CENTER FOR GLOBAL DEVELOPMENT

POLICY ROUNDTABLE ON ECONOMIC DEVELOPMENT AND POPULATION DYNAMICS

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P R O C E E D I N G S

Welcoming Remarks

MS. BIRDSALL: Good morning everyone, and a very warm welcome.

For those of you who were not able to come last night, I am Nancy Birdsall, the president of the Center for Global Development, and we are very pleased to host this session that brings together policy-makers and influential people in how the world works, you might say, with the members of our distinguished and hard-working working group on the issues of development and population, focussing especially on Africa.

Let me say a word about the Center for Global Development, which is a relatively young, still, think tank-plus. Our mission is to reduce poverty and inequality in the world. It is a very ambitious mission. We do that in particular by focusing on the policies and practices of institutions like the World Bank and the World Trade Organization and essentially of the rich advanced

economies who influence, of course, the policies and practices of these major global institutions.

We are very pleased to have had this opportunity to bring all of you together today, and the purpose is very much that the working group report, which is now in a consultation stage, there is an opportunity to see and talk about that working group report with those of you who represent policy-making in Africa and in places like the World Bank. We are very happy to be able to bring all of you together through the help of the Hewlett Foundation and with the co-sponsorship of DFID and the World Bank.

I want to say that our purpose today is that we be informal, that we have lots of interaction, that you feel comfortable interrupting, if that is appropriate, each other in order to get to the core of the matter. This is a fundamental problem and a fundamental challenge that we are talking about in the case of Africa.

Let me introduce now Paul Brest, who will start off giving us some vision from the point of

view of the Hewlett Foundation of what this is about. It is a pleasure to introduce Paul. He is the president, as all of you know, of the William and Flora Hewlett Foundation in California.

I was very excited to see that he has an A.B. from Swarthmore College. We have some favorite staff who came from Swarthmore and some board members who come from Swarthmore here at the Center for Global Development, and that he is obviously someone who is a distinguished lawyer.

As you see from his bio, he ended up--not ended up, but he was Stanford Law School faculty for some years, and they didn't bury him.

[Laughter.]

MS. BIRDSALL: He emerged to take leadership of really one of, I think, the great foundations that we have in this country and in the world.

I must say he and I had a great conversation last night. It showed me another side of a foundation president, very thoughtful and

analytic and devoted to ensuring that the world becomes a better and better place.

Paul.

MR. BREST: Thank you.

I hope that is not a surprise, for a foundation to want the world to be a better place.

It is my pleasure to welcome you to the Policy Roundtable on Economic Development and Population Dynamics, and the Hewlett Foundation joins our colleagues and our co-sponsors of the meeting today which is the UK's Department of International Development, the World Bank, and the Center for Global Development in thanking you for making the time to come here and, in many instances, traveling great distances.

We are grateful for the hospitality of the World Bank and John Page last evening and to Dr. Thoraya Obaid from UNFPA who framed some of the important issues on the role of reproductive health and population dynamics in helping households and nations reduce poverty and encouraging economic growth.

For four decades, the Hewlett Foundation's Population Program has invested in the health and well-being of women and men. Our work ranges from helping voluntary family planning to reduce unwanted pregnancies to investing in the basic education that enables young people to grow up healthier with improved economic opportunities.

For the past 10 years, the foundation has been engaged in making the consensus reached in Cairo a reality for people around the world. I know that some of you participated in the Cairo process, and we all have a stake in ensuring that people everywhere benefit from reproductive health and reproductive rights.

Ten years, almost 11 years, after Cairo, the landscape for development has also progressed with the emergence of the Millennium Development Goals which aim to reduce poverty and to measurably improve human welfare in many sectors.

The Hewlett Foundation seeks to advance the priorities of both of these paradigms. To this end, we must answer the key questions of the relationship

between investments to improve reproductive health and economic development. We regard today's event, which has been a long time in the making and for which we just have tremendous hope, as an essential part of our own continuing education and we hope the education of the field more broadly.

Our goal is to understand how healthy mothers, with control over the number and spacing of their children, and healthy children, strengthen economic outcomes at the household and national level. Research in this area will inform policy-makers who are charged with difficult decisions and tradeoffs every day and who required data to inform their choices.

What will emerge from our work here today and the efforts of the technical working group CDG has convened over the past few months is the intellectual basis for a policy research agenda.

It is customary to hold thanks until the end of the meeting, but since I have the floor, let me extend my thanks to our co-sponsors, particularly Hans-Martin Boehmer and John Worley and Elizabeth

Lule and Ruth Levine and Suba Nagaranjon [ph] of CDG, who led the steering committee that sets our agenda and the working group, whose technical consultations produced the document that you have all seen and that forms the basis for our discussions today, and thanks to all of you who by being here will help move the inquiry forward.

I hope you will emerge from today's discussion with new ideas about the types of research that can help answer the questions they raise about reproductive health, poverty reduction, and economic growth, about what research will assist you and others in making decisions and setting policies that impact people's lives and their future well-being.

Thank you for being here today.

MS. BIRDSALL: Thank you very much, Paul.

What we would like to do now is go relatively quickly around the room and have each person introduce herself or himself briefly.

Could we start, Alex, and go to the left.

MR. EZEH: Thanks, Nancy.

Alex Ezeh, the executive director of the African Population and Health Research Center, which is based in Nairobi, Kenya.

MS. LEVINE: I am Ruth Levine from the Center for Global Development.

DR. OBAID: Thoraya Obaid, executive director, United Nations Population Fund.

MS. DONNAY: France Donnay, Technical Support Division, UNFPA.

MR. BERNSTEIN: Stan Bernstein, Sexual and Reproductive Health Policy advisor of the UN Millennium Project.

MS. LULE: Elizabeth Lule with the World Bank, advisor for Population and Reproductive Health.

DR. MUGA: Dr. Richard Muga, the director for the National Coordination Agency for Population and Development in the Ministry of Planning and National Development in Kenya. Previously, I served as the director of Health Services for Kenya for 5 years.

Thank you.

MS. LLOYD: Cynthia Lloyd. I am the director of Social Science Research at the Population Council.

MR. BONGAARTS: John Bongaarts, Policy Research Division, Population Council.

MR. OSEI: My name is Barfour Osei from the African Development Bank.

MS. BASU: Alaka Basu, Social Demography at Cornell University, and I run the South Asia program there.

MR. ELOUNDOU-ENYEGUE: Parfait Eloundou, also at Cornell University teaching Development of Sociology and Demography.

MS. BUVINIC: Mayra Buvinic, Gender and Development, the World Bank.

MR. MERRICK: Tom Merrick, with the Health and AIDS program at the World Bank Institute and also professor in the Global Health Program at George Washington University.

MS. KAKANDE: Margaret Kakande. I had the Poverty Monitoring Unit, Ministry of Finance, Uganda.

MR. BELEW: Fantahun Belew from Ministry of Finance and Economic Development of Ethiopia, working on the macroeconomic policy in the management department.

MR. RADLOFF: I am Scott Radloff. I am with USAID, Bureau for Global Health, Office of Population and Reproductive Health.

MR. WARNER: I am Andrew Warner, senior economist at the Millennium Challenge Corporation.

MS. FOX: Tamara Fox with the Population Program at the Hewlett Foundation.

MR. MAY: John May. I am a demographer in the Africa Region at the World Bank.

MR. SCHULTZ: Paul Schultz, Yale University, Economics Department.

DR. DARROCH: Jackie Darroch. I am in the Global Health Program at the Bill and Melinda Gates Foundation in charge of Reproductive Health.

MS. GUPTA: Geeta Rao Gupta, president of the International Center for Research on Women.

DR. ADDAI: Eddie Addai, director of Policy, Planning, Monitoring and Evaluation in the Ministry of Health of Ghana.

MR. WORLEY: John Worley from the UK Department for International Development, Policy Division.

MS. SEIMS: Sara Seims, Population Program at the William and Flora Hewlett Foundation.

MR. CHATAIGNER: Jean-Marc Chataigner, director of Strategy Planning in the French Development Agency.

MR. NIANE: Thierno Seydou Niana, Poverty Reduction Strategy Unit, Minister of Finances and Economy, Senegal.

MR. BOEHMER: Hans-Martin Boehmer, head of the Human Development Group at the UK Department for International Development.

MR. SARBIB: Jena-Louis Sarbib, Human Development at the World Bank.

DR. MUSINGUZI: Jotham Musinguzi, director, Population Secretariat, Ministry of Finance and Planning in Uganda.

MS. BIRDSALL: And you all know Paul and Nancy.

Let's go around on the outside.

MR. BOS: Ed Bos, population specialist, the World Bank.

MR. ROYAN: Rabbi Royan, Population and Development, United Nations Population Fund.

MS. HIJAZI: Mai Hijazi, USAID, Office of Population.

MS. MALHOTRA: Anju Malhotra, Population and Social Transitions Need and International Center for Research on Women.

MS. CLARK: Sarah Clark, Packard Foundation.

MS. HELZNER: Judith Helzner, MacArthur Foundation.

MS. BIRDSALL: Well, thank you to all of you. I think we are a very distinguished group. I am very impressed with our group. It is a great combination of thinkers and doers.

Session 1: Bringing Population Dynamics and Reproductive Health into Development Policy Debates

MS. BIRDSALL: Now we are going to hear from Jean-Louis Sarbib, whom I have introduced before in the last couple of weeks. I have had the good luck to introduce Jean-Louis at several of our events. He is the vice president for Human Development at the World Bank. You have his bio. So I won't elaborate further. You will hear from him and know more about him when he talks.

Jean-Louis.

MR. SARBIB: Thank you very much, Nancy. Like you, I am very impressed and somewhat humbled by the expertise around the table because I come to you with a policy-maker view, but not much of a deep background on population.

So let me begin by saying that it is a pleasure to be here, and I want to thank you, Nancy, and thank the Hewlett Foundation and Hans-Martin and DFID for having convened this meeting.

I read the paper of the working group yesterday, and it was good enough to compete with this wonderful day we had. I think that it is

really taking us forward, and I hope that it will be a very good basis for our conversations today.

The Africa focus is, obviously, one that I welcome. I have spent a good part of my years in the World Bank working on Africa, and it is clear that it is a continent that remains a challenge for development--I am sure John Page told you that last night--but at the same time, it is also a place where many good things are happening.

I think it is very important not to have an overly negative view of what is happening in Africa and at the same time to be very realistic about the magnitude of the challenges, not the least of which is the continued impact of demography, population growth, high fertility, all of it compounded by the HIV pandemic, and I think we all know how difficult it is going to be for most, if not all, countries in Sub-Saharan Africa to actually reach the MDGs.

Africa in many ways is also a summary of the challenge that I will speak of later in my remarks of really how much of the population is young. Almost half of the population is under 15,

and I think that these are young people that have a lot of challenges ahead of them.

John Page talked to you last night, I am sure, about shared growth, about how to get more growth going, but we have done also a lot of work on the fact that this growth needs to be of quality, it needs to be shared, and it needs to empower women.

I remember many studies that were done over the years showing that a supplement of growth would surely come if men and women had the same access to assets, be it in agricultural research, land ownership. In a number of ways, I think this supplement of growth that we are so desperately looking for, that Africa is so desperately looking for, can come in part from really ensuring greater equality and great access to assets between men and women with all the consequences that we know on reproductive health and on demography.

I think the focus on Africa is certainly welcome, but it should not be in the work going forward exclusive because there is a lot that can be learned from the successful demographic transitions,

the famous demographic dividend in East Asia, to a smaller extent in South Asia.

Before taking my current job, I was in charge of the Middle East and North Africa in the Bank, and there, you don't see the demographic dividend. You see many of the same problems as you see in Africa at a higher average income level. So I think the lessons that we can draw from the interactions between economic culture, history, and dare I say religion in helping or not helping to reap the benefits of the demographic dividend I think are things that we should not ignore as we rightly focus on Africa.

I have a few reactions on the working group paper. I think that it provided a very good summary of the evolution from Cairo with the focus sort of shifting from the eternal discussions and the search for illusive causality between the demographic growth and macroeconomic behavior and focus much more on the behavior of the households, the behavior of the women and the men when it comes to these issues. I think it is clear to say that we don't

know quite yet whether we have done the work that is needed in evaluation to know whether or not these changes have actually made a difference.

I very much liked the dichotomy between the kind of evidence that you need to talk to the ministers of finance or the prime ministers and the kind of evidence that you need to design interventions that are likely to get to the outcomes that we want.

In particular, I have always thought that we really need to link macro and micro much more systematically than we have to really understand how the micro changes in behavior may or may not translate into overall macro results very clearly, the importance of impact evaluation and the need for appropriate methodologies and the right sorts of data.

I am not an expert on randomized trials, but I think that we need to look at as we all talk about scaling up. This is the methodology that is going to allow us to have the sort of evidence at a scale that is needed for making a difference, but

where I very strongly agreed with the paper is the importance of embedding, monitoring, and evaluation in the very design of operations.

I think we talked in one of the previous incarnations, previous meetings here at the center on HIV/AIDS, and I think it is fair to say that we don't have a very good story to tell yet on monitoring and evaluation on HIV.

At the World Bank, certainly we are putting a renewed emphasis on monitoring and evaluation and impact evaluation. I am pushing very hard that any operation that we finance and that we work on in human development should have a very strong monitoring and evaluation component, and I think at the global level, our chief economist, Francois Bourgiugnon, has launched a very big study to have an impact monitoring on what it is that we do that has the right sorts of results.

Obviously, that leads us to another conundrum, which is data, do we have the right data, and again, I am very encouraged to see that because of the MDGs and because of the scarcity of good and

reliable data, the international community is now focused much more on trying to get the right data. We have Paris 21, we have the STATCAP Initiative, and I think we should make sure that these initiatives as they move forward do not forget the kind of data that are needed for population and reproductive health.

At the same time, I think that we need to do much more, in my view, on understanding the behavioral sociological, almost anthropological, side of things. If indeed Cairo has focused on engendering development post-Cairo, we have to make sure that we understand what works and what doesn't work.

Again, I think the report of the working group is interesting because it talks about not only do you need empowerment, but you need "empowerment in a context," as they put it, that makes sure that the changed behaviors, the empowered behaviors, can actually make a difference.

It is very, very much in tune with the global strategy of the World Bank which talks about

the investment climate which is the context, if you will, and empowering people which is the fact that within the context, in the end, it is the people who will make a difference.

Another question which I don't think is touched enough, in my view, in the paper is why is it that the focus of the world on HIV and AIDS has not translated into progress on reproductive health issues and why is it that, in a way, these two communities--and Thoraya and I have talked about this many times--these two communities should be so united in their objectives, the HIV/AIDS fighting community and the reproductive health community, have come for political reasons to almost see each other as a liability. So that instead of joining forces, you have a very careful delineation of "No, we don't deal with reproductive health; we deal with HIV" or "No, we don't deal with HIV; we deal with reproductive health."

I think it is a tremendous loss of a potential synergy. I am not born yesterday. So I understand the politics of it, but I think we really

have to build evidence as to what this lack of synergy might be costing the world and might be costing in terms of making progress.

Obviously, this leads us to the big issue of our time, in my view, when it comes to health and the reproductive health and population and what have you, which is health systems. We really have a lot of verticalization of our interventions, and the health systems and the challenges of human resources in health are a big problem today.

It is very clear to me that what the paper proposes to build this kind of a research background is extremely important, and the general direction, I hope, will be enriched by our conversations today.

Let me just say two more things. One is there is not much about sustainability and environment in the paper, and yet, you cannot talk about demography without talking about sustainability. You cannot talk about population without looking at the migration from rural to urban, the condition that it creates and, in many ways, the consequences even on the reproductive

health. That leads us to what happens in agriculture productivity. I have images of what happens in places like Rwanda or Burundi with the increased intensity, the impact of migration which is becoming a very big topic, and also the link between the poverty and the inter-generational poverty.

Finally, my last point is not terribly original anymore, but it is the special challenge of youth. A majority of the people in the Bank client country are under 24 years of age. In some regions, it is 60 percent. Yet, I think we have a fair idea, not a perfect one, but we have done enough research for the zero-to-15 groups. For adolescents entering into adulthood, I think we have much less of a basis to make policies that work. So the 15-to-24 is really a very big challenge when over a billion people, young people, are about to enter into their transition to adulthood.

Somebody just gave me this "Growing Up Global," which is an attempt to begin to conceptualize these issues, and the World Bank

itself is going to devote our World Development Report in 2007 to development for and by the next generation, which is really a way for us to recognize that all of these transitions need to become an extremely important part of how we think about development because, when they are successful, good things happen. When they are not successful, not such good things happen.

The issues of youth, I am sure we will talk about that and the specific problems that it poses to reach young people, in particular to reach young women that tend to be disproportionately disempowered, how do we do this, what is the evidence that can convince the policy-makers that it makes sense, and how do we do this with the young people. Doing it to the young people or for the young people isn't going to work. I think it is very clear to me that our philosophy of participation of shared decision-making needs to apply to young people as well.

I just wanted to share some of my thoughts reading this very, very good paper that I hope we

will make even better after our deliberations, and again, to thank the center, the working group, the Hewlett Foundation, and DFID for making this conversation possible.

Thank you, Nancy.

MS. BIRDSALL: Thank you very much, Jean-Louis. I think you have started us off with some good questions.

As a former World Bank staff member myself, I have to say that it is always heartening to hear from leadership at the World Bank that is saying we have to worry about the relationship among sectors and try to cut through the politics of these internecine battles which are harming the overall objective that everyone has here at this table, which is to make lives better for women and children and families in Africa.

Let us go now to Hans-Martin Boehmer who is also a former or quasi-World Bank person, but now holds, apparently, a kind of position that is analogous to that of Jean-Louis, at DFID as head of the Human Development Group.

Hans-Martin.

MR. BOEHMER: Thank you, Nancy.

Yes, I am being paid by the World Bank, but I am speaking for the British taxpayer.

One of the things that I learned very quickly in my job was that there are two bilateral aid agencies almost. One is the political side of DFID, and the other one is the civil service side of DFID. My job is basically to make the link between the political side and the civil service side and to translate the political will into what then the development agency actually does.

What I was hoping to do now was just run through from the perspective of a bilateral aid agency, specifically DFID, why does what we are doing here today matter and how does it feed into decisions that will have to be taken and will need to be made.

Let me go through what the world looks like from the perspective of DFID. Specifically with reference to Africa, there are three elements that we think eventually need to come together for Africa

to have a prosperous future. One is peace and security, the second one is building effective states, and the third one is creating an environment for growth.

That is quite different from what politicians will continuously talk about, which is the MDGs, but the MDGs, of course, are the outcomes that we are trying to achieve at the end of the day. We just think that these pillars are the critical elements; if we reinforce those, we have the best shot at actually reaching the MDGs.

From the perspective of a taxpayer, the UK is increasing its development contributions quite significantly at a time when everybody suspects that perhaps taxes will need to go up to stay within reasonable fiscal framework. The taxpayer expects that outcomes, results, will be achieved and will be demonstrated that don't say, "Well, we have created an environment for growth," but rather that say, "No. We have achieved the MDGs, yes or no. We have made measurable specific progress."

So the question is how do we translate one into the other, and this framework of these there pillars in the case of DFID very clearly translates into how we work. One is budget support. We actually think that the best way to put countries in a position to build effective states is to give them the resources, and first and foremost, if the countries decide how they actually allocate the resources across different priorities, which means that inevitably tradeoff decisions are going to be made by countries. They are not going to be made by DFID deciding at a strategic level, "This is what we want to spend our money on."

The second one is that we absolutely believe in multilateralism. It is not going to be accumulation of bilateral programs that at the end of the day will make it effective. It is a more effective multilateral system that will work, which is why the World Bank is so important and why contributions to IDA, where one can now argue DFID is the largest contributor at a 14-replenishment round if one includes the supplemental contribution

that DFID is making, is so important for the whole development framework in Africa.

We also believe in what we in-house refer to as "cross-Whitehall collaboration." What that means is, if an issue refers to the Department of Defense on AIDS, we actually work with the Department of Defense in figuring out how do we have a common view on how AIDS in conflict situations in the way our own military operates actually is reflected. It is very much of a cross-governmental approach, cross-departmental approach where perhaps the development perspective takes the lead, but at the end of the day, it is trying to harmonize what the Department of Health does, what the Department of Education does, how health workers get recruited from Africa back into the UK, how that has an impact on development.

How do we get our money? When DFID gets its money, it does so based on what we call "public service agreements" with the Treasury Department. Those are specific targets that are incurred in the MDGs, in the targets for the MDGs and the

indicators, which is why what we actually put into those targets and into those indicators actually does matter quite a bit. Demonstrating progress means making progress against those targets. If we don't achieve that, no matter how good our work may be, if we fail to achieve the results, we will simply not get the money from Treasury anymore.

If one looks at Africa, there are three big red flags, red meaning we are far off track in our public service agreement. One is on gender, the second one is on under-five mortality, and the third one is on skilled birth attendance. Others, we are doing actually better, in poverty reduction overall, in education overall. These three are big red flags.

How do we address those? We don't want to get to a point where we address those specifically. We want to very much stay with a three-pillar approach that we have, but of course, the politicians are always thinking about what do we do and how do we rationalize it. You have seen perhaps in the last couple of months, a number of

initiatives from the UK on financing, on let's take the immunization IFF, which is basically massively scaling up vaccination programs.

You have also seen perhaps the advanced purchase contracts, advanced purchase schemes being approached. The rationale that is being used for these largely is around lives saved, how many lives can we save by having more vaccinations, how many lives can we save by moving forward immunization programs.

The point I am trying to make here is a very simple one, and it relates to the research agenda. How we rationalize what we do depends on how we then go about implementing it. If we think the reason for doing vaccination programs is lives saved, period, then the way we go about implementing it is very much and almost you can call it an "emergency response system," rather than a long-term sustainable system that is embedded in these three pillars on creating an environment for growth, creating stable states, creating capable governments.

Here, I think we are desperately seeking for a firmer empirical rationale for what we do and how we can actually demonstrate that is directly linked between the outcomes that we want to achieve and the way we think development actually works.

If we are sticking with lives saved as one of the primary rationales for a lot of the interventions, the criteria will be lives saved. It will not be will we actually alleviate poverty, will we actually have growth, will we not only have lives saved, but actually a more prosperous future.

Also, in terms of how we implement it, the pressure will be great to promote vertical programs because they often get you most quickly to lives saved, rather than long-term sustainable development. So one of the very concrete objectives that I was hoping to come out of this is really tie the rationale for what we are doing to the objectives that we are trying to achieve over the long term, find the evidence and have then the empirical basis for not only deciding what to do, but also report back to how does the approach that

we are taking link back with the outcomes that we are trying to support.

Thanks, Nancy.

MS. BIRDSALL: Thank you very much, Hans-Martin.

I must say that because at the Center for Global Development, we do a lot of work on aid effectiveness, I am not sure all of my colleagues would agree, and we don't have to agree at the center, but certainly we see DFID more and more as taking intellectual leadership on some of these big issues of the links between systems and short-term outcomes, the problems of budget support and ownership versus leverage and conditionality and so on.

From all three of these speakers so far, we see the outlines of a good discussion emerging for sure.

Let me introduce Jotham Musinguzi, who is the director of the Population Secretariat at the Ministry of Finance and Economic Planning in Uganda.

We are very pleased to have you and your colleagues here, who have come a long way. Please go ahead.

DR. MUSINGUZI: Thank you, Nancy.

I would like to thank the conveners of this meeting for the opportunity to share with you. I draw my inspiration from what I heard last night from Thoraya and this morning from the three main speakers, and I hope that what I am going to share with you will try to contextualize some of the pronouncements made by various speakers and probably to say really that, in the case of Uganda, we seem to be seeing a mixed picture of our government's efforts, especially since the Cairo conference of 1994.

Again, as I said, in the case of Uganda, I am trying to--I hope you can now go towards Uganda and see what we have on the ground--clearly show that since the 1990's, the beginning, Uganda has undergone a number of transformations. We have had deregulation. We have attempted privatization. We have tried to do some issues on governance, especially decentralization whereby powers evolve to

the periphery so that more people can participate in decision-making. We have opened up the airwaves, so that there is more public information available. There have been macroeconomic policies and changes, some of them including issues of Paris Peace and the rest of them as you know them.

Then, on the question of education, we have a program on universal primary education. We have also, of course, primary interventions, including for teacher education.

We have had some innovations in health, including issues of swabs, and we have health policies out there, including HIV/AIDS, and a number of changes.

In terms of changes, Uganda is obviously not short of changes, but what is it that we see out there? What we are seeing is that clearly Uganda's population is going up fairly rapidly. I just wanted to contextual this. Over the last 15 years or so, we have added about 10 million to our population--I will be coming back to that--and we have a rapid population growth rate.

Total fertility rate in Uganda has not gone down appreciably. An actual fact, even when you go back the last 40 years, we have been hovering around 7.4, 7.3, 7.1. So, clearly, we haven't been able to move on the fertility rate.

The question of contraceptive prevalence rate, we have improved on this, but as we shall see, although we have gone up almost four- or five-fold, we don't seem to be having the benefits of increased contraceptive prevalence rate.

Infant mortality clearly is starting off at a high level in about 1990, 122 per 1,000, and sort of stagnating. I will come back to show this in a more pictorial. Same thing with maternal mortality, not so much improvement on that.

The HIV/AIDS, yes, I will show this more dramatically later when I show a graph. Uganda has moved from a high 18 percent in the 1990's to about 7, as you can see. We will come back to this. We thought we had moved down, but we seem to be stagnating.

The point has just been made about skilled deliveries. In Uganda, we haven't moved an inch for the last 15 years or so. These are some of these issues that we can also be discussing.

When you look at education, yes, this is where we seem to be doing quite fine, and I think when you look at the MDGs, yes, we have some pluses. Literacy, yes, we are improving.

Of course, also, poverty levels, the percentage has come down, but I am going to be talking about what is it showing us in terms of numbers.

Uganda's population came from very low, 100 years ago. This is not scale, but clearly, we are seeing that we are going up. I will talk about that more in here.

I am going take a couple minutes on each particular slide to just show that when you look at the trends of population in Uganda for the next 20 years or so, we talked about the fertility rate which is still high, but I just want to invite you

to look at what we are doing with our population growth rate.

When we did assess ourselves sometime ago, 3 years ago or so, we are at 3.3 percent per annum. This is a very high population growth rate by any standards. What is amazing is that it is still going up. We aren't there yet, and it is probably going to peak around here in between these two before it starts going down, but it is going to take some time.

Another 20 years, the population growth rate of Uganda will still be more than 3 percent per annum. This is, therefore, going to lead to building up of a population. Another 20 years, Uganda's population will have doubled from what it is, from 25 million to 55.

