Foundation Roundtable: Future Family Planning Strategies

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Edited Transcript
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Bert Koenders (video):

Ladies and gentlemen, thank you for inviting me to take part in this roundtable, and well done to the Woodrow Wilson Center for organizing discussions on challenging subjects. Regrettably, family planning and reproductive health continue to post challenges in the world of today and I'm very sorry not to be able to take part in this roundtable in person. But I'm grateful for this opportunity to make my voice heard through this video message.

First of all, I will talk about our experiences in this field then refer to activities involving The Netherlands, and finally, I will discuss shortly some of the challenges we are facing. Taking your questions as a guideline, I'd like to focus on three issues. First, Cairo, the MDGs, and young people; second, opportunities; and three, challenges.

First, Cairo, the MDGs, and young people: I think everybody around the table will agree that family planning is one of the biggest success stories of development cooperation. I also consider the paradigm shift in this field from top-down family planning to programs of reproductive health and rights for couples and individuals, adopted in Cairo in 1994, to be a success story. It took us another six years of hard work before we saw the Cairo agenda duly reflected in the MDGs. MDG Target 5b, universal access to reproductive health by 2015, was not added until 2007. In those years we battled it out with delegations representing the United States. Nowadays, however, we want to join forces with the United States administration in order to work in complementary ways for sexual and reproductive health and rights for everyone in order to achieve Target 5b and MDG 5.

We consider MDG 5 to be the mother of all MDGs. If the two MDG 5 targets are not achieved, then the other MDGs will not be attained either. It is smart economics to invest in MDG 5. Universal access means that everyone has right of access. Protecting, promoting,

and fulfilling this universal right also means giving all women, adolescents, and young people access to sexual and reproductive health information, services, and commodities.

What are their needs? We have data on the unmet need for family planning for married women, but what about the sexual and reproductive needs of unmarried women? And the needs of adolescents and young people? If we do not know what they need how can we invest efficiently and effectively? My plea is that we should acknowledge the needs and rights of adolescents and young people, married and unmarried, in the field of sexual and reproductive health. They all have the right to information and services. I call on you to help convey that message, and to do so with energy and determination.

Then my second point, opportunities. The new United States administration is perceived by the SRHR community as the best opportunity for a long time. And I would like to highlight two other opportunities. There is a growing awareness, especially in Africa, that population issues have long been neglected in development and debate in national planning, in investment in health and well being and even in fighting HIV/AIDS. Demographic developments often mean fast-growing populations and is that an opportunity or a threat? That depends on your perception. So population issues need to be approached sensitively, and through well-informed and open debate. In my opinion, the starting point for the debate is the basic rights of all couples and individuals to decide freely and responsibly on the number, spacing, and timing of their children and to have the information and means to do so, as was agreed in Cairo in 1994.

The entry point for action is the unmet need for family planning. That is why I decided last year to increase our contribution to the global program on reproductive health commodity security from five million to 30 million euros per year. Another opportunity is that of working with the private sector with for profit and nonprofit organizations. I look forward to hearing more about the Gates Foundation's plans to expand their investment in reproductive health beyond maternal health. We would very much welcome increased investment in family planning and commodities.

I'd like to give some examples of public-private partnerships supported by The Netherlands. The female condom initiative was started by Dutch private sector organizations. Based on the existing demand by women, particularly in Africa, our current aim is to make the female condom more widely available, promote its use, and try to lower the price of this commodity. We also support a concept foundation, which promotes the production of generic abortion

drugs and helps with their registration and introduction in countries which want to provide safer abortion services.

Most recently we have stepped our support to Marie Stopes International, six million euros in 2009 and 2010 for expanding the social franchising activities, which means expansion of SRH services through qualified private practitioners.

And then number three, the challenges. I see a great many challenges in this field, but I will confine myself to mentioning just two of them. Now that you have heard my plea for the SRHR of adolescents and young people, you will not be surprised that I see investment in youth as the biggest challenge for us all. The unprecedented number of young people, more than half of the world's population, compels us to make their future our priority.

