates for the populations over 15, year of age, at 62 per cent.

Two thirds of the adult illiterates are females with a gender parity Index of 0.69. With large gender disparities at the primary level and adult literacy rates, the region has a long way to go before achieving its goals. Most Arab states have promulgated appropriate policies to reach gender parity, and to try to eradicate illiteracy. What is promising, however, is the fact that eight Arab states have achieved gender parity at the primary level while four countries have achieved it at the secondary level.

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Impressions

Plenary Session II

Access to medical service, medical supply and contraception

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This will be a very short session, because we will talk about sexual and reproductive health supplies, and there is one sentence that says it all: No products - no programmes. If you do not have reproductive health commodities available, if you do not have access to condoms, if you do not have oral contraceptives if you need them, there will be no sex-education programmes whatsoever. What we will lay out in the next couple of minutes, just for me to set the scene for our distinguished speakers, is: What is the problem with commodities and with sexual and reproductive health supplies at the moment?

Looking at current figures, you will see that the commodities that we have today are just covering one eighth of the current need and of the demand. So, basically, the simple message, again, is: We do not have sufficient supplies in the field of sexual and reproductive health, HIV/AIDS and health in general in developing countries. If you look at the family planning supplies, you will see something interesting:

The figures for the year 2000 show, that we have 1.26 billion women at the age of 15 to 49 who are in need of family planning and reproductive health supplies. Only less than half of them, 525 million, are using any form of modern contraception. Now, if you look 15 years down the road to the year 2015, you see that because of demographic changes, the number of young women in this age group has risen from 1.26 billion to 1.55 billion. Again, 125 million more are getting there because of the population growth, and another 92 million young women are expecting any kind of modern form of contraception, because they have been trained in sex education programmes and being made aware how to live a healthier life, in particular in developing countries in Africa, in Asia, and in Latin America.

Now, how is the funding situation like? The financial contributions are devastating. In the year 1992, a total of US$ 222 million was needed to cover the actual need for family planning supplies, for condoms, oral contraceptives, intrauterine devices or any related forms of contraception. Only US$ 82 million of the whole sum has been covered by donor contributions. Now, if you look at the year 2000, that gap is widening even more. We had US$ 811 million of need, and only coverage of US$ 200 million. So all in all the need will be close to US$ 150 million per year. And the question is: How much funding will be made available by donors like United Nations Population Fund (UNFPA), Kreditanstalt für Wiederaufbau (KfW), Department for International Development (DFID), United States Agency for International Development (USAID), and all the other bilateral donors?

Why is there a shortage? There is a shortage first of all because the funding does not fall in line with the demands stated from governments in developing countries and the need of women and men in developing countries. Second, because there is a lack of coordination of the donors. We have joined the Supply Initiative. It is an international initiative of four organizations, one of which is our, the German Foundation for World Population (DSW), to have a closer look at what the problems are in terms of reproductive health supplies, and how and to what extend international donor agencies could better coordinate their efforts, their procurement and their buying power to take full advantage of the available funding, and to get more commodities out of the same financial allocations.

There are also weak logistical systems on the ground. Weak logistical systems within the ministries of health in developing countries, a lack of distribution systems, a lack of storage capacity, and so forth. There is a stagnant or waning funding from the donors, which we have seen on the previous slide. And of course there are restrictive policies, such as the US policy, where the procurement or the use of condoms, for example, is prevented to some of the governments if they want to receive official development assistance from the US government – a complex political situation better known as the “Gag Rule”.

As Dr. Steve Sinding, Director General of International Planned Parenthood Federation recently put it: “If we do not have commodities, we cannot expect that family planning programmes or reproductive health programmes or HIV/AIDS prevention programmes will be successful.”

I would like to state here three hypotheses: once again - if there was sufficient funding, if donor agencies such as KfW, DFID, the European Union, the World Bank, USAID, IPPF, UNFPA, if they had more funding available and if they made more funds available, we would not see every year 530,000 women dying because of the lack of commodities or because of denied access to health services. This is my first hypothesis.

My second assumption is: If there was a better donor cooperation amongst all the donors, I just mentioned, the money could be stretched to an extent that at least one fourth of the funding gap could be covered by those existing funds that are already on the table the last couple of years and this year.

Thirdly, my question is: What could, apart from giving donations, loans or grants for commodities, what could donor institutions such as KfW, our Federal Ministry for Economic Cooperation and Development, just to look at the German scenery here, what could they do in order to improve the logistical systems in developing countries, in order to make sure that the commodities are not ending in a storage or warehouse near the harbour, but are getting to the clients where- and whenever they are needed?

We are still in the middle of a research process within the Supply Initiative; we have developed a web-based tool, which is being used at the moment by donor agencies such as UNFPA, USAID, IPPF, and also KfW has joined the reproductive health interchange. If you would like to obtain more information about those tools of the Supply Initiative, please visit the web site www.rhsupplies.org and receive regular updates on the issue of sexual and reproductive supplies world wide.

Tewodros Melesse
Regional Director, International Planned Parenthood Federation (IPPF), Africa Region, Nairobi

The population of Sub-Saharan Africa (SSA) has increased between 1975 and 2000 from 325 to 650 million, and this is projected to rise to 1.1 billion by 2025. Today, 47 per cent of the population is aged between 5 and 24, representing a huge potential for reproduction. Africa accounts for almost 70 per cent of the global HIV/AIDS case load, which results a big strain on the already over-stretched and under-funded health systems of many African countries.

The total fertility rate of Sub-Saharan Africa is 5.6 children per woman, while the contraceptive prevalence rate for married women aged between 15 and 40 is 16 per cent. Looking specifically at West Africa, the total fertility rate is 5.8 and the contraceptive prevalence rate is 8 per cent. Nigeria, which is a giant, almost a continent by itself, has a total fertility rate of 5.7, with a contraceptive prevalence rate of 8 per cent. These statistics illustrate the huge challenges in SRH sexual and reproductive health faced by the African continent.