When I shared this with my head of state, he said, "Congratulations," and so this is part of the problem. If the leaders see the population increasing, they think that may be good for the market. Our message is, as we sit in this room, are they going to understand it clearly, and I think

this such an agenda has to have very clear messages out there.

When I discuss this further, if you look at 2005, the total population, in about 20-years time, the labor force of Uganda will be 28 million, almost equal to the current population of Uganda. Will Uganda and other similar countries have an infrastructure, employment opportunities for this total population of 28 million, equivalent to the enter population now? Shall we be ready? Somebody in Uganda says, "Yes. That is my job. I should make sure there is employment."

So what about looking at the kids themselves? Currently, we have--[audio break].

[Side 1 of Audiotape 1 of 6 begins.]

DR. MUSINGUZI: Of course, they need health care. They need education. These are going to double in another 20 years. Is our infrastructure going to be ready to take this on? I think these are some of the challenges, and I think we need to move on.

It is true when you look at HIV/AIDS in Uganda, there is some progress, no doubt. About 15 years ago, the general population prevalence was about 18 percent. It has come down. Over the last 5 years, we have been trying to see whether we can move down, but at some point, it was about 6.2. This figure just came out last week.

So Uganda is doing very well with HIV/AIDS, but clearly, both 6 and 7 percent is an epidemic. That is not talking about the problems of orphans, the problems of HERS systems as has just been talked about, a question of human resources and issues of that nature. Uganda is a success story, yes, but this is a public health problem, and we are not yet out of the woods.

As you can see, this is the earlier graph which is in between here, in between the two, but we are looking now at the urban. Our epidemic is old now, among probably one of the oldest, but in 1987, talking about the urban, we had 24-percent prevalence, which peaked around 1991 and was around

30 about 1992. In '82, it came down. The rural area, of course, has been a little better off.

As to what made Uganda succeed, in addition to what else you know, we think that about this time we are seeing a lot of this, so a lot of people.

I recall as a civil servant, we are almost in the church every other day burying people because of HIV/AIDS, and I think people got scared. So the messages went out clearly, but also, people saw for themselves people dying, people that you knew, your own colleagues. President Musaveni, a number of his military generals dying off, he realized that he had to do something. So these type of things galvanize you into doing something, but I think we are becoming complacent in Uganda, and I think we need to move on that.

The other success story is in the case of universal primary education. When you look at actual performance, Uganda is moving up. As a matter of fact, when you compare what we want to do with MDGs, we think we are going to achieve the MDG

goal even before. So, again, that is a success story.

When you come to maternal mortality, our performance and rate here, you can see it is plateauing. Clearly, we haven't moved much. In 1990, the ratio was 523, and it hasn't gone down very much. Clearly, we have missed the MDGs so far as I can see, the MDG target, and even our own target--we set our own target within the country--we don't seem to be getting there. So there is a clear message there.

When you look at the infant mortality, again, this is something that we talked about. True, in the early 1990's, we seemed to have moved to 122 per 1,000, but we see stagnation over the last 10 years or so. So, clearly again, here we need to do something, and this is looking at it with putting in the numbers for the MDG.

When you look at poverty, again, Uganda has been said to have done well in terms of poverty. In 1992, 56 percent, for every two Ugandans, one was living under poverty. This came down, but again, we

are seeing some stagnation there. Clearly, it looks like the MDG target, we seem to be missing it.

My last slide is to try and put numbers to this. I am inspired by Margaret Kakandre who deals with the poverty issues and is here from Uganda. She is sitting there at the other end in a red sweater. I hope she will be able to say something more about this.

It is true that in 1992, Uganda's poverty levels were at 56 percent. As I said, for almost every two Ugandans, one of them was living under poverty. In terms of absolute numbers, we had 9.3 million people living in poverty in red out of the 17.5 million, and only 8.2 million out of poverty.

On a positive note, the government says yes over time. In green, we have increased the people out of poverty; an actual fact, more than doubled over about 13 years or so, 8.2 million compared to 17.1 million.

There is also the question of population factors. It was 17.5 million here, only 27.6 here, but I think where the problem is, is when you look

at people under poverty. Poverty reduction, yes, from 56 percent to now, 38 percent, but when you look at the numbers, the absolute numbers in terms of people below the poverty line, you can see we have now 10.5 million people as opposed to what we had 13 years ago. Clearly, the percentages of poverty have gone down, but the absolute numbers are there.

Members of parliament are telling everybody, are telling government, "When we go out to our constituencies, we are seeing more poor people than previously," and this doesn't seem to be very understood because the government says, "Yes, we have reduced the poverty from 56 percent to now 38," but the absolutely numbers in the rural areas are there. I think we have some work to do in this context.

So I hope that I bring some figures to show you what may be going on. In some of our countries, I see my colleagues from Kenya and Ghana here. I hope the situation in your countries is better than this. Clearly, we have a mixed bag of issues here.

We have made some progress along the line. Some programs are working, but it looks like our work is cut out for us.

Thank you very much.

[Applause.]

MS. BIRDSALL: Thank you very much.

I was thinking how good it is--I don't know if it would have been true 20 or 30 years ago--that there is a population secretariat in the ministry of finance. Then, when you were talking, I was thinking how good it is to hear from obviously a distinguished doctor using numbers that the finance and economics people can understand. Thank you very much.

Before we turn to Alex, I think we should ask David Canning and Steve Sinding to introduce themselves since they came in since the introductions.

David.

MR. CANNING: My apologies for being late. I am David Canning. I am from the Harvard School of Public Health, and I am an economist who has been

working on the links between health, population, and economic development.

MS. BIRDSALL: Thank you, David.

Steve.

MR. SINDING: Also, apologies for being late. I am Steve Sinding, director general of the International Planned Parenthood Federation.

MS. BIRDSALL: Ruth is telling me that we have time for some Q&A for any of our speakers.

We have another new person. Please introduce yourself.

MR. MEROTTO: I am Dino Merotto. I am a country economist at the World Bank.

MS. BIRDSALL: Oh, very good. I am glad you are here.

Paul.

MR. BREST: I wanted to respond to Hans-Martin's comment. As a member of the working group, it was really our effort to try to urge donor development agencies and people involved in this area to approach the reproductive health engagement as a human capital investment, not as a calculation

on simply health movements or lives prevented, but rather see investing in women's involvement in capacity-building through health and family planning as being a human capital long-run commitment.

That creates all the problems of data collection and evaluation that we might rather not face or confront directly at least, but it really asks this field to reconsider how it structures its appraisals of its achievements because adding to women's capacities to regulate their life has both the inter-generational implication that the children in all of our studies seem to come out with more human capital themselves, health, nutrition, survival, migration outcomes, we emphasize with the deal, but the women themselves get more education if they don't pregnant. In school, if you reach them at an early enough age, the capacities of these women to develop their own career commitments show up in higher productivity and health capacities to work in the rest of their lives.

So, if we approach this as a human capital outcome as opposed to the narrower, vertical, rigid

health mode that we have received from the field, I think we get very different answers, but it is going to take work. It is not easy.

MS. BIRDSALL: John?

MR. : Yes. I have a question for Dr. Musinguzi about the AIDS epidemic.

Uganda had one of the first, earliest, and largest AIDS epidemics, and it also has seen one of the largest declines anywhere in Sub-Saharan Africa.

You mentioned around '99 when the epidemic peaked, people became afraid, and they started taking action. There is some disagreement about what brought about a decline in HIV prevalence. Can you shed some light on that, what did people do and how did the government help the people to do what they did?

MS. BIRDSALL: Shall we take a couple more and then turn back? Yes.

Mai.

MS. HIJAZI: I have another question for Dr. Musinguzi.

You have presented sort of the overall fertility rates, but I think that the interesting thing now is to start desegregating these. Could you tell us, if you know, what the adolescent fertility rates versus the total fertility rates, to start looking at the age issue?

MS. BIRDSALL: Thoraya.

DR. OBAID: This is actually to Jean-Louis. He mentioned that we needed to look at the cause of not having the reproductive health people and the HIV people work together, but I think the question, Jean-Louis, if we start from now is how much would we gain if we worked together.

As long as there is a political climate that criminalizes reproductive health in any length with anybody else, that division will remain. So it is the ability of the HIV/AIDS people to accept to jump over it because they will be threatened with finances.

Now we have stories from developing countries with NGOs that work in the area of HIV/AIDS prevention at least who are changing to

abstinence only for resources purposes, to get the money. Therefore, the cooperation there is really built not on territorial, but on political pressures and who would lose and who would win. That is a different question that we need to ask.

MS. BIRDSALL: I think we should go to some answers and then go back to questions.

Dr. Musinguzi.

DR. MUSINGUZI: Thank you.

John, the question of HIV/AIDS and what made the difference in Uganda, I alluded only to one which I thought was clear, but at the peak, I think these deaths which people are seeing themselves galvanized them into taking action and starting to change behavior.

I don't know whether your question is related to issues of whether condoms were also useful, and if that is the question really, I know this is a debate, but let me say from the outset that I think some of that is driven by different ideological inclinations.

In Uganda, we believe that what helped us was to look at a multi-sector approach that used both abstinence, being faithful as we call it, and the use of condoms as well. In actual fact, as we say, we have seen action, and we have evidence that in all of these cases, the condom use went up. People reduced the number of their sexual partners. In all of these, we see that it is a culmination of that, and it is not just one and not the other.

It is also true that the political leadership by speaking openly about the issue--and you know sometimes when you have elected leaders, in the countries that have low education, when the leader talks you cannot distinguish it from whether it is a law or it is a directive. Also, people see them as role models on issues like that.

On the question of strong leadership from President Musaveni and also liberating everybody's talk, I remember when I was at the university by then, I could also go out and whenever I went to Europe, I could speak out that HIV/AIDS in Uganda is a problem. I didn't feel constrained.

At first, people were saying, "If you talk about HIV/AIDS being rampant in Uganda, the tourists may not come," and things like that, but clearly, I heard my head of state saying that if the tourists are not going to come, they do not come. It does not matter as long as we save lives of our people.

As I said earlier on, I think President Musaveni was also moved by his military, which he hold dear about, because they had led the guerilla warfare and they had trained some of these soldiers, and he saw them, some of them, dying. That also made him move on.

It is also true with the other groups as well. The fact that the head of state was able to speak out openly, civil society organizations went out, and they were close to the grass roots. The young people were given information. The health people did their programs. They treated the STDs, the sexually transmitted diseases that were a part of the process of acquiring HIV/AIDS, and the other international communities, of course, came in with the funds to make sure that everything moves on. So

it was a concerted effort through a multi-sectoral approach, and I think that is the way we should look at it.

It is true that we have had a discussion with our head of state about the messages that he sent out. He clearly presented Musaveni clearly denies that he is saying that we should not use condoms, and I think he is very clear on this.

MR. : He said it in Bangkok. He said it in Bangkok. He very clearly said that people should not rely on condoms; that faithfulness and abstinence is the right approach.

DR. MUSINGUZI: As I said, we have versed him since then, and he seems to see that it is not correct.

We needed to be clear. Sometimes some of these statements are also exaggerated by different reporters, but it is true that if you asked him again, I am sure he would tell you that it is the ABC. It would be interesting to see whether he would remove the "C" from the ABC. So there it is.

Regarding Mai's question, I am not so sure that I have enough information to give you about desegregating the fertility rates according to different segments. I think this is an area that we need to be able to move on, but at the moment, we don't have clear data on that. Ours are still at the global.

MS. BIRDSALL: Jean-Louis on Thoraya's question.

In a way, it is interesting, the response of Dr. Musinguzi on leadership in contrast to the point that Thoraya is making that there has never been the same visibility, the kind of leadership from the top about the urgency of reproductive health issues.

I think that is behind your question. Right?

MR. SARBIB: Well, I cannot disagree with Thoraya. I think she is absolutely correct.

What I was trying to say is there is a role for the research community to build evidence of what is it that we are missing by not having more synergy

between these different activities, and the question then is will that be enough to create the evidence base, so that the politicians will respond to it. I think for now, if I were running either one or the other, I would behave exactly the way Thoraya has described because otherwise my programs would not be financed.

There is a beginning of a reaction. I think that it was in Brazil recently that there was a refusal of money because of the conditions that were attached to it by the United States.

The more evidence we have, especially in the environment that Hans-Martin described of an increased premium on the effectiveness of aid and the fact that we don't have enough money to meet all of the objectives that the international community has given itself, if in addition we are not using this money in a way that gets the maximum effect, I think that we may be able to move the debate forward.

That is what I said. Politically, I agree with Thoraya. I think pragmatically, people have

got to continue, but there may be a role for the research community to create evidence with which those who want to change the current situation can base their action. I think that is what I was trying to say, but I don't disagree with you at all, on the contrary.

MS. BIRDSALL: If you want to put your name tags up if you want to speak, that will make it a little easier.

I did see Jackie and someone in the back on the left and then Steve Sending. Let's take those three.

DR. DARROCH: Thank you.

I was just hoping, Dr. Musinguzi, that you would reflect a little bit more on what looks like incongruity between decreasing poverty levels in Uganda and the lack of movement on things like skilled birth attendants and infant and child mortality, maternal mortality, many measures that we think should increase if more people have in common, therefore, access to services.

I think at the same time we are looking to improvements in reproductive health as having benefits economically, we also are thinking that economic development will improve reproductive health. So I would appreciate knowing what you think about the difference in that in Uganda.

MS. BIRDSALL: In the back, I'm sorry. I don't know your name.

MR. ELOUNDOU-ENYEGUE: Parfait.

MS. BIRDSALL: Go ahead, Parfait.

MR. ELOUNDOU-ENYEGUE: My comment is not so much a question as an invitation to Jean-Louis to comment a little bit more on what he calls "supplemental growth" and how he ties this with his special challenge of youth.

It was heartening to see in the document, poverty reduction having a prominent place alongside with economic growth, but at the same time, I think the implicit link is that you gain growth and, therefore, you reduce poverty. I think what he seems to suggest is that you can actually go the

other way around; that is, have poverty reduction itself being an engine for growth.

I think to that respect, we can draw from the experience of industrial countries where you pay a great deal of attention to your middle class, your economic core. In a context where we have most of our population being within the ages that you mentioned, between 15 and 24, do youth actually in reducing poverty among this group represent a potential engine for growth.

MS. BIRDSALL: Very good question. I like that question a lot.

Steve Sinding.

MR. SINDING: It is very bad form for somebody to walk in the room and immediately jump into a conversation. So I apologize for doing it, but I so appreciated Jotham's bringing in the issue of political leadership because I think it is so important.

My comment, I decided to raise my hand at your comment, Nancy, in how you interpreted what Thoraya was saying about the importance of

leadership in reproductive health and the perhaps earlier phases, and it is stimulated by the fascinating example of Kenya, which I would really like to ask a number of people around the table who know that situation well to comment on.

I always felt and have written that political leadership played a tremendously important role in doing what Jack Caldwell always talked about in talking fertility down, and that the absence of attention to reproductive choices and behavior in recent years is arguably connected to not only the plateauing in the rate of decline in fertility, but the actual increase in fertility and the increase in desired family size that we now observe having occurred in Kenya.

It seems to me that the Kenya example suggests at least that political leadership in some settings is tremendously influential in the course of demographic behavior as much in Kenya on the fertility front as in Uganda on the AIDS front. I just would like to put that on the table not perhaps

for a discussion now, but before we reach the end of today's deliberations.

MS. BIRDSALL: Shall we have some responses and then go to the other questions?

DR. MUSINGUZI: Jackie, on the question of reproductive health, it has killed attendants. It has killed attendants at delivery, and how this should be able to impact on the economic development and things of that nature, yes, I did not go into this because I assumed that that is something that we are also talking to ourselves now. Clearly, I think investments in this have been shown to impact on these issues.

I think our problem is whether in actual fact the economists, the people who are responsible for budgets, also believe in what we are talking about, what seems to be on the ground, and I think this is why having clear documentation, having the necessary data, to be able to go out and talk to these people and convince them that this is important, I think that is the reason why we should be able to put that. Clearly, from my own

background, I don't think I need to belabor the point that clearly if you can increase on investing in reproductive health and making sure there are skilled attendants and mothers are not dying, children are not dying, therefore, you are also impacting on infant mortality, so that couples know that they are not going to lose their babies and therefore they can have only two, if that is what they wish to do, instead of investing in four, knowing two of them are going to die, and issues of that nature. So I didn't elaborate because I came from that type of background.

I think this is important, and I think this is where we needed to make sure that we have data and we have the skills to be able to convince people that it is important that they should invest in this particular area.

For Steve, again, the point you have made I think is important. I should actually say, Steve, leave around the question of the condom, I think we think that in Uganda in actual fact, our fertility

is also driven by lack of leadership in this field. I think I should come back to that.

Like our political leaders have shown leadership in HIV/AIDS, they have not shown similar anywhere near similar leadership in the reproductive health and issues of that nature. If this type of data and the strategies come out will help on that, I think your point is very important.

Thank you.

MR. SARBIB: What I was trying to say, talking about the supplement of growth, is referring back to a study that was done by the Africa Region of the World Bank, maybe 5 years ago or so, which showed that assuming women would have the same access to productive assets as men--and I memory may fail me on the number, but I think there will be an increase in per capita growth of .6 percent.

Similarly, if you look at some of the numbers of what we would have if we were to invest against malaria, against a number of those kinds of diseases, again, you get a supplement of growth of the same order of magnitude.

What I am trying to get at is the fact that we should not look--and certainly, in the World Bank, we don't--at investing in people as something you do once you have growth, but that you look at investing in people as something you do to have growth. I think it is extremely important that we continue to build this evidence, whether it is in girls' education or reducing the kinds of issues that are around the table now. That is why I think what the working group is suggesting in trying to establish this evidence base, so that we can talk not only to ministers of finance, because these poor men and women are besieged by everybody developing their own evidence that their sector is the one that should be the answer to everything, but also, as Hans-Martin said, to public opinion in the donor countries to really show that maybe the best way to get a decrease in maternal mortality is to invest in education and not to have this increased verticalization right now, which is to say to do something to help on HIV, the only thing is just give it to the Global Fund.

The Global Fund needs money, but there is a lot of other things that need to happen for this money to be effective. So I think not only the ministers of finance need to see the evidence, but also the public opinion and the politicians in donor countries need to see that evidence, so that they go back to what Hans-Martin was saying. Peace and security, the competency of the state or growth are as important as what looks like on the face of it as something that will have an immediate impact no the MDG.

So that part of the research agenda that the working group is putting on the table is extremely important.

MS. BIRDSALL: Maybe we will just ask people to put their questions on the table, and then we will leave those questions for all of us and the respondents to think about as we proceed to the next session because we are running out of time. Would that be okay? If you can be as brief as possible in your question or comment.

Alex?

MR. EZEH: Jotham, one of the figures you gave, especially on the primary education, is one particular indicator where Uganda seems to be on track with meeting the MDGs, but what you are looking at is enrollment and not really what proportion are completing a full course of primary school. I was wondering if you could reflect on that.

Hans-Martin, in your discussion about the DFID strategy to do budget support, which increasingly they are getting many other bilateral partners to follow the same part, and oftentimes you have huge investments within a particular sector, within the government, and sometimes weak capacity to observe and utilize such resources.

In some other countries, the civil society is almost becoming irrelevant in terms of moving agenda, particularly with respect to reproductive health issues.

What type of evidence really guided this move from maybe more consideration of different

actors and players in the field to really put the money in one basket as budget support?

MS. BIRDSALL: The next questions have to be even a little shorter, maybe only one question.

Geeta.

MS. GUPTA: Okay. I will pick one out of the two I wanted to make a comment on.

To comment on the lack of synergy between the HIV/AIDS world and the reproductive health world, I don't think it is just political barriers. I think we don't have the answers on the "how" at the programmatic level. I think the evidence base that we need there is programmatically how does the integration work because in high HIV-prevalence countries, should we or should we not is no longer an issue. It is essential we do it, but how we do it is I think the question to be answered.

MS. BIRDSALL: Thank you, Geeta.

Elizabeth.

MS. LULE: Mine is regarding the fact that HIV/AIDS prevalence actually did go down, and we

have evidence that it was amongst, I think, the 15-to-24.

What I am interested in is if indeed it is ABC and indeed it is abstinence, how did the age-specific fertility rates of this group actually change in line with that? And I am sure if my memory serves right, actually there is hardly any change. In fact, fertility continues to go up in that group, and I wonder how we explain that discrepancy.

MS. BIRDSALL: Richard Muga.

DR. MUGA: Thank you.

I will respond to Steve's question later when I make my presentation, but I want to raise an issue with Jean-Louis, the issue of HIV/AIDS and the preventive health integration.

I want to agree that it is not that there is no evidence. We would want to know where is this problem. Is it because of development partners, because of the implementation level? You have one asset, the health center, and this is the same who

will offer HIV/AIDS care and also reproductive health.

Today, in Kenya, we begin to see people who have used antiviral drugs for some time. They are beginning now to look for husbands. They want their reproductive health organized again.

So I want to believe that this problem is not at implementation. This problem is somewhere that somebody wants to get credit for, saying I will only go on HIV/AIDS. For us in Sub-Sahara, it has created a havoc, and we wish it was just stopped immediately. We moved to have an integrated program.

One more to Hans, budget support. I think for us, if it is going to empower our countries to sit on the driving seat, that is the route we would wish to go. As long as the country is not held accountable by its citizens, then it doesn't matter how much money we put.

So what we are saying today in Kenya is resources are being targeted at the constituency level, so that the voters can ask where did the

money go, what have you done with it, and we believe this is the only way that will help remove the corruption that has been talked a lot about Kenya. We believe that is the right track.

We would want to know is there any opposition to it. Why do other partners find it difficult to go that route? You can answer it later, maybe.

MS. BIRDSALL: Sarah.

MS. : Thank you, Nancy.

My question is also to Hans-Martin. You are lucky that you come at the end, so you can answer these privately.

You said DFID had identified three red flags for Africa: gender, under-five mortality, and school birth attendance. So my question is why these red flags, not other red flags such as maternal mortality, and with regard to DFID's priority for budget support, what evidence-based policy dialogue opportunities do you see that can resolve the tension between budget support and having the country address what you have identified

as three red flags that you would like to see attention paid.

MS. BIRDSALL: I see one more. Very quickly, please.

MR. : Okay. Thank you.

I am referring to the selected indicators in Uganda. I think total fertility rate is declining. In the universal primary education, the government is showing it is significantly increasing, but still the population grows at a rate that is substantially increasing.

I want to know why the Ugandan performance has not failed to at least balance the population growth as the selected indicators show.

MS. BIRDSALL: If I can ask forgiveness from Jean-Louis and Jotham for not answering the questions now, I am going to ask Hans-Martin to answer the one question about why budget support because I think it is fundamental, as this background and setting, for much of the discussion that will follow today, and since you didn't get to answer any earlier questions.

MR. BOEHMER: Let me make a very dangerous comparison.

I think DFID's belief in budget support is a little bit like the Catholic Church's belief in the sanctity of life. The fact that there are a lot of implementation problems in it shouldn't mean that you deviate from the long-term objective of what ultimately you think puts countries into the right place to make the right decisions, but, of course, that also means that different players have very different roles.

DFID is never going to be in a position to actually provide the necessary capacity itself for countries to work through the question, how do we now within our own government structure, within our own accountability structure, put in place both the incentives, but also the technical programs to actually translate this into the outcomes they were trying to support. This is where we think the multilateral system can provide much better support than any one bilateral.

If you ask about the evidence, there is a very lively debate going on within DFID because the evidence is not very overwhelming. It is very much a question of where do we want to end up in the long term and are we willing to take the cost and the price into account in order to get there or would we rather safeguard our own resources and demonstrate somewhat fake evidence that our own money is used as effectively as possible. We don't think that is the point.

The point is do we at the end of the day empower countries to actually make the right decisions, even if that takes some time to get there.

MS. BIRDSALL: Thank you very much.

Session 2: Economic Growth, Poverty Reduction and Population Dynamics: Links and Pathways

MS. BIRDSALL: Now what we are going to do is move to the next session. I am finally getting myself a little better organized here, and I apologize for my confusion earlier.

We are at Session 2, starting at 10:30. We are doing rather well, and the session is called Economic Growth, Poverty Reduction and Population Dynamics. It is a big session.

What I would like to do to start is to say a few words and then turn it over to my colleague, Ruth, who is going to do an overview of the conceptual framework that is embodied in the draft of the working group's report that you have all seen. This conceptual framework links reproductive health to end population dynamics at the household community and macro level.

In doing that, I want to give special thanks to Ruth and to Suba for the work that they have done at the center. As you can see, they are the ones who are really behind what is going on, and I have been a little confused this morning.

Let met start us off by saying a few words of deep background that are in my mind about why Africa, and I think this is important because there was discussion of why Africa in the working group. And I think it is important as we proceed today to

keep in the back of our minds some of the assumptions at least on the part of some of us about the relevance of looking at these issues in a way that is specific to Africa.

So what I am saying is really more my own views, and others who have been in the working group will no doubt want to comment throughout the day on what is okay and what is not exactly about these views on why Africa.

I put down reasons in three categories. The first is that we do have evidence that the demographic trajectory that we foresee looking forward in Africa is going to be different from what we know about the past in other regions of the developing world. There are questions, I believe, about whether there will be the demographic dividend any time in the next several decades about which there has been a lot of discussion for other developing regions. Those questions come because fertility remains quite high, even if it is falling in some places. So they are not going to be at the same rate, at the same levels, the changes in

population structures which economists have zeroed in on, people like David Canning, as what was the demographic change that generated key economic changes at the macro level.

Just to remind you, even I was surprised to see Jotham Musinguzi's projections that Uganda's population growth rate will still be above 3 percent per year in the year 2025.

This is not unrelated to the fact that Africa overall is now growing--Jean-Louis probably knows better--but in per capital terms, perhaps at 1 percent per year even with reasonable good macro framework in the last decade or so and the fact that a 6-percent increase in per capita terms over 1 percent is a very large amount. Jean-Louis referred to this number being associated in simulations with more access to assets in Africa.

The special problems of youth that have come up are also related to the fact that this demographic trajectory will be different.

The second issue, why Africa, what I would cal the micro foundations, because fertility was

higher to start even in the '60s, '70s, and '80s than it had ever been in some regions of the developing world and because of the evidence that if fertility is falling, it is not falling everywhere, it is declining less quickly--the decline may be leveling off in some settings--that is part of a difference also at the micro-foundation level.

The second difference is issues of gender, child fostering, structure of the family in Africa being different or possibly different. I don't think we understand as a profession. At a technical level, there isn't much consensus about whether there is a difference and what that difference means.