The second challenge is to provide a counterbalance to the growing opposition to sexual and reproductive health and rights. It's not only about abortion but in a much wider sense, also about reproductive rights of women and girls. All these factors are closely linked to the deeply rooted imbalance in power relations between women and men, and the increasing sexual violence again women. Although our embassies do indeed report on progress in the field of SRHR, they more often report on the growing opposition to it. In some countries amendments to existing legislations have been proposed or have already been adopted, particularly in relation to abortion. These changes often result in unacceptable violations of the reproductive rights of women, severely impairing their chances of having the highest possible standards of health, which is a universal right. I find this unacceptable, and I will not be silent. During my country visits and meetings I speak to government ministers and presidents and I challenge you to do the same. We must join forces and use smart approaches in order to counterbalance the continuing growing opposition to sexual and reproductive health and rights. We need long-term strategies, and we must act now.

I wish you all a fruitful and inspiring roundtable discussion. Thank you very much.

Scott Radloff:

So I've been at USAID for 26 years. I joined back in 1983. And until this year, just two of the 26 years were years in which we had a supportive Congress and a supportive White House for family planning/reproductive health. You may recall the 1994 Cairo conference. 1992 was the year that the Clinton Administration came into power and 1994 was the year of

the Cairo conference. And the following year, 1995, was the high-water mark in USAID funding for family planning/reproductive health. One year later our funding was reduced dramatically by about one third. We went from $541 million to $376 million between 1995 and '96. And we also had our funds metered at that time. So with the change in Congress, there was an attempt to bring Mexico City back into place as law and, because there was an annual battle over that with the Clinton Administration, the consequence was lower funding for family planning and reproductive health.

Funding for this program actually increased under the Bush Administration, but family planning and reproductive health wasn't a particular priority and there wasn't a great deal of attention placed on family planning and reproductive health. And as you heard from Bert Koenders, there was actually resistance to MDG 5b on universal access to reproductive health. As I said, funding went back up under the Bush Administration, Mexico City policy came back into place, UNFPA was not funded.

So we now have a new environment since January. President Obama, on his third day in office, rescinded the Mexico City policy. In March Secretary of State Clinton announced the refunding of UNFPA, so we are once again able to work with key partners in advancing family planning and reproductive health. We have seen a positive engagement of the administration on reaffirming U.S. support for the MDGs, including MDG 5b and improving access to reproductive health information and services and reaffirming support for the ICPD program of action. And I must say that many bilateral donors, multilateral donors, and foundations are now very interested in working closely with USAID in advancing these programs. And you heard from Bert their interest in re-engaging with the U.S. government on these issues. Also, country governments, I think, are now more interested in this subject, family planning/reproductive health. But the environment, in general, is much better than it's been at least since 1992, and perhaps even, even ever, perhaps.

Just in terms of achievements that we've made in family planning, we have success stories in every region of the world. In Latin America most countries have graduated from bilateral assistance or in the process of graduating. In a few years we will be focused only on three countries in Latin America: Haiti, Guatemala, and Bolivia. We've also graduated various countries in North Africa and in Asia, particularly East and Southeast Asia.

So our focus now is on the poorest countries of the world, in Africa and South Asia. In terms of the biggest challenge facing our program going forward, I would say it's still revitalizing

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commitment and attention to family planning/reproductive health, both internationally and at the country level, especially in the poorest countries of the world. I think we have the elevated attention and interest in this area. It needs to be strengthened, moving forward.

We also have a challenge of reaching the poor and the underserved. If you look across the countries we work in, it's the poorest countries that have the greatest need for family planning assistance, and within the country it's the poorest segments of the population that have the greatest unmet need. We need also to focus on strategies for reaching the poorest and rural and peri urban populations. And one area that needs added attention is community-based approaches, getting outside the clinic, community-based distributors, outreach programs, mobile clinics, and private sector strategies for reaching the poor urban and rural populations.

