Report of

2nd INTERNATIONAL CONFERENCE ON REPRODUCTIVE HEALTH MANAGEMENT (ICRHM)

Emphasis on Family Planning

THEME :

"CONVERGENCE: WORKING TOGETHER FOR RESULTS AND IMPACT"

Kartika Plaza Hotel, Kuta, Bali - Indonesia
6 - 8 May 2008

UNFPA

PHANSUP

imRHma
International Movement of Reproductive Health Managers & Advocates

F O R E W O R D

The 2nd International Conference on Reproductive Health Management (ICRHM) has been success-fully held in Kuta, Bali on 6-8 May 2008. Distinguished experts from across continents come to share their experiences in managing the reproductive health program to achieve the better result and impact.

I am pleased to share this proceeding report to all of you who have been involved during the conference as well as those who were not able to attend the conference.

May I take this opportunity to express my profound thanks and appreciation to all of the distinguished speakers and experts who are willing to share their experiences and to make the conference success. I would also like to express my gratitude to those who contributed to complete this work especially national and international committee members for the valuable works and The Philippines NGO Support Program, Inc (PHANSuP) and UNFPA Indonesia.

Thank you.

Dr. Sugiri Syarief, MPA

Chairman of BKKBN/Chairman of National Committee 2nd ICRHM

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I N T R O D U C T I O N

Background

Reproductive health management (RHM) deals with maxi-mizing the poten-tials of individuals, groups, and institu-tions working in the reproductive health sector in designing, implementing and sustaining specific initiatives aimed at addressing relevant community aspirations and needs while contributing to the attainment of the MDGs. More than a decade after the International Conference on Population and Development (ICPD) 1994 in Cairo and eight years in pursuit of the Millennium Development Goals (MDGs), many public, civil society and private development organizations have already accumulated a wealth of experience in managing the implementation of reproductive health (RH) interventions to achieve results and create impact in target communities. Scaling up or replicating what really works at the community level will facilitate the attainment of the MDGs by the year 2015.

Recognizing the need to properly manage reproductive health initiatives, the Asia Pacific Reprohealth and Development Center (APRDC) of the Philippines NGO Support Program, Inc (PHANSuP) organized the 1st International Conference on Reproductive Health Management (ICRHM) on 2006, in Manila with the supported of European Commission, The David and Lucile Packard Foundation, the United Nations Population Fund (UNFPA) and the Australian Agency for International Development. The conference theme was *"Creating the Impact in Communities: are we ready for the future?"* The conference was attended by 625 participants from 11 countries and many international donors and communities. The conference was very successful in sharing the lesson learned of reproductive health management across the communities, organization, and countries.

In the 2nd ICRHM, participants shared their current expertise and experiences in managing the reproductive health program for achieving the better results and impact. The conference gave special emphasis on discussing the management of family planning program. It also highlighted critical issues of reproductive health programs, such as access, quality, leadership, community participation, and youth empowerment.

Objective

ICRHM aims to provide an opportunity for participants to develop a common agenda and build a consensus on ways to best pursue it, to share learning across individuals and organizations, and to renew commitments in continuing their work. Towards this end, ICRHM 2008 was:

a. Highlighting current and emergent practices in managing reproductive health

in relation to other development concerns;

b. Identifying gaps, gains, lessons, insights, challenges and opportunities in pursuing multiple priorities in the area of reproductive health and development; and

c. Reaching a consensus on future actions to advance reproductive health management in accelerating the achievement of MDGs

Theme

ICRHM2008 focuses on how is best to manage specific reproductive health initiatives with special emphasis on family planning in the light of equally pressing concerns that affect the living conditions of people particularly in developing countries. Thus the conference adopted the theme *"Convergence: working together for Results and Impact"*.

Venue, Date, and Agenda

The 2nd ICRHM 2008 was conducted in Kartika Plaza Hotel, Kuta – Bali, Indonesia on 6-8 May 2008.

Agenda of the 2nd ICRHM 2008 consists of plenary session, parallel session, and poster presentations. The plenary consists of 5 sessions while there were 8 parallel sessions and 48 poster presentations during the conference.

Speakers

Speakers in the oral presentation both from plenary and parallel were 41 persons, 19 were invited by the committee and 22 speakers were selected base on the incoming abstracts. In overall the committee has received 86 abstracts from various countries. Also the committee chose 38 speakers to presenting in the poster presentation based on the incoming abstracts.

Participants

The conference was attended by 388 participants from 25 countries namely Afghanistan, Australia, Bangladesh, Bhutan, Egypt, Ethiopia, India, Indonesia, Iran, Laos, Malaysia, Mongolia, Nepal, Nigeria, Pakistan, Philippines, South Korea, Sri Lanka, Sudan, Switzerland, Thailand, Timor Leste, Uganda, USA, and Vietnam. The participants were representing government institutions, NGOs, professional institutions, and donor institutions. There were 19 donors and international organizations which supported participants' attendance, such as International Federation of Red Cross, PPD, National AIDS Committee, Pathfinder International, UNFPA, AFPPD, JHPIEGO, Women's Health Foundation, Family Health International, USAID, AusAID, GTZ, UNAIDS, WPF, UNICEF, WHO, ICOMP, PHANSuP, and IMRHMA.

Budget

Budget for the implementation of the 2nd ICRHM was accumulated from BKKBN, UNFPA-Indonesia, PHANSuP, and participants registration fee. The transportation and accommodation cost were bore by the participants which came from donor supports and international organization, as well as the origin institution of the participants.

Committee

ICRHM is an international conference of reproductive health management which expected to be routinely performed in every 2 years with different venue location. To support that plan was formed an international committee which consists of international steering committee and international secretariat committee. In running the conference activities, the international committee worked together with the national committee.

For the implementation of the 2nd ICRHM 2008, the focal point for the National Committee was National Family Planning Coordinating Board (BKKBN) Indonesia and UNFPA Indonesia. Aside of that the National Committee also supported by Ministry of Health, National Development Planning Board (Bappenas), Ministry of Foreign Affair, Kusuma Bangsa Foundation, Ford Foundation, University of Indonesia, Indonesian Sciences Institute (LIPI), Indonesian Planned Parenthood Association (PKBI), Indonesian Ob-Gyn Association (POGI).

IMPLEMENTATION

Opening Session

Deputy Executive Director (Program) UNFPA, Ms. Purnima Mane in her welcoming speech at the opening ceremony of the 2nd ICRHM remarked that the highest leaders of government have reaffirmed the importance of reproductive health at the 2005 World Summit. The government leaders agreed to integrate access to reproductive health into national strategies to attain the Millennium Development Goals.

She encouraged that reproductive health problems remain the leading cause of illness and mortality or women of childbearing age in the developing world. She also emphasized that family planning is very much participated to improve health of mother and child. The researchers have estimated that in universal access to family planning alone could save the lives of about 175,000 women and prevent 2.7 million infant deaths in one year. Family planning is one of the best investments in the development package. Unfortunately family planning has dropped down from the list of international development priorities and action. Countries and international communities need to re-energize efforts for international family planning and meet the high-unmet need.

MDGSs target year 2015 will not be attained unless countries and international communities are committed for accelerated action. Each must acts with a sense of responsibility and urgency to mobilize the resources, lay out the strategies and set up the programs and systems required to achieve universal access to reproductive health including family planning by year 2015. UNFPA calls on international and national development actors to continue to build new strategic partnerships—between public and private sectors, governments and the international community for reproductive health and rights, including

family planning. UNFPA itself is fully committed to mobilizing support and scaling up efforts to guarantee reproductive health by year 2015.

Minister of Health Republic of Indonesia in her speech, represented by the expert staff Minister of Health Dr. Rahmi Untoro, again reminded the ICPD-94 Cairo agreement of access assurance to sexual and reproductive health services for all and protecting reproductive rights. The access assurance was a strategic essential for improving the lives of all people. She also recited the statement from Koffi Annan, the former United Nations Secretary General, "The Millennium Development Goals, particularly if the 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".

Minister of Health emphasized some key actions necessarily taken were: (1) Ensuring universal access to sexual and reproductive health services for all by year 2015, through the primary health care system, as a core strategy to achieve the MDGs; (2) Making sexual and reproductive health an integral part of national development planning; and (3) Giving priority to meeting the needs of poor and marginalized groups.

Minister of Health also emphasized that many developing countries including Indonesia are still facing reproductive health problem such as high maternal mortality rate, unmet needs, unintended pregnancies, STIs-RTIs and HIV-AIDS, gender issues, violence against women including female genital mutilation that still exists. She also stated the successfulness of family planning program in Indonesia. Decentralization system in Indonesia also has gained the attention of Minister of Health. In this regards, all programs including reproductive health should be adjusted.

Discussion on Convergence

Theme of the 2nd ICRHM is *"Convergence: working together for Results and Impact"*. What is meant by convergence? Is it something that should be led and managed? Roberto A.O. Nebrida, MDM, Executive Director PHANSuP, Asia Pacific Reprohealth and Development Center (APRDC) presented this issue in his paper *"Convergence: Is It Something that should be Led and Managed?"*. Aside of that Mr. Nebrida also conveyed NGO experiences

in Philippines in implementing convergence concept within their program.

Convergence means coordination, networking, collaboration, partnership, and mainstreaming in the implementation of one program. Convergence also means dreaming/visioning together (things that are easy, difficult, or impossible to do), working together, and learning/growing together. In his presentation, Mr. Nebrida showed some projects or program in several Asian countries which conducted with convergence principle, such as (a) PMCT Project in Myanmar between Department of Health (DOH), UNICEF, and Save the Children; (b) Pathfinder Newlyweds Strategy Project (RSDP) in Bangladesh; (c) Population and Community Development Association (PDA) in Thailand; and (d) AIDS Alliance-PHANSuP in Philippine. PHANSuP has successfully implementing convergence inside and outside the organization (as in community, national, regional, international), for instance International Conference on Reproductive Health Management. Currently there were more than 100 varied partners since 1993 (as from CBOs, FBOs, NGOs, government agencies, schools, LGUs, INGOs, bilateral and multilateral, business entities).

The key success factors in implementing convergence are whether there is (1) a Need; (2) a Commitment to serve people/client; a nature and kind of organization as well as level of democracy not a hindrance; and (3) a Willingness to work together despite of differences. Eventually Mr. Nebrida brought up the challenge and opportunity to implement the convergence concept: (1) Comfort zone at personal, organizational, and community/area levels; (2) Convergence is complex, multi focus, and diverse focus; requires generalist and specialist competencies, and need to develop/enhance capacity of stakeholders; and (3) Global debates on "vertical" versus "horizontal" funding/programming for health; also need to find the right balance and appropriate application.

Discussion on Leadership Challenges in Reproductive Health Management

Issue of Leadership Challenges in Reproductive Health Management was discussed by Catherine D'Arcangues, MD., PhD., from Department of Reproductive Health and Research (RHR), WHO-Geneva, with her paper *"Leadership Challenges in Reproductive Health Management: The Case of Family Planning"*; Prof. W. Henry Mosley, MD., MPH., from Johns Hopkins Bloomberg School of Public Health, USA, with his paper *"Strategic Leadership in Population and Reproductive Health"*; Triono Soendoro, MD., PhD., from National Institute of Health Research and Development, MOH, Indonesia, with his paper *"Leadership Challenges in Reproductive Health Management"*; Prof. Jay Satia, from International Council on Management of Population Programs (ICOMP), Malaysia, with his paper *"Leadership Challenges in Reproductive Health Programs"*; and Maria Leny E Felix, from AIDS Alliance Regional Technical Support for Asia-Pacific (AReTS), Philippines, with her paper *"Convergence of Reproductive Health Leaders in the Philippines: Strategies, Outcomes, and Challenges"*.