As sort of an observer, I would say that 20 or 30 years ago, it certainly seemed to many economists, perhaps naive, that women in Africa were much more autonomous in their economic life than women in other parts of the developing world, including Asia and Latin America.

You know from general observation that women were in the markets and seemed to operate on

their own, were in savings groups and so on. This seemed to be associated for economists with the fact that Africa has been historically a labor-scarce environment. So women's economic value in the labor force as workers was obviously very important.

On the other hand, there is the evidence that women are peculiarly vulnerable, perhaps more than elsewhere--I don't know--which we see from the spread of the HIV pandemic, the fact that for young women in particular, the HIV infection rates are so much higher in some countries than they are for young men, and that is obviously related to the age at which there is intercourse and so on and the links of that to reproductive health.

For economists, the fact that the nuclear family model may not be as pertinent as a starting point--[audio break].

[Side A of Audiotape 2 of 6 begins.]

MS. BIRDSALL: [In progress]--for Africa as it is in the west.

A third general area of why Africa, what might be different, is the whole question of

economic growth and poverty reduction when you have very many small states, some of which are landlocked.

We talked a little bit in one of our sessions. There is a debate going on now amongst economists who work on Africa between two views of the future success for Africa economically, one view being sort of what is called crudely a "hallowing-out view," which is that landlocked countries, the people have relatively few opportunities in a global economy, so that you would foresee and expect more migration to coastal areas and to cities where you would try to invest in export-oriented industries that would generate the kind of dynamic which occurred in East Asia some decades ago, and another view saying "No, no, no, no, no," "No, no, no, no, no," this is not recognizing the role of agricultural development in all regions in the world as triggering a dynamic growth process and, therefore, the key in terms of investment being to put resources, including for human capital, including for health and education, into rural

areas, so that you could see some increases in agricultural productivity more rapid than has been the case and then a dynamic starting from there.

So all of that is a little bit of deep background. I didn't even mention, of course, the fact that the HIV rates are higher in some countries in Africa than anywhere else in the world and the link of that to reproductive health which we have already touched on in the discussion.

Let me turn to Ruth to give us an overview of the conceptual framework.

Let me say in closing that both my remarks and Ruth's are actually directed primarily to those of you in the room who have not been in the working group and who represent policy-makers. At the same time, of course, we expect working group members to weigh in both on these issues that I raised and on Ruth's presentation of the conceptual framework.

Ruth.

MS. LEVINE: Thanks very much.

Maybe I could invite everybody to open your binders and look at Tab 8, where the draft research

agenda is, and page 5 of that document has a kind of terrifying picture on it. So let me invite you to be scared along with me about this particular spider web of potential relationships.

Just so that we are all close to being on the same page literally and figuratively, what I am going to do is not walk through every arrow, but I just want to sort of walk through the different levels that the working group discussed between investments in reproductive health programs--and we did pay some special attention on the issues of family planning programs--through to the ultimate sort of high-level outcomes of economic growth and reduction in poverty, which somebody rightly noted are not necessarily associated, but are mediated. The relationship between economic growth and poverty alleviation are mediated by a number of policy and other variables. So I am not saying that economic growth is equal to poverty alleviation.

Let me just walk through these levels starting by saying this is a little bit like the case of the blind people describing elephant, that

there is some elephant between the relationship between a change in reproductive behavior and access to services and these very high-level outcomes. People coming from different disciplinary perspectives, from different experiences will understand that relationship in very different ways, but let me try to briefly describe how we have thought about it.

Starting from investments in reproductive health services, that is, greater access to reproductive health services for different population groups. You can think of it differently for adolescents as for women who are in marriage or other types of union.

There are, roughly speaking, two possible outcomes from access to reproductive health services. One is a change in fertility; that is, either starting child bearing later or having greater spacing between births. So that is on the one side. On the other side is better health that these women enjoy, both because of changes in fertility and child bearing and also because of the

range of other kinds of services that are connoted by reproductive health, so fewer reproductive tract infections and so forth or better treatment for those.

Those are sort of direct outcomes of these sorts of investments: change in fertility, assuming that there is demand for contraceptive services; and improvements in health, assuming that the services are of adequate quality.

Then from there, there is sort of a next layer of possible outcomes. For the children of the women who are receiving better reproductive health services, you can imagine in your mind that there may be opportunities. Those children may benefit from more and better and longer educational opportunities. They may work fewer hours. So child labor may decline. Over time, there would be also a change as a result of fertility changes. There would be a change in the age structure with a reduction in the proportion of dependent individuals in the population.

I am sure as I am talking, you are finding all sorts of problems with this, but the next layer, there are relationships that you could imagine between those intermediate outcomes of more education for children, declines in child labor, and changes in age structure, as well as the direct fertility and health changes. There are implications for which individuals migrate, at what age, and from what length of time, and migrate either to urban areas or to other countries.

There are potentially implications for labor force participation, particularly of women. So women with the ability to control their fertility, for example, might be observed to have different patterns of labor force participation.

Similarly, the ability to control fertility and to have better health might have implications for starting businesses and being successful in small enterprise, and very importantly, though hard to capture in a box, is the implications for women's status and autonomy control over resources.

I am imagining I am seeing thought bubbles above people's heads and imagining that you are recognizing that for all of these levels of outcomes, whether or not investment in reproductive health leads to these sorts of outcomes, first of all, is quite hard to disentangle, but second of all is very much contingent on the policy context or environment, so whether or not there is an ability of the labor force, for example, to absorb women workers and absorb them in jobs that actually have some potential for earning income and so forth. So there are a lot of policy environment variables that we need to think about at that level.

Then following on from that, there may be result in changes in savings and investment behaviors that, again, could link both to those variables that I just talked about. For example, if women are able to participate more in the labor market, they may have different savings and investment behavior, but that savings and investment behavior may also be linked all the way back to how many children they have, and there is quite a

history of literature and economic demography looking at how changes in child bearing are related, at least in theoretical terms, to changes in savings behavior.

Also at that level, you can imagine that there is a relationship to the productivity levels, particularly for women. Again, this is mediated very much by the policy environment. At this level, you might think about how access to credit markets and different institutional arrangements really affect whether or not, for example, more labor force participation by women does translate into a greater savings.

Finally, we might think that there is a relationship to those very high-level variables and outcome of economic growth and poverty alleviation, and that might happen in one of two ways or both of two ways. One is adding up the micro-level changes. So, for example, if we think about savings, if you have more women participating in the labor force and they have fewer children and the credit markets are such that there is an encouragement for greater

savings, then the aggregation of those micro-level behaviors would be measurable potentially on a macro level.

There is also something else beyond the adding up, and that is what might be referred to as general equilibrium relationship or response, whereby if you have large-scale changes in the population size and structure and the associated labor market characteristics, savings characteristics and so forth, then you might have results that are not just adding up. So the easiest way to think about that, I think, is in terms of labor force participation.

If you have a large share of the adult women entering the labor market because they have control over their fertility and there is demand in the market, then those large-scale shifts in labor force entry may over the medium and long time have affects on the wage rate offered and much broader effects beyond the simple adding up of the individual's micro-level behavior, and I think David

Canning is going to get into this in the next session.

So I am hoping what you can take away from this is that there is a possible ladder of effects, or more rightly said, perhaps a web of effects between investments in reproductive health programs and those very high-level outcomes.

Many of those relationships are going to be very difficult to measure and to disentangle from other possible causes of, for example, economic growth. What the working group focused on a lot, as you will hear a bit later, is that sort of middle-level outcome of migration, changes in labor force participation, and improvements in women's status as the sort of level that we might want to focus a lot of attention on as key outcomes, thinking that it might be possible that from there, it would almost be stipulated that those changes would have a relationship to the long-term desired outcomes of economic growth and poverty reduction; that we wouldn't actually need to articulate the entire story all the way through using an empirical base.

So, hopefully, I have done more to clarify than to confuse, although looking at some faces, I am not sure I accomplished that.

Now I am going to turn it over to Alex Ezeh. I am going to turn over back to Nancy to introduce Alex.

MS. BIRDSALL: Alex is director of the African Population and Health Research Center in Nairobi and a member of the working group. So he can de-confuse us.

MR. EZEH: Thank you, Ruth.

I will try and share with you not like a discussion of the conceptual framework, but how I see it as being relevant to Sub-Saharan Africa, given that one of the principles that guided our work in the panel is a focus on Sub-Saharan Africa.

For those who have been staring at this and thinking what does it mean, if I am supposed to be meeting with a minister of finance and planning and trying to share with them why do you need to invest in family planning and reproductive health programs,

how can this type of model help us to understand the issue.

Before I go on, I want to underscore the fact that Sub-Saharan Africa is quite diverse, and I don't want you to presume that whatever I am going to say applies at all times to a given country or to all countries in the region. We do have differences across, and sometimes the differences within Sub-Saharan countries may be quite more diverse than the differences between Sub-Saharan and other regions of the world. So we need to bear that in mind as we look at these relationships.

As Ruth identified, there are two key areas in looking at this model where we see pathways of influence between investments in reproductive health and family planning programs and economic growth at the macro level on poverty alleviation.

If you look at the top, you have family planning and reproductive health. If you look at the bottom, you have economic growth and poverty alleviation. There are two ways you can trace those relationships.

The first is through its direct impact on fertility outcomes. You would be looking at the left side where you have the relationship being traced. The second would be to the right would be its effect on improving health, and that would be the arrows on the right.

Although the links between family planning and reproductive health and fertility outcomes--I am talking about the left side of this whole equation--in the population, it is well known. I think this knowledge appears to circulate more among experts in the population field in Sub-Saharan Africa.

The main challenge here is how to package and sell what is known about this linkage to inform policy decisions and resource allocation across various countries in the region. This is not a small challenge because the link between fertility outcomes on the one hand and migration and changing age structure on the other, which directly links to measurable economic levels, are often the lease perceptible, especially to policy-makers Sub-Saharan Africa, except for the effects of fertility outcomes

on increased education, which can occur to current generation of women and their children, which we see for generations.

All the other effects of fertility outcomes occur to future generations. I think this constitutes a major challenge. So, although the effects of fertility outcomes through migration and changing age structure constitutes some of the strongest demographic effects on economic growth, in the region where policy decisions are driven by the quest for short-term measurable results, conscious and deliberate efforts are needed to disseminate what is known regarding these linkages, especially with stakeholders outside the population field.

Such efforts will be effective to the extent that donors are willing to realize the demand for immediate results. Putting it differently, the commitments to funding reproductive health and family planning programs must live beyond Tony Blair's presidency of the European Union, his headship of the G7, indeed his positions as Prime Minister of Great Britain.

Because these outcomes are not things that we see immediately, you can demonstrate that because age structure has changed, this is the impact you are having. It is coming up in the next generation. We have some difficulty in trying to sell these relationships to policy-makers, particularly outside of the population field.

Regarding the link between investments and reproductive health and family planning on economic growth and poverty alleviation through improved health, I am looking at the right side of this framework. Although this appears obvious, it is not well known and demonstrated in Sub-Saharan Africa.

Apart from the links maternal mortality and infant and child mortality, very little is known on the other ways in which investments in reproductive health and family planning could lead to economic growth and poverty alleviation through its impact on improving health.

How much of the heavy disease burden in the region results from reproductive morbidities? What are the relative contributions of the investments in

reproductive health and family planning to overall well-being of our people compared to similar investments in other health sectors, such as infrastructure and communicable and noncommunicable diseases? There are so many questions that we can ask that are not yet explored around these areas.

Kenya announced last week that the Health and Education Ministries will receive a 300-percent increase in budget allocation next year, but how much of this increase would go to reproductive health and family planning programs? Often, the marginalization of reproductive health and family planning programs within the health sector is more pervasive than the attention given to health in national budgets. Persuasive arguments need to be made within the health sector for greater attention to reproductive health and family planning programs, and this calls for research on the many linkages between investments and reproductive health and improved health outside the maternal and child health areas, which I believe we should also not

ignore because they are often the most important in this area.

The panel's work placed priority on research that would be most likely to inform current policy questions about how to allocate scarce resources to achieve higher rates of economic growth and faster reduction of poverty.

For such research to achieve this nobel goal in Sub-Saharan Africa, we must take conscious steps to involve African scholars and African institutions in the generation of such evidence.

Three weeks ago, I had the pleasure of working with Dr. Muga, who is here, on a 3-year project that we have been working together in partnership within, and through that particular project, we were able to have a meeting with members of parliament in Kenya where we presented results coming out of these years of partnership.

That particular result showed three key factors: one, that reproductive health indicators in Kenya are worsening, and they are worsening at the same time that investments in this area has

declined, both from the donor community and from the government; that the poor are more than three times as likely to be affected by these worsening indicators compared to the rich, and this was evident in terms of the level as being maybe there times or more higher than that of the rich, their level for family planning as being much higher, and actually use of contraception being at least one-third of what you get for the rich.

Often the poor are particularly most vulnerable with respect to all of these various indicators in terms of child and infant mortality rates, with some children having almost 20-percent higher rates of infant mortality and 40-percent higher rates of child mortality than even children in rural Kenya.

This half-day workshop led members of parliament in setting a parliamentary committee on population and reproductive health, and the director of Medical Services in the Ministry of Health in Kenya pledged a direct budget line for reproductive

health in next year's budget for the Ministry of Health.

Dr. Muga is here, and I think his organization is now charged with working with this new committee of the parliament. A lot of this type of credible research can be done outside of Sub-Saharan Africa. The impact on national policies would have been much limited. Notwithstanding the relative difficulties we may have with funding African institutions in the past, I think it is important to underscore the fact that in order to facilitate the transition of research into policy and practice, we need to make a conscious efforts on decisions to involve them.

I am looking at African scholars within Africa who have greater opportunities to interact with these policy-makers at various levels.

I think the results of this partnership with Dr. Muga's National Coordination Agency for Population and Development in Kenya and the Global Equity Alliance led me to suggest that in looking to fund research on these vitally important issues, we

should recognize that increased investments in reproductive health and family planning programs does not necessarily mean that such programs will reach the poor who need it the most.

Therefore, attention should equally be paid in the Sub-Saharan setting to identify better and more efficient ways of targeting or reaching the poor with interventions linked to poverty alleviation. Currently, my organization, African Population and Health Research Center, is working with the Ministry of Health to look at how best to target the poor with respect to health services at the district hospital level, and we believe that similar work is needed across Sub-Saharan Africa on how best we can target reproductive health programs and family planning programs to reach the poor throughout the region.

Finally, many Africans and African countries remain in poverty due to a number of other factors outside of reproductive health and family planning and the health center in generale. Chief among these are corruption and bad governance, which

some of pointed to here. Unfavorable investment environment leading to much capital flight from the region weaken an institutional capacity for research, resulting and contributing to the trade policies that exist in some of the developed countries. I think these factors often constrain economic growth in our setting, therefore weakening our ability to really positively demonstrate the links between investments in family planning and reproductive health and macro- and micro-economic outcomes.

I think we really need to be able to say how do we accommodate these other externalities in this type of work because, at the end of the day, whether we are able to make the point and persuade people to see these linkages will be affected by the other factors that constrain these relationships within our setting.

Thank you.

MS. BIRDSALL: Alex has a copy of his presentation. We can make copies. So we will make

those available. Maybe we will put them somewhere where you can find them.

The floor is now open, and I already see some name tags going up. That is good.

Let me start the discussion. There are two questions on the agenda. We don't have to be confined to those, but let me read them: Can research from other settings shed light on questions in Sub-Saharan Africa, and what are the central concerns about the translation of research? Alex's comments went especially I think to that second question.

I must say, thinking about the earlier remarks and discussions this morning and what Alex said, that I feel as though we are at a kind of crossroads, combining a situation in which the donors, particularly DFID, but not only, are more and more looking to have ownership of decisions about allocation of budgets take place within African governments, and at the same time, we are hearing from Alex how important it is, consistent with that, to be working with African researchers,

African data, I would say, and somehow translating the findings from evidence into something that not only policy-makers can understand, but the people in Africa can understand as their governments become hopefully more and more open, more built on accountability in a democratic sense.

So I think this is very different from the discussion maybe not 10 years ago, but 20 or 30 years ago, which was much more donor-centered. It still is donor-centered. Obviously, there still are issues, but I would hope that this working group can be part of reinforcing a new direction.

Maybe we will just start around this way. I didn't notice the sequencing of the tags going up, but let's start with Cynthia.

MS. LLOYD: Thanks.

I am also a member of the working group, and I just wanted to maybe add a footnote to Ruth's introduction to the conceptual framework because I think that, as you can see, the task we had at hand was extraordinarily complex, and in fact, so complex that there may be actually another dimension that is

implicit, but we couldn't do a three-dimensional diagram. I would just put it on the table, and I am sure we will keep coming back to it during the day.

The phase of a life cycle at which these investments are made, whether the services are provided to young people who are still attending school or whether they are provided to older young women or adults for whom schooling is no longer a possibility, may have a huge impact on the way in which these chains of causation spill out. In fact, we may even potentially conceptualize a line which isn't yet in the chart, which goes directly from family planning, reproductive health, investments to increased schooling.

While we recognize in the conceptual framework that there is a possibility of impacts at the first generation and the second generation, we also have to recognize the fact that for that first generation that receives the impact, the way in which that is going to play out over time is going to be for family influence at what phase of the life cycle that young woman has the first opportunity to

encounter these services and what form they may take and the sense of whether they are going to be focused on a single dimension, whether they are going to be packaged in a more sort of holistic framework.

MS. BIRDSALL: Thank you, Cynthia. You were almost too subtle. You didn't use the word "adolescence," but I think that is part of what is behind your point, a very important one.

MS. LLOYD: Yes.

MS. BIRDSALL: Barfour.

MR. OSEI: I am looking again at the conceptual framework and focussing on the issue of policy. I think for purposes of research in terms of building up what is missing, we should be looking at how micro and small enterprises, for example, lead to decrease in education of young children in Africa, rather than an increase, and how these same enterprises lead to an increase in child labor, a declining child labor as we have in the conceptual framework.

Again, if we go around Sub-Saharan Africa, we see the same small and micro enterprises in a way leading to a decrease in women's status in Sub-Saharan Africa. So, in trying to build up evidence of what actually is missing, we need to look at these for purposes of policy.

Thank you.

MS. BIRDSALL: Thank you very much.

Alaka.

MS. BASU: Nancy mentioned the public and that is, in fact, the point I was wanting to make. The public discourse is as important I think as the public policy and the bureaucratic one.

I know we are the working group on how one can legitimize investments in reproductive health and family planning by showing there are economic benefits, but there is also the side of legitimizing these investments by showing how important, therefore, directed gut-level outcomes of some kind, numbers of death, numbers of vaccinations.

MS. BIRDSALL: Well-being, in the broader sense.

MS. BASU: So the different idea that maybe people want to see results is not such a bad idea. To appeal to these arguments at an emotional level or at a gut level in addition to economic arguments about the value for economic growth, et cetera, might be one way of strategically raising public awareness, which in turn exerts political pressure that might be more effective than these complicated relationships which are, in fact, very difficult to demonstrate. So it was the public I was wanting to bring up.

MS. BIRDSALL: Thank you.

Yes.

MR. : Just a comment about the framework as well, it is a beautiful one. It would be even more beautiful if it came with a lot of tape with Ruth's comment on it, so that we would know how to read it. There is a lot to digest here, and Cynthia said we didn't have a three-dimensional framework where you can capture this, but we have a two-dimensional space here, and I think this could

be used more effectively to convey two of the main principles that drove the work of the group.

One is the macro/micro linkage because intuitively, when you think about a connection between macro and micro, you think top down essentially, and you can organize some of the material along that dimension. Also, when you are talking about sort of inter-generational transmission, it is, more or less, left to right, and you can also organize the chart in ways that move up to down and left to right in ways that would convey the sense of how things move both from the macro to the micro. Over time, I think in a way that is visually more explicit. This is more or less for the presenters.

Now, for the substance, there is a big omissions here, and I am not sure why. I don't have anything about family structure and marriage and how all this reproductive health affects the family structure.

That is all.

MS. BIRDSALL: Thank you.

Tom.

MR. MERRICK: As an observer, I wanted to pick up on Alex's point about morbidities. For what they are worth, the burden of disease data for Africa suggests that about 75 percent of the burden of disease for women in reproductive ages is actually the morbidity rather than the mortality component.

I think the number now that we have on maternal deaths is that for every death, there are approximately 20--is it, France?--morbidities associated with poorly managed obstetric emergencies. We also have the data, however good they are, about the health consequences of early child bearing, which some of that comes out in the Growing Up Global chapter on early child bearing.

It points to two gaps. One is the measurement of the morbidities themselves and an even greater gap on the consequences of the morbidities. I was trying to find the arrow in the conceptual framework that would somehow capture it, and I am not sure I found it. Some of the red

arrows might go around to it. Anyway, it might be worth a thought.

Responding to Nancy's question about what might we get from other regions, the GEZUS [ph] study, which was conducted, I guess, from the mid '80s to the early '90s in Egypt provides some excellent approaches, although money-expensive approaches to measurement of morbidities, but even they ran out of money before they could really document the consequences.

MS. BIRDSALL: Can you just say another word about that for the group, how long it was, if it was paneled?

MR. MERRICK: It went on for several years. It was the Population Council. Who else, Cynthia, was involved in that? The center in Cairo, the center in Beirut, Hoda Rashad and Huda Zurayk were the co-team leaders. They just published the final book on that. It is the American University Cairo Press which, believe it or not, has an outlet here in Washington.

I then contacted the authors and said what about the consequences, and the answer was they ran out of money before they could really chase the consequences down.

MS. BIRDSALL: Basically, what was it? I don't know if everybody else knows.

MR. MERRICK: Well, for example, they found that morbidities associated with deliveries, prolapse, and other consequences of poorly managed obstetric complications were viewed as being, more or less, a fact that goes with being a women. Actually, it severely affected the quality of there lives, but it did not go on to look at how it affected productivity, some on social status and stigma, but by and large, the whole well-being dimension is not measured or not tracked.

MS. BIRDSALL: Thank you very much, Tom.

Margaret.

MS. KAKANDE: Thank you, Chairperson.

I just wanted to make a comment in terms of maybe focus for policy research when you look at all the framework.

For example, if you look at most of our countries that are coming up with Paris Peace, the concern is how do you reduce poverty, and people are talking about proper growth, whereby most of us are focusing on, for example, issues of employment, how do you ensure that people are employed.

So, when I look at this framework, my entry point would be basically on the box of labor force participation, whereby a number of policy-makers would be willing to listen first. If you give it what it is, the linkages, for example, between population dynamics and labor force participation, then it would click and then it would link to what we are trying to do in terms of creating an environment for growth.

So, in that case, what is it that links to the population dynamics, and also maybe only to play devil's advocate in terms of looking at this framework and taking into consideration a number of our countries, for example, mine, where a number of politicians don't want to listen to fertility decline, I was looking at the other part of the

framework. You can talk about reproductive health without mentioning the issue that you are going to have a fertility decline. To me, that question then would be what are the investments, for example, that would surely lead to improved health and lead to all of this improvement status.

In the end, if you look at the other side of the framework without necessarily looking at decline in fertility, which we won't have, for example, in my next country for the next 20 years, still you can achieve growth and poverty reduction.

So, in this case, can we repackage for some of our countries who may actually lose out by just looking at when you say fertility decline, and they close their ears, so where can we focus in terms of conceptualizing the research, whereby we are talking about the same thing with having the same outcome. The focus should be what are those types of investments, for example, in reproductive health. There are so many types where you can invest, but what is it that people should really be investing in, in terms of ensuring that we have improved

health? For me, that question would also be what levels of investments at a minimum in those levels?

For example, in Uganda, we are already having a debate in terms of what is the threat in terms of investing in social sectors vis-a-vis productive sectors. We are having that debate in light of the debt burden. If you put so much money in the social sectors, how do you pay back your debts? So we are debating already should we really put more money in the productive sectors, much as we should invest in our people for development. Those are key policy issues that we are trying to answer at this point in time.

MS. BIRDSALL: That was so good that I am going to try to repeat it with four points for our working group.

The first point was the employment worries of policy-makers, and actually, I would like you to say a word about whether that is mostly about numbers or mostly about skills, whether policy-makers are concerned about the problem of many people entering the labor market without the skills

that would make their economy competitive in a global system.

The second point was which investments are most effective and cost effective, and what level of investment is the minimum, I think you said, perhaps to get the system going.

A third question was who loses with growth without poverty reduction. So that has to do with the shared growth issue that came up last night with John and Jean-Louis today.

Then I put down something that is related to all of your questions, I think, Margaret, which is, is there a trade-off between short-term investments that improve people's well-being, the kinds of things that Alaka in part was referring to where you can get a public discourse going versus investments that may not have as rapid and dramatic short-term benefit--this is also what Hans-Martin was talking about--but ultimately may be more cost effective in terms of people who benefit.

So, if you would just say quickly on the skill-versus-numbers worry of policy-makers, I would be grateful.

MS. KAKANDE: In terms of employment, I think we are concerned about both. We are concerned about the numbers because, when you have a lot of people who are unemployed, it is an issue, but we are also looking at the skills because, if you are not competitive, you don't really have productive employment for poverty reduction. If you have people who are already employed, but they are almost getting nothing because of their skills, that is one issue. So we are looking at both numbers.

MS. BIRDSALL: Very good. Thank you very much.

Is it Scott who is next?

MR. RADLOFF: Thanks.

I just wanted to make a few comments, Nancy, about your overview, which I thought was very good, on why the fertility transition and demographic transition may unfold differently for Africa.

I think your last point was on HIV/AIDS. I think there are actually two parts to that, and one is maybe the obvious one that the HIV epidemic will impact on mortality and fertility outcomes in the region, but the second part of that is the resources that are being devoted to HIV/AIDS in Africa from the U.S. Government, other donors, the Global Fund. The resources are quite substantial.

A worry that we have in the family planning productive arena is how do you maintain attention on family planning reproductive health in the context of these growing resources being devoted to the HIV/AIDS response, how do you capture the policy-makers' attention, keeping family planning and reproductive health on the radar screen, particularly when HIV/AIDS programs are often implemented on a fairly vertical level.

We have been shifting resources towards Africa for family planning and reproductive health in AID, but the growth in the resources for HIV/AIDS in some countries, just from the U.S. contribution, may be 10 or more times that in a given country.

So there are political dimensions to it. As Steve said, you need to have the political will in country to make family planning services more available, but then it translates down to the health systems level as well, as resources are being focused on HIV/AIDS and given the human capacity limitations in Africa, will there be attention given to family planning in that context.

MS. BIRDSALL: Thank you very much.

Andrew.

MR. WARNER: Thank you, Nancy.