We also need to focus on long-acting and permanent methods. If you look across our successes, particularly in Africa, most of it is based on pill and injectable contraceptive use. We know, though, that there is growing need for limiting fertility, not just spacing. So as we go forward we need to figure out creative ways of bringing long-acting and permanent methods to make a wider range of contraceptives available. Throughout Africa we have contraceptive security issues. We need to focus on improving the availability of contraceptives and strengthening the systems to make them available at the service delivery points.

I would add as a challenge, repeating the Minister's point, meeting the needs of youth who are often underserved. And there's a special challenge for USAID in addressing needs in Francophone West Africa. If you look across the countries of Africa, the countries that are lagging behind in terms of increasing contraceptive use and availability of contraceptives, it's largely Francophone West Africa that is lagging. We have a special challenge here because we have very few missions in the West Africa region, so we need to figure out creative strategies of addressing needs in countries where we don't have mission presence.

Just to end on a positive note, I think there are many opportunities going forward. We have, in addition to having strong support in our administration, both a President and a Secretary of State that speak out passionately about the need to reduce unintended pregnancies and to make family planning more widely available. We have family planning and reproductive health included as a priority under the Global Health Initiative which was announced by the President back in May. That initiative encompasses family planning/reproductive health,

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maternal child health, and various infectious diseases, including HIV, TB and malaria. The fact that he placed these under a single initiative, rather than creating two new initiatives for family planning and maternal-child health, signals his interest in ensuring that we integrate these programs to the extent practical. And there are many areas where we can do integrated programming in ways that advance family planning and maternal-child health and HIV in particular.

Family planning, as we know, is an important intervention for reducing maternal mortality and reducing child mortality. It's also an important intervention for reducing HIV transmission. All of those are goals under the Global Health Initiative. We also have seen increased funding for family planning/reproductive health. About an $80 million increase last year, potentially another $80 million increase next year, with higher funding requests going forward.

So I think it's a time to be very upbeat about the possibilities for reinvigorating family planning/ reproductive health with U.S. leadership, and I think other donors and foundations will join together with the U.S. government in moving this initiative forward.

I might also just mention, too, in terms of opportunities going forward, we have a number of new technologies that may become available in the next few years. One is a new delivery system for Depo Provera, which will make Depo Provera much easier to administer, and must easier to make available in rural and peri urban settings going forward.

Maybe a couple of years behind Depo we'll have available the contraceptive vaginal ring, which is a one-year ring being developed by the Population Council. It's a woman-controlled method. As I said, will last for a year and we see real prospects for increasing use of family planning services with these new methods. So let me stop there and yield to the next speaker.

Jose Rimon:

I'm an optimist. I see three major trends happening as we speak. The first trend is that the decline for family planning/reproductive health resources, which has been happening since the mid 1990s, has been reversed. Up to 2006, it's been declining, but we have now seen numbers in 2007, 2008, 2009, in which this long decline in resources allocated to family planning and reproductive health may have been reversed. I was looking at the report of 16

NGOs from Europe working together to countdown 2015, and I was shocked, literally, to see the new numbers coming out in terms of appropriations from Europe for family planning/ reproductive health coming out last year and even maybe the numbers coming out in the coming year, despite the economic crisis.

So on the issue of resources, it seems like something is happening in the sense that this long decline has been reversed, and we see it here in the U.S. too, that not accounting for inflation, I think the U.S. government has allocated the largest absolute amount for family planning ever in its history.

The second one is a major trend towards more effective and better policies, and I think here in the U.S. we have seen that: the rescission of the Mexico City policy, the new guidelines in PEPFAR, and some with the new changes and policies that are also seen in Europe.