Dr. D'Arcangues expressed that sexual and reproductive health are essential to achieve MDGs. The convention between country leaders and governmental heads in year 2005 (MDG+5) had agreed on that issue. Therefore the commitment for achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development must be firmly hold by country as well as organization and international community.

Dr. D'Arcangues also flashed decreasing commitment both at national and global

level against family planning program, even currently CPR and unmet need has became an indicator to attain the fifth goal (Maternal Health) in MDGs. There is the wider gap between financial needs for FP program and the availability funds. Whether the donor commitment is as constant as recent, in year 2015 will be lack of funds for FP program amount of USD210 million. Whilst if there is an increase of donor commitment 3 percent per annum from current condition, then in year 2015 there will be lack of funds amount of USD140 million.

Dr. D'Arcangues also described the issue of the still high maternal mortality rate. At least half million women died each year because of pregnancy and giving birth. Those 100,000 deaths can be prevented if the women, whom did not want that pregnancy, effectively utilize contraceptive. Contraceptive utilization has impact on birth spacing as well as decreasing infant mortality rate. And contraceptive also can reduce recourse of abortion which means reducing maternal mortality. Contraceptive also has contribution in lessen HIV/AIDS. Unfortunately 14 years after ICPD, family planning was still not sufficiently integrated or linked to other reproductive health services.

In relation with re-increasing commitment against FP program, Dr. D'Arcangues suggested the necessity of Reposition Family Planning with locally relevant messages: (a) reduce maternal, infant, and child mortality; (b) reduce abortion; (c) avert HIV-positive babies; (d) address the needs of the poor; (e) recognize the special needs of adolescents; and (f) population and development. In local level, Dr. D'Arcangues disclosed some necessary issues, as follows: (1) Find new champions for FP; (2) Increase resources – both national and international; (3) Reduce missed opportunities for providing access to FP; (4) Integrate/link RH services with RH and HIV/AIDS services; (5) Involving communities, promote social marketing; (6) Strengthen adolescent-friendly programs; (7) Increase coverage and reach the poor; (8) Evaluate interventions; and (9) Monitor process (funds, trends, coverage) and impact (fertility, abortion rates; HIV-positive infants, child survival)

Prof. Mosley described 3 important issues (1) leadership role in the 21st century, (2) basic principal from leadership, and (3) change of paradigm on health intervention from top down approach to the new paradigm for health system transformation and leadership for health system transformation.

The 21st century will be the century of transformational change in many fields including health sector. The old paradigm on health was that government, policy maker, interest groups (donors, foundations, NGOs, universities, etc.), hospitals, health centers, health workers and other technical experts, are the "producers" of health and determiner of the family health. That mindset must be changed since households are truly the particularly mothers, are the primary "producers" of (reproductive) health. Therefore, Prof. Mosley argued that the health program managers should change their mind set of the "health system" –

from believing that Ministry of Health (with their doctors, nurses, hospitals, health centers, etc.) produce health to recognizing that households and communities are the primary producers of health.

The challenge of leadership is to learn how to capture the hearts and minds of this vast, diverse workforce and work with health providers to make the fundamental changes in their values, practices and resource allocations that are essential to produce better health outcomes. At the same time, it is needed to change many of the operating principles of health system to assure that the households and communities have the knowledge, skills, technologies and services to more effectively and efficiently produce health. The goal is to increase the resourcefulness of households and communities, not just to add material resources.

Transforming all the institutions in the health production system requires leadership that is visionary, enabling and oriented toward learning. The leadership tasks are: (1) to bring together as many actors as possible from every level in the health system around a shared vision of a health future that they truly want to create – a vision that they are willing to "pay the price" for, even it means relinquishing cherished traditions and established power relationships; (2) to enable people to act to solve their own problems; and (3) to develop action-learning groups to promote a deep understanding among all parties about the values, practices and resources constraining health production and to design, implement and assess the strategies for change.

Description from DR. Soendoro was focused on the implementation lesson learned of strategic leadership in Indonesia. In year 2000, Strategic Leadership Program was initiated in Indonesia with the support from the Bill and Melinda Gates Institute for Population and Reproductive Health at the JHBSPH (Johns Hopkins Bloomberg School of Public Health) with an initial focus on reproductive health and family planning.

The implementation of this program in the field was a join venture between Ministry of Health, BKKBN, and 4 universities (University of Indonesia, Gajah Mada University, University of Hasanuddin, and University of Mataram). The training materials modified from STAR-Guide, Strategic Leadership of JHBSPH consist of general understanding on Strategic Leadership Learning Organization (SLLO). It is the skill of nurturing change in a learning organization through Personal Mastery, Mental Models, Team Learning, Shared Vision, and Systems Thinking followed by Theory of Constraints.

Since the first National Leadership training course was initiated in 2000, the impact has been substantial. To date, more than 4,400 individuals from more than 200 districts have received this strategic leadership training. The leadership training has also been incorporated since 2003 into the Masters Programs of several universities. The success of the implementation of strategic leadership development

programs in a country requires a synergy among the three main components of development: government, community, and family.

DR. Soendoro also described that during the implementation of SLLO, studies were conducted to assess the changes process in a government institution, at community level, and at interaction among organization and communities. The observable parameter issue was whether those training and mentoring lead to individual and social changes. The second issue was to understand the process of change, how it happened or why it did not happen. The findings of the studies were (1) SLLO workshops were not sufficient to trigger a change; (2) SLLO workshops were considered successful if they bear participants' commitments to commence collective learning at the community level; (3) the key success of a monitoring activity lies on the establishment of trust among the mentors and the members of monitoring team; (4) the main objective of relational learning is to practice honesty and sincerity to each other during the dialogue and during their encounters with the community; and (5) in order to stimulate changes in the grass-root level and to accommodate voices of the poor, training and mentoring for the village core-team were required.

Furthermore DR. Soendoro expressed how to maintain the changes. He suggested that leaders should be able to analyze the living system and social system, and make changes from the inside of both systems not from the outside. He also reminded that most leadership strategies are potential to failure from the outset. Aside of that, leaders should especially focus on understanding the limiting process that could slow or hold the change.

Prof. Satia argued that the current RH condition has indicating that RH program needs a leader. Based on ICOMP experience there were 2 skills that necessarily developed, (1) Leadership (Doing the Right Thing) comprises creating a shared vision, assessing vision reality gap, finding a path/strategy and setting goals; and inspiring and empowering stakeholders to follow the path; and (2) Management (Doing It Right) requires implementing the strategy comprising of setting objectives to achieve the goal, plan to achieve the objective; implement/organize; and monitor and evaluate. Strategic leadership requires appropriate emphasis on leadership and management (Doing the Right Thing Right) to achieve success.

From experience, ICOMP believes leaders in the RH and population field should ideally have the following: (1) Self-related individual competencies: Commitment, innovative problem solving, sensitivity to gender and equity, share a vision, effective communication and public speaking skills, and interpersonal relations; (2) Organization-related capabilities: Updated knowledge of developments in the sector, strategic management skills, ability to inspire and empower people, create a learning environment, and ensure accountability; (3) Inter-organizational partnering: Skills for advocacy, negotiation and consensus-building to bring a cohesive and

consistent process of social decision-making, strategic alliances, and sustain policy dialogues; (4) Development of community capacities: Create empowered communities to meet their own aspirations, strengthen positive community values, and norms and institutions; and (5) Participation in policy and program activities: Effectively advocate and manage population concerns, programs and constrained resources, consolidate actions on population and updated on developments in the North, and pioneering initiatives in the South.

Furthermore Prof. Satia expressed that from ICOMP experiences the conclusion that leadership development is definitely not a stand-alone or one-off type of training. A simple description of ICOMP 'blended training' approach would be: (1) Self-learning; (2) 'Conventional' group training (geared to adult learning); (3) On-the-job support; (4) Mentoring/coaching; (5) Exposure; (6) Peer exchange, and; (7) Networking. These inputs, however, would need to be tailored to the context and customized for individual's needs.

Prof. Satia also described 2 leadership development programs which developed in ICOMP: (1) Visionary Leadership Program in Population and Development (VLP) which largely for RH NGOs, and (2) Strategic Leadership Development Initiative (SLD) for senior and mid level managers of RH programs, the majority of which were government programs.

Eventually Prof. Satia revealed five major RH issues which became leadership challenges in RH program: (1) Reduce maternal mortality; (2) Reduce unmet need for contraception; (3) Improve youth RH; (4) Eliminate domestic violence against women; and (5) Implement linked response to RH and HIV/AIDS.

Ms. Felix described an analysis exploratory study which she performed against the convergence strategies employed by the Packard-Gates funded leadership programs in terms of objectives, target, message, and activities. It also assessed the outcomes of the convergence with regards to policy changes, program implementation/service delivery, budget allocation and expenditures, and public awareness. The issues and constraints faced by the leaders in advancing RH and rights are equally examined.

The findings revealed that relevant fellowship activities such as facilitated mentoring, conferences, workshops, lobbying, and fellowship parties have facilitated sustained interaction among leaders. Convergence of leaders had resulted to significant contributions in RH policy development and advocacy, research, capability building, and increased public awareness of RH issues. The results also indicate key challenges to sustained convergence of leaders and the claiming of RH and rights.

Ms. Felix also highlighted vies a vies issues on Technical Assistance in Leadership Development covering design of leadership development programs which lacks of grounding in country-specific cultural dynamics, experiences and needs, coherent approaches to interfacing

country leadership plans; lacks of strategic convergence direction of RH leadership programs and leaders; lacks of country-specific indicators to measure impact of participation in leadership programs to RH care services in the country, that made difficult to attribute leaders' accomplishments to the leadership program, and top-down approach; and lacks of transparency in design of leadership program activities. Eventually Ms. Felix summarized the challenge in developing leadership program in RH field consists of: (1) How to consolidate the convergence initiatives performed by LDM; (2) Utilizes natural congregation of fellows; (3) Focused on geographic-level convergence rather than national; (4) Participatory in-country evaluation of leadership programs which using self-reflection as part of the process; and (5) Utilizes of facilitated mentoring in sustained leadership development to include young people and grassroots women.

Discussion on Revisiting Family Planning Program

Issue of the revisiting family planning program in the 2nd ICRHM was discussed by Dr. Zahidul Huque, Country Representative UNFPA Indonesia, with his paper "*Global Trends in Family Planning*"; Martha Campbell, PhD., from University of California at Berkeley, with her paper "*Family Planning as Freedom*"; Jane T. Bertrand, Ph.D., from Center for Communication Program of Johns Hopkins University, with her paper "*Evaluating Family Planning Programs: 50 Years Experience*"; and Dr. Sugiri Syarief, MPA., Chairperson of BKKBN-Indonesia, with his paper "*Revisiting Family Planning Program into National Development Planning Agenda in Indonesia: Learning from the Past Success in the Current Context*".

Dr. Huque showed the growth of world's population between years 1950-2050 referred to the estimation from the United Nations. The world population in year 2050 estimated to be about 9.3 billion and mostly will be in the less developed countries. Currently the total of world population is around 6.2 billion lives. Until year 2020, the total world population would still grow about 75 million lives per annum with the population growth tends to decrease from around 1.8 percent in the year 1980 to 1 percent in year 2020.

Nevertheless data also showing that the decreasing of fertility rate in many developing countries tends to stalling. Dr.

Dr. Campbell expressed that the ICPD 1994 was explicit about the threat of the rapid population growth. The Cairo Program of Action called for governments to "meet the family planning needs of their populations as soon as possible and should, in all cases by the year 2015, seek to provide universal access to a full range of safe and reliable family planning methods". However, following Cairo, funding for family planning collapsed, the unmet need for family planning has risen, disparities in family size between the rich and poor have widened, and in many places a prior decline in the TFR stalled.