Just a comment to underline Margaret's first point. The question is whether these interventions are--although valuable, necessary think we can agree--they sufficient to achieve the outcome.

A couple of weeks ago, I was in Senegal. Maybe 1.8 percent of the population is working in jobs that people would consider sort of normal private-sector jobs, a couple more percentage points working for the government. There is probably some over-employment there. Many people--[audio break].

[Side B of Audiotape 2 of 6 begins.]

MR. WARNER: [In progress]--seasonal employment, many people in sort of part-time household employment.

It is arguable that many of the economies we are talking about are severely underemployed economies. So the box here just sort of assumes that the labor force participation will happen, and I think it is an important assumption we have to deal with when you think about economic benefits and improved health.

MS. BIRDSALL: Thank you very much.

Paul Schultz.

MR. SCHULTZ: As a member of the working group and speaking only as an individual, I did want to at least say that the construction of the figure is a rather last stage of our evolution and not something that we put a great deal of emphasis on, but I think it forced us to conceptualize slightly differently than many other groups have. We felt from the top to the bottom that there should be

implicitly a large number of interconnections that would be nice to understand.

One of the main messages of our discussions, I should say, was that there were intermediate stages that theoretically and empirically we could not document at any time in the near-time future given our theoretical knowledge and our data.

Rather, what we thought could be done was to link from the top, the policy levers, to the outcomes of interest, to the development community, which is women's productivity, women's labor supply, women's involvement in production. I do think that women can be involved in the informal sector, just as well as the formal sector. We must not limit our view to production engagement as just those activities taking place in the formal market, but to see the savings and human capital formation and labor supply as the outcomes we could measure. These are our traditional inputs for macro modeling of modern growth in poverty reduction, which is

where most economists from the macro side can enter in and see the logic of the payoff.

We have many views on these intermediate levels, but how easily one can put them together and whether one diagram is to capture them realistically, I think there would be differences in the group and more or less optimism about what it conveys that is really new or interesting for this group to debate, the idea that intermediate links don't have to always be filled in.

If we knew the lever policy intervention, particularly, of course, if it is randomized in its application to a set of outcomes of labor supply and productivity, we have made our case. We should be making our case to the broader community at that level. We can do it in relatively short-term research done today.

MS. BIRDSALL: I think that is very helpful as a reminder.

My sense is that, in addition, the working group also explored in a somewhat different way the issue, which I am hearing policy-makers ask for,

what combinations of inputs are ideal in a sense of being cost effective. There, what is looked at as to whether it is cost effective or not is those intermediate outcomes, which in our first category of work, as you are saying, Paul, are hard to model in terms of causal relations.

I think it is also true that we are saying that it is possible to look at those outcomes in the context of the relative cost effectiveness of alternative program interventions, and it is from there that we went to the issues of evaluation, impact evaluation and so on.

I am just saying that. I may not have it quite right. So, as a working group, we keep both of those issues on the table to get reactions from our policy people on both questions.

Steve. I should be looking at people, not name tags.

MR. SINDING: There are some people you would know without name tags and some you don't.

MS. BIRDSALL: Right.

MR. SINDING: I am speaking as a policy advocate, of course, and from that perspective, I was disappointed when I read the paper because it seemed to me that we were somewhat further ahead on the relationship between the independent variables and the intermediate variables and more particularly between the intermediate variables and the large outcome variables 5 years ago, when we did our book together, Nancy, than this model implies. So something is wrong. Either we went beyond the data in that book or the research community has become more cautious than I thought we were 5 years ago.

I really would like to hear the working group explain that discrepancy because, as a policy advocate, I find a statement that says, "Attempting to estimate in quantitative terms the link from reproductive health or health services to larger economic phenomena, GDP per capita, for example, is likely to be a bridge too far," a very disappointing and frustrating conclusion, although I understand it and I understand why people engaged in this research are cautious in what they are willing to say.

What really is disappointing about the document is its failure to address the micro/macro linkages, its failure to say what are these intermediate outcomes in terms of family well-being, and how can we link those to broader economic performance, whether that economic performance is measured in terms of poverty reduction or in terms of growth.

The reason I stress this is because I continue to worry that in the terms that Scott put it, our sector is rapidly losing ground in the competition for scarce resources in the resource allocation game, and I think the reason that is happening is that we are failing to make the compelling case for this set of investments. We are failing to do it in an environment in which policy-makers are still focused on macro outcomes.

It is the competition between things that governments feel they must do, things that governments feel they cannot afford to ignore, and those things that are just nice things to do. I am afraid that the intermediate-level variables, as

committed as we are to them, are nice things to do when it comes to competition for scarce resources at the ministry of finance level.

So I really would like the team, the working group, to help me understand why they are so cautious with respect to the linkage between these intermediate-level outcomes and the economy-level outcomes.

MS. BIRDSALL: Okay. This is maybe a bad time to say that we are supposed to stop for coffee. We are supposed to now stop for coffee. So, if you have your name tag up, then you get to say something quickly, perhaps making a deposit on saying more later. If you don't have your name tag up, please don't put it up until after coffee.

So we will go with Jackie next, but let's be as brief as possible. We can come back to these very large issues.

DR. DARROCH: As brief as possible, I think it is important to address the criteria that we think are appropriate for advocacy and policy decisions in this area versus others and what are

the criteria that others are using, and we have a standard that is too high or too cautious is worth talking about.

I want to challenge us to ask whether the question I think that this paper and the model, et cetera, is addressing is the appropriate question. To some extent, I would characterize this as what are the benefits for investing in sexual reproductive health and family planning when I think the more crucial question, one is the comparative versus others, but I think the other is not what is the benefit from it, but what can we not achieve if we don't do it, which I think is much more what we need to be focusing on in terms of making arguments to policy-makers.

The last area that I want to talk about is the very beginning here of the box that says family planning/reproductive health and you characterize it, Nancy, as standing for investments in reproductive health. Sarah will be very familiar with this, but it is my real concern that if we don't unpack what is in there and specifically pay

attention to what is the demand side versus what is the supply side that we raise expectations inappropriately of what we can achieve with frankly very little. If we just had the commodities problems fixed, it would all work without thinking about the delivery, and especially in Sub-Saharan Africa with very high levels of desired fertility, and as we saw in some areas, political support and pressure toward high fertility, I think we need to think about what we really mean in the investments in reproductive health area.

MS. BIRDSALL: Thank you. Very good.

Who is next? John.

MR. : I am sure we will come to these issues at a later time.

I guess my point is whether it would be valid to try to include anything here as well. Appreciating is very much kind of a two-way process.

On perhaps the impact on ideational change and behavior that reproductive health encapsulates by the term "reproductive rights" brings about in terms of helping also to establish kind of new

norms, a standard related to the ability of people to control their own sort of reproductive destiny, and the impact that has on expectation and social transformation in a way that is methodologically must be a bit of a nightmare, but nevertheless plays out in these various parts of the framework in some way or another.

MS. BIRDSALL: Right. That goes back to some of the leadership issues that came up earlier.

Jean-Marc.

MR. CHATAIGNER: I will be as brief as possible.

I think that the point made by Jacqueline was very good to say what will happen if we are doing nothing. I think it could be also a way to explore.

Jean-Louis spoke about environment. I think we have to speak about peace and security, also, because if we are doing nothing, in fact, there are big issues of security. There is a big issue of poverty. Many issues are linked to the fact that if we are doing nothing, what will happen,

and I think you can convince so many policy-makers with the definition of negative impact, that it will happen in this case.

I really think that we have to draw resources from outside Sub-Saharan Africa, and that we have to first employ some historians or some demographic people to explore the reasons for the Chinese policy or the Tunisian policy in the years, '60s, '70s, and '80s, why are these governments at this time convinced to put in place really a policy that changed tremendously the pattern or the demographic trend.

I think that you have to explore that issue because the issue is also an issue of policy will, and as you have said, Jotham, an issue to convince really policy decision-makers like presidents.

MS. BIRDSALL: Right. It is the ideational change, and that is the connection. John looked a little puzzled when I referred to leadership.

Finally, Stan.

MR. BERNSTEIN: I would just like to pick up on a thread that actually has woven through

several people's comments that I think points to a missing element in this.

There is another outcome besides what is happening with regard to overall macroeconomic growth and even individual well-being that I think might be worthy of some attention, and that is what is the impact of different priorities for investments in different kinds of health activities for the strengthening of health systems, both in terms of their coverage and their responsiveness. I think that is an element where there might be a case to be made that higher priority on some public health concerns on family health issues and some reproductive health issues might have more relevance to strengthening health systems.

I know it is a complicated question because it is not just what you invest in, but also how you finance it and what accountability systems there are. I would suggest that one of the outcomes that also gives a little more life to some of these macro/micro, sort of a meso-issue that is in here that I think is worthy of attention are the

implications of different investments on health systems strengthening.

We have heard comments about vertical pipelines and their adverse effects on health systems. There are a whole lot of threads and comments so far that indicate that people are aware of these issues, but I don't think we have thought them through formally yet.

MS. BIRDSALL: I was supposed to sum up, but I wouldn't dare to do that. Maybe later I will try. Why don't we have coffee now and then return. Thank you all very much. Ten minutes only, please.

[Side A of Audiotape 3 of 6 begins.]

Session 3: Macro-Level Economic Policy Decisions

MS. BIRDSALL: I would like to welcome Peter Heller who has just joined us. Peter is an important person at the IMF. I don't know his exact title, but I know he is an important person at the IMF.

MR. HELLER: That is actually my title.

[Laughter.]

MS. BIRDSALL: He has spent many years actually in the fiscal department, and he is one of the rare people in the IMF who has focused for much of his recent work in terms of being an economist on health issues and the health sector. Peter is going to chair the next session.

Peter, thank you very much for joining us.

MR. HELLER: My pleasure.

I just raced here from giving a talk to Swedish parliamentarians about the long-term fiscal challenges that confront the Swedes, and here I am now talking about something which is probably just more important actually.

David Canning. I am sure this will be very interesting. For those of you who are not sitting where I am sitting and don't have the privilege of looking next door at the way in which David has sort of jotted out ideas, you have no idea what you can expect.

David is someone I have known a long time. He is a professor at the Harvard School of Public Health in Economics and International Health, a

Ph.D. from Cambridge University, has held faculty positions in the London School of Economics, Cambridge University, Columbia University, Queens University-Belfast. It says here he has carried out extensive research on the impact of health improvements and demographic change in macroeconomic performance, but I have known David more since our mutual work together on the Commission on Macroeconomics and Health where I heard him on a number of occasions and also heard his collaborator often, David Bloom. They have some very interesting and some very provocative views on the implications of demography and demographic developments, demographic transition for growth and development process.

It will be challenging to sort of hear what you have to say and to kind of reflect on its relevance to what we are doing today. So let me just turn it over to David.

MR. CANNING: Thank you, Peter.

I am going to talk about a number of issues and I hope try to answer some of the questions that were coming up this morning.

The first thing I would like to say is that there is a distinction between welfare improvement and economic growth and poverty reduction. The focus on economic growth and poverty reduction is a different focus than a pure welfare focus, but I quite like economic growth and poverty reduction on the grounds that if you are a finance minister and someone comes and asks you for money to improve welfare, you would be open to that, but if someone talks about economic growth and poverty reduction, that means a bigger pie in the future. That means not only giving money for someone today, but easing your constraint tomorrow. So I think the focus on economic growth and poverty reduction is well founded.

I want to talk, first of all, about the macro and to talk a bit about the macro/micro links. One thing I was disappointed in, in the draft report, is there is a statement in there that in the

past there has been a strong finding of no link between fertility reduction and economic growth. That is actually completely false. That is a false statement, but it actually is a mind-set. It is actually very revealing that in this sort of document, that would be stated.

What is available in the past literature is a finding of no link between population growth and economic growth. That is sometimes bureaucratic code-speak for wrong. I am not quite sure if that was Peter's view, but I feel very strongly on this point.

The policy consequences that have come from that have been completely wrong, and the reason is that population growth is made up of two components. The two components are fertility and mortality. There is also migration, which we will get to in a little bit.

I think what we are finding today is that fertility effects and mortality effects have very different consequences on the economy. In particular, reducing population growth through

fertility reduction and through causing more deaths among adults are very different things.

One of the big advances academically over the last 5 to 10 years has been decomposing population growth into fertility and mortality in thinking about, for example, health effects separately.

I think whenever you do economic growth models with fertility--and fertility has a huge effect--global fertility appears to be very good for economies, but also low mortality tends to be very good for economies. So the new link between population growth and economic growth in a sense is correct, but because it is confusing mortality reduction and fertility reduction.

I think the evidence that fertility reduction and consequence changes in age structure have large effects on economic growth and poverty reduction is incredibly strong.

If we turn to the diagram that we had, I was actually involved. I think I was sitting in the room when this diagram was drawn. So it behooves me

now to raise some criticism of it, but I shall do it.

I think this diagram misses a point. I think the lowest number of links in this diagram between family planning and reproductive health and economic growth and poverty alleviation is three links. So a break in one of those chains could undermine these effects. I actually think there is a much more direct link.

I would draw a red arrow from fertility decline, delayed fertility to age structure. A reduction in fertility has an immediate effect on age structure and dependency ratios. A change in age structure then has a direct effect on economic growth.

The reason is even if there is no behavioral change, if everyone keeps doing exactly what they are doing, having one less child will raise income per capita. It will also reduce poverty as conventionally measured in terms of expenditure or income in per capita terms at the household level.

So we have a direct link between fertility decline, age structure effects, economic growth, and poverty alleviation. I think there is a big question mark here which comes from the fact that this raises a concern that economic growth and poverty alleviation and poverty as conventionally measured are not welfare effects.

If you can increase economic growth by lowering the number of capitas by having fewer children, a lower dependency ratio, it is not clear that you are better off. So I think that this highlights the fact that when you think about economic growth, you are not thinking about welfare, but to the extent that we are concerned with economic growth and poverty alleviation, we have this direct mechanism.

Sometimes I will refer to this as the accounting effect, and what we have in this diagram are mainly the behavioral effects. The accounting effect is enormous.

We did some work about 5 years ago on India and China meeting the poverty target of having

poverty by 2015. Everyone now expects them to meet their target because they are having high rates of economic growth. Our work showed that they would meet their target purely through their fertility reduction. There has been high fertility reduction in both China and India. The consequent changes in age structure of the population, even if income per worker stayed the same, they would meet their poverty reduction targets. So I think that there is this direct effect.

We can then get into a more detailed debate about whether this is a welfare effect, but certainly, if you are interested in economic growth and poverty alleviation as conventionally measured, I have very little doubt of a direct effect.

The second route, separate from fertility, is the route through health and reproductive health on economic growth. Again, looking at the diagram, the only red arrow from improved health is through improved women's status.

I would have a more direct arrow which runs from improved health to improved productivity and increased labor force participation of women.

MS. : There is. Improved health is there to the left.

MS. : Anyway, there should be.

MR. CANNING: Okay. Well, the improved productivity I think is in a red arrow. I think one of the suggestions on this diagram is to separate out the short-term effects, which are the red arrows, and the long-term effects into two separate diagrams.

Looking at this arrow, if I was looking for the short-term effects, there don't seem to be many red arrows that go all the way from the start to the end, and I think one of the questions is policy-makers may be looking for those red arrows because of their "short-termism."

If we think about income growth and poverty alleviation particularly in Africa, I think there is a real issue of a poverty trap. We essentially have two sets of countries, those that are mired in a

poverty trap and those that have gotten out of it and are undergoing rapid economic growth.

In the case of rapid economic growth, I think almost all policies work, and we can see their effects. In the case of a poverty trap country, the marginal effect of any one policy may be zero. When people are poor, there are usually multiple sources of deprivation, and so what you need is a package of policies. An argument that one thing in particular is what will solve the problem is almost certainly wrong.

I think a problem for academics is that academic research tends to focus on one thing at a time. We like to isolate effects. It is very clear if you are in a poverty trap Sub-Saharan country, you want a package of things to get you out. We have very little information about what the right packages are.

One thing we find very strongly on macro evidence is even the accounting effect seems very conditional on the environment. We find in countries which are measured to have good policy in

institutions, there are very large effects of age structure change, essentially what you would expect from accounting; in fact, a bit larger than you would expect from the accounting, which I think is some of these behavioral arrows that we see in the diagram, particularly things like increased female labor market participation when fertility rates decline.

However, in countries that have the worst institutions, governance, and policies, we estimate a zero effect of the demographic dividend. So it is quite possible that there will be no effect at all, which I think reinforces the point several people made about the effect that supply-side improvements, having more workers, having more people who potentially will save, having more people who want to be educated, it may not work unless the demand side of the economy is functioning. So the two things have to go hand in hand.

I think you will only see the benefits of these sort of supply-side policies if the economic side of the economy in the sense of aggregate

demand, institutions open to trade, and these sorts of issues have been dealt with.

Looking at the behavioral consequences, I think the major one I just mentioned is labor supply, particularly female labor supply. That one, I think is potentially a very large effect.

The second one is education.

One that hasn't been mentioned very much is the potential for savings, which I think is quite important.

One that has been mentioned marginally, but I think is potentially very important is migration. One of the reasons I would emphasize this is if you look at the developed countries, there is a huge issue of population aging. My own feeling is that there is going to be an increased demand for workers in the developed countries, and there is going to be an increased potential for international migration.

International migration is, in my mind, a form of human capital. Migrants tend to be more highly skilled than average. It also requires some

investment to migrate, but the returns are potentially enormous.

In many developing countries, we are in a state now where the remittances of the migrants exceed the foreign aid. So, potentially, this is a very large benefit, and I think a major issue facing the global economy is hard to productively manage migration so it benefits everyone. There are winners and losers to migration, and managing that I think is a real issue.

In terms of the evidence base, one of the big problems with the macroeconomic analysis is we essentially use timing to get a causality. So we look at changes in population age structure, changes in fertility and mortality, and look at how that traces out into the economy. I think there are always questions marks on this.

So I would be a very strong advocate of future research on the macroeconomic links. If we are seeing these large macroeconomic effects on income per capita and poverty reduction, we would also expect to see them at the household level. So

I think merging up and finding if the results are the same at the household and aggregate level is something that is really important.

One issue is macroeconomists have tended not to look at income per capita of the household as an outcome measure because it is not a welfare measure, but I would expect to see very strong effects with smaller numbers of children average income per capita roles in the household, which would get it above the poverty threshold, even though you might not think of this as a direct welfare measure.

One very big issue is the fact that at the aggregate level, we tend to focus on economic growth. We do have inequality data at the aggregate level which allows us to talk about poverty, but my own feeling is that the inequality measures are so poor, it is very dangerous to draw conclusions about what is happening to poverty from macro data. So I think if you focus on poverty rather than growth, you really want to look at individual countries' macroeconomic data.

Here, an instructive case is India where it is undergoing rapid economic growth, but there appears to be a bimodal distribution of income opening up. So you have a large group of poor people and a smaller concentrated group of rich people emerging. So you are having economic growth, but it may not be closely linked to poverty reduction in the short run.

One issue here on fertility is if you look at Latin America, there is some evidence of a bimodal distribution in many Latin American countries in terms of income, and this is actually linked to a bimodal distribution of fertility. So you actually have the emergency essentially of two separate economies, rich and poor, with differences in income and in fertility. So the poverty trap I think can exist within countries as well as between countries. So it is not just a matter of getting a country out of the poverty trap.

Another issue which macroeconomics is not really designed to cope with is the difference between desired fertility and unwanted fertility. I

think this comes back to the issue of what we can actually do.

Your family planning programs can have very large effects in countries where there is unwanted fertility. However, in much of Sub-Saharan Africa, desired fertility is still very high. So it is unclear that family planning programs will have a big fertility effect.

My own view is that the family planning programs can be a very large multiplier when development gets going. Once desired fertility falls, family planning programs allowing people to achieve that lowered desired fertility can have large economic consequences.

In countries where desired fertility is still high, it is unclear to me whether there is a policy role there for more information and for these issues like ideation or whether it is essentially that you have to reach a higher level of income before that will change.

This issue about what macro can and cannot show also refers to the beneficial effects of

reproductive health on health. I think macroeconomic evidence is pretty good on the link between health and economic growth, but to try to bring health into separate components, so different types of morbidity of mortality link each of those separately to economic growth, so a sort of macro role for reproductive health versus, say, malaria, HIV/AIDS or some other things is probably more than the data can bear. So I think the microeconomic links are probably more informative.

One issue, again, and I think I have said this already, but I think I am increasingly coming to realize that there is a gap between academic analysis and what policy-makers want. Part of that gap is that, as an academic, we like to look at single arrows on that chart that we have shown, and we like to understand individual arrows. We like to isolate effects. Whereas, policy-makers are much more interested in packages.

As an academic, I have been guilty of this. When someone says I want to look at a package, I say, "It is a badly designed study. We won't know

which part of the package is doing the work. Go away and rethink what you are doing," but when you think about policies, it is very unlikely someone is going to introduce one policy in a complete vacuum of everything else. Policies are always packages, and policy-makers probably aren't as concerned with exactly which part of the package is doing the work.

So we see this here in the concept of the health benefits of reproductive health versus the fertility decline benefits, and I think we saw it earlier in your talk about AIDS prevention. Academics like to focus on which exact element of AIDS prevention is doing the work. Whereas, I think if we look at successful countries, it is a package of interventions that worked. I think that is a gap between academic and policy.

In terms of the micro/macro gap, I think that there is a gap there. I think the solution to it is to measure the same things. Part of the gap at the moment is we are measuring different things. So looking at things like income per capita at the

micro level would be very informative for us to see if the same things are happening.

The other thing I would emphasize is looking at the measle level. I think particularly regional analysis of countries like India, China, and Nigeria or very large countries is potentially very interesting. The reasons is within those countries, you have some common policy framework, but very big regional differences, and looking at how family planning and fertility effects affect those regional economies I think can be very informative, particularly somewhere like India where you have very large differences between north and south India. That would get over this issue to some extent of essentially trying to look at effects across countries where lots of other things are changing.

In Sub-Saharan Africa, I think we do face a series of very particular differences, and so this issue of how much we can draw on research from other countries to apply to Sub-Saharan Africa is I think really an important one.

I think I will emphasize this point that has already been made that the nuclear family model does not apply very well to Sub-Saharan Africa. One issue is in many countries, for example, in South Africa, women and men typically shift partners several times in their twenties and thirties. So women may well have children by several different partners. In addition, there is a very large amount of fostering of children. The nuclear family base models that we use may not be that appropriate.

Okay. I will stop there and see if there are any questions.

MR. HELLER: There have to be. I think this is a very rich discussion, and I am sure there will be a lot of questions.

Let me just throw a few that I had sort of thinking about it on the board. I think you kind of made this point indirectly on the subject of migration. It is the fact that when one is looking at the economic effects, you have to kind of have a broader perspective than simply the effects on the national economy because you may stimulate greater

labor force, reducing fertility, strengthening health. It may lead to greater labor force participation of women. It may strengthen the capacity of women, and it may lead them to migrate. You need in some way or another to bring in their welfare or in the economy to which they have migrated rather than simply looking at what is going on in the economy per se.

I think if you actually add their product, you might say outside the national economy. You might have much greater effects than if you look on the inside, basically.

A second point that struck me, and this kind of runs through your whole discussion, is this issue of context which you raised, the kind of environment, the cultural context or whatever, and the way in which benefits are realized.

There are some ways in which you can see these channels working directly benefitting women, but there are other ways in which it may benefit the household, but it may not benefit women or children. It depends on who controls household income. So you

have to kind of disentangle the way in which the effects are felt, and some of them may be shared within the family, but some of them may not be because of the way in which household income is controlled.

The third point that struck me was the point that you made in situations of bimodal distributions. One wonders. You could see a lot of the positive effects coming from low fertility, but if the health effects and the demographic effects are principally realized in the low income strata of the population, you can imagine that what you will see is really not much economic effects, but a lot of growing pressures, dis-equilibrating pressures, tensions building up because you have got increased labor supply or healthier people and not finding jobs, so to speak, among the lower strata. That has to break through in some way, whether it breaks through by migration or whether it breaks through with some kind of change in the equilibrium within the economy where these poverty traps within the countries become unsustainable. I don't know, but

you might miss it if you just focus on the aggregate economy initially. It may take time before the effects are realized.

The other thing which sort of struck me in your talk was it really was very much focused on fertility reduction more than issues of mortality, and certainly, in the Sub-Saharan Africa case, particularly the high AIDS prevalence countries--and you kind of alluded to this at the end when you talked about the nuclear family--the effects of improving health and the way in which this plays out within the household, within the economy is very, very complicated in these very kind of crazy worlds of Sub-Saharan Africa where women are sort of HIV-positive or where their husbands die and they sort of end up being shunted from their husband to their uncles or their brothers-in-law or whatever. One would imagine that there are a lot of very complicated ways in which all of this plays out, which is just not captured, as you say, in the nuclear family world or in the traditional way of analysis.

So let me just put those on the table. Let me start with John, who I immediately see, and then Nancy.

MR. : A comment on the distinction between wanted and unwanted fertility, which is a crucial dimension particularly in Africa. You are absolutely right that wanted fertility is higher in Africa than any other region of the world, but for family planning programs, it is not just that they want to prevent unwanted child, which occurs after the desired family scientists reach, it is also unplanned fertility. This is where there is a huge demand in Africa.

In fact, if you look at measures of unmet need for contraception, they are larger in Sub-Saharan Africa than almost anywhere else, and the reason for that is that conventional birth-spacing practices are disappearing, abstinence, and breast feeding. Women want long birth intervals. Short birth intervals are bad for their health and for their children and for their families. So I think

this is a particular opportunity for family planning programs.

MR. HELLER: Nancy.

MS. BIRDSALL: I think that was great, David, and you took us a long way to addressing some of what seemed like a difference between what Steve was saying and what Paul was saying.

I would just like to go through two questions that you helped me frame and give provisional answers in part to get reactions from our policy colleagues.

One question that we have had is why isn't there more interest in reproductive health/family planning interventions. Thinking about what you said and what we have been talking about, I put down three reasons. Each reason is associated with a different constituency.

On the side of the public, which Alaka mentioned, I think it is important that the demand for reproductive health and family planning services is not as implicit. It is not realized in the public discourse because women are voiceless in many

societies or certainly have less voice than they should have. They are peculiarly vulnerable. That may be more true in certain settings in Africa than it is elsewhere now. So there isn't any demand from the public that goes through the health and other ministries to the finance minister where we have the finance minister doing some allocation, and this is related in general to the fundamental point that men still run the world.

The second reason why there isn't more interest in reproductive health/family planning--I am using a little bit of provocative language, but to get people going--is that sex is scary, especially for the donors. The Pope doesn't like it, and the donors get worried. Some bilateral donors in particular have their own political reasons for being worried.