And the third one is one area, which is a little bit controversial: the long era of self censorship, in the sense that this community has not talked about family planning and population, but talked only about largely sexual reproductive health and rights, and forgotten about family planning and population issues, which were also in the ICPD. I think that the space, the demographic space, for bringing those issues has become better worldwide; that many of us in different communities can now talk about family planning, can now talk about population within the rights perspective, and at the same time talk about sexual reproductive health and rights.

You have seen Bert Koenders talk there. I was monitoring a speech in November 2008 he delivered in Rotterdam. This was when he announced the increase for reproductive health supplies to UNFPA from five million euros to 30 million euros, and a huge investment they have in Yemen. And for a Dutch Minister to talk about family planning, population, security, maternal health all in the same speech and try to put them all together was unprecedented. The Dutch didn't talk about population in the past. They didn't talk about security issues in the past. But for him to put those issues in a very coherent way was an eye-opener for me. And I think many of the Europeans are also looking at this issue in a much more comprehensive way.

So family planning/reproductive health –- as Bert has mentioned -- we are a victim of our own success. A relative success, if I may qualify that. First, in the 1960s to about this time, we know that completed family size, roughly TFR, has fallen from about average of six in

developing countries to now three. That's a huge decline. And if you look at the contraceptive prevalence rate, it has increased from ten percent in the same time period to about 55 percent today. And excluding China, that's probably a little bit lower. But even if you take a 50 percent CPR, remember that you could never have 100 percent contraceptive prevalence in any given country. Maybe the highest you will achieve is probably 80 percent, and that's extremely high already. So at 50 percent you're already two thirds of the way. In other words, it has become a norm, a social norm. It's not controversial anymore in many of those countries.

Let me take the case of Indonesia, for example. In 1997, Indonesia suffered its most severe economic crisis. Everybody predicted that the family planning program in Indonesia would decline, because no government money would be available, and yet what happened? Contraceptive prevalence in Indonesia, in the worst economic crisis, as measured by DHS, actually increased in terms of modern CPR. Why? Of course, there are many reasons. But the primary reason, I believe, is that the norms in those districts and provinces were in place. The people would sit for those services from the private sector or wherever they are because the norms are there. They are not controversial anymore.

I'd probably cite one country which many of you may be shocked to know. Take the case of Zimbabwe. If you look at every single health indicator and poverty indicator in Zimbabwe, it's all going down.

And yet there's one measure where it's going up: CPR -- in a place like Zimbabwe. How can you explain that? All other indicators are going down. To me, again, it's the norms that have been in place in those countries. And the people, once they have valued those norms, will seek the services wherever they come from. But this relative success blinds us from the fact that if you study 49 percent of the developing countries, the modern CPR is only about 24 percent, according to UNDP. It's very low. And if you look at Africa, Africa seems to have not been affected by this demographic revolution. By 2050, we will see an increase of about two billion people residing on the continent of Africa: two billion people. India will be around 1.7 billion and stabilizing. China will be around 1.5 billion stabilized. And Africa would be at two billion and still growing, in some of the most fragile countries which have very serious economic and development issues.

So while we have relative success, and relative success has gotten or taken all family planning and reproductive health off the map, I think there is unfinished major business in

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the sector. We at the Gates Foundation believe that without revitalizing the global agenda for family planning and reproductive health and investing in making sure that the other donors around the world and emerging donors and other players invest in this area, it would be impossible if not difficult, and difficult if not impossible, to achieve the health Millennium Development Goals. And probably even beyond the health goals.