Huque showed fertility data from Kenya and Indonesia in the past which was significantly decreased but currently tends to be stalled. This condition is not boundless from the progress of family planning program which was currently has lack of attention both from global and national levels. The financing for family planning program decrease from 54 percent from the whole population program in the year 1995, become only around 7 percent in year 2005, whilst the need of family planning service is enormous.

As recommendation, Dr. Huque expressed the need to reinforce the ICPD PoA and MDGs specifically related with family planning. Ministries such as education and finance need to address RH/FP to achieve their national education and economic goals, continue to support other components of RH suc as HIV/AIDS, ARH, maternal health and violence against women, and to underscore appropriately the involvement of youth.

Currently according to Dr. Campbell, the attention of the world was focused on how to assist people get out of poverty. But the picture is even more complicated because rapid population growth undermines nearly all of the Millennium Development Goals (MDGs), particularly in the developing world, where more than 99 percent of the growth will be concentrated.

The loss of focus on family planning has occurred for a number of reasons since Cairo. In addition to being an intrinsically sensitive area where many people are fearful to step in and advocate policy changes, Dr Campbell stated that combined issues over the past fifteen years to push population and family planning off the global agenda: (1) Incorrect publicity and statements about the low fertility in Europe and Japan has led to an assumption that the population growth is no longer a problem; (2) As climate change began to dominate the world agenda; (3) The spread of HIV/AIDS became a major subject in the press; (4)

Some people still fear that attention to population implies racial bias; (5) Some religious conservatives tend to prefer silence around family planning; (6) Efforts to help and empower women during the 2 year ICPD process were linked to a political strategy drawing attention away from population growth and family planning and (7) An assumption that the population factor is just a "given", and as practical matter little can be done to change it; (8) A focus on the situations where coercion in family planning had occurred, (9) The teaching, promoted widely, that all efforts in family planning before 1994 were "population control" in the worst possible sense; (10) Integration of family planning and broader reproductive health services, and a broadly promoted rejection of vertical programs as not sufficiently respectful of, or helpful to, women who had many health needs, not only family planning. The assumption was that family planning would be covered by reproductive health services; (11) and unacceptability of attention to a link between population growth and the environmental decline.

Dr. Campbell also described about the freedom model or unconstraint access model in the fertility behavior which was developed in University of California at Berkeley. The freedom model focuses on women, rather than couples. According to this model, the timing of fertility decline appears to be dependent on the degree to which the woman has unconstrained access to fertility regulation. Unconstrained access is defined as the freedom, or ease, with which women can obtain both the technologies and the supporting information they need to be able to have control over when to bear a child. It is important understand that this model is not concerned with family planning programs, but instead with the ability of individuals to have access to fertility regulation methods and supporting information from any source, regardless of whether any program is present.

Lastly Dr. Campbell presented about discussion which once was went on in British Parliament of how is the relation between population growths with the MDGs attainment. She expressed that 53 agencies, universities, and specialists submitted written evidence in response to this question, and 26 experts presented oral evidence on 8th Monday evenings to British Parliament. The report, published in 2007, drew on the broad spectrum of evidence presented, and it cited overwhelming evidence that "the MDGs are difficult or impossible to achieve with current levels of population growth in the least developed countries and regions". Population is only one factor in the achievement of MDGs, but a critical one. It did not try to argue that population is the only, or even the leading factor in development. Instead, it explains that if we continue to neglect family planning in developing countries, crucially important goals will be undermined.

Dr. Bertrand flashed the evaluation of family planning program within the last 50 years. According to her, the international family planning movement represented one of the most successful public health interventions in history in the developing

world. It began in the early 1950s with growing concern over the rapid population growth in India, and then expanded to a worldwide program that now exists in the vast majority of developing nations.

She also mentioned that only few areas of public health or social development have enjoyed the volume and quality of systematic evaluation that one finds in the field of family planning. Some of the expertise has spread to benefit other areas such as HIV/AIDS. With 50 years of experience in evaluating family planning programs, we are blessed with a comprehensive set of tools. Our duty now is the more systematic application of these tools to programs worldwide, taking full advantage of new information technologies for collecting, processing, and disseminating results.

Dr. Syarief described on the triumph of family planning program in Indonesia in the time range 1970 until 1990s which fertility rate had declined from 5.6 in 1970s to 2.6 in 2003. The success of the program was among others due to political commitment from the Central to District Government, supports from traditional and religious leaders, good communication from the program leaders, and solid management and leadership.

However, currently there were several challenges encountered by the program, such as stalling the program achievement, decentralization, promoting and protecting the rights of individual and couples, serving the underprivileged groups, and rejection of family planning especially among some religious groups.

Furthermore, Dr. Syarief also described that family-planning program in Indonesia was not only a matter of contraceptive but more to the prosperity issue. The national family planning program in Indonesia has been gradually shifted since 1960s until now from developing FP infrastructure services, enhancing the demand, developing FP social norm, moving beyond FP to reproductive health, and revitalizing again the FP movement.

Dr. Syarief expressed that population is closely related with all goals of the MDGs including with poverty, education (additional education infrastructure), gender (women's fertility as pre-requisite of gender equality), child mortality, maternal mortality, HIV/AIDS, and environmental sustainability. However, little attention was made to strengthen the population program. The population issues were neglected due to low birth rates in several parts of the world, and emerging other issues such as consumption and climate change, HIV/AIDS, and religious conservatives.

Hence, Dr. Syarief suggested the necessity of highlighting the linkage between populations with all MDGs is substantially important to revitalize and revisiting the consensus on the objective of FP on fertility reduction and is highly needed to revitalize the family planning program. In Indonesia, currently BKKBN was conducting revitalization of family planning programs such as through changes vision and mission by inviting all stakeholders including community and family to be involved in the FP programs. To strengthen back the FP program management, and changes the mindset of

FP program organizer which is in the government sector from the mindset of centralization to decentralization.

Discussion on Decentralization of FP Program

Issue on decentralization of FP program in the 2nd ICRHM 2008 was discussed by 6 speakers: (1) Prof. Terence H. Hull from Australian Demographic and Social Research Institute of the Australian National University, with his paper *"Redefining Family Planning through Decentralization"*; (2) Prof. Laksono Trisnantoro from Gajah Mada University Medical School, Indonesia, with his paper *"Decentralization: Added Value and Challenges for Family Planning Management in Indonesia (2000-2007)"*; (3) Adrian C. Hayes, PhD., MPH., from Research Associate at the Australian Demographic and Social Research Institute, Australian National University, with his paper *"Management Challenges Facing Mature National Family Planning Programs: The Case of Indonesia"*; (4) Sri Sunarti Purwaningsih, from Research Center for Population, Indonesian Institute of Sciences, Indonesia, with her paper *"The Challenge of Managing Family Planning Program under the Decentralized System: Example from Some Regions in Indonesia"*; (5) Cecilia C. Villa, from Foundation for Adolescent Development, Ind., Philippines, with her paper *"FP and RH: Taking the Cue from Franchise Models Foundation for Adolescent Development, Inc. Philippines"*; and (6) Joan Regina L. Castro, from PATH Foundation Philippines, Inc., with her paper *"Integrating Reproductive Health and Coastal Conservation for Food Security: Evidence of Cost-Effectiveness"*.

Prof. Hull flashed the decentralization process in Indonesia and its impact towards FP program implementation. He expressed that decentralization was the nations inevitably struggle to balance governance between levels of organization from the central national authority through layers of sub-national provinces, states, cities, districts or counties, to small local communities such as villages, towns or hamlets. Each level

involves a variety of issues to be resolved including determination of authority, accountability, responsibility, resources, accessibility, efficiency, effectiveness, and equity.

In the case of Indonesia, Prof. Hull highlighted that the history of Indonesia society of One People One Language implicitly means forced centralization. The New Order System provided a strong vertical command. Decision produced at the top complemented by a strong delegation of authority to the regional level. Thus there existed a structure of authority. The core responsibilities of the central government were management and maintenance of sovereignty; promotion of economic development; and fostering an environment for welfare.

The changes of governance system from centralization to decentralization moved the decision making to local level. The decision must be shared between Head of District/Municipality and District/Municipality Legislature. Both types of district leaders require solid information for decision-making since they would be setting up priorities, managing implementation, and ultimately considering the success or failure of their activities.

According to Prof. Hull, the radical change in the structures of governance produced equally radical challenges to the structure and function of most central government departments, including the nation family planning program. The family planning program during the New Order was one of the most successful of the bifurcated, centralized, and technically sophisticated approaches to population control through the National Family Planning Coordinating Board (BKKBN). With decentralization, the tensions had the potential not to only increase, but locus of any negotiation would also change. Potentially the head of district/municipality could oppose any request from BKKBN. The variety of structures in district level proved to be a major challenge as the central office attempted to maintain some of the national activities that BKKBN had been involved for decades, including the task of monitoring contraceptive services. BKKBN has also endured a major shift in role and responsibility.

Prof. Laksono highlighted decentralization process which occurred radically in year 1999 without followed by mature preparation. Management of FP program in decentralization era happened more complex since there were various structure patterns in district/city level. The varied and increased power of local government for family planning management is an important challenge. Within this context, a careful national policy on family planning which considers local government demographic, health, medical system, and political situation is needed. A transparent objective of national family planning program must be articulated.

In the implementation of FP program in decentralization era, Prof. Laksono offered several things that must be performed, such as demands of data improvement for decision-making purposes in allocating resources and/or political analysis. A discriminated

budgeting process based on fiscal capacity should be done by central government in family planning budgeting process. A political map should be drawn across Indonesia. Data management needs special managerial programs. To influencing policy makers at various levels, family planning managers should be equipped with social marketing and lobbying skills. The transition period (2000-2007) was quite long which consequently some of high skilled family managers might have left or retired the post. Therefore, decentralization also called for capable and competent human resources mapping in each district.

DR. Hayes highlighted management of FP in Indonesia currently related with (1) The changing demographics of a population as it goes through the demographic transition additional to the complexities of providing appropriate services; (2) The changes in the international development agenda which can impact on the program management; (3) The management challenges associated with decentralization; and (4) The practice difficulties for incorporating "good governance".

In relation with demographic transition issues, Dr. Hayes highlighted few things that need to be noticed by program managers was demand for services related with (a) unmet need, (b) method choice, (c) adolescent and the unmarried, (d) source of supply (public versus private or subsidy versus autonomous), and (e) regional and socio economic differences. To solve these problems he suggested the improvement of private sector in managing FP. The Government of Indonesia should focus to serve the poor and other vulnerable groups, and for areas where there is still a demonstrable need. In general the government role should focus on (a) to develop national FP policy and guidelines, (b) to protect people's reproductive rights, (c) to monitor districts' performance of essential FP/RH services, (d) to ensure satisfactory quality standards are followed by service providers in all parts of the country, and (e) to monitor fertility behavior.

Dr. Hayes also flashed that the implementation the integration of FP program into RH services and rights were not going well. This would be the challenge in performing FP program. The challenge for FP managers in central and provincial level will be to negotiate performance targets in districts which fairly measured for substantive improvements in FP services.

In decentralization of FP program, Dr. Hayes highlighted aspects of administrative and politic, and how the manager visions both aspects. Program managers could not resolved administrative matters effectively before political questions of distributions of power and authority were resolved. Therefore in handling decentralization issues necessarily performed organizing of political aspect initially between central government, province, and district/city before entering the administrative management level.