Population and reproductive health

The challenges facing Sub-Saharan Africa as it strives to closely approach or meet its development objectives are more daunting than those facing any other region in the world. These objectives and goals include those for 2015 set at the ICPD in 1994, ICPD+5 that followed in 1999 and the UN Millennium Summit in 2000.

Sub-Saharan Africa's population has grown far faster than any other region in the last three decades. The population growth rate is 2.4 to 2.5 per cent per annum, and one in every 16 women dies, and many more are disabled by pregnancy related complications. Ensuring safe motherhood is a priority issue.

Significant challenges exist to addressing population and reproductive health. These include:

- Efforts to eradicate poverty, empower women, reduce child mortality and improve maternal health in the region continue to be severely undercut by the devastating HIV/AIDS pandemic.
- Massive human displacements due to disasters, violent conflicts and political strife increase the social, economic and political vulnerability of communities and leave them struggling to simply meet their basic needs.
- The contraceptive prevalence rate in most countries remains low, except in Botswana, Cape Verde, Mauritius, Kenya, South Africa and Zimbabwe.

- Surveys show that the unmet needs for family planning among women in marital or consensual unions is over 20 per cent in over 20 SSA countries and over 30 per cent in six of them.

In addressing reproductive health , we need to look at the general health budgets. On average health budgets lie between only three to nine per cent of the national budgets of many African countries. We have to be aware that this figure already includes donor contributions. When the African ministers met in Brazzaville in September, they set a target of increasing their health budgets to 15 per cent of the national budget. But this is still a far cry from what is necessary. Of course we have to ask, what percentage of this budget will go to contraceptives, family planning and HIV/AIDS? I am very pessimistic. Look at the progression of Kenya: 15 years ago, Kenya was spending US$ 9.5 per capita for health. Today this figure has gone down to US$ 3.5.

In addressing access to services, we have to have a segmentation: a segmentation of those who are wealthy and those who are poor. The rich can fly to Paris or London and get their contraceptives or abortions there. If you are middle class, maybe you can get some subsidized or free services from NGOs or other institutions. And then you have the major part of the population: the poor. In most of the countries on the continent, more than 50 per cent of their populations live in rural areas. Where services are available, they suffer problems of deteriorating quality. At the same time, the effects of devaluation of local currencies and inflation lead to falling purchasing power, especially for the already poor. Unless access to quality and affordable health services is expanded widely, we will continue to face this big problem. How to get commodities and services to the poor remains a huge challenge.

Infrastructure

The health systems infrastructure in Sub-Saharan Africa is poor and dilapidated with inadequate systems for maintenance. Sometimes even the most basic equipment is in shortage, and other times, equipment is either old, inappropriate or totally lacking. Particularly in rural areas and on community level, the health systems are inadequate and fail to provide for the basic health needs of many communities.

Drugs and supplies

There are often perennial shortages of drugs and supplies through all levels of the health system. Corruption and delays in procurement result in inadequate quantities of commodities, and in-country distribution is often slow, resulting in expiry and wastage. At service delivery points, further wastage of drugs and supplies occurs due to the lack of standard treatment protocols and guidelines and often poorly qualified prescribers.

Health Providers

SSA has a shortage of health service providers, both in terms of numbers and qualifications. A very skewed and unequal rural-urban distribution of service providers exists. In

general, service providers are underpaid, poorly motivated, often overworked and frustrated because of the perennial shortages and working environment. Service providers attitudes may sometimes be conservative and judgemental, particularly on issues such as abortion and adolescent/youth reproductive health.

In light of these challenges, I believe that we cannot always cry foul and say: “Well, we cannot do it ourselves, so the donors have to increase their contributions.” But what other possibilities exist?

Firstly, our governments have to be serious and show their commitment to addressing reproductive health. Contraceptives are, and should be essential. That is the first political commitment our governments should make. Secondly, however low the finances for general health services may be, whatever the percentage is – perhaps between three per cent and nine per cent of the national budget – governments must allocate money for contraceptives in their budget.

Budget allocations should then be followed up with capacity building to plan and organize the distribution of contraceptives. In the name of equity, the same quantity of commodities should be sent to all regions, districts and provinces, whether rural or urban. The situation may arise where in some places levels of contraceptive use are low, so you get an over-supply, whereas in other regions, there is a high demand for contraceptives, creating a deficit.

Another important area to consider is institutional capacity. Sometimes there are contraceptives available, but if you cannot distribute them, and if you cannot educate the health provider and ensure that the provider is capable and willing to provide contraceptives, then it is a problem. Institutional capacity building should be an important component in the assistance.

Financing of Reproductve Health Services

What are the requests from the donors in relation to funding health initiatives? That the assistance should be tied up to the prerequisite of putting contraceptives on their essential drug list and in the budget. Donors can give budgetary support as an initial step, but the government has to make sure that they are progressively taking increased responsibility for the financing of health services. There is need for a strategy of stratifying the segment of the population. Everybody cannot be poor, and everybody cannot say; “I cannot pay for contraceptives”. Those who are able to pay for contraceptives and services should pay, those who cannot afford to pay should be assisted, and those who absolutely cannot pay should get them for free. But there should be a clear stratification and a strategy of evaluating income.

Today in Africa most of the International Planned Parenthood Federation (IPPF) Member Associations offer reproductive health services and contraceptives for free or at very low prices. While it is true that most of the population in many countries lives below the poverty level making it difficult to charge for preventive services, some effort could be made to at least partially recover the cost of services and commodities. The population

has to be segmented to determine those not only willing, but also capable of paying for services.

Services should offer a wider range and should be of high quality, targeting the middle and upper middle class in urban areas. They should in fact be competitive with the private medical practice. Once this type of service is established, even with a concessionary loan from development banks, clinics will easily attract the middle and upper middle class category of the population. The income derived from these clinics will not only enable them to be self sufficient, but can enable our associations to subsidize services to underserved populations and to implement community based activities. Private companies and insurance companies can also use our facilities to provide a wide range of reproductive health services to their employees. The prices will be established in such a way that they are certainly higher than the public sector but lower than the private for profit sector which provide comparative quality services. We have also to franchise this model by organizing ourselves to be able to provide the required technical, management, promotion and support. This will enable us to undertake a social enterprise venture to ensure at least partial sustainability of reproductive health services and commodities.