If you take a look at some of the studies, such as work done by Vlasoff at the Guttmacher Institute, just addressing the need of the 60 million unintended pregnancies in the developing world could reduce maternal mortality by 31 percent. It's your single biggest cost-effective intervention to reduce maternal mortality. If you take a look at infant mortality, the same study shows 22 percent. So again, here it's a major cost-effective intervention to reduce infant mortality. If you take the case of HIV/AIDS where we know that a huge number of pregnant women in Africa actually don't want to get pregnant when they're HIV positive, it's 90 to 92 percent, but many of them don't have access to family planning contraceptives and services. The Family Health International made some studies and between 1999 to 2006, showing that contraception averted more than ten times the number of HIV-infected pediatric cases in sub-Saharan Africa, compared to providing ARV drugs alone to pregnant mothers. So you could actually help achieve your goals in pediatric cases by investing in family planning, not just by providing the drugs.

So we believe that without a serious reinvestment and revitalization of the family planning global agenda, it would be very difficult for the world to achieve the Millennium Development Goals in maternal health, in infant mortality and HIV/AIDS, and even on equality of women. I'm not even talking about population and climate and environment here. I'm not sure if we have a representative from Hewlett Foundation here, but any time now there will be two articles that I have been informed will be coming out in a journal soon. One is done by a climatologist and the conclusion is that investments in family planning/ reproductive health is equivalent to at least one and probably two wedges out of the 14 wedges in the Princeton study in order to reduce carbon emissions by half: One, most likely two wedges, out of the 14 wedges. I'm not an expert in this area, but I heard that one or two wedges are equivalent to all of us driving electric cars. Let's look at the comparison in terms of cost-effectiveness.

And another study which was done by an economist who used to work with the Bank and now with one of the NGOs has concluded that the most cost-effective intervention on climate change was, in fact, family planning and girls' education. I'm looking forward to the

publication of those studies because I think the studies which were done were highly sophisticated methodologically, and very respectable people would probably contribute to the literature and the evidence in the discussion that we have today.

So I'm very positive that the last year and a half and the future years, I think you will see a revitalization of this agenda from the North to the South, among the South, within the foundations, among the donors, and we can talk again about population, family planning/reproductive health, and essentially have a unified community. Because, as Professor Shipman said in his study published in the Lancet, the first precondition of effective advocacy in which you can get the resources that you need, like our friends in the HIV/AIDS community and our friends in the black community, is unity within the community. And I think if we achieve that kind of unity that our other colleagues have been able to achieve, the resources that are sorely needed for family planning and reproductive health to help achieve the Millennium Development Goals, I think we have, we have a better chance, this time around. So thank you for that.

Musimbi Kanyoro:

When you speak when everybody has talked and you want to say all has been said, let's go home. But I speak from the vantage point of a foundation that has been committed for nearly 45 years in reproductive health and has stayed committed for that long. For the prospective that I want to bring, which is grounded in the David and Lucile Packard Foundation, are the implications that we need to have in family planning, in thinking long and thinking big. Because the times in which we live are times in which we value quite quick harvest, but we know that when we work with family planning it's a long term agenda. It's an agenda of today and tomorrow and the years to come. And I think what we can illustrate by the funding, the grant-making that we make in our foundation is that kind of long term commitment and what it yields in learning both to the field and specifically to the issue that we are dealing with.

So first of all, I say thanks to all the speakers that have spoken before and for the facts that they have given. I agree with them, and I had them in my points and so I will skip them and move on.

So, what have we learned from 45 years of commitment to family planning as a foundation that we could bring and say it really needs to be reflected in the future? One is it is important

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to build the capacity of society, and also maintain the ground when sometimes that success is threatened by the different political eras that we can go through, the different social eras that we can go through, and different individual times that we can go through. And this has been the case in the area of family planning. I think as has been outlined by my two previous speakers, there are ups and downs in commitment, but at the present time in the area of family planning, we know what works. We know that we can make family planning available to everybody in every place if we committed ourselves to it. And commitment includes not just the will to do it but to commit resources to it.