Presentation of Ms. Sunarti based on study result conducted in year 2005 which was collaboration between LIPI (Indonesian

Institute of Sciences) and UNFPA on the impact of decentralization against implementation of FP program in Indonesia. Sunarti argued that decentralization has different effects across regions regarding its unique policy and capacity at provincial and district levels. Ms. Sunarti also exclaimed that there were decreasing on performance of family planning at district level and the family economic welfare program that introduced at the community level.

The study found the challenges in family planning management were (1) The new family planning office's structure, nomenclature, and legal status are varies; (2) Funding, which only few local governments provide contraceptive with their own budget; (3) The new role and function of BKKBN; (4) Performance of field workers; and (5) Access to FP services and information. BKKBN has a poor structure yet has many functions as a result of decentralization.

Ms. Sunarti offered several alternatives, they are (1) Informing that changes of responsibility of family planning in program planning to local government provides opportunities; (2) Improving family planning district office with strong leadership to convince local government on the importance of family planning in development; (3) Partnership to implement family planning whereas the coordinating role of family planning district office needs to be re-established; (4) Supplying the poor which should be supported by central government; (5) Good supply provision that should be retained in warehouse, especially in areas where family planning is merged with other institution; (6) Adequate infrastructure support and personnel capacity development should be provided to service providers; (7) Increasing the number and quality of human resources in district level and below; (8) Alliance between family planning field workers and women's organization; (9) The current family planning management information system should be developed to improve population-based program planning; (10) Bottom up mechanism program planning from village until district level should be retained, therefore family planning field workers and village counterparts need to be strengthened to provide reliable data for decision making.

Ms. Villa described the franchising model for FP services to adolescents that has been developed in Philippines. The model called "Teens Health-Quarters Social Franchise Model" is a service center that makes young people able to access information-education that values clarification and behavior, modeling and medical services relevant to sexuality, reproductive health which managed by youth friendly, competent professionals, and volunteers. This model can be utilized in the context with decentralization and the less role of government in program implementation.

At the initial development in year 2000, Foundation for Adolescent Development (FAD), Inc. saw the possibility of applying franchising method in family planning, as in other commercial product. The crucial components were information, education, and behavior modeling, and a select medical service relevant for RH managed

by youth friendly competent workers. This model had developed in 5 locations (organizations) as the operator.

The Teen HQ elements which became brand images were uniqueness, standardization, brand equity, sustainability, and support to franchisee. Uniqueness emphasized on how to include the mindset into the sexually active youth including information, education, referral, and medical services. The franchise model attracts youth to visit since it focused on youth friendly and standard layout of the building. Brand equity refers to services that provided by the center. Furthermore, Ms. Villa expressed that resources involved and challenges in sustaining the progress especially THQ. In setting up a typical THQ the franchise fee is for exchange of materials, the box, and technology while physical THQ varied from one city to another. The cost to sustaining a THQ covers THQ technology such as modules and materials which were already in place. The minimum fund is required for advanced education of the staff since we need to entice the youth with creativity.

Presentation of Ms. Castro described the lesson learned of the effort in integrating RH program with coastal conservation for food security in Philippines. This program was performed by PATH Foundation Philippines Inc. (PFPI) in 2001 through the Integrated Population and Coastal Resource Management (IPOPCORM) project. The program aimed to improve life in communities dependent on the sea for their livelihoods as well as their reproductive health status. There were 3 main interventions in this program, namely (1) Community-based distribution of needed commodities funds, training assistance, and other support; (2) Micro-credit to finance alternative livelihoods; (3) Advocacy that targets national, provincial, municipal, and local executives with information on population-environment poverty linkages and other countries' experiences with mainstreaming reproductive health into natural resource management agendas and programs.

The study result showed that the investigator with environmental missions can rapidly develop the capacity to facilitate and manage community-based family planning services, given the appropriate training, technical, and commodities support. Also access to family planning services in areas has increase which means the program succeed in establishing or strengthening marine sanctuaries and other stewardship arrangements to protect and conserve coral reef structures, sea grass beds, mangrove stands, and wildlife population. The most inspiring result is that the approach being adopted more and more by the local government. This study also showed that integrated programs have greater positive impacts on human and ecosystem health than single-sector programs, and at lower total cost.

Dwindling Funding for Family Planning Strategies to Improve Resources Mobilization

Three speakers, (1) Prof. Dr. Sri Moertiningsih Adioetomo, MA., PhD., from

University of Indonesia, with her paper *"FP Resource Mobilization through RH Costing Indonesia 2005-2015"*; (2) Abigail Acuba-Cainglet, from Philippine Legislators Committee on Population and Development (PLCPD) Foundation, with her paper *"Budget Legislation for RH: Current Challenges for Local Governments"*; and (3) Girlie Grace Casimiro, MA., from National Economic and Development Authority (NEDA), Philippines, with her paper *"Saving Mommy from the Grave: The Impact of Health Financing Scheme on the Promotion of Facility-Based Deliveries in the Philippines"* discussed the issue of funding the family planning program.

Prof. Adioetomo described the study she conducted to develop costing model of reproductive health services. According to Prof. Adioetomo, costing of reproductive health services including family planning is necessity to perform since it is an advocacy tool for policy taker. Costing can become (1) Fund raiser and resource mobilization; (2) Acknowledge cost sharing by government, private sectors, and partners to invest in RH and FP programs; (3) Program planning and managing activities; (4) Monitoring performance, evaluation, and redirecting of program implementation; and (5) Advocacy to executives and legislatives at national and sub-national levels.

Furthermore Prof. Adioetomo presented the case study on costing of reproductive health service which once performed in Indonesia work together with University of Indonesia and UNFPA-Indonesia. That study estimated cost of RH and FP services (2005-2015) at national level, 6 provinces and 22 districts. The study was using software application of RH Costing Model version 1.1 MP developed by UNFPA. Application of Activity Based Costing (ABC), and a bottom up process, starts from estimating numbers of population requiring RH and FP services. The result of conducted enumeration showing that at national level there is a very significant saving in term of cost which required for reproductive health services whether the government able to control birth rate. The carried out simulation was whether CPR still 57 percent until year 2015 and CPR increase to 70 percent in year 2015 has able to reduce cost of reproductive health service to 92 million US Dollar. That saving amount elaborated that with CPR increased to 70 percent in year 2015, large number of births can be averted and

large number of pregnancies can be avoided. Therefore, it will lessen investment in cost for maternal health care and other cost of services related to reduction of births.

Ms. Cainglet set forth that currently the local government in Philippines was having less attention to financing the reproductive health. Therefore the Philippine Legislators Committee on Population and Development (PLCPD) Foundation together with partners from the local government units (LGUs) were now into budget advocacy strategies alongside advocating RH and FP policies. The tasks of PLCPD are (1) to generate local policies on FP/RH and mobilize resources for family planning and reproductive health; (2) to provide technical assistance on policy development and policy advocacy to policymakers and advocates; and (3) to mobilize multi-sector participation in policymaking (locally and nationally).

Ms. Cainglet in her presentation displayed some of the good practices in resource mobilization while at the same time explored the challenges encountered by LGUs amidst the heightened competition from infrastructure projects and other basic services that the LGU was mandated to provide. Ms. Cainglet explained that the 1st local advocacy project was implemented in 3 pilot areas: Sorsogon – Sorsogon; Balingasag – Misamis Oriental; and Tanjay – Negros Oriental between years 2000-2004. The first thing carried out was formation of the Municipal Advocacy Teams (MATs), which were composed of local legislators (members of the *Sanggunian Bayan*), NGOs, Local District Officers (LDOs) of the respective congressmen and media. The next thing is assistance to the MATs in identifying and formulating their advocacy plans to increase and mobilize resources on population, family planning, and reproductive health. The impact was that there is a rise in the attention and fund for reproductive health at project location.

In order to replicating that initiative into another area, PLCPD were (a) conducting local modeling responses to RH and FP; (b) assigning Legislator-Champion; (c) organizing local legislator-champions for Population and Development; and (d) establishing multi-stakeholders consultations on Population and Development.

There were some challenges encountered in the field implementation which were from aspect of budget allocation and process of advocacy. The aspect of budget allocation related with the issues of effectiveness and efficiency from budget allocation; while the process of advocacy covered sustaining a strong network of advocates at local level, continuous awareness and advocacy, developing local leaders, and putting policies in place to support the advocacy.

Casimiro, MA presented her paper that was a result of impact evaluation from health insurance in preventing the maternal mortality. Casimiro, MA also explained that the objective of this study was intended to know in what extent has the introduction of social health insurance as a new health financing scheme lead to

increase facility-based deliveries. It also analyzed women's experiences and opinions on giving birth as it influence their decision on whether to use social health insurance (SHI) in giving birth in a facility or not. The study was performed in two locations, urban and rural.

Evidence presented in this study proved that the extent to which the introduction of SHI could lead to increase facility-based deliveries though would depend on how the SHI is organized. It appears that SHI as the health-financing scheme could have a positive impact on the maternal mortality if the women actually applied it. However, three strong points came out that could significantly dilute the impact of SHI: (a) Decentralized budgeting has impeded both the provision of insurance and the quality services, as inaccessibility, unavailability, and poor quality of maternal services was the biggest factor that hindered women to utilize their health insurance; (b) The whole process of implementing the SHI specifically the sponsored program for the poor has been very political; and (c) The national government's theory that broadcasting SHI maternity care coverage will increase population was weakening the whole policy exercise.

Discussion on Improving Comprehensive and Quality of Services: an Unfinished Agenda in Addressing RH Issues (Maternal Health, STI/HIV/AIDS, Family Planning, ARH, and Elderly)

The six speakers presented in session on improving comprehensive and quality of services in RH issues were (1) Endang Achadi, MD, PhD., from Faculty of Public Health, University of Indonesia, with her paper *"Discussion on Improving Comprehensive and Quality of Services: an Unfinished Agenda in Addressing RH Issues"*; (2) Katherine Tumlinson (represented by Dr. Atiek Anartati), from Family Health International, USA, with her paper *"What Women Want: Integrating High-Quality Family Planning Services into Postpartum and Post-Abortion Care"*; (3) Dr. Duong Quang Le, from UNFPA-Vietnam, with his paper *"Lessons Learned from the Development and National Application of Standards and Guidelines for Reproductive Health Services in Vietnam"*;

(4) Suneeta Mukherjee, from UNFPA-Philippines, with her paper *"Achieving MDG 5: The Philippine Experience"*; (5) Rolando G. Borja, MBA, from Development of Peoples Foundation, Philippines, with his paper *"Reproductive Health Mainstreaming in Governance"*; and (6) Dr. Margaretha Sih Setija Utami, MKes., from Soegijapranata Catholic University, Semarang, Indonesia, with her paper *"Do Pregnant Couples Understand about Pregnancy and Delivery?"*

Dr. Achadi expressed that improved access to a broad range of sexual and reproductive health services would positively influence the achievement of all MDGs, particularly MDG5. However, reproductive health problems remain the leading cause of illness and death for women of childbearing age worldwide.

Dr. Achadi also presented reproductive health situation in Indonesia where two mothers died every hour, despite the double increase of skilled birth attendance from 35 percent to 69 percent achieved in about 15 years. There are significant differentials in service use and outcome with regard to reproductive health between the poor and the rich.

In other part, Dr. Achadi described the lesson learned from the Immpact Project (Initiative for Maternal and Mortality Program Assessment) in Indonesia, in order to improve maternal health status. That study showed that the improved quality of professional services in a strengthened service delivery system and prioritizing access to quality services to the poor and those living in remote areas, are called for. Removal of financial barriers and provision of sufficient information for all should be in place and will be materialized only if (1) the political will from both legislatives and executives at national and local levels were strengthened; and (2) collaboration among all related sectors such as public, private, NGOs, and community can be mobilized.