Re-defining partnership

There is need to re-define the partnership between the North and the South. Not just between governments, but also between the non-governmental sectors in the North and the South. In today's world, there are many non-governmental organizations, international and regional that are operating in Africa. We have no problem with that. But donors should ask for accountability in institutional output. Are donors perpetuating this dependency on NGOs? Brain-drain is not only external, it is also internal. What is happening is that for example if you are in the government sector or in a local NGO, and you leave your job to go and work for an international NGO or a corporate agency, the country is loosing out. International NGOs and corporations are ready to pay over ten times the local salary, but are not ready to increase by ten per cent of the public sector or the other salaries to maintain them in their institution. That is unjust and unfair. That has to be renegotiated.

Our institutions should be much more serious and accountable, because setting up an NGO in some sectors has become like setting up a business. There is no crime in setting up a consultancy firm, so we should not call it a non-governmental and non-profit organization. We can just simply call it a profit-oriented consultancy firm. We have to re-examine ourselves, we have to define ourselves, we have to be sure that we deliver and that we give the value for the money. The legal framework in some countries is still in the 1920s, 1930s, and this has to be re-examined. Our parliamentarians should be examining these legal issues and the implementation of the law. Similarly, policies should be analyzed in order to ensure that they are much more conducive to development.

In conclusion, we have to re-enforce the commitment to health from our governments. Before we go to the donors, we should put our own house in order first. The times when the NGO sector was supposed to be the angel without fault, when all the corruption and

the ills were only to be found in the public sector are over. Transparency should also come to civil society. The private sector has to learn to deal with scrutiny. I liked the presentation from Schering where they said that there should be a longer-term commitment. But the longer-term commitment should also come from the private sector and from the donor community. Today, we want quick results, but institution building and having a long-term commitment will take time. We cannot change things in a year or two. We have to have a longer-term vision. There should be a strengthened public sector and NGO sector in Africa. I know, that most of our governments are very suspicious of the NGOs. But is it because they are uncomfortable themselves, or is it because of the NGOs? Let us talk about it! Let us engage! Let us talk openly!

Let us not take it, that there is one NGO that can do everything, we have to complement each other at the local level. I have already talked about the north and the south NGOs, and the donors have also got their own interests: political, business and strategic. We cannot say; “leave that alone”. Because that is the essence of protecting the national interest, we have to be realistic. But when it comes to the basics, I think there should be a much more open and sincere dialogue between the donors and the national governments, and among the donors themselves. This will avoid unnecessary competition and confusion, and will also stop giving some opportunity to those who are irresponsible enough to play one donor off against the other or try to hide behind that. I think the essential comes from us who are from the South. Let us put our house in order, let us be clear on our priorities, let us have a longer-term vision and put the building blocks for a better future, for where it is, the contraceptive security will also ensure the security of our nations and our development.

Statistic for Reference

Demographic Profiles of Selected Sub-Saharan Africa Countries

Region	Country	Population	CPR (modern methods)	Maternal Mortality	Literacy rates (%)	HIV/AIDS prevalence (%)	Infant mortality rate	Per Capita health expenditure US$ (1998)
Anglophone	Kenya	31.6	32	1,300	82.4	15	78	31
	Botswana	1.7	42	480	77.2	38.8	62	127
	South Africa	46.9	55	340	85.3	20.1	48	230
	Zimbabwe	12.7	50	610	88.7	15.6	65	36
	Mauritius	1.2	60	45	84.5	0.1	13.2	120
Francophone	Burkina Faso	13.6	5	1,400	23.9	6.5	83	9
	Cote d'Ivoire	16.9	7	1,200	46.8	9.7	102	28
	Madagascar	17.5	10	580	66.5	0.3	84	5
	Niger	12.4	4	920	15.9	1.4	123	5
Lusophone	Angola	13.3	4	1,300	42	5.5	145	No data
	Mozambique	19.2	5	980	44	13	127	8

Source: 2003 World population data sheet – population reference bureau/ : UNDP Human Development Report 2002 : prb policy developments and indicators 2003

Availability of Health Providers in selected countries:

Region	Country	Physicians per 100,000 people
Anglophone	Kenya	13
	Botswana	24
	South Africa	56
	Zimbabwe	14
	Mauritius	85
Francophone	Burkina Faso	3
	Cote d'Ivoire	9
	Madagascar	11
	Niger	4
Lusophone	Angola	8
	Mozambique	No data

Source: UNDP Human Development Report 2002

Maternal Mortality Ratio

Region	Country	Maternal mortality ratio per 100,00 live births
Anglophone	Kenya	1,300
	Botswana	480
	South Africa	340
	Zimbabwe	610
	Mauritius	45
Francophone	Burkina Faso	1,400
	Cote d'Ivoire	1,200
	Madagascar	580
	Niger	920
Lusophone	Angola	1,300
	Mozambique	980

Source: Population Reference Bureau (prb) indicators 2003

Contraceptive Prevelance Rates

Region	Country	Percentage of women using mordern methods of contraception
Anglophone	Kenya	32
	Botswana	42
	South Africa	55
	Zimbabwe	50
	Mauritius	60
Francophone	Burkina Faso	5
	Cote d'Ivoire	7
	Madagascar	10
	Niger	4
Lusophone	Angola	4
	Mozambique	5

Source: 2003 World population data sheet – population reference bureau

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Until 2050 the total number of the world population will increase by the total number of the population living on earth in 1950. 96 per cent of the population growth takes place in developing countries, where, unfortunately, poverty is prevalent and where we have also a high HIV/AIDS prevalence rate. As a result, we will face a very young population in these countries. In the year 2000, about 123 million women did not have access to safe and effective means of contraception, and 24 per cent of the married women in Sub-Saharan Africa did not have access to any method. 350 million couples have no access to comprehensive services. And one third of the pregnancies, up to now, are without follow-up.