That makes it hard to get leadership within countries. It is one more barrier to the changes in norms that can be triggered by good leadership. That has not been the case with AIDS as it is with reproductive health and family planning because, as

Paul and I were discussing last night, you see the victims of AIDS. They call out to you, but the women who are the victims of failure to move on reproductive health and family planning are much harder to see. They are, in a way, invisible, as I was saying, under number-one reason.

Then, the third reason for why not more interest is this paradigmatic finance minister, poor fellow, usually a fellow, but increasingly women. The finance minister doesn't see the benefits in the short run, and it is perfectly reasonable in a sense. Governments do tend to be myopic, and it is the role of the finance minister in his or her own setting to be a little bit myopic, and second, this is a sector which has a history of being particularly difficult to run well.

Like education, health sector is one where when the finance minister sees the health minister coming, uh-oh, more hiring, more patronage, more leakage, more problems. We are talking about a difficult area, and I think we are asking what evidence of effectiveness in terms of poverty

alleviation, well-being, growth, productivity gains might make a difference in changing the hearts and minds of these different groups.

I am beginning to feel, but I just put this out as a thought, that the working group focused too much on the finance minister and the apolitical donor which is characterized especially by the World Bank. That is apolitical, less subject to the short-run winds of political movements. The World Bank is a little bit more the technical multilateral agency insulated a little bit, for example, from U.S. nervousness, the Mexico policy, and so on. So maybe we are focusing too much on the finance minister and not enough on the public, particularly in Africa.

I think what is good about what we had presented, linking back to what David Canning said, is the idea of looking at the effects of reproductive health and family planning on short-run economic benefits in terms of jobs, maybe labor force participation, and poverty alleviation in the accounting sense is a neglected area. As Paul

Schultz was characterizing it, it is a little bit of a reduced-form approach, not trying to understand how, whether it is because of better health or because of more education, all of these family relations, but just going straight to the question of whether you get more, faster, deeper poverty alleviation, more productivity gains, and so on. So that is a good thing.

David also brought out that we may be missing, going back and reemphasizing the macro point and the more direct linkages, because we do know from other regions how important they are, and I think we fear that those linkages in Africa are still at risk because fertility remains high. The fertility effect remains at risk because fertility is quite high still and is not falling very rapidly. The whole business about age structure changes in the other regions had to do with the levels and speed of fertility decline in sequence with prior mortality decline.

We just have now, from a demography point of view, a bit challenge to understand how those

issues will work out in demographic terms because they are going to be so different. The mortality decline is arrested. We now have this evidence that is not only true maybe because of AIDS in some countries, but the Uganda evidence of the slowing down of reductions or leveling off to some extent of reductions in infant mortality rates, maternal mortality problems, and so forth.

I am sorry to go on too long, but this package issue that David brought up is extremely important, and I think we need to go back and think about it more not for the finance minister, but for the public, the public discourse, because it is true. Women, if they have voice, they are going to be demanding the package, and we want them to demand the package.

We have some movements happening now that are actually undermining that because of the vertical programs, because of the very rapid uptake in resources for the AIDS problem, and so I think we want to think about evidence around this package question. It is there. It is in the working group

draft, all the issues of evaluation, but hearing what is going on today, I want to go back and think about this good point that David made.

As scientists, we always want to unbundle the interventions and try to understand the specific effects of a single intervention. Maybe what we need, as is actually said in the report, a lot more attention within countries where you have one policy environment, but different levels in terms of the package, one region that is not getting much education or much access to health care or much attention to reproductive health and AIDS and so on versus another, and then within these packages start looking at the question of whether we are losing a lot, to use Jackie's language. We are risking a lot by not having reproductive health and family planning included in the package more aggressively, given that we don't have the same immediate demands either from the finance minister or the women and their families who are poor or the donors. I think it is a big challenge.

Sorry to go so long, and I hope that helps.

MR. HELLER: Margaret?

MS. KAKANDE: Thank you, Chairperson.

Some of my issues have been covered by Nancy, but I just wanted to say maybe one thing which struck me when the presenter was making the presentation, the issue that most of the African countries actually still desire to have high fertility levels.

I was looking at our framework, and I was just asking myself is there a possibility of the research beginning before you have family planning because now you are assuming that the poor people want family planning, but supposing they don't. Like he is saying, if the poor still want many kids, can we have another lower level of research, first of all, to establish what it is that must be put in place to lower this desired of fertility in these countries? Then you come to planning and blah, blah, blah.

MR. HELLER: France.

MS. DONNAY: Thank you.

Two comments, and they may be somewhat more relevant for this afternoon's discussion, but I thought I would put them on the table now.

One has been addressed a little bit by Nancy and then John. I think women are demanding some family planning services in Africa through unsafe abortion. The high prevalence and the rise in prevalence of unsafe abortions particularly among young women in urban places in Africa is a hidden demand. It is a form of untold or hidden demand. So that is the first question.

The second is related to bridging the gap between research and policies and implementation. I know there is a great deal of work being done within the World Bank on access to services by the poorest segment of the population, but not only do we need to work on a package of services versus vertical programs, but we also need to discuss the question of do we target the poorest segment of the population or do we advocate for the package, universal coverage of the basic social services package to the majority of the population, maybe

with some exception of the very richest segment of the population, but a more universal coverage of interventions versus targeting so-called "poor, poor policies" and what works best. I think that is also something we are really struggling with.

MR. HELLER: Alaka.

MS. BASU: Since we are also trying to set up a research agenda, I wanted to make one small suggestion for a kind of research that would demonstrate an impact of reproductive health and poverty in a very direct and short-term way, which is the kind of thing also that catches policy attention. The idea I had in mind was something that I did 12 years ago on a very small pilot scale, but turned out results that I didn't expect, which is we just looked at how sources who had lost an adult family member for any cause, for any reason, who had had the death of an adult family member and what had happened to their poverty levels as a result.

The striking thing was that a loss of a female member really did slide households into

poverty very strongly, much more than we expected, even when these women were not productive. So the arrow that I would talk about is not one that goes through improved health and then improved child labor force participation and productivity, et cetera, but directly through poverty, and a lot of it occurred through something as simple as women being responsible for the family budget.

In fact, the absence of the women due to morbidity or mortality led to households sliding into poverty because there was no one who could impact households on the day-to-day allocation of expenditures and managing of the budget. It is a female task, and when that became a male task, in fact, you had households disintegrating.

We did a small study, a small sample, but we found it so striking that I kept thinking at some point this is something that should be seen in other places and has a direct immediate policy impact, if that is what happens that households slide into poverty as soon as reproductive health is

compromised and leads to maternal mortality or morbidity.

MR. : Just a brief comment. A couple of points. It was mentions that it is made on fosterage as an element of the discussion, but is not expanded, and I would like to draw on this to make a large comment which is about agency. That is, as much as we would like to believe, the IMF and World Bank are important, African societies are not just sitting and waiting for the World Bank to come and do things or they are not just sitting and waiting for even the states to do something.

There is a civil society that is in the works. There are extended family systems that have historically tried to address some of these questions.

They may be coming to a breaking point, but what I want to suggest here is that we should also invest some time in understanding the mechanisms by which sort of indigenous mechanisms by which African societies are trying to both reduce poverty, but also promote growth, and fosterage is one

understudied, but important system as far as poverty reduction goes.

There are two extremes. One is, more or less, to glorify the fosterage systems as being a real buffer, and one is to neglect them. Both extremes are not appropriate, and this is on the inequality side.

In the growth side, I think David pointed to this, and it is a important point. It is the importance of the remittance economy. It is also something that is understudied.

We had a discussion with my fellow from Senegal this morning where we have a potential for--[audio break].

[Side B of Audiotape 3 of 6 begins.]

MR. : [In progress]--as much as Senegal does a good job tapping on this potential, a country like mine doesn't do as good a job. So this is also an area that could be studied.

Thanks.

MR. HELLER: Steve?

MR. SINDING: Two points very quickly. One, I think Nancy identified exactly the factors that I believe have been responsible for the decline in interest in funding this sector.

When we lost rapid population growth as the driving rationale for investing in reproductive health and family planning programs, funding started sliding, and it has been sliding ever since. It seems to me that unless we can connect it to the things that are today's compelling global issues which are driving the resource agenda, whether from donors or from developing countries, that will continue.

I think that the poverty reduction MDG agenda is one of those, and I think that within it, HIV/AIDS is the other. From a policy advocacy standpoint which requires an evidentiary base, those are the connections that have to be made.

The point in that, that I would like to emphasize--we have talked a lot about the poverty linkages, and David's presentation I think was very helpful in playing that out further--there was a

comment earlier, and I can't remember who made it, that we know very little about the how of linking HIV/AIDS and reproductive health programs. I don't agree with that. I think we know a great deal about the how.

I think that there are political agendas that are driving the two programs into vertical silos, but I don't think it is because we don't understand at many different levels, especially to the extent that the disease is sexually transmitted. It is not that we don't understand that there are just crucial programmatic linkages between our approaches on both.

The second point I wanted to make is just a very quick addition to what John Bongaarts said, and it is to reinforce the point that I think John Worley was making earlier. Family planning programs not only respond to unwanted fertility or to unexpected pregnancy. They also change fertility aspirations. They are very important and have been shown to be very important in changing people's

expectations about the numbers of children they want.

We should not underestimate the role of communication and ideational change not just in fertility, but with respect to a whole range of public health outcomes. Leadership matters and communication matters, as articulated by leadership, and I think we consistently underestimate this factor in our modeling. So I would just like to make the case for that within the research agenda.

MR. HELLER: John May.

MR. MAY: I would like to stress the linkages between fertility reduction and mortality reduction.

I recently was in Niger. There is an experience in Niger of mobile clinics from Tunisia, and they go from villages to villages in the region. Niger has the highest fertility in the world. It is about eight children per women. So it is a very difficult situation.

Yet, after 2 or 3 years, the results are quite spectacular. From 4 percent of prevalence,

now we are at about 18, 20, 22 percent. I think it shows two things. First, that by gaining the confidence of women about the survival of their last child, you can start to initiate or to reinstate the traditional birth spacing, as was mentioned by Jon Bongaarts.

Also, in the case of Tunisia, there is the tremendous importance of leadership, tremendous importance of girl education, and the importance of legal reform. At the time in Tunisia, a lot of very far-reaching reforms were taken, including the abandonment of polygamy.

I would like to make another point. The discussion this morning has really focused on family planning, reproductive health, and fertility reduction. As a demographer, I just want to remind us that even though we would reach in Africa a fertility of replacement level, the population would still grow for the next 70 years because of the population momentum. So, therefore, whatever we do now or later on fertility, we still will need to have other policies put into place as well.

Migration has been mentioned. I think urbanization is another case in point. We will need to try to bring those policies together in a global framework because fertility is one aspect of the story. It is a very important aspect because it has human rights implications, it has health implications, it has women empowerment implications, but on the demographic side, it is only one aspect of the story, and we will need definitely to look at the other policy levels as well.

Thank you.

MR. HELLER: My failings as a chairman are emerging as I look at the time. So I am going to have to ask all of you to be brief, if you could.

Let me start with Jean-Louis and then Thoraya and then Cynthia, and then I will give David the last word.

MS. : I think you missed Paul.

MS. : You missed somebody.

MR. HELLER: Did I?

MS. : Paul Schultz.

MR. HELLER: Oh, I'm sorry. I didn't see you. I will fit you in.

MR. SARBIB: I will just be very brief and make three quick points.

The first one, at the risk of disagreeing slightly with Nancy, I think convincing the finance minister remains important, all the more so now that we are moving in a PRSP framework where increasingly the dialogue is going to be led by the minister of finance or the prime minister, but not forgetting the role of civil society in the policy environment.

So I think continuing to move on arguments that have a combination of immediate short-term impacts that are good for the minister of finance, good for the donors, as well as continuing the way in which these need to be sustained over the long term is part of what I hope the working group will do.

The second thing, as a policy advisor, I think that the frown looked at this diagram makes me believe that it is very important to continue to work on it because that is where the answers are.

It is in this package of interventions, not forgetting the demand side as well, how do we make sure that when the package is available, it is used by people at the bottom of the income and usually the power distribution, what are the interventions that are needed to do this.

So don't sacrifice the reality of policy-making for the beauty of research. Continue to muddle through. Continue to provide us with the kind of packages that we can then advocate. That is the contribution that you can make.

Finally, I am always a bit worried when I begin to hear about cultural exceptionalism. In the case of Africa, this business about the nuclear family, let's just make sure that we understand, and somebody suggested that we needed to go a bit deeper in analyzing what are the coping mechanisms that are behind the current situation in Africa rather than to say this is a given that we need to take into account in doing this.

I have seen that when there is progress in Africa, I think you see the emergence of nuclear

families. In many ways, one of the causes of migration of skilled workers in Africa is because they want to protect their nuclear family. So I think that you really have to think a bit more, in my view, using anthropologists and sociologists as to what is that dimension, so that we can really understand it and adapt the policy package to the cultural reality and not to some kind of a preconception of it.

Thank you.

MR. HELLER: Thoraya.

DR. OBAID: I just have questions, more than answers. One of them is that in the countries in Africa where AIDS is killing many people, the population division estimate that some of these countries will decrease their population. Now many of the anti-reproductive health are coming up and saying why are you promoting reproductive health in countries when people are dying.

I know, Geeta, you are looking at me, but it is something that also needs to be answered

because that is coming up and facing us, even from Africans themselves.

The other one, again, referring to what Steve said and Geeta also, we know programmatically how to link reproductive health and HIV/AIDS. What we are trying to find out is how to break the deadlock between the two groups to get it moving, and that is the operational part and the political part.

The third one, there was a discussion maybe this session or the previous session, but this has come up with the example of Tunisia, and then China was mentioned earlier. I think the issue is that we are in a different context where human rights has become the framework in all the reproductive health/family planning context. That was not there. Borgayba [ph] decided it was a central decision, and that is what China did. We are in a different context, and therefore, really these models in that sense cannot be transferred to this environment we are in right now.

MR. HELLER: Cynthia.

MS. LLOYD: I will just make it very brief because I think we can continue on this point this afternoon, but I just was going to pick up on David's point about packages. I really think that that is very important, particularly when we look at the framework we develop because I think what we haven't developed at all is we just have this generic box that says family planning/reproductive health. Obviously, some programs work well, and some programs don't work so well. What works well will vary according to the context or according to the particular age group or population group you are addressing.

So I think we may need to be a little bit more careful, particularly thinking about the African context and the phase of the demographic transition as to how to articulate this box in a way that is going to be more useful.

MR. HELLER: Paul.

MR. BREST: Going back to David's talk, I thought there should be at least some statement that this linkage between macro and micro relationships

is something we all need, and I think the reason we need it mostly that is not emphasized in circles like this, that the macro relationship across countries which we tend to attribute to the demographic transition is not replicated at the micro level. Careful work at the level of households' savings rates is not strongly related to age. So these age effects that we are imagining drive the rise in savings rates are not really supported by the micro-level studies. Yet, they could very well be linked back to the decline in fertility that families want to transfer resources to their future old age period because they no longer are going to have as many children. So we have to look at quite different evidence to support the micro and macro consistency.

Similarly, labor supply, yes, it varies by age. Children and old age people don't work, but the main growth in labor supply is from women entering the labor market. This is released not by the age structure, but because fertility has fallen for these women and they can be freed both before

child bearing, by choice, and after child bearing and enter the labor market in a more forceful fashion.

The human capital is a third dimension of growth that is linked to the demographic transition, and again, it is related to women restricting fertility and investing more in children. So, to build the micro and macro stories consistently, we can't rely upon the aggregate cross-country relationships to carry the weight. We have to do harder research at the micro level, build up to this macro level, explain why it adds up to more than age structure changes. That is a challenge, and it is one that I think we can present to the finance minister, if we could ever do it, but let's not forget that that is not going to be explained by cross-country progressions.

MR. HELLER: David, do you want to respond?

MR. CANNING: Yes. I have a number of things. Just a couple of points.

The first one is I think this distinction between mortality and fertility is really crucial.

If you base things on population growth, that is not going to be a good basis.

The 20th and 21st centuries are going to be looked back in history as a period of rapid population growth in the world. The population has exploded, and the reason behind that explosion is mortality decline. Fertility didn't suddenly rise in the last century. Mortality decline is what is driving it.

The effects of mortality decline and the effects of fertility are very, very different, and you have got to look at them differently. That is the answer to your question about the population is declining, so why do we worry about fertility.

The second issue is this point that I emphasized fertility reduction rather than the health benefits of reproductive health, and that, I think is a pure consequence of the macro data that we have, that we can look at fertility. It is hard to disentangle reproductive health as part of overall health, but I think the thing that leads me to suspect that element is also very, very large is

that it is largely morbidity burden, and the economic consequences of ill health I think flow more from the morbidity than the mortality burden. So having large numbers of women who are unable to work or unable to produce because of reproductive health problems I think is a potentially major issue, but micro data is the way forward there.

I just emphasize that I couldn't agree more with Paul about the need to reconcile micro and macro data. I think when that is done, microeconomic analysis will be changed dramatically.

[Laughter.]

MR. HELLER: Okay. Shall we stop at this point? You have approximately 50 minutes for lunch, I am guessing. It is being served in that room.

I think this is a very productive discussion. You asked me to summarize it, and I would find it very difficult. The only point I would make is--I think Jean-Louis, you actually made the point for cultural exceptionalism, and I am not arguing on the nuclear family, per se, but I think you do have to get into the cultural realities, and

I think the cultural realities in Africa and also the way in which demographic developments have evolved are very different from what you have seen in other regions.

I am not responding necessarily to you as much as David. Trying to sort of look at what has happened in Asia and then transplant it in Africa where the patterns are just very different in the way in which it happened and the way in which the demographics will unfold intensifies the argument for a very Africa-specific and even an almost country-specific or region-specific assessment of these relationships.

MS.   : And the Middle East.

MR. HELLER: And the Middle East. Yes, of course.

MS. BIRDSALL: Lunch will be served in the room over there where it says exit, and hopefully, it will be a nice lunch. We will resume around 2:00.

[Luncheon recess.]

Session 4: Poverty Reduction and Inter-Sectoral

Priority Setting

MR. ANSU: Hello. Welcome back. I hope you all had a nice lunch and you are going to manage to stay awake.

My name is Yaw Ansu, director of Human Development in the Africa Region in the Bank, and my task this afternoon is to preside over the presentation on poverty reduction and inter-sectoral priority setting; in particular, how do you decide how much to put in the stuff that we have been talking about here versus education, rules, agriculture, and all the other good things that are pragmatic that the finance minister supposedly provides over.

To lead us in the discussion, we have Dr. Richard Muga. Dr. Muga is the director of the National Coordination Agency for Population and Development in the Ministry of Planning and National Development in Kenya.

He has worked for about 26 years in public service, and he was very much admittedly involved in the exercise that Kenya went through in trying to

set his priorities. He is going to try to illustrate the principles involved in the topic by leading us through the Kenya process, a process that Kenya went through.

He will take about 15 to 20 minutes for the presentation. After that, I would also give about 5 minutes to Cynthia Lloyd to give us a brief presentation, and then we will open the floor for a discussion.

Dr. Muga.

DR. MUGA: Thank you very much, Ansu, for this opportunity to share with this important audience Kenya's experience with the PRSP.

I also want to take this chance to thank the conveners and the sponsors. We have to thank the Center for Global Development, the DFID, and the World Bank for giving us a chance to come, so that we can share with you what we have on the ground.

Kenya, like many other countries, had gone through the development of PRSP, and for us, it was a participatory process that started from the bottom where we had different communities participating and

coming to the districts and trying to set up what was their priority. It was hoped that this process would lead to these priorities being funded.

These priorities were also debated and listed, so that education was there, agriculture was there, health was there, and they were ranked. Unfortunately, resources did not come to support these and, therefore, left the minister for finance with a lot of difficulty to weigh again what comes first after the communities had recommended what they thought was a priority.

Of course, number one was the issue of food. Agriculture was priority number one, and it still remains a priority for most of the rural populations. Then number two was the issue of infrastructure. When the rural population was not able to go and sell their products was an issue. Then health came as number three as a priority in this process. Then, of course, education was also there.

So that when we talk about poverty reduction, then we really want to listen to what the

different stakeholders are saying, the dialogue, and move to the stage when the first priority can be funded.

Unfortunately, when the poor don't have a voice, then they will set the priority, and then that is the end of it. We see this very clearly when they had the expectation, but this was not to be. Therefore, there is a lot of distrust, and we believe that the process to go with PSRP is to ensure that what has been recommended as priority, that the poor are also given a voice to continue to track down where the implementation is taking place.

So the strategies that were set in place in this process in Kenya included facilitating sustainable and rapid economic growth, and this was through a blueprint that was derived from the PRSP as the economic recovery strategy for employment and wealth creation.

This is the blue book that seems to guide Kenya's progress. Processes have been made to report on whether we are on track, whether we are

achieving that, and continuously give the lower levels a chance also to give their feedback.

When the former government did not seem to move on that track, then the people of Kenya went to vote and made a decision. We believe that developing countries must now use these processes for making change.

When the new government came into place, they played that what had been said in those documents will be implemented, and so they started with the free primary education as number one. Number two is to try and improve security, which was a major concern to the population when this document was being developed.

So you hear a lot of talk today in Kenya about issues of corruption. Those of us who are inside, for us it is healthy because you can no longer do something under the table and hope that it will remain under the table. We believe that this is an evolving process that people are going to be held more and more accountable. If you are in a public office and we have the Public Ethics and

Crime Act, which is already in place, that requires every public officer to declare what he has and not to abuse his office.

We also begin to see the public holding their representative accountable in this process. The Kenya government has come up with a process where resources are allocated to the lower level, which is the constituency. The residents in that consistency are taught, and they are able to exchange and have dialogue on radio, on TV, on what their representative is doing. We believe that if resources were able to go in this direction, then we are going to see the economic growth.

The last area was the passage of equity and participation, and this is the major concern. There has been a lot of disparity in Kenya, for example, where different regions, some were privileged. They had better infrastructure. They had better access to food, better access to education. So now this is a debate that everyone is asking, what is our share of the national cake. I believe these are the processes which should be allowed to go on if a

country is going to be held accountable to its people.

The issue of equity to health has been debated, and currently, on the Kenya's parliament, we have the bill on the national social health insurance, which is aiming at offering a minimum package to every Kenyan. It is contributory, and for the indigents, the government would love to take responsibility and contribute.

We believe that this scheme, if it went through, is going to cover reproductive health as part of the minimum package, and so when you hear this debate, we thank the UN because Jeffrey Sachs came over into Kenya and really swung when many development partners were very skeptical on this.

In parliament, it has been passed, but Kenya's president has not signed the bill, which means he must be getting advice on whether to sign or not to sign. You can see that the general public is demanding it. They are supporting it, and I believe that if people are empowered, then we can get to the MDGs.

One major concern has been the commodity security. That has meant that many women who wanted to plan their families could not get the commodities and, therefore, went home and got pregnant and got the babies. We believe that this could be part of what I will show you soon.

So, if we are going to spend money on priorities, then reproductive health commodities is critical for the rural population, and in Kenya, we have 80 percent of Kenya's population living in the rural areas. So, unless we are able to give the critical commodities to them, then we will not achieve what we planned out to do.

The other area is human resource. Today, there was a debate on whether we should continue vertical programs. In the real sense, outside there, you go to a facility, there is only one to two nurses, and these are the same ones that offer HIV/AIDS care and these are the same ones who offer family planning and these are the same ones who do counseling. So that the issue of a running vertical program, it will not work. We just have to train

these nurses to offer a package, as it were, to the population.

Of course, the other area is the issue of having appropriate policies in place. We have the national population policy for Kenya. We have the adolescent reproductive health policy which has been developed and which was also a participatory process. We have the youth policy, the Children's Act, and then the tracking of ICPD plus 10.

But in spite of all this, relying on some of the latest data, we begin to see that all is not good, and I will share with you just a few slides.

If you look at this slide, which you already have in your documents, starting from around 1975, there was the realization that the total fertility of 8.1 could not continue for long because our economy was also weak, and it is at this stage where we had very strong political support in the form of the current president. Then he was the vice president of Kenya.

Kenya developed population guidelines and introduced very strong a family planning program,

and we begin to see a definite decline up to the year 2003 when we had the recent demographic health survey.

We don't know whether this is going to be a permanent upturn, but this is the subject for a lot of discussion and analysis of about Kenya demographic data to show what is happening here, but suffice it to say that we know that around this time, most of the commodities were not there. You walked into a facility, and you were not able to get the contraceptive of choice. We don't want to say that is the only explanation. There could be something else happening.

So, if you ask what are the research areas, one would want to try and see and explain and understand because, for the minister of finance, he wants the answer now. If you tell him, "I will give you an answer 20 years to come," he will not be the minister for finance. So he wants it now.

We begin to see that with very good political support, in between there was a lot of partnership. We had the World Bank here. We also

had UNFPA and USAID. This support gave rise to a definite decline.

We had what we call community-based distributors. Today, we don't have those people because USAID stopped. They said it is not cost effective. DFID, they were not very keen on it, and therefore, we don't have community-based distributors anymore. So the women demand contraceptives. They are not there, so what do we see maybe?

Then, if you look at fertility preferences among the currently married, you see 44 percent saying they want no more, 29 percent saying we will want it later, and 16 saying that we want it now.

Next, I show you with that figure, you see this is the map of Kenya. This is around Lake Victoria, and this region has a total of 8 million people. This is western with a fertility rate of 5.6, and Nairobi, 2.7, and Central Province, 3.4, and this morning someone said that you cannot take one general figure. There is a lot of variation in this process.

The average now, then, is 4.9, and so you find, where I will show you in the next slide, that around the Lake region, an average of 5.6 is already too high, as you will see in the next slide to come.

Contraceptive prevalence rate. In the region, Kenya did well during the time when there was a lot of support and effort. We were able to reach 39, but now it is plateauing. We don't know what is happening in this sense. This is the subject of further analysis of Kenya's demographic health survey.

So, when we talked to the minister for finance, he wants to know what has happened. When we tell him there are no commodities or people's demands are not being met, that is when he will listen. So you need this type of information to convince the minister for finance, but if you tell him that I will tell you a projection and we will predict, he is not interested.

I was director of health services for 5 years in Kenya. So I had a chance to try to put a case for Kenya, a case so that we can have more

resources in the health sector, so we know how they think. Until we are able to put this type of data packaged that makes sense to them, we cannot get additional resources. So the unmet need remains quite large.

In the latest Kenya demographic health survey, we had up to 24 percent. In fact, if we were able just to meet the unmet need, then the Kenya's level would go way beyond the 39 that we have shown you.