Dr. Anartati described the case study result in Peru on female demands for Integrating High Quality Family Planning Services into Post Partum and Post Abortion Care. This study illustrated how supportive family planning policies may fail to deliver intended results, leaving women unprotected against unwanted pregnancy and initiate high rates of maternal and child mortality. That condition was initiated by lack of information and counseling as well as high quality services.

This study suggested several recommendations to be performed: (1) Update medical and nursing school curricula to include post partum and post abortion FP; (2) Conduct additional research to understand the motivation of service providers to deliver counseling (or not); (3) Improve training and supervision of service providers; and (4) Empower women to know and understand their reproductive rights.

Dr. Quang Le presented the lesson learned from Vietnam experienced in developing and applying National Standards and Guidelines for Reproductive Health Service (NSGRH) in Vietnam. The national standard was developed with

consideration: (1) The elements of RH care were partly and separately available, but not integrated as a whole; (2) Fulfilling the RH need through the ICPD's comprehensive approach as a commitment of Vietnam's government; (3) Following "The National Strategy on RH care 2001-2010"; and (4) Improving RH quality and meeting people's needs of RH care in the following ten years.

In the developing stages there were 6 steps to take: (1) Formulations of the National Steering Committee were finalization of topics and working modalities, and recruitment of local and international experts; (2) Reviewing existing standards, protocols, and guidelines for RH services, and developing national standards and guidelines for RH services; (3) Pre-testing national standards and guidelines for RH services, and finalizing the documents; (4) Submission to the Ministry of Health for approval; (5) Printing and distribution of the documents nationwide; and (6) Updating and further revision of the established standards and guidelines. Constraints and challenges in implementing the NSGRH were resistance to change, misperceptions, clients – service demand, providers, service supply, shortage of RH logistics, overload of record system due to un-computerized data based, and un-unified health management information system.

Ms. Mukherjee presented Philippines experience in achieving MDG 5. The MMR target in Philippines for year 2015 is 52 per 100,000 live births. Following the trend of deriving MMR between years 1990-2007 will make MMR in Philippines in year 2015 become 140 per 100,000 births.

Ms. Mukherjee described the policy and program in Philippines related with RH/FP, such as in year 2000 the local government of Manila issued Executive Order 003 resulted in the removal of contraceptive supplies and services from health centers, hospitals and clinics, both public and private. The local government of Manila promoted responsible parenthood and upheld natural family planning not just as a method but as a way of self-awareness in promoting the culture of life while discouraging application artificial methods of contraceptive. In the absence of RH bill, some LGUs passed own RH codes. Currently FP financial concentrated on government and UNFPA.

Seeing on the policy, program, financial, and manpower made the effort to achieve MDG 5 target very ponderous. However there were opportunities such as (1) The new paradigm whereas every pregnancy is at risk; (2) Government acknowledges shortfall in attaining MDG 5; (3) The adoption of Safe Motherhood (under health sector reform) as flagship program (for every 500,000 population at least 1 CEmOC and 4 BEmOC, and USD100 reimbursement for the first 3 deliveries in PhilHealth accredited facilities for members); and (4) Delegation of authority/devolution.

Nevertheless, Department of Health (DOH) has future plan which consists of (1) Expanding pilot areas/scale-up DOH-led Formula One (F1) sites with development partners; (2) Strategic programming with DOH renewed policy on

Maternal and Newborn Health; (3) Strengthening role and participation of civil society and youth; (4) Joint programming document on Saving Lives of Mothers and Newborns by UN agencies and the government; and (5) Auditing every maternal death.

Mr. Borja presented evaluation result of gender mainstreaming project in reproductive health field which was conducted by Development of Peoples Foundation in partnership with 16 cities in Mindanao, Philippines. This evaluation aims to monitor and documents how the local government units (LGUs) implement program on RH after participated in gender mainstreaming training.

Evaluation result showed that no set of numbers or any quantitative discussion can truly capture the rich diversity and complexity of gender-based issues and concerns on reproductive health management. However, the evaluation also found it helpful to identify quantitative targets and use indicators to measure status or progress whether project implementation on compliance monitoring among Local Government Units (LGUs) in particular areas of concern like RH/VAW and Men's Involvement. Likewise, hopefully it will contribute in monitoring the issue of accountability for gender mainstreaming and transformed into concrete policies and programs, including national and local budge allocation in government.

Dr. Utami, presented study result that performed on female knowledge against various aspects of pregnancy. Objectives of this study were (1) to measure knowledge about pregnancy and delivery of pregnant couples; (2) to know the relationship between knowledge about pregnancy and delivery of pregnant couples and delivery problems; and (3) to know the information sources about pregnancy and delivery of pregnant couples.

Study result showed that knowledge about pregnancy and childbirth of both wives and husbands were very low. Most couples (around 70 percent) mentioned that health workers were their information sources. There was significant correlation between knowledge about pregnancy and delivery and wives' awareness of delivery problems. Knowledge as well as emotional stress during pregnancy was influencing to the problem during delivery.

The results showed that improving knowledge about pregnancy and delivery in pregnant couples was very important to improve maternal health and to improve communication ability of health workers since health workers were the important information sources to pregnant couples. The study also showed that health workers failed to transfer their knowledge about pregnancy and delivery to pregnant couples. Midwives also having problem to transfer their knowledge to the patients since had lack of ability of communication. Most of midwives do not get communication training, yet on the contrary couples were reluctant to ask health workers about pregnancy and giving birth since there were psychological gaps between health workers and them. Aside of that, in front of them, health workers always seem very

busy which made the patients do not want to interrupt health workers.

Effective community empowerment to ensure the fulfillment of reproductive health and rights

The six speakers presented in discussing the issue of strengthening community within RH program were Prof. Dr. Haryono Suyono, from Damandiri Foundation, Indonesia, with his paper *"Management Strategies to Implement MDGs in the Community"*; Rachel Chua, from International Council on Management of Population Programs (ICOMP), Malaysia, with her paper *"Empowering Communities for Self-Reliance in Reproductive Health"*; Amit Kumar, from Prachar Project – Pathfinder International, India Country Office, with his paper *"Barefoot Counselor: A Sustainable Endeavor Community Ownership Program on RH and Rights through a Network of Volunteers"*; Erlinda Castro-Palaganas, Ph.D., MPH, from University of the Philippines Baguio, Philippines, with her paper *"Learning with Communities: Structures and Mechanisms for RH Programs among Indigenous Peoples"*; Ir. Inne Sylviane, MSc., from Indonesian Planned Parenthood Association (PKBI) with DR. Samidjo, from UNFPA, Indonesia, with their paper *"Involving Husbands to Improve Maternal Health in Indonesia: A Community Based BCC and Management Interventions"*.

Prof. Suyono exposed a program called Posdaya which is a People Based Management to achieved MDGs targets. This program was developed by Damandiri Foundation to empowering community, hence it is based in community level and gives comprehensive services for community as to infants, children, adolescents, young and reproductive age, as well as to elderly. The services were in

form of human resource improvement which given through various training and fellowship, working capital, and health service including family planning. Basically the aid was directed toward family.

In running that program, Damandiri Foundation worked together with various stakeholders like investors, college institutions, NGOs, professional foundations, etc. To keep program sustainability they also worked together with local government and local parliamentarian.

Ms. Chua was presented project of community empowerment for self-reliance in reproductive health funded by ICOMP. The pilot project performed in Batam, Indonesia in 2006-2007 which was focused in creating linkages between income generation and RH promotion of poor women.

There were several strategic keys developed in this pilot project: (1) Capacity building and leadership skills for volunteer 'cadres' whom were community leaders chosen by community members; (2) Interventions for economic empowerment through setting up income generating groups; (3) Innovative mechanisms for self-reliance by establishing a village revolving fund; and (4) Community-based RHCS institutionalized through a community managed village pharmacy.

Ms. Chua also described several lessons learned from that pilot project: (1) The process of community empowerment and change requires long term commitment and mobilizing support from other stakeholders; (2) Despite most cadres were active and dedicated to the project, there have been a few drop outs, mostly related to their economic activities; (3) It takes time to build up a village revolving fund while external financial support for community activities is still in need; and (4) Role of local government which is very important in program sustainability, made tour of duty amongst local government staff hardening this program sustainability performed.

Mr. Kumar presented a pilot project in India of sustainable endeavor community ownership on RH and rights through a network of volunteers. This pilot project was aimed to: (1) Create pool of Voluntary Family Welfare Counselor (VFWC) and catalyst from community to bring sustainable behavior change; (2) Equip VFWC with knowledge and skills to perform the role envisaged for them; (3) Inform the community about VFWC and their roles; and (4) Develop community acceptance for VFWC. Meanwhile the expected outputs are improving contraceptive utilization and contraceptive quality services within study area.

Several expected roles from VFWC were: (1) Developing social relationship with families; (2) Being vigilant on key events like birth, engagement, marriage, etc; (3) Informing, educating, guiding, counseling, supporting, and following up with the couples; (4) Referring for higher services; (5) Maintaining records and reports; and (6) Coordinating with change agents in the area.

Through a well selecting process, capacity building, promoting VFWC existence in the community, and linking VFWC to services provider proved this program has high sustainability. It also shown there were ownership program, social recognition and satisfaction, consulting clients/families that went well, confidence to communicate and counsel, coordination with the co-partners, and support from local governance. Another amusing result was that monthly monitoring indicated the contraceptive utilization rate were correct and consistently among couples which having no or one parity increases from 5.3 percent to 20 percent.

The supremacy of this program that VFWC is a voluntarism concept without any financial support hence these catalysts will continue even after the project ends the activities, as trained volunteers available in community and cost of the model is low (USD27) for creating one VFWC. Some challenges encountered in program development, such as: (1) Preparing efficient training teams; (2) Creating shelters for training teams; (3) Ensuring mobilization with punctuality; (4) Keeping the team spirit alive; (5) Making the participants sit for 30 hours within 5 consecutive days; and (6) Illiterate participants.

DR. Palaganas presented evaluation of the implementation of a Community-Based RH/Gender/Population Development Program in Cordilleras, Philippines. The evaluation is based on 3 years of implementing a Participatory Action Research of the indigenous people in the northern part of the Philippines. The methods of evaluation were document reviews and interviews of program while staff was drawing the stories of learning from the field. The summary drawn from this study was that the Community Needs Assessment (CNA) is the basic issue of success the implementation of community empowerment program.

A good CNA will improve plans, actions, interventions, and partnerships that were truly participatory having gained the recognition and acceptance of communities. CNA activities and intensifying RH education built a certain level of community awareness of RH needs and rights, and encouraged community to implement it. In addition to community structures at local level and sustained partnership with relevant stakeholders will encourage policy formulation and service delivery more responsive to the identified RH needs.

Ir. Sylviane and DR. Samidjo presented a Behavior Change Communication (BCC) Project in Tasikmalaya and Indramayu Districts of West Java, Indonesia in improving husband involvement in all aspect of maternal health, such as men's realization and plays their roles in protecting maternal health, men's awareness on women's sexual and reproductive rights, men with sufficient knowledge and information on condom and is willing to use it, etc. This project was part of Asia Regional Project jointly implemented by the Japanese Organization for International Cooperation in Family Planning (JOICFP), Indonesian Planned Parenthood Association (PKBI), and UNFPA-Indonesia.