Now, the positive story: there was a dramatic increase in family planning use since Cairo. Nowadays 600 million married women worldwide use contraception. Out of these 600 million, 500 million women live in developing countries. The contraceptive prevalence rate has risen globally from 55 per cent to 64 per cent. In contrast, in most countries in Africa, the rate has risen only one to two per cent, and therefore, the contraceptive prevalence rate is still quite low in Africa. Prognosis shows that until 2015, there will be a 23 per cent increase of couples in reproductive age and a 40 per cent increase in contraceptive users.

Why should we care for the spreading of contraception? Using contraception will reduce maternal mortality, education possibilities will be higher, and household incomes will also rise. There is a notion that has not yet been mentioned during this conference, the so-called “demographic window of chance”. This means: if couples have less children, there is more household income available for investment, for productivity and growth, until the society is starting to age, as we are experiencing in Germany, for instance. So, it is only a window of chance that will close at a certain point. Most African countries are not yet at this stage, but other developing countries are very close to it.

Let me point to other facts: by 2015, US$ 1.8 billion are estimated to be needed for the financing of contraception. And we already know, that only a part of this amount will be available from donor funding. The question, therefore, is: How can the gap be filled? We learned already that increases in efficiency as well as increased donor funding could be considered as possible solutions. But increases in government budgets, loans and user contributions should also not be excluded from consideration. The development funding needs to reach the Millennium Development Goals by 2015 are huge. They are certainly not being financed by household budgets, neither by the developing countries nor by the donor countries. Then, the only solution left, will be so-called public private partnerships (PPP). In the mid-90s already one third of sexual and reproductive health pro-

gramme-costs were paid by donors. Sexual and reproductive health, in a number of societies, is not perceived as a real need, and it is rather taken as a global public good for which other countries take the responsibility to make it available. This has to be born in mind, while dicusssing whether or not to finance recurrent costs of health and population sectors in developing countries.

As you all know, Official Development Assistance (ODA) trends are not rising as steeply as hoped. And ODA to health is only three to four per cent of which only a third is going to reproductive health. So we see clearly that even stressing all ethical arguments we would not get the necessary funding to fill the gap, and we have to find a new solution to fill the gap, as already mentioned above.

What are the main available options and possibilities? A study by the interim working group on reproductive health and commodity security, set up a number of years ago, identified five possible solutions for closing the contraceptive financing gap:

Firstly: user fees for commodities and service provision.
At the moment, user fees now cover up to five to 14 per cent of health service expenditure, and a lot of people argue that this is too small to debate about. They argue, that one has to strive for public financing. However, in a number of micro-economic studies, it has been found that often 100 per cent of the non-salary service operating costs in developing countries are covered by user fees, whereas salary costs are usually covered by the public health services. However, user fees bear the danger of exclusion of the poor. So, what we need to do is to subsidize the poor and to exclude those people from consumption of subsidies who do not need it, who are benefiting from free services, even though they would be able to pay for them.

Secondly: increase community financing schemes.
Usually, community financing is done by NGOs, and it is a mixture of pre-payment and again user fees.

Thirdly: expand private sector participation.
Studies have shown that the estimated savings for projected government costs are in the range between 10 and 15 per cent, depending on the structure of the services in the country. Market segmentation, reducing administrative and legal barriers for private providers and also building incentives for private service provision, for instance tax deductions could be a solution.

Fourthly: expand social protection, social security mechanisms, and particularly to include reproductive health commodities in these social security packages.

And finally, a practicable solution could be adopted, based on experience with funding immunization programmes: an innovative new financing mechanism under the heading “contraceptive independence initiative”, would make use of economies of scales, access to hard currency for countries that do not have it, as well as of partnership arrangements.

These are five feasible measures, and it depends on how they are brought together in a complementary way in order to make use of their specific benefits and to close the financing gap.

Conclusion:
Germany is one of the most important donors in contraceptive supplies and, therefore, has a responsibility. From Dr. Michael Hofmann's presentation it became clear that the Federal Ministry for Economic Cooperation and Development (BMZ) is supporting the international trend to go for programme and budget financing.

However, there is a need for increased and coordinated reproductive health supply funding, as Dr. Maas has exposed.

Let me expose three options – which may still be visions, though:

First: German development cooperation in reproductive health should further explore existing possibilities in collaboration with the private health sector. We are collaborating in a number of fields, but not yet in the social sectors - at least not yet enough.

Second: partnership with other organizations and donors: We should use the available financing experience and comparative advantages of German development cooperation being one of the big contraceptive donors.

And third: if an opportunity arises, Germany should be prepared to participate in the preparation and structuring of a global supply fund as a way of bridging the existing financing gap for contraceptive supplies.

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The need and potential for output-based assistance in health and family planning*

While the need for development assistance to improve social, economic or health outcomes is great, the effective allocation of the available resources is sometimes difficult. Currently, most overseas assistance is given as input-based support where grants are made to the recipient government or to local non governmental organizations (NGOs) to cover the various costs associated with implementing an agreed programme of work. Output-based assistance agrees on a unit cost for a specified essential output, and then pays that cost directly or offers a subsidy to low-income groups through coupons or vouchers, with or without a co-payment from the client. We are arguing, that in selected circumstances, output-based funding has advantages over input-based assistance. It uses examples from international family planning, reproductive health and HIV/AIDS. New strategies are particularly important at time of serious challenges, such as the exponential spread of HIV/AIDS in some communities.

Input-based assistance accounts for the overwhelming majority of external support to family planning and reproductive health. The commitment of the international donors to the budget set out at the 1994 International Conference on Population and Development (ICPD) has been disappointing, and more recently the US administration has been seeking to reverse some parts of the ICPD Plan of Action. This is occurring while the largest cohort of young people in history is entering their fertile years. In many countries contraceptive prevalence is rising, but there are serious shortfalls in the resources needed to subsidize contraceptives for poor people. Challenges in broader areas of health are also extremely large, including the expansion of HIV infections and tuberculosis. As a result of these trends, foreign aid agencies need to be sure they are rewarding efficiency, so that their available support will help as many people as possible.