So in our 45 years, one of the areas that we have found that has been fluctuating over and again is the funding of the resources. And I think the advocacy for the future must include a really sustained effort for advocacy for sustained funding resources, because the funding of the resources -- or the resource availability -- affects the supply chains; it affects the human resources. If we look at the era that we have passed, when HIV was better-funded than family planning, what happened is that there was a flight of the people that specialized in family planning into the HIV area that so much needed people, but at the same time it meant that it left family planning poorer than it was supposed to be. We can name country after country, but we can also tell in those countries where we have been deeply involved, because the Packard Foundation brings the examples of working deep and long in countries where we are. The 45 years here in the USA, the ten years in Nigeria, India, Pakistan, bring example after example of staying long and sustaining the people that you are funding for a longer time.

The second thing that I mentioned was capacity building, and the examples that we have supported in the Packard Foundation. We have always emphasized leadership development, growing leaders who are advocates, but also growing leaders who are actual practitioners, planners, budget managers. We have very strong leadership fellows in the countries in which we work. This is important, and as we go into the future we see the development of the local capacity of leaders and organizations as really a top-notch area that we should look to sustain those gains. We have seen places where the leadership is not committed to family planning unless you have a caliber of people that call them to accountability. Once again, you lose the momentum on family planning.

Telling the stories of practitioners is very important. In the programs where we work, our success is because organizations have given us data on which we can build credibility to go into the future. Recently in our evolution research in India, in Jharkhand, we actually found

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that through funding Pathfinder for nearly seven to eight years, we have been able to see a community raise the time of delay of the first birth by two and a half years. That's incredible in the areas in which we work. And having such evidence is very useful for the field, and very useful for the donors, and very useful also for the governments of those particular places to really see that the needle is being moved.

We can give examples of the work that we have been funding over the years in Ethiopia, which now is famous work. Community workers are people who are able to deliver, from house to house, information about family planning or holistic information about health. Now governments all over the world look at health systems and they look at service delivery and caretakers. We see that this example, that we began at the grassroots, has really yielded something that you can show. You can be able to lift up and show. And we can be able to tell the number of grantees that we work with in Ethiopia in the beginning years in order to develop community-based activities and supporting them. So that's another example that we would like to lift up.

The challenge for us as we go into the future is to how to work collaboratively so that we can bring things to scale. I come from Africa, and I know that we can literally grow anything. We can have every small project. But the really big difference is when those problems are brought to big scale. So part of our collaboration, I think, would be bilateral donors like USAID or DFID or the Dutch government and others really beginning to talk right at the level of the experiment. I think private money is really good for paving the way, but I think that private money and government money is really what makes the biggest difference in scale. And I think this is an area that we should go into the future really ready to cultivate to the maximum, so that things can be brought to scale and examples can last for a long time. Sustainability is important, and I see that as one of the things that we need to do in the future.

The biggest challenges that I see we are going to be facing together, collectively, in five years' time: can we deliver on MDG 5, maternal health, and MDG 5b, universal access to contraceptives. I think there's a big challenge there, and this is an opportune time because the climate is right. But it really means working much harder to get this MDG delivered properly.

The second thing that I think is going to be a challenge is that there are still 200 million women out there with unmet needs and we cannot forget that unmet need is a big area that we should look at. Today I think we can talk of this as a human right. That unmet need

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needs to be met and it can be met, not just by repositioning, but really, also inventing at this particular time new technologies that are actually easier for women in low-resource areas to be able to use. What is available now are good and fine and are utilized now more than ever before. But we need some three-four month contraceptives that women in the lower-resource areas can use.

One area that we in the Packard Foundation think that we really want to experiment with, because we see a lot of potential, is linking reproductive health with girls' education, being at the same table with people who find education and really making sure that education is part of the agenda of family planning. The second area is taking seriously the voice of women in leadership position. This morning I visited a training of women repositioning family planning and I saw in that room women leaders who are going to make a difference, who are going to speak for themselves from the countries where they are coming from, and who are going to be able to actually name their own demand and touch the hearts of many in their advocacy work. This is an area that we think has a lot of potential for the future, because it also helps to link the family planning agenda with also the other agendas that affect communities in which we work.