This project is performed through a community based BCC i.e. and management interventions including development of BCC tools and materials, community radio program, religious and village community gatherings, male volunteers' home visits and local traditional performances. In addition, several supporting activities were carried out to create conducive environment to promote men's individual behavior changes, which among others include (a) family and community savings for antenatal care and deliveries; (b) involvement of local religious and community leaders, and (c) involvement of health personnel to provide services and referral system.

The evaluation showed that after a three-year implementation the project has been able to increase the knowledge and attitude of husbands in maternal health, in prenatal and antenatal care, and other decision making process related to maternal health; which contribute to the reduction of maternal mortality and morbidity. Some lessons learned gained from this project were: (1) Community radio has been quite good mode to transfer information on reproductive health related issues; (2) Traditional performance was benefited in a very effective way inserted messages to be transferred to the community; (3) Group discussions among neighborhoods is very effective to have in-depth information on reproductive health and they can talk directly to the male motivators; (4) Home visits are one of the ignition communication to change the desire behavior; (5) Involving formal, informal and religious leaders is good for entry point to gain support to encourage male or husbands; and (6) Building the network for handling the high risk pregnant women and for referral services which is very important.

Discussion on Investing in the Largest Group of Population: The Youth

The issue of investing in youth through reproductive health program was discussed by Lingga Tri Utama, from Indonesian Planned Parenthood Association/PKBI Yogyakarta, Indonesia, with his paper *"Reproductive and Sexual Health Education in Indonesia School's Curricula"*; Mark Molina, MD., (represented by Romeo Arca Jr., MA), from Visayas Primary Health Care Services, Inc., Philippines, with their paper *"Addressing the Paradox of Sustainable*

Youth Programs: The Case of Yo!Lead"; Sanjay Kumar, from Prachar Project, Pathfinder International, India, with his paper *"Investing in the Future: A Unique Intervention with Newly Weds"*; and Dr. Salah Abou El-Einin (represented by Dr. Mohamed Afifi), from Takamol Project, Pathfinder International, Egypt, with his paper *"Facing Taboos: Enhancing Reproductive Health Awareness of Adolescent"*.

Mr. Tri Utama described the condition of adolescent reproductive health in Indonesia and the needs of information and reproductive health service facility for Indonesian youth especially in Yogyakarta Province. Mr. Tri Utama also described the effort that performed by PKBI Yogyakarta to incorporate reproductive and sexual health education into high school curricula. That effort was regarded very strategic since mostly adolescents still in school while the existing curricula do not support their needs to improve knowledge upon sexual and reproductive health, thus, make the students searching for information beyond school which often mislead. Two schools have chosen to be the pilot projects that incorporate reproductive and sexual health education into locally specific curricula.

In the implementation, PKBI Yogyakarta has created modules, conducted lobby to local schools, and workshops for teachers. There were 6 issues to be taught they are (1) Human relationship; (2) Human development; (3) Self development skills; (4) Sexual orientation and sexual behavior; (5) Sexual health; and (6) Culture and society. The orientation of reproductive and sexual health education for teachers covered: (1) Giving accurate information on reproductive and sexual rights; (2) Developing skills of critical thinking, communication and negotiation and self-development; and (3) Maintaining positive attitude and positive values. Besides of implementing the workshop for teachers, PKBI also formed Youth Forum in related school. The objective was to make adolescent at school be lobbyist for school managers for paying attention on adolescent reproductive health problem.

Dr. Molina described the pilot project of adolescent reproductive health in the Visayas Primary Health Care Services, Inc. (VPHCS) called "Yo!LEAD" (a leadership program for youth initiated RH advocacy and services). The project uses an innovative model of youth training and peer counseling where youth leaders in the community were trained to design and implement initiatives that provide sexuality education and SRH services to vulnerable youth populations. The project emphasizes youth leadership and peer relationships. The project also gives capacity building combined with small grants, services delivery and building network to adolescent. The project expects to establish a movement of youth-directed RH initiatives such as more comprehensive SRH education programs and better access to SRH care.

Over the last two years, Yo!LEAD project has more than a hundred youth leaders from schools and communities in three provinces on SRH issues, communication,

project management, and leadership development. It has also supported 20 community-based and 9 school-based youth organizations that implemented various SRH information and advocacy projects. In addition, it had provided sexuality education for about 3,000 youth and provided contraceptives for about 1,000 youth.

The Yo!LEAD model was a work in progress yet the results so far indicate that peer-led programs work best when youth leaders get sufficient inputs on technical issues and leadership and were backed up by a support network of adults, youths, and friendly services on the ground. Several lessons learned during project implementation were (1) the importance of local government involvement within the program and taught young people how to engage with government, (2) program of youth empowerment will open opportunity for adolescent to be involved in the development program, (3) strengthening the network among youths and other stakeholders, and (4) in developing program for youths the approach must be specific with youth behavior to make the expected behavior changes occurred.

Mr. Kumar presented the Pathfinder International India Country Office project named "Prachar Project" which located in the urban slums and rural areas. This project was meant to increase contraceptive use by newlywed couples and postponed the first birth until the wife reach at least 21 year old, by providing a platform to couples to communicate with each other on sensitive issues and highlighted the need for joint decision making, develop negotiation skills to handle familial and societal pressures, and provide information on contraceptive use and available services. It is expected this initiative brings into focus prevailing gender roles and cultural norms that influence and shape a couple's reproductive health choices.

The target groups were newlywed couples, parents, and influential community members through home visits, interpersonal counseling sessions, street theatre, small group infotainment events, and group discussions. Over 4,800 couples have attended infotainment events and more than 100,000 parents and other community elders/leaders received similar messages. Data collected from home visit registers for all 4,800 couples, percentage of newlyweds whom began using contraceptive within the first three months of consummating marriage increased drastically from 0.1 percent to 20.8 percent. The interval between marriage and first birth increased from 21.3 to 24 months. Among a sample size of 1380, the use of contraceptives does postpone the first child tripled from 5.3 percent to 19.9 percent.

Dr. Afifi described the Takamol Project was developed by Pathfinder International in form of Family Life Education (FLE) to improve the adolescent - boys and girls aged 13-18 years - knowledge. FLE program was designed to be implemented in collaboration with local NGOs then can be replicated by them when the project assistance ends. Therefore this project developed with direct target on

adolescents and intermediaries targets such as religious leaders, teachers, etc.

The adolescent were given information on basic life skills such as relevant RH topics and gender roles, and responsibilities. It is expected through this project there will be improvement of health outcomes, achieving sustainable reduced fertility, continue improvements in key indicators of maternal and child mortality, strengthen program, planning and implementation capacities, mobilizing community (stakeholders) involvement (men, women, religious leader, media, agriculture workers, etc).

Project started by giving training of trainer for volunteer facilitators whom either NGO, community outreaches workers, local community leaders, or teachers. These facilitators then supported to facilitate FLE classes of 20-25 participants at local youth centers, NGO premises, or schools. Facilitators were using posters, flash cards, and booklets to reinforce health messages.

During year 2007 the program reached 4,160 male and female adolescents from 31 rural communities in four governorates.
Initial and after test were utilized to measure changes in knowledge, attitudes, and practices. The results showed a mark gained in RH knowledge of the facilitators from 14 percent (initial intervention) to 72 percent (after intervention). Interviews of 1,108 participants revealed a 25 percent increase in positive attitudes towards females' rights and a 32 percent increase in knowledge regarding modes of transmission of HIV/AIDS and Hepatitis B.

Discussion on Reaching the Un-Reach Group

Four speakers discussed the issue "Reaching the Unreachable: Challenges and Lessons Learned" were Lucas Pinxten, MD. MSc, MPH., from IMPACT (Integrated Management for Prevention And Control and Treatment of HIV/AIDS), Bandung, West Java, Indonesia, with his paper

"Living on the Volcano, Sexual Risk Behavior and Low Condom Use among IDUs in Bandung, West Java: A Challenge for the Family Planning Program"; Dr. Suneth Agampodi, MBBS, MSc., from Department of Community Medicine, Faculty of Medicine, University of Peradniya, Sri Lanka, with his paper *"Linking up for Reproductive Health Service Provision"*; Dina Bebawi (represented by Manal Eid), from Pathfinder International, Takamol Project, Egypt, with her paper *"Involving Rural People in Addressing FGC in Rural Egypt"*; and Dr. Elden Chamberlain, from Asia Regional Representative, International HIV/AIDS Alliance, United Kingdom, with his paper *"What has Sexual Reproductive Health Got to Do with HIV/AIDS and Vice Versa?"*.

DR. Pinxten presented the IMPACT program in Bandung, West Java, Indonesia. IMPACT program started run on January 2007. This program is purposed to (1) to reduce HIV-related risk behavior (adolescents, information, and education); (2) to establish sustainable, comprehensive, evidence-based prevention and care of HIV/AIDS in IDU (injecting drug user); and (3) to establish capacity in order to conduct this and replicate/scale-up.

IMPACT program focused on (1) IEC/Health Promotion about HIV-related risk behavior in adolescents; (2) Scaling-up HIV-testing and VCT; (3) Harm reduction (including methadone), for IDU's in community, prison, and hospital; (4) Scaling-up treatment and care for HIV and AIDS, including antiretroviral treatment; and (5) Building capacity, transfer of knowledge to local professionals to conduct and up-scale the above activities.

In his presentation, DR. Pinxten expressed that West Java is the third worst affected province in HIV and AIDS. In 2006 it was estimated 22,000 IDU of which 21 percent are in prison and an HIV rate of 60 percent. Also the last ten years in Bandung drug use and HIV prevalence increased steeply. It is evident that risk behavior is common among IDU: apart from the use of contaminated needles and syringes (37 percent), the 2003 survey results indicating that 70 percent of IDU have regular unprotected sex with SW (sex workers), probably still stand, given the fact that consistent condom utilization by IDU is currently only 8 percent while 35 percent of the SW always wear a condom.

Furthermore DR. Pinxten conveyed that careful modeling of risk behavior indicates that Indonesia is moving towards an HIV epidemic of at least 1 million by the year 2015. Indonesia (Papua excluded) has a concentrated IDU driven epidemic (80 percent of new HIV-infections). IDU-HIV prevalence was more than 50 percent. "Overflow" from IDU to non-IDU is likely because of the IDU high rate of unprotected sex with multiple regular and casual partners and SW.

He argued that condoms are instrumental to stop this epidemic, but based on the current law No. 10/1992, the national RH/FP program only targets married women/couples make roughly 30 million adolescents left out, and this hampers the national AIDS response. Moreover

condoms have a poor reputation; conservative politicians, government officials and religious leaders often believe that condoms are only used by SW and infidel husbands, and promote "free sex". The condition is complicating the prevention of HIV distribution from IDU to non-IDU.

In the IMPACT's view, the barriers for RH/FP management specifically related with HIV and AIDS covers mindset which was still too much supply oriented, also rivalry between BKKBN and Ministry of Health, with no substantial adolescent RH/FP infrastructure and Law No. 10/1992 especially about contraceptive limitation for couples. Nevertheless IMPACT also saw the opportunities for RH/FP management which was capitalized on increased HIV/AIDS-related funding through the "global verticals", harm reduction (evidence-based interventions including condom distribution, clean needles, methadone substitution treatment), VCT and brief interventions by health care providers which can result in substantial reduction of HIV transmission risks among HIV-pos and untested/HIV-negative.

Positive policy environment to stop "overflow" should be used to make HIV/AIDS epidemic a national (public) health crisis and a national emergency. Whilst challenges for RH/FP management covered individual level condom promotion (for vulnerable population) should go together with (a) appropriate societal interventions targeting attitudes, (b) values, practices, and commitment of policy makers and communities, (c) need for necessary knowledge on RH, drugs, and services cannot longer be ignored, (d) refocus on reproductive rights through strategic NGO partnerships, (e) adapt Law 10/1992 to target vulnerable youth, (f) open the RH/FP program for unmarried adolescents, and (g) make HIV/AIDS top program priority.