*** This speech held on the conference refers on professional articles by**

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Traditionally, international support for health is provided in the form of input-based assistance in government programmes or non-profit organizations (NGOs, non governmental organizations), which are responsible for allocating the funds to their services, administrative costs and infrastructure. In contrast, output-based assistance (OBA) reimburses governments or other entities a unit payment for a specified product or service. OBA in health and family planning can be offered to the ministry of health, NGOs or private health providers. In international aid OBA has been used successfully in the water and energy sectors, but its use in health care in contemporary developing countries is exceedingly limited, although encouraging. Forty years ago, successful OBA experiences occurred in South Korea and Taiwan. They involved domestic policies to use OBA to fund private sector health providers, as well as government facilities, but unfortunately they have been largely forgotten.

There are isolated cases in contemporary international assistance. Currently OBA projects are being launched in Uganda, to provide sexually transmitted diseas (STD) treatment, in Kenya, to subsidize safe delivery and long acting methods of contraception in West Bengal. It is an appropriate time to review the potential strengths and limitations of this way of implementing foreign aid. This review will focus on the potential of OBA for external donors to developing countries, although one of the several advantages of OBA is that the transition from external funding to support by the domestic government is easy.

Allocating donor money

External donors provide 40 per cent or more of the health budgets in at least 30 developing countries and foreign aid plays a significant role in another 30 nations (2004). Government agencies and philanthropic foundations comprising the international donor community (donors) generally have two objectives when transferring money and skills to the low-income countries. One is to help subsidize selected essential needs, and the other to encourage changes in the adoption of technology, management or economic structures judged to be beneficial to low-income groups. Examples of this dual-objective approach to essential needs would be treating tuberculosis, offering the choice of voluntary counselling and testing for HIV status, or providing contraceptive services. All of these service needs either are not affordable by people living on US$ 2.00 a day or less, or involve aspects of preventive care that very poor people, struggling to survive to the next 24 hours may not choose to invest in – or both.

OBA payments to providers are similar to a common commercial transaction, such as paying for a hair cut or servicing a motor vehicle. Germany under Bismarck was the first nation in the world to introduce a compulsory insurance system (1883) and OBA has been the basis for remuneration in the German health system for a century. Many of the basic principles developed in Germany apply to any output based system of paying for health care. Physicians seeking reimbursement from the insurance system were accredited in 1914 and item of service fees were negotiated annually. A joint association of physicians and health insurers was established in 1938, “sickness vouchers” were introduced in 1950, a chip card in 1990 and a smart card is planned for 2005.

Defining out-put based aid

OBA exists as an important option for external donors and national governments to subsidize selected items of essential health services for target groups of poor and vulnerable individuals. Payment is managed either by issuing coupons or vouchers with cash value for services by service providers, or by direct payments to providers without vouchers. These payments can be combined with a variety of governmental and private insurance schemes. A small co-payment from the low-income client may or may not be required. OBA can underwrite or subsidize curative and preventive medicine in the public, NGO, faith-based organizations (FBO) and private sectors.

OBA was used effectively in international family planning in East Asia four decades ago. In the 1960s, coupons for family planning services (intrauterine device (IUD) insertion, vasectomy and tubal ligations) were used on a large scale in the family planning programmes of South Korea and Taiwan (Potts, 1981), and this form of OBA made a significant contribution to the cost-effectiveness and spectacular success of these programmes. In Korea, the average family size dropped from 6.0 to 1.8 children in 30 years, and the decline began before - and probably helped precipitate - the striking economic changes that overtook South Korea slightly later (Potts, 1997). Clients seeking an IUD or involuntary sterilization were given a coupon at the primary health center that they could cash in, with a co-payment, to obtain the procedure they wanted from a government or private service provider.

More recently coupons were given to sex workers in Nicaragua, who exchanged them for the treatment of STDs (Sandiford et al., 2002). When the scheme was in place, gonorrhea rates fell by five per cent a year and syphilis by 10 per cent a year. In the large Kibera slum area of Nairobi, the Centers for Disease Control has supported a local NGO that is implementing a successful voluntary HIV counseling and testing voluntary counseling and testing (VCT) service (Marum, 2003). An OBA project to provide STD treatment is about to begin in one district of Uganda and a large scale OBA project is being developed in West Bengal, supported with government donor money. Although the experience of OBA in health and family planning is limited it is encouraging.

The advantages of output-based assistance for donors

OBA has a number of logistical advantages. It encourages both efficiency and quality in services; it enables donors to target external resources, and makes possible an entirely different, more efficient model of project management for the donor agency. OBA permits funds to be disbursed rapidly, something donors sometimes want, but without the distortions of input-based assistance.

An ability to expand rapidly is even more important as the international health community tries to confront the disaster of HIV infection in high prevalence countries. The Ministry of Health in Uganda wishes to provide assisted reproductive technologies (ART) through accredited treatment centers and OBA would be an appropriate way to reimburse centers once they have established and meet minimum service criteria. Some of the innovative work currently taking place in franchising clinic services in the private sector offers

subsidies for life-saving interventions, such as tuberculosis (TB) treatment, represents a sub category of OBA (Montagu et al., 2003).

Responding to changing needs

Input-based assistance is often unable to respond to altered need until another funding cycle is initiated. For example, the Global Fund for Malaria, Tuberculosis and AIDS is based on input-based assistance responding to national proposals from national committees. A goal of the Fund is to support in a balanced way the three areas of malaria, tuberculosis and HIV/AIDS. Currently 65 per cent of grants have been given HIV/AIDS and only 14 per cent to tuberculosis. An OBA for tuberculosis treatment could be instituted readily and if there was a policy decision to increase assistance to this important area then it would be easy to offer more services for voucher transactions or in some other related form. The Gates Merck input-based funded support to supply anti-retroviral drugs to Botswana is another example of input-based assistance and it is falling behind its expected targets. An OBA policy could be used to accelerate the responsible and effective allocation of antiretrovirals (ARVs).