And finally, we will continue to focus our work in some specific countries, but specifically, take a good look at what is happening in sub-Saharan Africa so that we can be able to address some of those areas that are the weakest in the link. And in this area is not just a matter of being present there, but a matter of doing really high-level advocacy, such as a planned advocacy that we hope to do with the Gates Institute, to make sure that these messages go across not just one country but several countries and even, if possible, benefit from inter-regional work. This is going to be very, very important for us as we go into the future.

Geoff Dabelko:

I'd like to pick up on Musimbi's point about the roles of collaboration between the private and the public and particularly that notion of the private as the experimental and the pilot, and the public sector coming in and helping bring it to scale. And I wondered if, Oying or Scott, you'd like to reflect on that model and/or other models that you see as productive

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directions that we go in, whether it's co funding or divide and conquer, between the public and private avenues.

Scott Radloff:

Let me just say, one of the principles of our Global Health Initiative is a focus on system strengthening. And when we talk about system strengthening, often we think of government systems. And government systems are critical for providing family planning, maternal-child health services but it's not the only system. So when you look at a country's system, you need to look at both the public sector, and the private sector and the NGO sector. And not just to view them as independent of each other, but they're interrelated, and the ideal is when the government recognizes the private sector, the NGO sector, as partners and develops strategies that incorporate the contributions of the private sector and public sector, and acts in ways that improves the environment for private-sector investments and involvement. I mentioned we have graduated quite a number of countries from family planning assistance, and almost uniformly where we graduate countries is where there is a strong private sector providing services to those who can pay. The government is focused on those who can't pay, and there's an NGO sector that involved in either providing services or providing advocacy also on the outside. So those three elements are critical.

Geoffrey Dabelko:

I think Gates in some ways has the potential to play both those roles, supporting experiments but also helping with scaling up.

Jose Rimon:

I think when you use the word private, two things come to mind. First, foundations are private sector. And it's interesting that research was conducted jointly by both a Democratic and a Republican consulting research firm on family planning and reproductive in the U.S. among voters and among policymakers, concluded that if the U.S. government is perceived to be in partnership with foundations in the U.S., there would be much more likely voter support for family planning/reproductive health. So that's very interesting that the partnership between the U.S. government and the foundations are perceived by both policymakers and voters as a positive thing. It adds value, one to the other.

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The second one is the real private sector, the commercial private sector. Again, since I am familiar with the data, let me use the case of Indonesia. In 1986, Minister Haryono Suyono, said that at that point in time, Indonesia was already one of the most successful family planning programs in the world. But he said, I want to see my country and my people 20 years from now to be self reliant in the use of family planning. And I want them to pay for those contraceptives, except maybe for the 20 percent who are really poor, then we could subsidize. Help us make this happen. Because we are successful but government-dominated, government-funded. If you look at Indonesia today, you will be actually shocked at the data because they have actually far exceeded the dream that Haryono had 20 or 25 years ago. If you look at the top two methods in Indonesia, the first most popular method in Indonesia is injectables, and the second is the pill. I asked a colleague from the Rand Corporation, could you run some studies on who are the people who are actually paying for this? 99 percent of those who are using injectables and pills in Indonesia pay full commercial price; the rich and the poorest pay full commercial price. Whether they get it from the physician, they get it from the midwives, they get it from the pharmacy or they get it from somewhere or even get it from the government post, because the government posts also charge as part of their cost-recovery program.

So I said, wow, the poorest of the poor, the poor up to the rich people pay, almost all of them, 99 percent pay at the same full commercial price. If it can happen in Indonesia among the poor, why could not it happen elsewhere? Maybe Indonesia is unique but maybe there are other countries where this can also happen. But why did it happen in Indonesia? Probably a lot of factors. Again, political commitment and a strategy to really shift the program away from government-dominated, government-funded, into a much more self reliant program with the use of the private sector, not social marketing, but working directly with the commercial private sector. So I think that the private sector can play a large role. Many in our sector don't believe in that, but my own personal experience has shown that, in fact, it can play a critical role in a self sustaining effective family planning program.