Dr. Agampodi described the program of improving counseling skills of public health field staff, in order to improve reproductive health care service provision. Objective of this program is to improve utilization of Intra Uterine Contraceptive Devices (IUCD) for national contraceptive program. As visualization, Dr. Agampodi exclaimed that currently the utilization rate of IUCD in Sri Lanka was 51 percent from all existing contraceptive user. This activity was a cooperation between (a) NGO that provide financial backup for the staff training workshop, (b) private company as IUCD provider, (c) MoH as provider of technical guidance, planned and conducted the skill development session, guidance during field visits and supervised the field staff on counseling process, and (d) University of Peradniya as the activity evaluator.

Intervention performed in area which level of IUCD utilization and some other indicators of reproductive health are relatively low. Based on analysis result, underutilization of services could be due to the lack of communication/counseling skills among grass-roots level healthcare providers, and also lack of services. After performing training, technical assistance, and IUCD provision within 2 years since intervention of IUCD utilization conducted in that area, there is increase 81.8 percent from initial condition. Therefore

make counseling skills are the utmost importance to provide reproductive health care at community level. Reproductive health service provision can be improved effectively with public private partnership.

Dr. Eid described effort that carried out on prevalence Female Genital Cutting (FGC) case in Egypt. According to Dr. Eid, FGC is still very much prevalent in Egypt with a 96 percent prevalence rate among every married woman ages 15-49 (DHS, 2005). FGC has been illegal in Egypt since 1997, but despite the law, the practice is still ongoing. Members of rural villages, where the majority of FGC took place, were unaware of the physiological and psychological repercussions that might accompany the procedure.

Regarding this, the USAID-funded Pathfinder, managed Integrated Reproductive Health Services Project, Takamol, works with community development associations (CDAs) to emphasize these issues within the health messages that they disseminated to the community. As FGC in Egypt was based on a combination of cultural and religious views, CDAs employed doctors, nurses, religious leaders, and outreach workers who are trained in communication and FGC messages to help raise awareness of the FGC risks. Outreach workers conducted home visits, while doctors and religious leaders conducted seminars together to support the messages, through religious and medical standpoints, to educate local women. Youth coordinators helped in spreading these messages to younger generations by coordinating Youth Mobilization Week.

The initial and after tests were applied in intervention communities which collectively demonstrated changes in opinion on the issue, as well as an increase in the number of clients whom inquire about FGC risks to their physicians. Home visits conducted by outreach workers reached a total of 2,000 women whom received FGC health messages. 25 percent of the women reported that they do not support FGC anymore. These women also committed to become advocates to fighting FGC. Furthermore, to date, 4,183 community participants received training on FGC messages and other related health issues, which these trainings contributed to a 32.0 percent increase in knowledge of the repercussions of FGC.

Dr. Chamberlain described that the rights to live from People Living with HIV/AIDS (PLHA) included that related with their sexuality rights. According to Dr. Chamberlain, regardless of the HIV status, the ability to express oneself sexually and the desire to experience parenthood were, for many, central to what it meant to be human. Acknowledging these needs and aspirations is essential for the basic human rights of PLHA. HIV prevention efforts must address the sexual and reproductive health needs of PLHA such as child bearing, safer sex, STI management, and contraceptives and ARV's.

A sexual rights approach allowed all people to decide freely and responsibly on all aspects of their sexuality, including (a) protecting and promoting their sexual health, (b) being free from discrimination, (c) coercion or violence in their sexual

lives and in all sexual decisions, (d) expect and demand equality, (e) full consent, (f) mutual respect, and (g) shared responsibility in sexual relationships put PLHA in charge of their sexual health. However, structural, social, and cultural issues, as well as the lack of programmatic support, hinder the fulfillment of the right to quality sexual and reproductive health care and support for having a family.

Dr. Chamberlain later explained the presence of the International HIV/AIDS Alliance in relation with creating right to live from PLHA, how this organization networking with various similar organization in various countries such as India, Philippines, even Thailand. Dr. Chamberlain also gave example some programs which already developed by that organization with its network within some country.

In developing the program, Dr. Chamberlain gave few important tips, they were: (1) In designing policies and programs, policymakers, public health experts, and national-level program planners must consider the best available scientific data; (2) They must also take advantage of the perspectives, expertise, and accumulated experiences of PLHA; and (3) PLHA and their organizations have a key role to play at all stages in the process, from program and policy design to the delivery and evaluation of sexual and reproductive health services.

Knowledge Management: Building and Maximizing our Intangible Asset to Measure the Impact of Reproductive Health Program

The issue of knowledge management on reproductive health program was discussed by Jane T. Bertrand, PhD., MBA, from Johns Hopkins University-Center for Communication Program, USA, with her paper *"Knowledge Management for Reproductive Health"*. DR. Bertrand presented the comprehension of knowledge management which means systematically and routinely creating, gathering, organizing, sharing, adapting,

and using knowledge – from both inside and outside an organization – to assist achieve organizational goals and objectives.

Knowledge management is about getting the right knowledge to the right people at the right time for they can work more effectively. At society level, knowledge management very much participated in influencing decision taking at level of global, national, even local, also as a catalyst in performing changes. The cycle of knowledge management covered: (1) Knowledge generation and synthesis; (2) Knowledge capture and organization; (3) Knowledge sharing; and (4) Knowledge adaptation and use.

In utilizing knowledge management the organization should notice 3 important aspects: people, process, and technology. At the people aspect, several issues need to have attention were (a) develop a shared vision, (b) foster a culture of trust, (c) encourage use of available knowledge management systems, (d) reward knowledge sharing achievers, and (e) formally coach and mentor staff about knowledge management. At the process aspect, the should be noticed issues were (a) central system for knowledge sharing (e.g. intranet); (b) formats standard for taking and posting meeting notes; (c) communities of practice to foster cross-fertilization; and (d) to mentoring the programs. While at technology aspect, it is important to notice various technology advances which occurred around us and can assist the implementation of knowledge management, e.g. (a) evidence-based knowledge acquisition, (b) knowledge repositories and databases, (c) knowledge portals, (d) intranet and extranet, (e) blogs, (f) wikis, (g) short message services/SMS, (h) mobile devices, etc.

DR. Bertrand also highlighted the reason why knowledge management was difficult to be developed by organization. Several factors identified were (a) lack of time, (b) fear of losing one's own special expertise (or personal value to an organization), (c) not knowing what to share or whom to share with, (d) not having knowledge in an easy-to-share format, (e) no organizational value to put on sharing, (f) fear of criticism, and (g) difficulty of sharing skills and expertise. Although from the technology aspect there were many information provided which can be shared through the internet. In the field of reproductive health no less than 14,000 webs which contain information on current reproductive health. In the final part, DR. Bertrand conveyed the variable key of evaluating knowledge management which was (a) Reach, the knowledge able to reach expected target; (b) Usefulness, the knowledge is useful for end user; and (c) Use, the knowledge is utilized by end user.

Parliamentarians' Participation in Management and Good Governance of RH Programs

In this topic, there were speakers of Asian parliamentarians facilitated by AFPPD: (1) Tuti Indarsih Loekman Soetrisno, MP-Indonesia, with her paper *"The Role, Rights and Responsibility of Indonesian*

Parliamentarians in Management of Reproductive Health Programs"; (2) Vallabhbhai Kathiria, MD, MBBS, MS, MP-India; (3) Donya Aziz, MD, BSc, MBBS, MP-Pakistan; and (4) Malinee Sukavejvorakit, MD, MP-Thailand, with her paper *"Thailand's Reproductive Health Policy"*.

The other speakers were (1) Faith I. Bacon, from Philippine Legislators' Committee for Population and Development (PLCPD) Foundation, Inc., with her paper *"Managing a Parliamentarian-Led Advocacy Institution: The PLCPD Experience"* and (2) Vice Governor Vincent Homer Revil, (represented by Abigail Acuba-Cainglet) from Province of Masbate and Local Legislators League on Population, Health, Environment, and Development (3LPHED), with his paper *"Effecting Change through Responsive Legislation on RH in the Philippines: The Story of the Local Legislators League on Population, Health Environment, and Development"*.

While another speaker, Dr. Shiv Khare, the Executive Director of AFPPD, Thailand, with his paper *"Parliamentarians' Participation in Management and Good Governance of RH Programs"* brought another topic: The Role of Parliamentarians, together with Rozzano Rufino Biazon, Congressman, Philippines, with his paper *"The Role of Parliamentarians in Management and Good Governance of RH Programs"*.

Dr. Khare conveyed the reasons why parliamentarians able to play a role in the program: (1) they are leaders; (2) have a mandated and public trust to work towards the interest and common good of the people they represented; (3) could influence the resource needed to secure programs and affect change; and (4) they can participate in policy, legislative, and program development as well as in monitoring and good governance. Members of parliament can take part at level of constructing legislation and policy, also monitoring the program implementation and accountability, whereas budget planning is include since in some countries Parliament holds the budgetary right.

Dr. Khare expressed that what should be conducted was improving comprehension and awareness of parliament member on population and development.

Parliamentarian Forum on Population and Development took part to improve awareness of parliament members in population and development problems. Within this context, AFPPD assists the country members (26 countries) developing various activities in each parliamentarian environment through Small Grant Program (SGP). SGP was focused in reviewing legislation and drafting of bills. Aside of that, AFPPD also able to support human resource development activities, such as through workshops, conferences or training, person to person advocacy, field visits, and resource mobilization.

The Asian parliamentarians presented various activities they have performed, the success also challenges they encountered. They stated that the total forum membership has showing improvement from time to time. That circumstance indicated the awareness of parliament members on population and development issues improved increasingly. Nevertheless they admitted is difficult to see whether there is quality improvement of parliament member's role in assisting solving problems of population and development.

Mr. Biazon presented his perspective on given role of parliament member for population program, RH/FP, that is (1) Establishing public policy on reproductive health and family planning; (2) Appropriate funds for programs and projects which implementing the policy; (3) Exercise oversight in the implementation of policies and programs; (4) Educating the public through advocacy work; and (5) Localize the implementation of national government policy based on their own areas of jurisdictions and constituencies.

Most challenges encountered by parliament member in Philippines were struggling for the population issue, RH/FP which covers: (1) The influence of religion in public policy; (2) The limited resources of the national government; (3) The lead start of an uninformed growing population; (4) The separation of powers; and (5) Political dynamics. From the field experience, Biazon conveyed necessary strategy to overcome the above challenges: (1) Go direct to the constituents; (2) Prioritize the most vulnerable sectors; (3) Identify and link up with allies; and (4) In the absence of a national government policy and program,

they "localize it".

Ms. Bacon shared the drafting policy in Philippines currently its relationship between legislative and executive, and input from various stakeholders such as civil academic and research institutions, business, faith-based organizations, media groups, and others. This political reality was the reason of forming the Philippine Legislators' Committee for Population and Development (PLCPD). The objective was to improve the awareness and ability of parliament members on population issue, RH/FP. The PLCPD is a membership-based organization from both chambers of Philippine Congress. It is led by a mix of pro administration and opposition policymakers bonded together by a common vision of an improved quality of life for all Filipinos through the passage of population and human development legislation. This mission is backed by a sound strategy performed by a national secretariat lead by Executive Director. Managing this parliamentarian-led advocacy institution has proven as an effective venue for advocacy of reproductive health and human development policies. PLCPD provides rich leadership and management lessons in building an engaging non-profit policy institution comprised of policy champions from within the State Parliament.