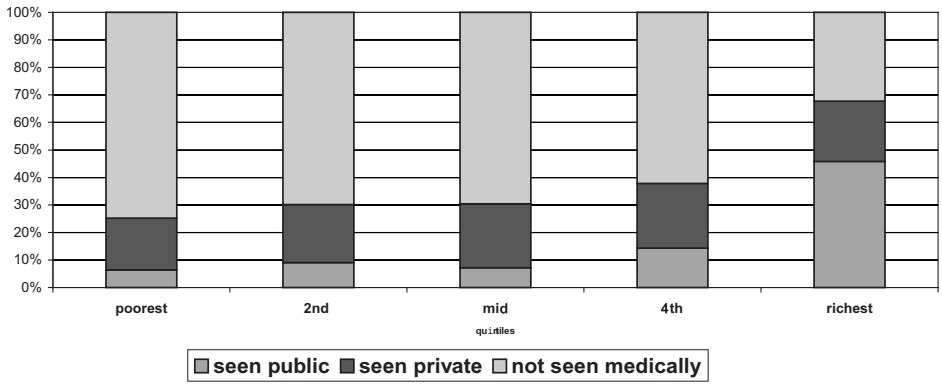
Conclusions

The transfer of money from rich countries to subsidize health needs in poor countries is an intrinsically difficult task for which there is no perfect pathway and no perfect system.

Nevertheless a strong case can be made that output-based assistance for selected items of prevention and treatment are more cost-effective, can be brought to a large scale more rapidly, will help build the autonomy of local institutions, can be more user-friendly for clients, and are easier for donors to manage than the input-based donor mechanisms most commonly used today.

The same dollar cannot be spent twice. In the end a poor use of resources denies many individuals the services or essential drugs and devices they need, which could have been provided without any increase in the total budget if that budget had been allotted in more cost-effective ways.

Health seeking behavior for diarrheal diseases in rural Mozambique



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Closing Summary and Reflection

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I was asked to give a closing summary and reflection. I appreciate this task, but I have to say, with mixed feelings. On the one hand, I feel at ease because, doing a summary, I am not expected to provide additional input to the wisdom that the assembly has added to this discussion. But as there is the demand for reflection in addition to a summary, there is some challenge ahead.

So I will try to give a summary as well as a reflection. But I will do it by an approach that we call in Germany “Mut zur Lücke”, which means, I will be very eclectic.

I would like to focus more on overall policy issues than on rather sectoral questions.

The first item I would like to address is Millennium Development Goals (MDGs) and reproductive health (RH). Here we have to keep in mind what the MDGs really are. The MDGs are results, results that define what needs are to be achieved. They do not say what needs to be done, and they do not tell us how these results can be achieved. In other words, the results can be achieved in very different fields with very different development processes, and the MDGs do not require to concentrate all activities on just those fields which are sort of backed up with indicators in the whole MDG scheme. That is important, and that covers also the question of: Do we need a ninth MDG on reproductive health? No! I think it was very clear of the whole day that reproductive health is an essential field for reaching all the MDGs. Since it is part of the basis, we do not need to single it out, and in addition there are political reasons that Ms Obaid has referred to.

The MDGs have to be achieved at the national level, and that is my second point: National strategies and local actors matter. That, amongst others, leads to our consensus that reproductive health has to be reflected in all poverty reduction strategies, in all national development strategies. Some nations are already doing that, but others don’t or do so inadequately. Now, saying national strategies, we talk about national governments: It is not just enough to develop strategies, they have to be credible as well; and one means – it was also very clear this afternoon – that one way of providing credibility is that the governments put their own resources to those strategic fields that are laid down in the overall frameworks. Despite scarce resources there is at least some scope to reshuffle the budget in many countries, for example from military expenditures towards health expenditures. And here, again, I would just repeat what has already been stressed today, namely that national strategies are to be not only done by governments, they have to be owned by governments. A national strategy becomes credible and fundable from external sources when the developing countries’ governments, as we have heard from

Tewodros Melesse, put their house in order before going to the donors, and I just wanted to highlight that again.

This leads to the third point: Implications for donors. Of course, there was the notion that more funding is needed - I will come back to funding in a separate chapter - and that we, as Germans, did not live up so far to the promises we made in Cairo and elsewhere. But there was another, very strong, point made: In addition to more funds, funding needs to be reliable. We have to make an end with that stop-and-go policy. We have to be aware of the need for structural, sustainable changes in the field of reproductive health. We also have to see, that education requires long-term engagement. It is not that with a three-year programme you can really make a lasting difference. This morning, and Mr Hofmann was also relating to this issue, we were discussing new means of donor funding, namely sectoral approaches and budget funding. This might bring about new chances to resolve the issue of reliability in the long-term – with all the “buts” and the “ifs” that certainly must be considered when we talk about budget support.

The fourth point refers to the private sector. In brief: without the private sector, the MDGs cannot be achieved, full stop. And in addition to that, we have heard today that the private sector can also play a major role in those areas that are normally associated with public service provision, in particular health. In the very first intervention this morning the extremely important point was made that the private sector is not just to make profits but also has a social responsibility to live up to. There were some other requests to the private sector, like putting prices down. There is scope -even in Germany I would say there is scope- to put the prices down for medicine. Of course we have to take into account that there are issues of economic viability, of profitability and logistics, but prices do matter. At the same time I would like to highlight here that more research is needed, more research on medicine that can really be used easily. One example that was given was microbicides for women.