Geoffrey Dabelko:

Terrific. We had a couple of you, obviously the minister and Musimbi, talk about the MDGs. Perhaps it's a bias of sitting in Washington, and perhaps it's reflecting heavily towards the last eight years rather than the future years but that hasn't necessarily been a frame that has animated the Washington policy discussion. Is that changing? Is that a hook upon which we can measure progress? And this is, I guess, obviously a question for Scott, but also in terms

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of the foundations obviously based in the U.S. Is that something that we will see as an increasingly useful tool in measuring a way to measure our progress?

Scott Radloff:

I think from USAID standpoint, you're right, in the last eight years, the MDGs weren't a real focal point for our work, even though we were working in those areas that affected the MDGs, but it really wasn't part of our organizational framework. I think the new administration is changing that. The MDGs are a focus. So I think we will be speaking more frequently in terms of our contributions to the MDGs, and I think speaking a language that's more common across other donors and the countries we work with.

Musimbi Kanyoro:

I think it's important to frame this debate within the MDGs because we work with countries and focus countries in the South who will find international instruments as very important to create a debate around it, both the advocates and even governments, whose financing sometimes is done according to these agreed instruments. And definitely the MDGs with the focus on reducing poverty are very important for the Southern governments because poverty is a big issue. And the rest of the MDGs really are lined along so that they speak together, they go as a unity. And being able to lift up the centrality and the importance of the MDG 5 maternal health and universal access to reproductive health is extremely important.

In financing, I think that when we look at it and look at other declarations that have been made by governments in various places, the MDGs can also help to try and say, yes, you have health financing, but how much of this is on actually MDG 5 or MDG 2 or MDG 3, according to whatever that one wants to, because then you can be able to see the segregation of financing and that is another important thing. And then I think the civil society uses these MDGs to call their own governments to accountability. So there is a way in which having some frame that we can all use, globally, can be very useful.

Jose Rimon:

That's a really good question, Geoff. My own personal experience is that before, when I started to link family planning/reproductive health as a critical and essential component of achieving the MDGs, people laughed in the beginning and said, what are you talking about?

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You know, in the U.S., nobody thinks in terms of the MDGs. And I said, but it's the most effective way of doing it. But now the world has changed. Within the Gates Foundation, for example, in many of our staff meeting always say whatever we do, whatever investments we have in the area of global health, we must look at it in terms of what our contributions are in achieving the health MDGs.

And if you remember, Bill Gates was one of the speakers at the U.N. General Assembly meeting, I think, last year and he gave the MDG goals an A plus. In the sense, you know, that the world community has come together in a greater and a common good and agreed to be monitored against progress towards the common good.

For this research that I mentioned in the U.S. that was conducted by both this Republican and Democratic consulting firms, in the beginning I said, could you check whether linking family planning/reproductive health to MDGs would make sense? And they said, what are you talking about? You know, people in the U.S. don't think in terms of MDGs. I said, just test it. Because the advocacy strategy that we use revolves around that. And they were completely surprised that if you define the MDGs to the voters as a common good, that the world has agreed upon, and don't use the word MDGs, but use the words halving poverty, universal access to primary education, decreasing maternal mortalities, saving mothers' lives, decreasing infant mortality, saving babies' lives -- that of course, they do understand. And if you link family planning in relation to the achievement of the common good, the voters are intelligent. They do understand that. The policymakers do understand that.

But that would not be an issue in Europe because as far as I know, in talking to all our friends and colleagues there, both in the donor community and NGO community, they are so stuck in the language of the MDGs that they're like what Dr. Kanyoro said: they look at many of the things that they do and their investments in ODA in terms of their contribution to achieving the Millennium Development Goals.

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