So you look at HIV/AIDS. This is that map superimposed. You look at around the Lake, 15.1 percent. The highest, this region is the one that is driving the epidemic in Kenya, and you will find a number of districts around the Lake, some of them having as high as 40 percent, some 30 percent. This was from actual testing.

My friend Jotham showed you what Uganda's situation is. We are not able to show you the trend because there is no time when we had actual testing. So the other figures were from certain surveillance, and we believe that 5 years down the line, we will

be able to show what has happened, but Kenya's figure was 6.7 percent.

MR.   : What portion of the survey didn't respond to the question?

DR. MUGA: I think it was about 23 percent. Yes.

We have also just finished the Kenya service provision assessment. That was also done by our ministry to try and see whether the services being offered are consistent with the distribution of the epidemic. Very interestingly, you will find around the Lake, the services are very weak. Areas offered only up to 7 percent by the facilities, and that is a major concern which makes us think that although HIV/AIDS is a priority, resources which are being put do not seem to reach where it should reach.

For us, that level of policy if it is not reaching, then that funding mechanism is no good for us, and it has to be reviewed. Research has to be put on the table to try and answer this process.

There is only one more remaining. Some very critical lesson that we learned, the Kenya health ceiling, where it came from. We see 51 percent of the total health care finances is from the households. So, if we are going to make any change and we are going to support the Kenyan people, we have to address this one.

Some studies have shown recently in rural villages that households which go out of their way when one of them is sick, whether the man, the child, the husband, they will spend a fortune. They will sell their land. They will sell the ox. They will sell the plow in order to buy health care.

If we are going to make a difference, we have to address this scenario because it is already too heavy for them. As you know, most of Sub-Saharan African countries had introduced co-sharing. It showed that co-sharing did not work.

My project has come, and it still showed there are difficulties. Households are still spending a lot more on health care. So, in terms of research, this is where we need an answer because

for as long as this is left there, then we cannot go out of poverty because, as soon as the head of the household has died of HIV/AIDS, that household slips into poverty, even if they were doing well. So how do we change this scenario?

But on the other hand, the minister of health is given a shilling. What do they spend it on? Already, up to 51 percent of the resources in the ministry of health goes to personnel, and if you put a situation where you tell health don't spend any more on personnel and even with spending 51 percent, most of the facilities don't have personnel. They cannot offer care. There are no drugs because we spent only 11 percent and only 10 percent on operational maintenance, and new buildings only take 0.2 percent. So we are saying that this model for funding cannot work.

Of course, I say this with humility that IMF and World Bank, they would say, "No, no, no. Don't employ anymore," and if you can't employ anymore, even contraceptives cannot be given. The women will go to the facility, and they will find

there is nothing to give their provider or to give implants. Therefore, a new funding arrangement has to be found if we are going to continue to fund the priorities that were set in PRSP.

We believe that a new review has to be done, so that the funding that is available can rehire human resource on contract to be able to deliver these packages. Households are already spending their fortune on health, and unless relief is given, they cannot come out of poverty.

New strategies have to be found. Now there is a small project that we are working on in Kenya, the output-based approach, output-based assistance where households will be given a voucher and they can walk into a facility and they are entitled to reproductive health packages. We believe that that type of approach may relieve the households, so that the bull which they use for plowing to make food can be spared. Otherwise, that bull is sold. The plow is also sold. They go into poverty, and they remain in poverty.

So what we are saying here is that through PRSPs, priorities were set, and these priorities are not being met because of these intricacies. Research questions, what are the alternative models, what can be done, how do we continue to reposition family planning, how do we continue to reposition primary health care if we are going to help our communities to come out of poverty.

Thank you.

MR. ANSU: Thank you very much, and thanks for staying within the constraints of the time allotted.

I will now turn it over to Cynthia who is the director of Social Science Research, the Policy Research Division of the Population Council.

MS. LLOYD: Thank you.

I am also a member of the working group. So I think my contribution, which hopefully will be complementary, will be to draw on some of my own recent experience and the work of the working group to make a few points about inter-sectoral priority setting.

To do that, I think it is good to go back to the point that David made before lunch about the fact that the average person is interested in the package. We are obviously interested in the package, what is going to be the best package that is going to lead.

Ideally, if you go back to that complicated set of drawings, if you could find the package that actually would have a set of arrows, it would just go straight down, and it would sort of bring all of that together and lead to the desired outcome.

What kind of research can we draw on that would allow us to think about certain elements of that package? For me, given my recent experience, which is chairing a panel for the National Academy of Sciences, with a report that is going to be published in 2 weeks entitled "Growing Up Global: The Change of Transition to Adulthood in Developing Countries," we faced this challenge in thinking about the transition to adulthood for young people and recognizing the fact that many things are going on during this phase of life, and that ultimately,

for young people to emerge as "successful adults," various investments have to be made in order for them to be able to become productive adults.

What we mean by that is, well, first and foremost, we were concerned about their productivity in terms of being able to support themselves and their families, and we are very concerned about the kinds of outcomes that this group is concerned about. So we have focused the first part of the book on the two critical areas of investment, and that is health and education.

We developed various criteria for success and a conceptual framework in which we set those criteria in a very dynamic framework in terms of recognizing the rapidity of global change and the fact that the goal posts are constantly shifting and that what young people will need as adults is going to be different from what their parents needed to be successful and productive.

So we focused in this part of the book on good mental health and physical health, including reproductive health, and critically, the knowledge

and means to sustain health during adulthood. That is a critical part of it because we saw this phase of life as not just a phase where you need to be healthy to transition successfully, but it is during this phase that you are able to acquire the behaviors and the knowledge that is going to sustain you as an adult.

Then we also looked at the education piece and obviously recognized that with the rapid global change that is taking place in the world that what will be an appropriate stock of human and social capital to become a productive adult member of society will be different today than it was 20 years ago.

One of the interesting findings that emerged from the study are the kinds of synergies that we see going on between the health and schooling sectors. So one of the challenges that we face in sort of presenting our results, given the kind of vertical way programs exist today, is that a provocative finding that the conclusion that the panel came up with that maybe one of the most

effective investments in the reproductive health of young people is schooling, pure and simple.

In other words, we found that the most risky behavior that young people engage in is unprotected sex. It is risky because of what can happen to them in the long run, but it is also risky because it is setting up behavior patterns for the long run. So, even if your health is not compromised immediately, it can be compromised in the future in terms of your behavior.

So, in looking at health behaviors, we found that teenagers who are in school--and increasing numbers of them are in school because there has been a tremendous and unprecedented historical rise in schooling rates among adolescents, so this will continue to be the case--in all the countries that we have data, less than half as likely to have sex than their same-aged peers who are not attending school. So there is something going on about schooling, even bad schooling, that is making a difference. Of course,

if schooling could be good, it could be all the better.

So I think that my main message is going to be when we think about the framework that we are developing as a group and when we look to that very top box and we put in it reproductive health/family planning, is there a particular package which would be very powerful to think about, particularly when you recognize that the next generation is going to be the next generation of adults. It is their behavior and influencing their behavior that is going to make a different, not just for what happens to them when they are 15, 16, and 17, but what is going to happen to them for the rest of their adult lives.

So I would like to sort of think more broadly about what we really mean by what is in that box and put a particular priority in the discussion on thinking about young people.

MR. ANSU: Thank you.

MR. ANSU: Thank you, Cynthia.

From the excellent presentation of Dr. Muga, we know that political commitment helps in reducing the fertility rate. So does the availability of commodities that households spending on health is already too high in Kenya, that the ministry of health's budget is not enough and most of it is spent on personnel, and that, however, when people are asked to set priorities in the PRSP process, health came third. Within health, we don't even know where reproductive and family planning and fertility reduction stands. We also don't know how much is being spent on health relative to the other sectors.

I am sure other sectors, if you go to their transport minister or their agriculture person, they could also point to programs that are working, but I don't think just because a program is working, it will be enough to convince the finance minister to allocate the marginal dollars to reproductive health vis-a-vis other present programs that are equally desired by some stakeholders.

So I think that is really an effort here to really work out where the marginal dollars should be put, should they be put in reproductive health or in some other priorities, and that more work and research, at least a framework that allows you to show not only that a program is working, but that it is the best program to put money in relative to other areas that are required.

As also Cynthia pointed out, with the impact of expenditures in other areas, schooling and education, towards some of these objectives also probably needs to be spelled out a little bit more.

With that, let me open up the floor for questions.

Sarah.

MS. : This is really a question about how the policy process might work. So it is addressed to Dr. Muga.

We have heard here a lot about the package. We have also heard that implicit in that is the family planning/reproductive health community work with other sectors, whether it be education in the

case of Cynthia's example, HIV/AIDS that we have spoken about.

I have this picture of a minister of finance with a long line outside his door. You made the whole process come alive with your example of the presentations that have resonated with the minister of finance.

When it comes to making a case for a package, a multi-sectoral case, in your experience, when is that successful? Is it true that you have to be able to make your case standing on one foot, that you have maybe just a tiny number of minutes to capture the attention of the policy-maker, particularly the minister of finance? I bring that up because our community, the family planning/reproductive health community, we are constantly telling ourselves we have to reach out to other sectors, we have to work together, we have to make the case together, and yet, operationally, how can that be done in your experience? How can that be done successfully?

MR. ANSU: Hans.

MR. BOEHMER: Thank you.

Dr. Muga very eloquently brought up the issue of health workers and the issue of budget constraints and expenditure ceilings and various things, and of course, there is quite a bit of discussion internationally going around both the health worker issue as well as how one can figure out macro frameworks that are consistent with scaling up aid.

I would suggest that actually it is not just the question of where do we spend the marginal. It is also actually demonstrating that additional resources can have an impact.

I think there is no doubt that one would have to have that package that extends well beyond health. So it is not just a question of reallocating resources from an infrastructure to health and so on.

I think in terms of a research agenda, the importance of health workers and what exactly does that mean, what kind of skills do they have and where do they need to be deployed and what are they

going to do, I think it is still one of those questions that is slightly unanswered. There are great calls from almost every African country that I have heard of that we need to have more health workers. If you look at the health worker density, it tends to be often less than 1 per 1,000, and one doesn't get very far with less than 1 per 1,000.

It is very difficult to then have a constructive dialogue exactly on the financing issues with the IMF, with the World Bank, on what is the relative importance of addressing some of those structural issues about how we finance health workers, how we finance larger health expenditures, be it public sector or private sector, and make that a policy priority. It always seems to be acknowledged, yet perhaps insufficient drive, perhaps because there isn't quite a belief that that really is the binding constraint, and I would just suggest that as one of the important subjects to look into as the research agenda.

MR. ANSU: Thank you.

Ruth.

MS. LEVINE: I will see if I can articulate this. The working group, we focused a lot on trying to look at the potential benefits or impact of investment in reproductive health, recognizing the importance of some contextual or environmental variables such as what the education system looks like, whether there is the ability to absorb more kids into the education system, what the labor market looks like, what the overall economic growth strategy is.

We discussed those, if I am remembering the conversations right, sort of, as I said, contextual or environmental variables. This recent conversation about the package and the multi-sector thinking makes me wonder whether or not there would be a real value in trying to better understand how you could, for example, get more benefits out of your education investments in the presence of a high-quality reproductive health program that is focused, for example, on young adults, really trying to unpack and measure what those inter-sector relationships look like.

If I have been able to express what I am thinking, I would be curious to hear from Dr. Muga and others whether that sort of analysis in the findings would have some power, if you walked into the ministry of finance and said, "You have made a tremendous commitment to expand access to primary education partly based on your expectations of what the long-run economic impacts will be. We have evidence to show that those will likely only be met if there is in parallel good reproductive health programs."

Peter.

MR. HELLER: Just a few questions that sort of struck me. One, I thought, Dr. Muga, you made a very interesting observation when you were talking about what the priorities were in the PRSP, and health was number three. That made me wonder. That must create some tensions presumably when the donors really are sort of putting a lot of emphasis on health or education and the country sort of puts a higher priority initially on some other things and how those conflicts are resolved.

The second point I wanted to make relates to the issue of the package. It just struck me that the IMF and I think the World Bank are trying to bend over backwards to make sure that IMF program ceilings on overall wage bill or overall fiscal deficit are not standing in the way of hiring of nurses in countries. I can point to several cases where we got ceilings, but with an exception of health and maybe education. Malawi is a good example of one where we certainly tried to do it in health.

If you are focusing on a package of policies, that kind of exception may, in fact, end up still excluding vital components because you may say, "All right, fine. We can spend money on the health sector," but you may want to spend some money in some other things as well, which gets you back to the fundamental question of what the priorities are of the government in terms of where it is putting its money and where it will cut back given some overall budget constraints.

I guess the last question I want to ask, how close a link do you see? You have got these priorities that are coming out of the PRSP process, but in a way, you seem to be suggesting that those aren't being translated into the budget priorities. I think what you sort of suggested was because the donors weren't coming across with money, but even within the budget constraint that the Kenyan authorities had, you would have thought the shape of the budget priorities would have been in shape by the PRSP priorities. That seems to be less the case. So I would be interested in your reactions.

MR. ANSU: Why don't I give Dr. Muga a chance to respond now, and Cynthia may come in, if yo need to. Then we will take another round.

DR. MUGA: Okay. Thank you very much. This is a mouthful.

I will start with what Sarah raised, the package issue. If we were given a choice, most people who work in the rural countryside would go for a package because it is the same mother who has a sick child with malaria, and this is the same

mother who is going for family planning. This is the same mother who is infected with HIV/AIDS. So a package would be ideal, but will the minister for finance be convinced with this?

I think the minister would want to see how this eventually affects the economy, and when he is on the table debating with IMF and World Bank, that he can put his money, or when he collects money from revenue, that he can say if we put in these monies, we will see these results.

This is why for us we have to or this frame must show the immediate results and long term, and we have to use the immediate to empower the minister for finance to make a decision. If the FRIP [ph] does not do that, then it is of no good, and the research will remain an academic approach.

But the package is what we support. This is 28 years working as a doctor. From different levels, we need an integrated package. That is what makes a difference.

Vertical approach was actually imposed on most of the health care systems because there was no

choice, but if people had a choice, they would go for an integrated approach.

Hans has raised the issues of health workers and what are they doing. Recently, there was a study that was done in Kenya to try and assess the workload and actually determine what does a health worker do. This was funded by DFID.

It is interesting, and questions like should you employ a doctor full time or just contract him, a consultant and just contract him and give the service. If you are talking rural areas, you are not going to have that doctor today come there and then tomorrow he is somewhere in Nairobi. It is not workable. Therefore, if we are going to improve coverage, then you have to have health personnel there.

Twenty percent of Kenya's population lives in an urban area. So that one, you can deal with, but the moment you go outside the cities, then you really have to get health care personnel, and I think this is true for most of the Sub-Saharan African countries.

Ruth has raised the issue of weighing the priorities. In Kenya, we go through the medium-term expenditure framework where we sit around a table an argue. The team from education is there, agriculture is here, and we tried to argue. For Kenya, the number one that was given funds was the free primary education. The envelope that went in there was enormous, until health could not get anymore. At that time, education and health were on the same envelope. So we fought that health and education should be separated because then education was swallowing the whole of health.

That has since been done, but we think that this is a healthy process, that if you have information and you have facts, then you can put it on the table. Slowly, we have seen with a lot of advocacy that health this time was given a little more, particularly targeting reproductive health commodities. There is now a budget line to go and buy commodities.

Of course, one lesson that we have had to learn is you don't leave donors to be wholly

responsible for reproductive health commodities because if there is any change in issues of governance, then you are stuck.

So we are telling our government, "Look, put money in for contraceptives. Put"--[audio break].

[Side B of Audiotape 4 of 6 begins.]

DR. MUGA: [In progress]--and let partners just add on. We would wish to see this supported, so that our governments can wake up and take this matter seriously, rather than make them be dependent on external flow and then abdicate their responsibility. We believe that we have to put this thing clearly with facts and information from surveys that could convince the whole process.

Peter is raising the issue that health was number three. Yes. If you give people a chance to decide, they will tell you that we want food first. So that is what they said. They would wish to see that agriculture is developed, that they have something to eat, and then after that, that they can transport or go and sell their commodities. With

that, then they can buy some form of health care. This was the scenario, and this is the PSRP. This was the debate.

It doesn't mean that health was less important. When resources are there, they would want to see that there is food for their family because, if there was no food, then it ends up with many--so, even if funds were given, it doesn't mean that it is going to be misplaced, in my opinion, but this was their priority, and health was rated number three.

In fact, in the Kenyan scenario, free primary education and then the next thing was to have a national health insurance, to be able to cushion and tackle the out-of-pocket expenditure which I think was rational, but which many partners also still put question mark and didn't feel that that is the right approach. We felt that this was one way of cushioning the issues of reproductive health, so that if you get a package, that package includes full cost of family planning. Also, the adolescent and the user-friendly centers will be

developed. Provision of condoms will be part of the package. This was the debate.

MR. ANSU: Thank you.

Paul.

MR. BREST: I am not very knowledgeable in these areas, but it sounds like one of the problems I see in other parts of the world, not knowledgeable enough in Africa or certainly Kenya to speak to it, but certainly I see it in India and some other parts of South Asia, that the monitoring and incentive structure for delivery of education and health services in the village, in the local community are so poorly constructed that resources can provide personnel or even provide supplies, and they aren't being delivered or aren't being responsibly put in the hands of the local populations.

Schools aren't necessarily confronting a school teacher when the students arrive in the morning, one day out of six in India. These things may be also a problem in delivering health care and figuring out what the balance between private and public subsidies should be for the people to receive

the same quality of care of public investments and the drug balance versus personnel. It is very hard for a public sector to make those decisions of whether to spent the marginal dollar on drugs.

Are there mechanisms by which the organization monitors who is receiving these services, how well the supplies are being maintained, making a judgment of whether you need more personnel or more supplies, that the public sector isn't delivering a service the people want and they are going to private sectors and paying three times as much for the service because they think it is a higher quality, more reliable supply of drugs perhaps going with the personnel? How do you monitor this system? That would seem to me, the hardest things in the United States, to get schools and educational systems--and I would think the same problem attaches to health--working efficiently.

MR. ANSU: Geeta and then Tom.

MS. GUPTA: I am just going back to Ruth's question because I think it was an important one, and this session is on inter-sectoral priority

setting, particularly given the context that you set for us about Kenya where health was a third priority among the public.

Can you make a case, and would evidence that would help you make that case be useful to you, where you could make the case that investments in reproductive health will give you a higher rate of return on investments in education? I think that is the question that Ruth was asking.

The reason that I am interested in that question is that, in fact, reproductive health services are not just provided through the health sector. Sex education, HIV education, reproductive health education, of course, are in the school setting. I don't know where that money comes from. Does it come from the education sector budget, or does it come from the health sector budget? The priority setting on budgets for those two sectors, do you benefit from those linkages, or does it act to your disadvantage?

MR. MERRICK: I also wanted to speak to Ruth's question about potential contribution of

better reproductive health to education system performance.

When you look at least at one of the performance measures in the evidence base, which would be dropouts, the survey data--and Parfait can add to this because he has looked at this--is that poor reproductive health, for example, as measured by early pregnancy is rarely at the top of the list. Poor performance cost, competition especially for girls' time at home usually are much higher on the list, and the girls who did become pregnant as adolescents never got to the secondary school where you would be looking at this.

Then, looking at another measure when the voices of the poor are exercised, which was trying to get poor people's perception of why they were poor and what they needed, again, it was echoing the point that at the top of the list were food security, employment security, personal security, and hardly a mention of health. At least in my attempt to go through the many volumes, rarely was

reproductive health/family planning mentioned. You could count on one hand, the number of mentions.

That suggests, perhaps, that the way these questions were asked may have led to the answers, but it also suggests that we need to go beyond survey questions to really get at the dynamic of these relationships.

MR. ANSU: Elizabeth.

MS. LULE: Thank you, Dr. Muga, for your excellent presentation.

I know Kenya very well, having lived there for 10 years, before I came to the Bank. Over the years in the '90s, I saw a deterioration in the public sector of health services.

To what extent was this due to the reduction in the budget allocated to the health sector, but also to what extent was it a fact of the unregulated private sector? I saw that you actually did not talk about the private sector at all.

The other interesting thing is you talked about governance issues, and I am wondering if any

studies have been done in Kenya on how much of the shilling actually reaches the beneficiary.

In Uganda, there was an interesting study in the education sector. I think it was conducted by the World Bank, which showed that out of a dollar, only 13 cents reached the beneficiary, and when a more transparent process was put in place and where they actually posted the school budget on the door with something like that and put it in the newspapers, that actually the beneficiaries benefitted much more than the 13 cents. I was wondering if something similar is anticipated or has been done in Kenya, looking at the health sector.

DR. MUGA: Starting with Elizabeth since she is sitting here, the issue of public-private partnership is a major debate today. As you may be aware, in Kenya we have laws which allow private practice. You can open your facility, and what we are trying to enforce is the issue of standards.

Then, of course, you will find those who are working for the government, some of them sneak out also to go and do private practice. I think

this is copied from other developed countries; that this is done.

It is a bad practice because then it denies the poor some of their rights, and it is a very strong debate today whether government should ban private practice at all or not. So we don't know. The doctors union is very strong on it, also, that it should not be banned. They want to continue to work for the government and at the same time do private practice.

It is true that the public sector ran down, and this was largely due to inadequate funding. Sometime in ABUGA [ph], African countries agreed that they will spend 15 percent of their recurrent budget on health. Sadly to say, Kenya is now at about 7 percent. So it has taken quite some time before that was achieved. This, of course, means that it is still very difficult to convince the finance ministers on the priorities on health, and we have to look for another strategy that could be more appealing to this process.

One way that Kenya was trying was to see whether you can turn an out-of-pocket expenditure into some process that also helps to finance health. I have yet to see any government which will give enough money for health. So there has to be alternative mechanisms.

The issue of linkage of education and health, I think is very important. Right now, when we give health education through the ministry of education, they use their own budget. They don't get funds from health. So it is on goodwill that they can continue to give health education.

It is a requirement in the curriculum for primary education to give health education, but this also shows that you can still achieve a lot if there was collaboration between sectors. For example, the minister of water, if water was available, then, of course, it would contribute to health. So this collaboration is important, and that is why we take a multi-sectoral approach in setting up the priorities.

How do you monitor the resources and the use of these ones? I think this is one weak area. Let's say in Kenya. Monitoring and evaluation has been very weak across government, and I also want to believe that it is the same even in other Sub-Saharan African countries.

It is today when we are working in joint MND frames for HIV/AIDS and we are now moving towards having also for reproductive health to see whether we can document and show that did the shilling work or what happened, what was the outcome, and if we are able to show that, then we can convince the minister for finance that, yes, what you give is doing something. If that information is not there, then we still remain on the weak side. I think this is the scenario.

Lastly, what Tom is saying, the voice of the poor, I agree with you that if you want people to benefit, you have to empower them to ask these questions. You have to be able to tell the poor that these funds are meant for you, so that their eyes are open. This is where the Kenya government

is trying to do that. Some funds are set aside to go to constituencies, and empower the constituency community to ask did it do something, did it come to the school, if it was meant to make this road, how come this road has not been made. I think that is a much better empowering process.

If a woman dies in the rural community, somebody will ask why did this woman die, but until we are able to make people ask, then deaths occur and it looks like it is normal because they are not empowered to know that there is no normal death. Especially if a woman dies in a household, then that household is likely to slip into poverty straight away.

Thank you.

MR. ANSU: Thank you.

Any more questions?

MS. : I want to come back to the issue of allocating a budget line for commodities in the ministries of health. I think we are trying to do that, to convince more health ministers to introduce the commodities' budget line and to put

whatever amount that could possibly be put at the beginning and then slowly, but the issue is how do you go with them to have a budget line. You already need to have all of the arguments, even with the minister of finance, to convince them that that budget line is necessary. So it goes back to what you are talking about. The budget line is the end result of the arguments, convincing them to do it. This is one.

The other issue, too--and we are trying to do it in Nicaragua as an experiment, where we had a 20-year agreement. We began by 20 percent by the government, and then every 2 years, they increase 20 percent and the donors decrease 20 percent, until they become self-sufficient. Can that model work in other areas? Otherwise, you will have a budget line that will remain small, and it will never grow. So it has to be put within a phased process in order to reach the self-sufficiency that Muga spoke about.

DR. MUGA: Maybe I can just comment. Sometime ago, we had an arrangement with DFID when we were buying vaccines for children. We put a

shilling; they put a shilling. That encouraged us to get the resources from the drug fund, and we had money for vaccines until Bill and Melinda Gates came in with the support to buy vaccines.

So I want to believe that we must encourage African governments to take the position to put resources. This point, we cannot overemphasize anymore because we have been twice beaten. Just one small political change throws the whole country in a quagmire. There are no commodities because governance is bad. Research needs to be done to show how do we put evidence to countries, so that they can set aside the meager resources as an initial budget line and then look for models that could help that to grow. If this is not done, then they become passerbies, and they leave critical issues like commodities for reproductive health and also vaccines just for a good willing donor to support.

For us, that shows there is no commitment. So we will need to measure commitment by their willingness to put a budget line. The minister of

health in Kenya this time has put a small budget line after there was a lot of lobbying. We talked with members of parliament to demand to be shown where is the money for reproductive health. That is when now it has started to appear.

MR. ANSU: Any more questions?

[No response.]

MR. ANSU: I would like to thank Dr. Muga and Cynthia Lloyd for a very rich presentation and the contributors for your excellent questions.

I won't presume to summarize this rich discussion, but only to say that I take away about three key things.

The first one really reminds me of a discussion that I was having about 3 or 4 days ago with the minister of health in one of our countries. The minister was very unhappy as we moved into the PRSP and putting things in the budget rather than supporting them with the traditional health safety program.

The advice that I gave to him--and I think it is very pertinent and one of the things I take

away from this discussion--is that, look, in the PRSP process and the PRSC process, you need to be able to go to cabinet and sit with your colleagues and put your analysis on the table and to convince the finance minister and all of your colleagues that what you are advocating for relative to what others are advocating for, there is merit for it. You need to have the data, and you have to have the indicators of programs that are working and to show how much the contributions of a national effort, whatever the national objectives are.

This train is moving, and it is going in that direction. So it is critically important that you begin to do your homework to be able to convince rather than just relying on the age-old how can you be against health, how can you be against maternal mortality. I think that is critical here in terms of whatever research program that is mounted.

The second point that I take away from this is the extreme importance of this package concept of inter-sectoral linkages. I guess one could argue that expenditures in reproductive health and family

planning contribute to the objectives of the minister of education or the minister of whatever, and then you are in a better position to get support from those ministries.