Mr. Revil (as represented by Ms. Cainglet) described the role of the Local Legislators League on Population, Health, Environment, and Development (3LPHED) in programs of population, health, and environmental in Philippines. As an organization 3LPHED has established 9 provincial chapters nationwide. The objective of this organization is to strengthen the voice among local legislators at the local level and eventually share resources and knowledge. Recently the 3LPHED is sustaining growing to be a bankable organization of local legislators-advocates on RH and FP. As their mandate, 3LPHED has sponsored and enacted in their local government units various RH and PF legislation. Together with advocates from the grassroots level, 3LPHED has been actively participating in all efforts in educating the public on RH and FP. They have also been able to help advocates clarifying misconceptions on FP as well.

International Cooperation in Population and Reproductive Health Program: South-South Initiative, Partners in Population and Development

Dr. Harry Jooseery, Executive Director of Partners in Population and Development, Bangladesh, presented his paper *"The Role of Partners in Population and Development (PPD) on South-South and North-South Collaboration on Population, Reproductive Health and Family Planning Programs"*. This organization is owned by 22 developing countries.

According to Dr. Jooseery, PPD has its inception since 1994 and made impressive achievements in promoting South-South Cooperation in the area of Reproductive Health, Population, and Development. A

series of meaningful program ranging from exchange experience and lessons-learned, skills and leadership development, transfer of expertise and technologies, promotion of Reproductive Health Consultants, research and documentation on best practices have been undertaken.

PPD has trained over 1,000 reproductive health leaders and 118 consultants, and has created a database of consultants that are regularly being tapped by other agencies. PPD also has documented 16 cases of successful interventions of South-South Collaboration in capacity development in 5 developing countries namely Bangladesh, India, Indonesia, Thailand, and Tunisia. PPD conducted various studies on RH/FP including in management areas. PPD also has promoted the creation of South-South Training Centers of Excellence in Indonesia, Mexico, Thailand, and Tunisia, and organized a series of national, regional, and international workshops and conferences in various reproductive health issues.

PPD is working with Minister of Health and Population whom constitute its Board Members and assembled at least once in annual 22 ministers and high officials from 22 member states; and this constituted an important advocacy platform. Besides, PPD is a unique intergovernmental organization of developing countries that is mandated to promote South-South Cooperation in the areas of population, reproductive health, and development. As PPD has well positioned make it the voice of the South and to ensure that competence, expertise, and knowledge are effectively shared, both among countries in the South and between the South and the North.

Dr. Jooseery also described the new focus of PPD that consists of (1) Integration of ICPD goals with MDGs; (2) Integration of HIV/AIDS with reproductive heatlh; and (3) Improvement of Reproductive Health Commodity Security and Supply with strategic direction that covers: (a) strengthening South-South Cooperation; (b) Promoting capacity building; (c) Expanding networks and partnerships; (d) Activating resource mobilization and promote sustainability; and (e) Strengthening the organization.

Closing

Chairperson's Summary

1. On the 6th to 8th May 2008, the second Conference on Reproductive Health Management was held in Bali Indonesia, organized by the National Family Planning Coordinating Board (BKKBN) in partnership with the United Nations Population Fund (UNFPA), PHANSuP-Asia Pacific Reprohealth and Development Center (APRDC) and the International Movement of Reproductive Health Managers and Advocates (IMRHMA). The meeting was officially opened by the Special Advisor to the Minister of Health, Republic of Indonesia and the Deputy Executive Director of the United Nations Population Fund and was attended by 320 participants from 24 countries representing experts, academia, civil society, and government officials engaged in the field of Family Planning including Reproductive Health.

2. The conference is a continuation of the first International Conference which took place in Manila, the Philippines in 2006 with the theme *"Creating the Impact in the Communities: are we ready for the future?"* This year's conference followed the theme of **Convergence: Working Together for the Results and Impact**. It discussed key issues in the area of reproductive health management through highlighting critical issues at the plenary session and technical discussion through parallel sessions.

3. The issues of reproductive health including family planning in many countries have come to a crossroads. Despite the evident benefits of family planning programs in the past few decades, it continues to fall in priority in development agenda of countries. The amount of funding that continues to fall is also an indication that requires new thinking on the issue. For many countries, it is an age of transformation driven by global and local forces. It is important for health officials to review their approach and paradigms to enhance greater ownership on the issue. The recent World Summit in the United Nations in 2005 has reinvigorated the discussion by supplementing new indicators within the Millennium Development Goals no. 5. In this regard, practitioners and experts in the field need to optimize this new global political momentum through greater leadership, management, greater participation of parliaments and the youth.

Leadership Challenges in reproductive health

4. In addressing leadership challenges in reproductive health, participants recognized the need to have a shared vision between the leaders and the community and also to shift the reproductive health leadership paradigm

from health-professional centered to community-centered. The additional indicators in MDGs 5 must encourage leaders to place special attention on reproductive health to garner continued international support, particularly in receiving the necessary funding it deserves.

5. Leadership in reproductive health demands policy makers to think strategically in producing an aggressive and innovative approach that both empowers and encourages practitioners and communities to play significant roles in achieving the desired condition. This would require a clear communication strategy complemented by sustainable funding. A shared vision between leaders and communities must be maintained. Ensuring the availability and access of contraceptive needs, particularly for the young and poor hence is crucial.

6. To this end participants agreed the importance of shifting their paradigm and avoiding the "business as usual" mentality. Through a technical discussion on *Reaching the unreachable: Challenges and Lessons Learned*, participants called for linking up reproductive health service provisions with the role of SRH with HIV/AIDS treatment.

Decentralization: Reproductive Health including Family Planning Management,

7. Participants recognized that in this globalize world, government and practitioners need to continuously adapt their activities through health reform programs. Governments need to play and empathic role that encourages the local governments and also fosters strong engagement of civil society. The accumulation of reliable data needs to encourage greater commitment from the local and international level.

8. The varying fiscal capabilities of local governments and also the community economic abilities may be factors that the central governments could utilize in enhancing the national and international assistance. In formulating policy, local and central governments need to balance between the interests of local community, while taking note of long-term development goals. Hence, the role of parliamentarians, local communities, including the business sector, academia, NGOs, media and prominent figures is crucial in ensuring the success of these reproductive health management goals.

Revisiting Family Planning Issues in the Development Agenda at the National and Global Level

9. Participants recognized that the issue of family planning has undergone major transformation since the 60s. However due to the shift in priorities in countries, rapid population growth has continued in most parts of the world. The growing awareness of environmental degradation and current situation on food insecurity have required countries to review populations factors in formulating their development agenda. To better understand population factors, it is pertinent for policy makers and practitioners to enhance communications opportunities that recognize culture sensitivity and encourage greater

community participation and ownership on the issue, particularly at the local level where the poor is prevalent.

10. Participants were deeply concerned with the falling value of global funding for family planning. In effort to maintain the international commitments, participants recognized the need to educate the community of their collective responsibility on this issue and to ensure a prosperous and healthier future. Furthermore, the role governments and donor communities must continue to be enhanced, despite the limited funding and resources. In this regard, the global community must continue to give substantive attention to the issue of family planning. Corporate social responsibility need to play an encouraging role not only in setting working conditions attentive to the needs of women, but also aggressive investments in family planning infrastructure to ensure long term business interests.

The role of Parliamentarians

11. Parliamentarians have an important role in addressing the issues of family planning, including reproductive health. They can support the formulation of reproductive health and family planning policies and programs and also ensure the implementation of effective population and family planning programs. Hence there is a need to educate and motivate Parliamentarians so as they could provide the needed support for the legislation and resources. To this end, close partnership between legislative and executive bodies is necessary, including the active engagement of religious organizations.

Management Issues in Reproductive Health

12. Participants recognized that changing times require adjustments in the management issues relating to reproductive health including family planning. In the area of coordination, relevant institutions, particularly the family planning institutions, ministries of health, women empowerment, social welfare, employment, education, police and internal affairs, and national statistics must play a leadership role in addressing reproductive health and family planning campaigns. The role of international organizations should also play a supporting role in providing technical training, building infrastructure and collecting data.

13. Among the emerging areas that support these programs has been though South-South Cooperation. As a complement to international assistance, South-South Cooperation has demonstrated its effectiveness in providing practical support for the needs of developing countries.

14. Participants also recognized the importance of convergence in order to achieve a common goal. Constant analysis of the local conditions is needed in order to achieve sustainable action. People have to be central in the development process. Without the participation of the local community and a sense of ownership no program can be run effectively and sustainable. Interventions should be directed towards

the family based on their needs in order to achieve a higher level of welfare.

Investing in Youth

15. This group in society needs to always be empowered. Participants recognize many opportunities to include the youth enhancing reproductive health and family planning programs. The youth should be empowered so that they are in a position to make better decision on the matter. Through dialog, education, and entrepreneurship, youths can play the spearheads in promoting reproductive health and family planning. Schools and extra-curricular activities become the primary medium for all youths in which governments must continue to invest in.

16. Reproductive health must be incorporated in school curriculum to ensure that all youths receive the necessary information needed to make a well-informed decision.

Recommendation for Future Action by All Stakeholders

In enhancing efforts of governments, parliamentarians, practitioners and civil societies in addressing reproductive health management, the participants of the conference proposes the following action:

1. Recognize that reproductive health management including family planning is inherent to ensuring the welfare of people, and acknowledge the importance to continue enhancing family planning programs that creating better quality communities, through better preparation of mothers for healthy reproduction and by integrating facilities and services in reproductive health and other health facilities; In this regard, calls upon the continued support of the international community, including through the active role of the United Nations systems, particularly the United Nations Population Fund and the United Nations AIDS program to actively engage in this area;

2. Cognizant that the role of leadership in reproductive health, especially family planning is crucial at all levels of government to ensure that the people can receive the best service available for them. To this end, encourage leaders in government, parliamentarians, NGOs, business sectors, local communities and religious organizations to ensure the health and safety of all people, particularly women and children through applicable family planning programs;

3. Notes that although the commitments of funding to the Cairo Program of Action is being fulfilled, but are deeply concerned that the funding for family planning has fallen to 7 percent of the total amount, and in this regard calls upon donor communities to deliver its commitment in accordance with Cairo Plan of Actions;

4. Recognizes the importance and effectiveness of South-South Collaboration as a compliment to international cooperation, and advocates for the promotion of South-South Collaboration as an effective strategy to address Reproductive Health, including family planning, population and development;

5. Deeply concerned by the increasing number of women and children falling

victim to practices of IDU, STDs and in this regard stresses the importance of converging of reproductive and health facilities to ensure their needs in reproductive health;

6. Call upon all stakeholders at all levels to support reproductive health, including family planning programs, through improved leadership and management, greater medical, health and counseling programs, communications and education modules, and continuous civil society dialog and campaigns on the importance of promoting the welfare women's and children through family planning;

7. Recognize the important role of the Parliamentarians in addressing the issue of reproductive health and family planning and encourages their strong participation and commitment to ensure greater awareness and education on the issue at all levels;

8. Encourage the formulation of solution for Reproductive Health Management on all components under the era of government reform such as decentralization, and recognize its importance to address many global issues including food security and environmental degradation;

9. Welcome the efforts of civil society, academia, NGOs and the media in providing greater understanding and awareness to the issue of reproductive health, including family planning and in this regards encourage them to continue their efforts in coordination with national and international agreed development programs.

Urge all stakeholders to empower young people to in actively participate in the formulating programs and policy making related to youth; and encourage the creation of an environment that fosters youths access to information on reproductive health, sexuality and family planning, particularly through school curriculum, and youth friendly services; In this regard calls upon the continued implementation of the recommendations set out in the Manila Youth Manifesto of 2006.