Now, on funding: That is, I think, the most disputed issue, and not everything really came to a conclusion in consensus. Of course, the first issue is: Money from where? More external funding is needed. I have already said that there is special need in the field of education, and very much also in the field of medical service supply. But at the same time mobilizing more internal resources is possible. We have heard just one example during the afternoon, which seems to be rather innovative, although the Kreditanstalt für Wiederaufbau (KfW) does not claim to be the innovator, and that is the OBA. That is a means not only to mobilize resources from within, but also to combine them with external funding. There were a number of other means and ways shown to enhance internal funding. The second issue with funding is: Money for what? We had a somehow, as I would say again, inconclusive discussion on financing of running costs, of salaries for teachers, salaries for health workers, and so on. There was, I think, consensus that this has to be looked at with caution, but possibly there was also consensus that one should not exclude it, that in well-governed poor countries who have put their house in order, this might be an option. The third issue on funding is: Money alone does not do the job. This was also something we all agreed on. It is easily accepted that more money is necessary, but we have heard a strong case for looking at quality from the outset, and that is still very

often overlooked. MDGs would be misinterpreted if they were just seen as sort of standards to reach certain numbers. It is not enough that children go to school; they have to learn something. It is not enough that you put up health centres if there is no medicine and there are no health workers. So, the number of health centres per hundred thousand people does not really say a lot. It is a necessary but not a sufficient condition for improving people's health. In this respect the point has been made and has to be stressed again, for quality, capacity and institutions matter and are essential. Of course that also requires funding, investing in capacity, and here donors can also and should do a lot, and that has to go hand in hand with funding for infrastructure.

That leads to the last point that I just want to reiterate very briefly: accountability and institutions in all fields of development are extremely important; there is no such notion as technical approaches to development alone, and that is true for health and it is also true for education. The institutional set-up, the governance structure have to be really taken into account. In that sense a GTZ, as an association for technical cooperation, has to be very much a political institution, living up to what the very core of its goal is, namely building capacity of people and of organizations.

Finally I want to make a personal remark, and that is that I found both the inputs of the speakers and the discussion extremely fascinating. I would say that they were high quality, and they were down-to-earth. This combination, I think, made out the quality of this day. I would like to express very sincere thanks to all those who contributed to this quality.

Impressions

Annexes

3rd International Dialogue

Population and Sustainable Development
Implementing the Millennium Development Goals

October 21st 2004
GTZ-Haus Reichpietschufer 20 10785 Berlin

10:30 **Welcome Address**
Assia Brandrup-Lukanow, Director, Division of Health, Education Social Protection, Deutsche Gesellschaft für Technische Zusammenarbeit(GTZ), Germany

10:45 **Opening Address**
Family planning – Schering's commitment to Corporate Citizenship
Ulrich Köstlin, Member of the Executive Board, Schering AG, Berlin

11:00 **An Overview**
Status quo - new insights - new challenges?
Is sexual health rightly consolidated under the MDGs?
Thoraya Obaid**,** Executive Director, United Nations Population Fund (UNFPA)**,** New York

12:00 **German commitment**
Global Partnership - 10 Years after the Conference on Population and Development in Cairo
Michael Hofmann, Director-General, Global and Sectoral Policies, Multilateral and European Cooperation, Federal Ministry for Economic Cooperation and Development (BMZ), Germany

13:00 Lunch

14:00	**Plenary Session I** The importance of educating girls and women in particular
Chair and Introduction	***Dietrich Garlichs***, Executive Director, German Comitee for United Nations Chidren's Fund (UNICEF), Germany
Inputs:	***Namptip Aksornkool***, Senior Specialist, Literacy and Women's Education, United Nations Educational, Scientific and Cultural Organization (UNESCO), Paris ***Flavien Nkondo***, Consultant, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) Camerun ***Samir Jarrar***, Chairman, Board of Trustees, The Arab Resource Collective, Lebanon
15:30	Coffee Break
16:00	**Plenary Session II** Access to medical service, medical supply and contraception
Chair and Introduction	***Jörg F. Maas***, Executive Director, German Foundation for World Population (DSW), Germany
Inputs:	***Tewodros Melesse***, Director Africa, International Planned Parenthood Federation (IPPF), Nairobi ***Wolfgang Bichmann***, Vice President, Sector and Policy Division Health/Subsaharan Africa, Kreditanstalt für Wiederaufbau (KfW), Germany ***Claus Janisch***, Senior Medical Advisor, Kreditanstalt für Wiederaufbau (KfW), Germany
17.30	**Closing Summary and Reflection** ***Klemens van de Sand***, Deputy Director-General, Commissioner for Millennium Development Goals, Federal Ministry for Economic Cooperation and Development (BMZ), Germany
18:00	Reception

Curricula Vitae of Speakers

Dr. Assia Brandrup-Lukanow is the Director of the Division of Health, Education, and Social Protection, GTZ (Deutsche Gesellschaft für Technische Zusammenarbeit), and a former Regional Advisor for reproductive health at the WHO Regional Office for Europe. Areas of special expertise and interest are: health system reform, reproductive health in resource-poor settings, gender and health, women's health, child health, adolescent health, health care financing, quality of care. The main geographical focus of her work have been the Newly Independent States (mainly the Central Asian Republics and the Russian Federation), as well as Central and Eastern Europe (Albania, Bulgaria, Romania, Kosovo). She had also worked in Rwanda, Gambia and Yemen.

Dr. Ulrich Köstlin is a member of the Board of Executive Directors, Schering AG and is in charge of Marketing and Sales, Supply Chain and Environment - Europe and Africa. Before, he has worked in various positions in the pharmaceutical industry, such as the General Manager of Infarma S.A. (Schering-Bayer JV) Quito, Ecuador, VP Marketing & Sales Berlex Laboratories, Inc., USA, and VP & General Manager Diagnostic Imaging, Member Executive Committee Berlex Laboratories, Inc., USA. Mr Köstlin holds a doctorate in law.

Dr. Thoraya Obaid is the Executive Director of the United Nations Population Fund (UNFPA). She has joined the UNFPA in 1999. Prior to that, she was a member of the United Nations Strategic Framework Mission to Afghanistan, September 22-October 12, 1997. In 1996 Obaid chaired the Inter-agency Task Force on Gender in Amman. She also was a member of the International Women's Advisory Panel and of the Regional Programme Advisory Panel, of the International Planned Parenthood Foundation IPPF. Ms Obaid was in particular involved in women’s issues in the Arab States. From 1983 until 1990 she was a member of the editorial board of the Journal of Arab Women and a member of the Working Group for formulating the Arab Strategy for Social Development sponsored by the League of Arab States. Ms Obaid was the first Saudi woman to receive a Saudi government scholarship to study in the United States.