Conversely, I think the idea that one should also explore how one can achieve the same objectives of reproductive health, fertility reduction, through programs of other ministries. The education one has been mentioned. I am sure there could be others, too. So these two linkages, I think are worth exploring.

Lastly, Dr. Muga made a big point, which I agree with, about governments putting their own line items in the budget, but I think it is not enough to put a line item in the budget. I think I would very much support the last point that was made by Thoraya.

I think this line item should be made with the expectation of gradually the donors phasing out and the government picking up. I think that has to be within the PRSC concept. This should be in terms

of long-term development goal. It should be one of the things a country works toward.

Thank you very much for a stimulating discussion.

[Applause.]

Session 5: Within-Sector Priority Setting and Program Design

MS. GUPTA: We will go right into the next session. In theater, we would call this a change of scene. Imagine that you are changing the backdrop. You are no longer the minister of health sitting with ministers of other sectors trying to argue with the finance minister on why your sectoral investment is more important than the other sectors, but instead now you are sitting on your own in your office of minister of health, trying to determine which package of reproductive health services is the right package to invest in, in order to get the outcomes that you are seeking which are health outcomes for women and children in this instance.

So we are going back to that box on the model of reproductive health and family planning and

unpacking that some and trying to decide what is the evidence necessary fro the health minister of any country to be able to make that decision, what evidence would help you decide which set of services combined or in isolation from each other would give you the outcomes, the maximum outcomes that you are seeking. So this is about within the reproductive health sector, what do we know about what works and how it works.

The working group actually did discuss this, and we all bemoaned the lack of rigorous evaluation data on different types of interventions and felt that a main focus in this arena should be developing a base of evidence on what works for perhaps different populations of interest, different types of interventions, and the gold standard that we have recommended in the paper is the randomized trial with the hope that it would be possible to do that in circumstances where interventions are being scaled up, so that you can have a control group where the scaling-up has yet to occur, where the intervention has yet to be put in place, an

intervention group where it has already occurred, so that you don't face some of the ethical dilemmas that you might otherwise face in actual experimental settings.

So that is what we have recommended in the working group paper that you read, but in this session, we are going to hear from two individuals, two experts, Dr. Edward Addai and Dr. Jacqueline Darroch, who will talk from two different perspectives.

Dr. Addai is going to talk from the perspective of a policy-maker. He is director of Policy, Planning, Monitoring and Evaluation in the Ministry of Health in Ghana and has over a decade of cumulative experience in the design and delivery of health services, both at the district, national, and international levels. So he will give us the health policy perspective.

Then we will hear from Jackie on the perspective from a foundation, from one foundation, but a large foundation. She is associate director of the Reproductive Health Program in the Bill and

Melinda Gates Foundation and prior to that was in the Alan Guttmacher Institute. Based on your research experience as well as the experience of the Gates Foundation in trying to implement and evaluate, I know, rigorously different models of health services, we would love to hear what would you consider to be research priorities of importance and interest.

We are hoping that each of you will speak for about 7 minutes each, so that we will have about a half an hour or perhaps more for discussion.

So over to you, Dr. Addai.

DR. ADDAI: Thank you very much.

First of all, let me thank the organizations for inviting me to share the Ghana experience. I will talk out of my prepared presentation because I am asking the question do we need a package. I think we need a package.

Do we need something new? For us in Ghana, I am wondering whether we need something new. I think we know what will change, what packages are needed to deliver maternal health.

I also think that we have a fair idea of how to deliver them. I think there are challenges in relation to resources, and there are also some challenges with regard to how to personalize some of the thoughts that we have on how to deliver health services.

Nevertheless, let me say a few things about Ghana. Probably, as some of you are aware, we adopted a sectoral approach to health delivery sometime in 1997, and under this approach, we decided to pool some partners, decided to pool their resources to complement government budgets to deliver a package of health interventions. So that is the context within which we are operating.

It is in this context that we are talking about priority setting. Within the sector-wide approach, a lot of us in the health sector hoped that would have a very rational and evidence-based process of priority setting. Unfortunately, our experience is that is not always so. That is the reality that we face.

What we have learned is that priority setting is driven by institutional mechanisms and by political processes. If the president decides that this must happen, in spite of the evidence, that is what we have to focus our efforts on.

The good news is that this process may incorporate an element of rationality, but not necessarily be completely rational. More often, the process is political, reflecting ideologies, opinions, arguments, and historical commitments. I have deliberately brought this up, so that we can place research in context.

What we have been doing as part of the health swap is to embed a generation and use of evidence into the health sector governance structure and processes. We don't think it is ideal, but what it does is that it brings together multiple perspectives and interest groups and also provides us the opportunity to use evidence in our health summits where we make decisions on priorities and also we negotiate and agree on priorities.

Let me talk a bit about the process itself for us to understand what I am talking about. Each year, the ministry of health and partners go through a very comprehensive review process. It has four main components.

The first is a review of performance of any recipient of budget within the health sector. So what we do is that we look at the performance of every--we call them "budget and management centers." Then the performance is aggregated to a sector level. So everybody who receives public funds has to review their performance, and that is nonnegotiable.

Concurrently, what we also tried to do, this is the evaluation that is to ask ourselves which areas within our programs need to be evaluated and commission evaluations up front and to conduct in-depth reviews to understand problem areas with regard to the way we organize to deliver services.

Alongside, we have researchers who sometimes go along a tangent and do their own research. What we try to do is to engage these

researchers to understand the issues that are of concern to us as a health sector.

We have just finished our summit, and we have had a meeting at which we defined every such agenda that is coming out of the summit, so that our research units can take that forward.

Because the budget management center reviews are done by ourselves and because partners have given us their money to support the delivery of a program of work, we always put together a team of independent experts to review what we have reviewed and provide objectivity into the reports that we have provided.

What happen is that the independent team of experts gives us their recommendations, which we take into a summit and discuss and adopt or fail to adopt the recommendations.

This is the institutional process that we have, and at the summit, we bring together all of our key stakeholders in health. We use the summit to do a number of things. We use it to disseminate the findings of our policy-oriented researchers, at

least those that are relevant to use. We use the summit to account for the performance of the health sector to the general public, but we also use the summit to decide on the priorities for the sector.

For that reason, we normally divide the summit into three parts. The first part is the technical session, which is also the scientific session, what is the evidence on the ground, what research has been done, and we get researchers to come and tell us things that have gone on, on the ground.

The second part is cost on the program of the work itself, and we look at our performance with regard to the program.

The third part, which I guess is very relevant to this meeting, is the business session. In fact, at the business session that will review the evidence, we debate. Then we argue on them, and then we define priorities. Then we capture these priorities within an aid memoir that is signed by the minister of health and the heads of delegations of our partners.

Subsequently, we start a planning process. So now we are going to start a planning process that is guided by the priorities that we have defined in the review that just ended.

The planning process also ends with a summit, during which partners endorse the program of work and the priorities defined in it and decide to use it as a basis for providing support for health sector. So this is the swap arrangement.

From a priority-setting perspective, the point I am trying to bring out is that we have a review process that is linked to a planning process, but that measures the issue of perspectives, interests, and evidence. That is what we are operating in Ghana.

The key question probably for those of us here is how do we deal with reproductive health. I am sure a lot of us want to hear something about that.

Unfortunately, we don't stick our necks out to deal with reproductive health. What we have done is that we have a package of interventions that

should be delivered through the district health system.

The way this package was defined, we went through a rationale process involving a review of the diseases and the conditions that are in Ghana, the level of delivery of various interventions, the costs, and also what we call the strategic objectives, whether we should aim at eradicating control or eliminating.

We also looked at our national obligations. If the whole world wants to eradicate polio, then it immediately becomes something that we as a nation must comply with. So, if the whole world wants to go MDGs, then we have to look at MDGs. So that is how the international community influences priorities.

Basically, our package of interventions are aimed at improving maternal and child health, controlling communicable diseases, preventing and controlling noncommunicable diseases, and health promotion and nutrition.

Reproductive health is one of the key priority health interventions for improving maternal and child health. So that is how reproductive health is positioned.

Let me say up front that on paper, it includes all the packages defined at ICPD. In reality, this is not so. In reality, our focus is on save motherhood, including family planning, and I am saying including family planning because we are having debates on whether family planning is part of save motherhood or not.

In reality, we are also giving less attention to concepts of reproductive tracks post-abortion care and menopausal issues.

What we normally do is we use our review and planning process to make marginal changes to the content in each package and also to improve the coverage of existing packages. So what we do is that we have it at the summit. We decide if it is too small, let's expand it, all the populations that are being covered, let's expand access.

Let me also say that we have adopted an integrated approach to service delivery, and that is part of the packaging. It is a package delivered within an integrated system.

For that reason, our strategy is to strengthen the district health system to deliver the package of interventions and reorient the central level, including regional and tertiary hospital to support district-level activities.

We, however, note that within this integrated approach, some diseases targeted for eradication may need vertical approaches. This is polio, and in particular, we have made room for a vertical approach, but even within this vertical approach, we insist that a district system be responsible for managing such programs.

Within this broad system, how are we allocating resources? Broadly, we have decided to allocate resources to support integrated service delivery at the district level. For that reason, unfortunately funds are not allocated to specific programs, but rather to levels of the health service

or to levels of the health system; for example, funds allocated to health centers, to district hospitals, to regional hospitals, and to tertiary hospitals.

We have also adopted a pro-poor approach to resource allocation, and therefore, we are refining our resource allocation to increase resources to the poor areas.

Within this broad arrangement, we have defined clear resource shift targets. That is moving more resources to the district level, away from the teaching hospital level.

The way we have allocated resources, we expect budget and management centers, such as health centers, to plan and organize their services and system to deliver the package of health interventions and achieve targets set centrally.

Reproductive health services are delivered within this integrated approach to service delivery, and funding from reproductive health, by and large, comes from the pooled fund mechanisms.

However, there are a few exceptions. UNFP continues to provide earmarked funds to support reproductive health activities, and USAID also provides some funds, but the position of UNFP is shifting. Indeed, last year, UNFP provided funds and decided to join the pool funding mechanisms. We hope that USAID will shift more and more funds into the pool funds.

So I think the issue that we are raising, how does the national-level leverage district-level actions to ensure that districts, indeed, meet the priorities and targets defined centrally, and that is the challenge that we face. What we do is that we use the monitoring system to ensure that districts are on national-level priorities.

In the particular case of reproductive health, 4 of the 31 sector-wide indicators are reproductive health indicators that are reported and monitored routinely by the health system. For us, in Ghana, every manager knows that poor performance in reproductive health means poor performance of the health sector. So we are using reproductive health

as that indicator of performance of the health sector.

Given the recognition that information systems are very weak, what government is doing, what the ministry is doing is it is investing in strengthening the health management information systems and also the analytical capacity of the sector, so that we can always get the information and analyze the information that will enable us to know what districts are doing that.

In the last 3 years, concerns have been expressed about the plateauing of coverage of key health indicators in the country. As Uganda was making the presentation, I could really identify with it.

Questions are being asked, nevertheless, about whether the integrated approach is the best way to do business; in particular, because there is no obvious link between priority health interventions and resource allocations to these interventions. At the same time, there is serious development of international and, indeed, national

earmarking of funds to support specific programs. So things are changing in Ghana, really.

For example, the Global Fund for AIDS, at the international level they are earmarking funds to support specific programs. In country, we are also earmarking funds to support poverty reduction and also for central-level procurements, such as procurement of reproductive health commodities. Because USAID moved away from procuring, we have made funds available for doing that.

It is also becoming very difficult to convince donors with specific interests in particular diseases and programs that the integrated approach is the way to go. We have, therefore, under enormous pressure to go back to vertical approaches to planning and implementation in the name of scaling up. So this is where we are as a country.

At the recent summit, we agreed also that the current pace of development in the health sector, if we continue at the current pace, we will not achieve the Millennium Development Goals,

particularly those related to maternal and child health.

So what we have done is that we have used our reviews and summits to identify a number of priority actions to scale up reproductive health services, all within an integrated fashion, and we believe that if we are able to use the integrated approach to deliver the health outcomes that we have defined, then we can justify using that approach. Otherwise, in the next couple of years, that is going to collapse, I am afraid.

The policy interventions we have now introduced include exemptions of antenatal care and supervised delivery from user fees. I am sure most of you are aware that most of our services are tracked user fees. At least we intend to sustain the exemptions until the national health insurance fully takes off. We are currently implementing that.

There are discussions about whether to include family planning, a benefit package or not.

At the moment, it is not part of the benefit package.

I might say that these issues are not necessarily evidence-based. We thought that user fees introduced exemptions. We have introduced exemptions.

We have also conducted a review of health sector response to maternal mortality in light of the [inaudible]. Currently, we are developing a reproductive health strategy, and we are incorporating training in deliveries management in the curriculum of our community health nurses, so our community health nurses can manage deliveries.

The bigger question is that we do not know where our maternal mortality ratio is at the moment, and therefore, we are conducting a maternal mortality survey.

I would like to conclude by saying a few words about linking evidence to priority setting and program design. For us, I think it is important to recognize one reality, and that is policy- and decision-makers will make policies and define

priorities based on information available to them. For that reason, researchers have to be ahead of policy-makers in the generation of evidence in order to make the evidence available to policy-makers before the decisions are made.

A number of lessons, nevertheless, about the Ghana experience that I would like to share, the first is that it helps to have an institutionalized policy process that links the examination of evidence and the decision-making process, as we have done in Ghana by having the technical program and business sessions during the summits.

[Side A of Audiotape 5 of 6 begins.]

DR. ADDAI: The second is that defining the research questions from the reviews and experiences on the ground enables us to conduct policy-relevant riches that then feeds into the policy process, and it also creates demand for the research that is being conducted.

The third is that timeliness of research findings is crucial if we are going to get policy-

makers to use the research findings, the evidence in their decision-making.

Last, but not the least, is that more effective dissemination of research findings that draws out policy-relevant conclusions and uses the language that policy-makers can understand is critical.

Thank you very much.

MS. GUPTA: Thank you.

DR. DARROCH: Thank you very much.

I was asked to give some comments mostly from the chair I am sitting in now when I am home, which is at the Gates Foundation. As I have been listening today, I am also thinking of how similar it is to many of the situations that especially the policy-makers are talking about in terms of making decisions.

Although I know at the Hewlett Foundation that Sarah and Tamara and Coolie [ph] just need to say this is important to do. President Brest will either say yes or take it to the board and get a yes.

As much as reproductive health was one of the really core areas of funding from the very beginning of the foundation and it continues to have a strong commitment, there is a lot of overlap in our environments that we are talking about because this is set within our foundation within a global health group. We have had some others that have also had their requests for funding for education, global libraries, and specific Northwest giving. But within our global health program, there is competition for resources and attention across a wide variety of areas, mostly those that apply and lead to different part of the global burden of disease, most of which are diseases.

So I will just mention that, first of all, I think that in terms of catching attention and also in terms sometimes of immediacy, reproductive health can feel, thinking of the chart, very far removed from impact when you are talking about other diseases that are more clear in terms of their morbidity and mortality immediately.

First of all, I would say that we obviously make use of research and also fund research, and I thought I would split it into kind of three areas. One is for priority issue, problem choice, and solution choice, where is the foundation going to be investing, then in terms of development and tools and strategies, in terms of what the foundation provides funding for, and then a category of advocacy in which I will talk a little bit about the implementation issue as well.

I just want to follow up with echoing the point that was just made about Ghana. As number-pylic, I guess, as we are of just focused on numbers and evidence and as important as evidence is, it is not the only factor. The touch of the heartstrings, the attention, the new issue is something that also sometimes can overwhelm some of the evidence in terms of focus.

First of all, in terms of making decisions about essentially where to be investing, I would say there are two areas where I need research, we need research, and use it. One is in terms of the

potential impact of what the problem is or what the solution might be and then the promised impact.

First of all, just in terms of the potential impact, our measures are very much focused on health, on attributable benefit, what is the attributable benefit of some intervention essentially for saving dallies [ph], although we can make those measurements based on mortality.

I mention there that I think we still have some real measurement issues in the field in general, but certainly in our field. One is the weights within the dallies, the way to which morbidity especially is weighted in terms of how important it is viewed, which may be different from women and from a particular setting than it is in the data that we use for weighting them, then mention that has already been made here on the difficulty of identifying morbidity and its cost in terms of health, in terms of well-being as well as its economic cost, and then, as France Donnay had mentioned, given the fact that we really have very poor data on induced abortion, the real invisibility

of many of the costs of poor fertility control and unavailability of means for it. So measurement is something that still is needing to work on because these are the tools that we need for making comparisons and arguments.

Then, also in terms of impact, I wanted to mention something that I don't think we have talked enough about, and that is relationship to other goals or other interventions in a package or in a program.

One is the potential for, I will call it, the multiplier or additive effect. One maybe that I think is hopefully clearest is that we are now focusing a good bit of attention on infant health and especially newborn health in terms of lack of care and attention in those early hours and days. I have not heard any discussion in that about the fact that many of the babies who are born are to mothers and families who do not want to have that child and what impact that may then play on the high rates we have of poor care and then infant mortality.

I am not arguing that that swamps the poor health care, but the ability to better plan may have an impact on helping us better use the tools we have in terms of health care in those early times.

Another one we have just mentioned is HIV prevention and treatment, and I think there that we really are moving to a point where we are really needing to start to talk about how much more efficient as well as effective it may be to combine services in various ways rather than simply the idea that it is the right thing to do, but to talk about efficiency.

There is another area of relationship that I want to mention, and that is our difficulty as a foundation, but as a field, of also thinking about what impact changes in one area will make on another. I will mention specifically something that has just been touched on here, the commodity area.

Thoraya knows we have been working very hard together with Elizabeth and Steve and others trying to assess and figure out ways to improve the real commodity crisis we have, at the same time

starting to ask some questions of if, in fact, we could move commodities well through the system, do we have the health personnel there to deal with them, especially if we talk about switching some of the commodities or some of the methods that people are using towards something that is more provider-dependent like IUDs, are we going to have the capacity, and would especially Sub-Saharan African countries have the capacity to move toward that.

I am going to go really fast and mention then just my bullet points, not my detail on it. One is talking about impacts and the need to measure those. Another is everybody, including us, we are arguing is promising for the impact or the vision this solution can have, and often, we don't talk about the context that is important for that.

It is much harder when we are arguing for something that has an indirect impact; for instance, fertility controls impact on health versus reproductive health, if we call it treatment of SDIs or SDTs, maternal and child health, so separating out direct and indirect effects and giving a bit

more attention to the importance of the indirect effect there of fertility control is important.

Often I think we are in a position in the health field of we can talk about typical use. We have got methods that can be very good, but we know that they are very difficult to use effectively, and our delivery of them is so dependent on systems and providers and then the ultimate users. Whereas, in many other fields, they are comparing it to perfect use. If we have this vaccine and it will reduce X disease by this much and we immunize this many people, here is what we can achieve. I think we have a lot of lessons that people need to learn to understand how perfect use gets translated into the actual impact of a program. Sometimes we are at a disadvantage because we are talking to people who have the vision of perfection when we have reality.

In terms of developing tools and strategies, the issues that Cynthia mentioned what will work, the importance of development, and really evaluation, but also I think both within this foundation and in general, it is so much sexier to

do that kind of work, develop a new tool, than it is to give attention to the issues of implementation, to replicating programs to fidelity of programs to scaling up, what are the system demands, and in all honesty, that leads me into the advocacy area because the foundation's emphasis has moved quite strongly towards development of tools and strategies with I think more than an assumption, but a real commitment to the goal that then governments and the private sector would implement those. I think that still is an open question sometimes.

Actually, we are beginning a project called Planning for Success to try to address what might be needed for especially the new disease treatment methodologies that are being developed in terms of scaling them up. In that, much of what we are paying attention is the importance of advocacy, to get support and resources at national and international levels.

There, I would also echo that evidence is important, but the crucial elements of it has got to be relevant to what questions there are, the time

frame is one that I think really scares all of researchers because it takes time to do the research, and the policy attention may well have passed us by.

Also, the people in the packaging, that it is accurate, that there is certainty to it, and it is simple, but not simplistic, but that we also build that capacity and think from the very beginning about it.

The final point that I would make is both what I have seen in this past year, but also especially from my past life at the Alan Guttmacher Institute is that it is a luxury for us in this field to assume that we are the only voice presenting information or advice.

Actually, the Uganda experience is one which we were having some discussion last night. Everybody wants to know what is the one thing that made a change come about in Uganda, and on the one hand, we were talking about as researchers how much we would like to research more and find out and at the same time recognizing that certainly in this

arena there are enough hints of impacts from so many factors that now what we have are warring factions that are coming from as much ideological as any other perspective that are grabbing onto bits of research. I think this happens often in reproductive health. So that not only do we need to have good information, but we need to be able to have it to bear up against the tax as well as address others with different perspectives.

MS. GUPTA: Thank you very much.

We don't have a whole lot of time yet. So I am going to go straight to any questions or comments anybody has on what was presented.

Yes.

MR. CHATAIGNER: Jean-Marc Chataigner.

I appreciated very much the two exposes. I like the idea of Jacqueline and to say that you have too much initiative and you have to take the initiative to stop all of these initiatives. I think we bear a responsibility, a donor responsibility that we didn't talk so much about that, but I feel that the donors, in particular the

G8, has a big responsibility in changing the international agenda on pushing its share of one new initiative, one new idea, and this different vertical fronts that you have done. I believe that we have to think about that, about the international architecture, and to really check when you are launching something new that there is not something older existing and to try to use that.

What is striking me also is many times we are always saying the field is important, the country's view is important, but at the same time, as it was cited by Edward, we are asking for specifics that are coming from heads of state, and we need perhaps to clarify this issue.

I have two questions for Edward. One, just to note if in this swap that you described to us, does it integrate NGOs, and do you integrate, in fact, the private sector, or it is only a swap fro public donors and how do you work with NGOs?

The second question is about the relationship between the sector-wide approach and multiple budget support approach. Some people and

the donors are advocating for general budget support. Do you feel that there is still a need for the kind of swap that you have described, just to put more focus on certain issues?

MS. GUPTA: We will take more questions.

Yes, Mayra.

MS. BUVINIC: We recently did a review of cost-effective interventions in health because we were looking at gender differentials in health, and sort of what comes out of the review is really that there is a lot that is known in the area of reproductive health and MCH in terms of cost-effective packages.

My plea here is let's not re-create the wheel. Let's go back. This is substantial from the earlier studies of the Population Council and quality of care. The issues I think is not sort of how cost effective these packages are. The issues are ones of access, how do we get them out there and have implementation, as Jacqueline was saying.

I think that is also where the issues of what do we do for young people, how do we deliver

health to specific populations, how do we combine reproductive health and HIV/AIDS interventions, that those seem to be more so it is not the cost-effective packages per se, but issues of access and implementation.

MS. GUPTA: Margaret.

MS. KAKANDE: Thank you, Madam Chairperson.

I have a comment on--first of all, to thank the presenters for their presentations. There has been a little talk about evaluations. So, for me, I have a comment on evaluation, on effective use of valuative findings in the area of reproductive health, given that the outcomes from this sector are influenced by a number of outcomes, if you are talking about reproductive health. So, for me, the issue is attribution.

If you are doing evaluations in this sector, how do you handle attribution of the results? Take an example of maternal mortality. This can be a result of things at different levels. It can be household-level decisions. It can be

issues of access, do they have the roads, or it can be issues of the facilities or the health centers.

So, in this case, if you are looking at maternal health as an outcome indicator and you are doing an evaluation, how do you deal with attribution of the different levels and be able to tell us what it is that the health facilities and reproductive health services are accountable for in the findings for us to really make meaningful use of their findings?

MS. GUPTA: Why don't you get ahead and answer this set, and then we will take another set.

DR. ADDAI: Thank you very much.

Let me deal with the last part, one comment. I agree fully that we know the packages. The real challenge is operational, let's get on and deliver the packages to the right target groups.

The first question was around the household in Ghana deals with NGOs and private sector. In reality, what we recognized when we designed the swap that the government would be pooling funds and the government would create an environment where the

government would keep all the funds. So, as part of our sector-wide indicators, we have actually defined the proportion of funds that must go to the private sectors, and this is monitored and reported on as part of the swap.

I must say that in dealing with the private sector, we have been able to look at the admissions sector. We treated the admissions sector a lot better than we have treated the private for-profit. What we have done, actually my office is setting up what we call a strategic initiative fund that would go just to the private sector. In reality, governments are not used to giving private sector money for service deliveries. So we are using the indicators in the sector-wide process to ensure that there is adequate incentive within the system to ensure that the private sector gets resources. We get a lot of pressure from our partners to demonstrate result in this area.

Swap and general budget support. I have made this case and continue to make the case that budget support will work in situations where you

have a functional swap, the links of anybody that supports a functional sector dialogue. The moment that breaks down, in my opinion, budget support will not work. This is what I think.

I don't have the evidence, I am afraid, but this is what I believe.

In view of that, we consistently make the argument that us partners move into sector support. They should not take the technical expense away from the sectors, and we continuously make that argument for that to happen.

We don't know whether partners will listen to us. What we know is that the decision to go into budget support is more ideological than anything, and the decisions to do things really rests with the partner institutions. We think that there is value in maintaining a vibrant sector support even in budget support.

For us as a sector, we have tried to integrate the budget support, harmonize the budget support process, and a sector-wide approach to minimize transaction costs. The transaction cost is

very, very high. You get called to various meetings.

The way we have tried to do it is that we have tried to use the sector-wide approach to determine what must be determined within the budget support in terms of what must go into a policy matrix. So the indicators, targets, triggers are determined at a sector-wide level and from our program of work.

We use our review process to decide on whether we have achieved those targets and triggers, rather than what we jokingly say let a group of economists and budget support determine whether heath has achieved its targets because we think that achieving those targets and triggers is more complicated than just taking them off.

So that is how we have negotiated the ministry of finance, and we are trying to harmonize the two processes.

What we have also done as part of the move towards budget support is to wave the ABUGA flag.

In other words, we are saying 15 percent of recurrent budgets must come to the health sector.

For this year, we were able to negotiate with our ministry of finance to allocate us 15.3 percent of the recurrent budgets. We have engaged the ministry of finance with the ABUGA flag, made arguments, and we are getting that money. We do not believe that we can get more than that, but that is where we are as a sector.

Evaluation of findings, I am trying to delineate attribution for outcomes. From a policy perspective, it is a very exciting thing to do, to try to show whether motherhood interventions or for that matter routes or whatever have led to reduction in maternal mortality. Nevertheless, I do not think that the issue is--I mean, what would you do if it turns out that save motherhood did not. Are you going to stop delivering save motherhood? My position is that it might be more exciting to show contribution, but in reality, it is an exciting thing that must continue. I would just like to demonstrate that I have used the cost-effective

intervention. I have achieved maternal outcomes, and I would not bother too much about whether it is from the health sector or from the rural sector, but I am humble enough to understand that others may be interested and I will use the findings when they come up with them.