Dr. Michael Hofmann is, since 1999, Director General of the department Global and Sectoral Policies, Multilateral and European Cooperation at the Federal Ministry for Economic Cooperation and Development (BMZ) in Berlin, Germany. From 1979 until 1980 he was the assistant of the president of the Brandt-Commission. He worked at the research institute of the Friedrich Ebert Foundation and as a researcher at the German Development Institute (DIE). From 1988 until 1992 Mr Hofmann was an advisor of the former German Chancellor Willy Brandt and he was in charge of the office of the Social Democratic Party leaders Björn Engholm and Rudolf Scharping. He is a member of the German United Nations Association, the Society for International Development (SID) and the advisory board of the German Foundation for Development and Peace (SEF).

Dr. Dietrich Garlichs is Executive Director of the German UNICEF Committee, Cologne. He is holding this position since 1989. UNICEF is the world's leading children's organization. He also is Chairman of the UNICEF Foundation, founded in 1996. Mr. Garlichs studied Political Studies and Economics at the Universities of Tübingen and Konstanz as well as at the University of Harvard. Mr Garlichs had worked in the Federal Chancellor's Office and was Research Fellow at the International Institute of Management, Science Center Berlin. From 1982 untill 1984 he was Assistant to the CEO, DUGENA Uhren und Schmuck e.G., Darmstadt (Watch and Jewellery Industry) and from 1984 untill 1989 he was Director Publisher's Office Jahreszeiten-Verlag/Hoffmann und Campe Verlag, Hamburg (Book and Magazine Publishers)

Namtip Aksornkool is a Senior Specialist for Literacy and Women's Education at the United Nations Educational, Scientific and Cultural Organization (UNESCO), Paris. She is the editor of various gender sensitive training manuals. In her work she tries to identify gender training and awareness raising activities for education advisors at the headquarters of international agencies. She also produced post literacy materials and radio programmes for women and girls in Africa. One of her main objectives is to integrate gender awareness into mainstream development.

Flavien Nkondo is an anthropologist (PhD) from Hamburg University. He has worked as a consultant for the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) in health programmes in Cameroon/Yaounde for seven years. His main field of activity was the prevention of HIV/AIDS and unwanted pregnacies amongst youths and adolescents. As a hobby he does research on the relationship between Germans and their dogs and he has published several articles on this.

Samir A. Jarrar is a chairman, Board of Trustees at the Arab Resource Collective (ARC). This is an Arab independent non-profit organization founded in 1988. The focus has been on producing resources and organizing regional workshops. Today the ARC´s approach is promoting networking to be regarded as a culture and process, rather than the setting up of formal networks. The programmes are organized in three intersecting circles such as childhood and youth programmes, health programmes and as thirdly training: learning and communication. Mr Jarrar is from Beirut/Lebanon. He is a specialist on Arab education in transition and he published a handbook on core skills in teacher training in Jordan. During the eighties he was employed as an Education Specialist at the World Bank and he was a visiting Professor at the George Washington University and Georgetown University in the USA. Since 1994 he is the director of Rawdah High School, Beirut, Lebanon.

Dr. Jörg. F. Maas is the Executive Director of the German Foundation for World Population (DSW) – a private foundation and charity dealing with world population issues including sexual and reproductive health and HIV/AIDS. Mr Maas studied in Bonn, Berlin and at Harvard University and holds an M.A. in Philosophy and a PhD in the History and Philosophy of Science. He has been working for various institutions of the European

Union, the World Bank and UN organizations and serves on the boards of several European non-profit organizations.

Tewodros Melesse is Director Africa at the International Planned Parenthood Federation (IPPF) in Nairobi, Kenia since 2002. Prior to that, he was his country's representative at Pathfinder International in Addis Ababa, Ethiopia. He coordinated the technical assistance for numerous projects. Mr Melesse studied at the Roman Catholic University Louvain, Belgium and he holds a Degree in Macro Economics and a Diploma in Commerce. He later began a professional training in Health Care Financing and Management Scienes for Health in Boston /USA. He is a member of the American Public Health Association and a Board Member of the Ethiopian Orthodox Church's Development Commission.

Dr. Wolfgang Bichmann is Vice President - Sector and Policy Division Health – at the Kreditanstalt für Wiederaufbau, (KfW development bank). With a background in tropical medicine, environmental and public health as well as social sciences, he has practical work experience in health system development in Africa, as a researcher at the Institute of Tropical Hygiene and Public Health, Heidelberg University, and as a consultant for several international agencies. Mr Bichmann has published on tropical public health and community involvement, and in recent years has chaired a DAC/ WHO sub-group on poverty and health. He is a member of the thematic team for sexual and reproductive health in German development cooperation.

Dr. Claus-Peter Janisch is currently the Senior Public Health and Population Expert at the Kreditanstalt für Wiederaufbau, (KfW development bank). The KfW is financing, alongside many other German Government and European development programmes, substantial grants and loans. Mr Janisch is an OB/GYN who specializes in family planning, social marketing, social franchising and private sector involvement in health care delivery. He has been working as a senior heath advisor at the KfW since 1989.

Dr. Klemens van de Sand is Deputy Director General and Commissioner for Millennium Development Goals at the Federal Ministry for Economic Cooperation and Development (BMZ) in Bonn, Germany. Before, he was Assistant President, Programme Management Department of the International Fund for Agricultural Development (IFAD) in Rome, Italy. In the 90s he was Chairman of the OECD/DAC Working Group on Participatory Development and Good Governance and Deputy Director-General Development Policy, Planning Research, Evaluation, Donor Coordination within the BMZ. Prior to that, he had been working more than 15 years as Director of the BMZ Minister's Office and was the Head of the Planning Division. Mr van de Sand was also the representative of the Konrad-Adenauer-Foundation in Indonesia.

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