In reality, I am saying that it wouldn't change the package that we are delivering. So, with my limited resources, I don't put money in it. I'm sorry.

MS. GUPTA: Let's go Stan, Alex, and Elizabeth.

MR. BERNSTEIN: I am the carrier of some comments and questions from Thoraya and than a simple question for myself.

Thoraya had to leave, but she thinks that one thing that should be given some priority in the discussion--and I guess, Edward, it relates to your presentation--there are counter-pressures towards integrated packages versus vertical pipelines with regards to cost effectiveness and monitoring and accountability issues. Her question concerns the

evidence base that the various delivery mechanisms either do seriously contribute to senses of ownership, cost effectiveness, a reduction of transaction costs.

She raises the question also about what is needed and what is the evidence base on monitoring and evaluation of integrated programs, and that is part of the accountability issue as well. I am sure we would be interested in hearing your responses to that.

I have, as is my usual style, a complicated question, but I will make it very simple. The bottom line on this one is when you talked about the integrated package, that at the moment family planning is not included within it, and that there has been an extended debate about that. My question is what has been the nature and content of the debate and what kind of information might inform the discussion that would lead to one outcome or another.

MS. GUPTA: Alex.

I would request that you keep your questions short, so that we can get everybody in.

MR. EZEH: I will continue from where I stopped, just to also add, who are the people that are really involved in that level of discussion within Ghana, but more importantly, I think your presentation brought to home the challenge that reproductive health programs face in many parts of Sub-Saharan Africa.

If you look at the MDGs, almost five of the eighths are related to reproductive health, but it is not clearly stated as an objective that can be pushed forward. If you look at this, four of your indicators of the health sector performance are in reproductive health indicators, and yet, in the actual implementation of the programs, these are not taken on board.

I am thinking, how can we be able to unpack this reproductive health and really identify the key levels that can strengthen and push the health sector reform and then be able to, in a way, take them on board and strengthen an argument for why

they should be incorporated at this level of policy decisions?

MS. GUPTA: Elizabeth.

MS. LULE: Ghana is a real puzzle to me.

If you look at the TFR, it has continued to go down. If you look at the CPR, there is a disconnect there. It is about 13 percent. So what actually is driving the demographic transition in Ghana? It is unsafe abortion.

I am wondering if in your research, you have actually unbundled what is happening exactly in Ghana. Of course, your MMR, which is unreliable, is very high. So, yes, family planning can be the means to safe motherhood, but I would think that following on, on the question that Stein asked, that the debates should be driven if you provided family planning by itself, could you actually achieve other health outcomes, including the safe motherhood one.

My second issue is on the policy intervention. You have just introduced free antenatal and delivery care. I believe it is focused just on the poorest northern provinces. I

am not quite sure to what extent it has actually been implemented and whether the money is actually flowing to the district health system.

For research purposes, I am very much interested in whether we have actually baseline that we could use to evaluate the impact of this policy, and I believe we have the variation within the country. We could compare the south to the north.

Also, I would interested to know if you actually have looked at the household expenditures and consumption patterns, given all of the other methodological issues that we have, what is wrong with the well-faceted quintile that we use, but also the consumption indexes that we use at the moment.

MS. GUPTA: Steve and then John.

MR. SINDING: I really thought, Edward, your presentation was excellent, and it has stimulated equally excellent questions which we could go on with for a long time.

I was going to ask a question about this issue of evaluating health outcomes in terms of the improvements in health status, which inevitably

leads you toward vertical programs, no matter how hard you try to avoid that, whether it is externally driven or internally driven versus health systems outcomes; that is, access and availability and the assessment of the population regarding the quality of the services they received.

It seems to me that which outcome measures you use will have a profound impact on some of these resource allocation questions. I would be very interested in how Ghana is addressing that question.

Then a second and more general and simpler point has to do with the role of NGOs. Historically in Africa, NGOs have carried a very large proportion of the burden of health services, and I am talking about religiously based as well as secular institutions.

One of the things that deeply worries me about the sector-wide approach and health sector reform and the way things are going in the sector is that it is so statused, that it is essentially a dialogue between donors and governments about government programs. I really wonder in Ghana, but

in other places as well, whether the role of NGOs going forward is given adequate attention in the resource allocation question. To what extent are these systems discriminating against effective existing nongovernmental delivery systems?

MR. : In this discussion of resource allocation within the sector, I think there is one issue that perhaps deserves a little more attention. When you have limited resources, then you have people asking for investments in maternal health or in child health or in family planning, but one advantage of family planning is that it has an effect on the other sectors directly.

Roughly, one in five births are unwanted. If you could eliminate those unwanted births, it would benefit the woman directly, but it also will certainly make 20 percent more resources available for maternal health. If you have the same resources, you have fewer people needing them. So your colleagues arguing for that should support your claim for more resources in family planning.

MS. GUPTA: Did you want to go first, Jackie, since you didn't get a chance the last time around?

DR. DARROCH: No. Let's let Edward talk, but I appreciate the note. It also is just the more we can talk about direct impacts, the stronger we are, and that is a question about the kind of research that we are here to think about because it is directed at a different question. It is directed to this long-term question, which is also important, but may not be what we really need at the time.

DR. ADDAI: I am not sure whether I can answer all of the questions. We have 3 minutes. So I can jump some questions.

[Laughter.]

DR. ADDAI: So the question I will jump is the first one, a very complicated question, just to say that we monitor the sector-wide level. So we resist monitoring individual packages, the complete package. Sector-wide, we have defined some indicators that tell us whether we are doing well as a sector or we are not doing well. We leave the

program managers to deal with the details of the various programs.

Family planning is included in an integrated package. What happened was that we have just started insurance, and family planning was not included in the insurance package, which means that we have to finance family planning from the government budgets. So it remains part of the integrated package with a different financing mechanism.

Who are the people who are involved in the swap? It starts with everybody who is somebody with the technical session and with the program review, but the business session is for what some people call the "elitists." The business session is for people who are contributing to the health fund and to the sector budgets, so ministry of finance, ministry of health, and then our donor partners, but before we go into the business session, everybody else can have a say in the discussion in the swap.

I would like to maintain it that way, so that you move from these big discussions to more

focused discussions that enable you to make decisions.

I have so many questions.

MS. GUPTA: Any that you think are important.

DR. ADDAI: Well, the question on free ANC and delivery, we have gone nationwide. We have gone nationwide with it. We have problems with managing exemption schemes, but in reality, what we know is that the evidence that we collected at the end of 2004 is that the poorer regions are doing better than the richer regions. So we are beginning to go back. We are seeing our resource allocation criteria may have worked. Let us revisit the resource allocation criteria again, so that we don't make the richer regions worse off. So there is some work that is going on in that area.

We are working with impact to conduct an evaluation of exemptions schemes and other reproductive health schemes. Like the discussion we had here, they want to be able to identify with/without, before/after to pick out certain

intervention areas and outcome areas, and we are telling them that the door is closing because we are going nationwide. So, at best, it is going to be a process in which some regions have gone slower than expected. So, if they don't hurry up with that evaluation, it is likely that by the time they realize it, all regions and all districts would have implemented the scheme.

I have been told I should stop. So I will stop.

[Laughter.]

MS. GUPTA: I suggest you continue the conversation over coffee because I have a strict message here from the organizers saying I should wind this session up. There were clearly lots of important points made that have methodological considerations for us in the working group that we need to pay attention to, an important point about watch what you spend your money on in terms of research, do it on things that will be of importance practically. The issue of integrated packages has come up again and how we evaluate that, how we sort

of deal with the issue of attribution, and most importantly for me was the first point that Edward made, which was that there is the political and there is the evidence-based decision-making. The point I think that we need to pay attention to is how do we use the evidence base in order to attract or move the political agenda.

So I think I will stop there, and we will break for copy for 5 minutes. So grab a cup of coffee and come back to the next session. Brings your coffee back.

[Side B of Audiotape 5 of 5 begins.]

Wrap-Up

MR. LEVINE: This will be the last two sessions of the day for the next hour or so, and it has been I know a long day for everybody. I am hoping that other people's brains are functioning a little better than mine.

We will have the last couple of sessions of the day to try to sort of draw out what we have learned in this conversation and what the steps might be going forward, and then if we do our work

well, we get the benefit of being able to go outside for a breath of fresh air and to toast our hard work for the day. So, hopefully, that will give us motivation to work just a bit harder over the next hour or so.

I have the unenviable position of doing a kind of instant recap of what the working group might take away from this discussion, and it will be a poor substitute for what we will do over a slightly longer period of time when we have a chance to reflect a bit more on what we have heard, but it will, hopefully, just be a check to see that at least some of the main points have been captured.

Before starting, I just want to observe that in this room today, a couple people have left, but in this room today, we have had something between 25 and 30 organizations represented and people from about 21 countries, at my rough guesstimate, although I don't know everybody's nationality. So I might be a little bit off on that. Like Hans-Martin, I don't know if he is German or British or American.

MR. BOEHMER: I am a full European these days.

[Laughter.]

MR. LEVINE: Right. If I put the whole EU together, there might be a slightly smaller number of nationalities, but still a very impressive diverse group of perspectives, and it has been a very rich discussion.

I have five points that I am going to take away from this conversation and really a very rough synthesis. So I am going to say what they are and then go back and give a little bit more detail, bt really very briefly.

The first is that I take away from this conversation that the work proposed, looking at the relationship between reproductive health and economic outcomes at the household, community, region, and national level represents an important area of inquiry.

We have heard from UNFPA, from the Bank, from DFID, and most importantly from economic and

social planners and policy-makers the importance of building this evidence base.

Second is that we need to recognize the value of getting and making available, making accessible the best available evidence in the short term and also working on developing the best evidence over the medium and longer term. We have heard a lot of requests for accelerating it to the point where we can actually say something that can be valuable for policy-making today and tomorrow, not just in 5 years.

Third is that we have heard about a number of elements that people observed were missing from at least the way the working group's work was represented in the background paper, and I will go through some of those.

Fourth, there has been a lot of discussion about the package. I will say a couple of words about that in a moment.

Fifth, there has been some discussion about the context for research and for translating

research findings into something useful for the policy world.

Back to the first point, that this is an important area of inquiry, there was a clear point made at the beginning of the day about the value of understanding this relationship between health and fertility and key economic outcomes, economic growth, poverty reduction, and importantly, what I took out of part of what Jean-Louis Sarbib said, understanding how economic growth strategies are related to poverty reduction. This question of will the growth be shared and how will it be shared may have something to do with reproductive health and the consequent impact on women's empowerment and access over resources.

We also heard about how decisions on funding priorities are taken and influenced by three key audiences for some version of this research agenda, finance ministers who may be interested in economic outcomes--and particularly, Margaret and others told us in the outcome of labor force participation and employment--also the audience of

donors who may be interested in the link between investments, both by countries and by the donor agencies, on the one hand, and results on the other, some concern about the focus on short-term thinking and short-term results. The third sort of potential audience, at least indirectly, would be the general public or the interested public who might be looking for the results of research on how public investments are related to meaningful outcomes at the household level, reductions in morbidity and mortality, for example.

The second point that I referred to was the need to get both the best available evidence and also the best evidence into the hands of policy-makers. Points were made that decisions will be taken at the policy level regardless of whether the research community agrees on whether the evidence base is strong. So it is incumbent upon all of us to make sure that the best available evidence is made accessible.

Yet, at the same time, there is a persistent call that I at least heard among the

group for answering the question of what works in many different guises. This will clearly require a longer and sort of strategic investment in research designed to answer that sort of question. It is not something that actually is going to be made available overnight.

At the same time, Mayra made the very useful point that there is a strong base of knowledge about, for example, cost effectiveness of different kinds of interventions and that where we really need to work in that domain is pushing on how to know, how to expand access, and how to implement programs rather than on the much more sort of narrow technical question of the cost effectiveness.

I have a long list of what I will refer to as "missing elements." At the risk of this sounding like a laundry list and also at the risk of not including every single thing that we heard, which we do have detailed notes on, I am going to just highlight a few.

One is that we are missing a clear focus on adolescents for whom the benefits of better

reproductive health will be felt both immediately and over quite a long life cycle.

We are missing an emphasis on sustainability and environmental issues as well as on peace and security questions.

We are missing an adequate attention to the role of ideational change and political leadership.

We need to focus more and more explicitly on building links between macro- and micro-level research.

We need to include some look at the effect of reproductive health and family planning programs on family structure and what then the more distant outcomes of that are.

We would be well advised to separate out the short-term and the long-term pathways that we have sort of been confusing and confounding in putting those together in one framework.

There are several others. There are probably, actually 10 more on my list, but in the interest of time, I am going to put them aside, but not forget about them for the future.

The fourth point I wanted to make, as I said, was on this question of the package which came up in this conversation and was not actually present in much of our working group discussion. In this, there are three points that I heard, and it was different interpretations of what "package" might mean, I think.

One is how can reproductive health services be organized to support health systems development more broadly, so where does reproductive health services fit in the broader package of the health sector.

A second is what are the potential synergistic relationships between investments in reproductive health and in education or other types of particularly social investments. That is another kind of package.

Then the third kind of package, which is very big and frankly hard for me to think about, but clearly on everybody's mind is what is the combination of economic and social sector policies that could accelerate a kind of pro-poor growth.

I am not 100-percent sure where the working group is going to take this, but I know that these sorts of questions about where reproductive health is within this broader set of interventions, both within and outside of the health and social sectors came up in every single one of our conversations. So it is clearly something that is on people's minds.

Finally, on the context for research, there were some very useful reminders that developing an evidence base is only one part and sometimes a small part of the broader effort to make social policy more responsive to the poor; that there are many political realities to be taken into consideration, and that those are actually quite extreme in the case of the reproductive health sector. Whereas, Jackie usefully pointed out, at least what I heard usefully pointed out is it is not a case of sort of arguing for something against a known hypothesis. It is arguing for something against others who may be arguing for exactly the opposite type of

approach. So that is a real challenge that is almost unique to reproductive health.

Also, in the context for research, there were several comments about the value of providing support for African institutions and researchers doing work on their own environment.

Our friend from Ghana reminded us of the value of having an institutionalized policy process that systematically has a way to use the results of research as well as the value through that institutionalized policy process of involving the policy audience, the policy-makers in defining what the core research questions are.

That is something that we are trying to do in a limited way in this meeting, and clearly, it is a reminder. I have learned from this meeting of the tremendous value of doing that and the importance of making sure that in any of our recommendations we are supporting that sort of process going forward, that it is not a one-off kind of exercise.

So, with that, I will close humbly, asking for any comments on major things that I have missed.

We will also be sending around more extensive notes from this meeting, but I would love to hear from people, particularly if you disagree with anything I said.

Tom.

MR. MERRICK: On your last point, I would like to refer to page 9 of the report where there is a discussion of research strategies. The report mentions two strategies; one, the use of available household survey data, and the other on panel survey data. Embedded in that recommendation, I think there is another agenda, which is the whole question that came up at several points in the discussion about standards of evidence, which I think could be a bit more explicit in the discussion of strategies.

For example, the first strategy, I would take as a statement that also it is not necessarily to repeat what you call "gold standard causal research" in every single instance that you want to move toward policy recommendations at the country level that one might on the basis of existing gold

standard research be able to come more quickly to conclusions at country level.

Where it would also be helpful on that recommendation is recognizing that the strength and the direction of the causal relationships is often context-specific; that is, what we have heard about fostering, for example, not to go to the extremes of--what are they called?--the swamps of contextual something or another. But context does affect the outcomes, whether it be labor markets or gender systems or family structures, so to have some guidance for investigators or some further reflections for investigators who would follow strategy one on how to do that effectively, to draw on the known causal relationships and apply that with single-round survey data, for example, in their country, so as not to be led astray in terms of policy recommendations or to come up with recommendations that might lead in the wrong direction. I think it would be helpful to make that standards of evidence either strategy or guidance a bit more explicit in this strategy section.

MS. BIRDSALL: Ruth has asked me to take over the chair, and let me call on Sarah.

MS. : Tank you. I think you did really an excellent summary, but in terms of what I would hope that the working group will think about, I want to second Tom's suggestion. I think that would be extremely useful.

Some work along those lines, related work sponsored by MacArthur, is looking at other available datasets and what is out there and just some guidance to us for the future, where those gaps are.

I also have a problem, a real problem I always have had with context. Everything is related to everything else, and everything is context-specific. So what can you do? Are you going to research every single village everywhere all the time? So some guidance from the working group on that question would be helpful.

MS. BIRDSALL: Elizabeth.

MS. LULE: You talked about what works, and I think you are also involved in the disease control project.

Many of the chapters actually do talk about the cost-effective interventions, and I was wondering perhaps if part of this work we could compile from the various chapters, what they have put together as cost-effective interventions rather than reinventing the wheel, and then perhaps begin to see where the gaps are.

MS. BIRDSALL: Steve.

MR. SINDING: I am concerned about relevance. We have had around the table today a very knowledgeable, deeply committed set of insiders, people who all know a lot about and care a lot about reproductive health, although we may sit at various points along the spectrum from researcher to policy-maker, but I am concerned about whether we know enough about the questions that policy-makers want answers to.

It seems to me that an important task for the working group and for those setting the research

agenda going forward is to examine that question empirically; that is, to undertake some kind of an analysis of the major information gaps that the pragmatic minister of finance has or others who are involved in these resource allocation judgments.

Even the representatives of the World Bank at this table who come as close to a minister of finance that we have are far more sophisticated in their understanding of the issues that this group has been talking about than the pragmatic finance minister is, and I think we need to know more about the perceptions of that community about sexual and reproductive health and about whether Nancy's listing of the reasons they are not funding us is accurate.

Jotham.

DR. MUSINGUZI: Thank you.

I am just trying to reflect on the question of relevance, and I am not so sure that this is something that can be sorted out.

I think my colleague, Dr. Richard Muga, made the point that some of these ministers of

finance, where they are appointed yesterday, maybe tomorrow they will not be there, but they probably would like to hear about something they can be do within a very short time.

If you talk about the research agenda, to what extent does it need to be relevant in the context of the MDGs and the way we are going to move forward, such that we can seem to be not only relevant clearly in the short and medium term, but also to look at priorities set by the global agenda and we know that our ministers will finance? Our countries are heavily influenced by the bilaterals and multilaterals that are strong and have monies and things like that. So to what extent this can also be addressed is an issue, I think.

MS. BIRDSALL: Paul.

MR. BREST: I certainly don't disagree with any of the suggestions that we try to provide evidence and frame it in a way that is useful in the short run, but these problems are not going to go away in the short run. Twenty years from now, unfortunately, I think, it is going to still be

important for people to understand what the relationship is between reproductive health and economic development and economic welfare at the household level. So I would not subordinate the short-term answers to setting out a long-term research agenda.

MS. BIRDSALL: I think we should stop in order to give time to our two speakers, but I am going to ask a couple of questions of us. And I am going to pretend that I know what the policy-makers' questions are. So I am going to ask these two questions for the working group to revisit tomorrow, hopefully in the light of what the real policy-makers said today.

One question is the what works question, but I don't really think that you researchers are going to come to any conclusions about cost effectiveness of alternative interventions that are really going to affect much, whether if I could add to the budget of the health ministry versus the education ministry versus the rural roads, public works group, et cetera.

I think I want you to tell me something about what is effective, period. Don't mix me up with details on cost effectiveness because I don't think you really can ever figure that out, frankly. Even more than effective, I want you to tell me what I can implement that will work at all, that will even be marginally effective.

So could you please tell me what is from past experience where budgets are limited, institutions are relatively weak, I have problems with my civil service, what has worked? What interventions have made any difference? That is my first set of questions.

The second question that I have as a policy-maker--this is sort of fun--is this package issue. I heard you talking about package, and really, what I was thinking because I live in this world of MDGs and the first MDG, poverty reduction, sometimes thought of as in one category and the other MDGs thought of as being in another category, so I am in this world where the donors are talking to me about poverty reduction and growth on the one

hand and human development and social interventions on the other hand. So what I really want to know is not what difference reproductive health makes to economic outcomes. I want to know what difference a package of social interventions at the household level makes for short-run and medium-run economic outcomes. I am the finance minister, by the way. I forgot to say that.

I am not that interested in your arguments about the relative importance of girls' education versus reproductive health versus preventing AIDS because all of these things are difficult to implement, and if any of them can be implemented effectively, including vertically, then maybe it is worth doing.

But really what I want to know is, assuming I could respond to the great needs of my people and respond to the donors' interest in seeing human development and wanting to believe that human development in the short run is consistent with economic growth in the medium run, what difference does it make? Why is my country going to be

different from Sri Lanka where they have been doing these social interventions for a long time and they have relatively high levels of education, relatively low levels of fertility, all sort of a context that is reasonably good in terms of well-being, but they are not seeming to succeed on the growth path?

Those are my two questions that I hope we can come back to tomorrow, which I gleaned from the discussion today, with apologies for missing part of the discussion which was unbundling, I suspect the social indicators.

[Side A of Audiotape 6 of 6 begins.]

MS. BIRDSALL: Two speakers who will really bring it all together for us, John, Health Advisor at DFID.

MR. WORLEY: Thanks very much, Nancy.

I am not sure I am going to be able to rise to that tall order. I want to say a few things about where research and development fits within DFID. I guess the position on population reproductive health research and some of the policy horizons relevant from our perspective and maybe or

maybe not that that will have some implication for the working group.

DFID's mission is defined by the MDGs and a commitment to country processes and sector budgeting as a matter of principle, and based on I think judgment and experience and increasingly recognizing the need to try and find evidence in support of that approach.

I guess also we work in parallel in an environment with an increase in new disease-focused aid instruments and global health partnerships that account for quite significant sums of money. One of the other things that it is going to determine I think DFID policy in the near medium term will be the recommendations of the report from the Commission for Africa.

So where does research fit? I guess DFID's medium-term strategy, which is I think is available on our website, highlights the importance that DFID attaches to research and I guess kind of the place of research within DFID.

If you read this, it is very evident that a key focus is on diseases of poverty and development of new products such as microbicides and vaccines of medicines for malaria to combat diseases of poverty, and the place of social science and economic research including that related to population and reproductive health is seen to provide an important platform for influencing policy and in steering strategy. What is perhaps less defined is where it is and how it takes place.

A key point of the strategy also is that DFID needs to be clear about where and how best it can make the most difference in terms of the research that it supports and where we get the biggest bang for our buck, I guess, and being clear about the potential value of what we are doing, why we are doing it, and where and with who we are doing it, and I think increasingly a recognition that we need to position our contribution within the context of what others are doing and work collectively and collaboratively.

I think it is probably true to say historically DFID's sort of funded research is a bit of a hobby, and I think the establishment of a new central research department and research strategy is trying to put a little bit of discipline on where research fits within the organization. That is quite new for DFID.

One of the things that is reflected in the strategy, if not exactly what we are doing, is a recognition that we need to do much, much more to strengthen research capacity within partner countries in order to better support the countries themselves to generate, use, communicate, and put evidence into policy and practice.

So where population reproductive health research fit? It is one priority among many, and an important task for us is to be clear about when we talk to our secretary of state, our ministers, our management, and our central research department colleagues about what the key gaps in knowledge are and what the key priority researchable problems are. One of the things that strikes me from the

discussion that we have had so far is that there are a lot.

The reproductive health and child health team and others in the DFID Human Development Group need to be able to make a convincing case to colleagues who manage our central research department why and what population and reproductive health research is important, who needs it, and who should be doing it.

Research related to communicable diseases, including HIV and AIDS, is a major priority and has the attention and commitment of high-level policy-makers, and I think this is part of a bigger overall commitment to intensify efforts to combat disease. We can see that within the G8 and other processes, and it is demonstrated by new instruments like the Global Fund, GAVI [ph], and other instruments. It is clear that processes like the Commission on Macroeconomics and Health plays an important role in doing that.

It is somewhat schizophrenic in that you have a principle of related support with these kind

of new instruments kind of flaring almost daily, but none focused on reproductive health, and one of the things, a recent study that we did of global health partnerships, that it did show was that the extra money they generate may or may not be marginal, but they certainly serve as an important focus for advocacy and action. Again, I feel that that is something that we don't have in the reproductive health field.

I would say probably that the level of commitment and political visibility to communicable diseases is something that we don't have in the reproductive health field in the way that we certainly had 10 years or so ago, and I am not even sure it is seen in the way it might have within sort of mainstream policy discourse. I think that is an issue that we need to grapple with.

I think the reasons may be partly political, with a changed kind of political environment, but I think also we haven't kept pace as well as we might in demonstrating, quantifying, and communicating to tell a compelling story about

the links between all aspects of reproductive health and the wider health gain, poverty, growth, and opportunity links that they are, as complicated as those may be. I think also we need to be a little bit more creative in doing this.

Now I need to be able to convince my colleagues in the central research department why we should be interested and, therefore, the extent and burden to be able to convey in some way the extent of burden of reproductive ill health isn't well captured and why it is important to be able to capture and enumerate as best as we can the ill health and related costs that can be averted through investing more and paying more attention to reproductive health.

That is something that I know that in practice, I am in competition with, with other parts of the office within DFID. That is the reality.

Trying to look ahead, DFID is committed to reproductive health and rights in our policy, and we say that the Millennium Development Goals will not be achieved without seeing progress also at

improving access to reproductive health services, and the report of the Millennium Project supports that case.

I guess I am slightly less clear about what else is it that government policy-makers, my ministers, DFID, country program managers and agencies such as UNFPA need to be able to make the case that reproductive health gets the priority we think it should have.

One of the things I ask myself, if I went back to our new secretary, still the same secretary of state, but if our minister asked what are the top three research priorities that came out of this meeting, I would scratch my head because I have got no idea what the top research priorities are, but that is the sort of environment occasionally that we operate in. We have to be able to say these are the top three things, this is why we should be doing them, and I think that is perhaps something that is relevant to the way that you communicate and summarize what comes out of this process.

Once the needs of country policy-makers may be specific, I think the global policy arena provides an important fora for norms and standards for policy and action. ICPD did this, and now the MDGs do it. Clearly, we have now got more than half an eye on this year coming up with the G8, but particularly I guess the AIDS UNGAS [ph] in June and, in particular, the Millennium Review Summit in September as pretty important processes in determining the position of reproductive health within the global policy agenda.

Because they are processes that are important for collective global vision and I think in some way for influencing national policies and responsive, but perhaps demonstrate better than almost any other process that policy is most often not usually based on sound information and evidence, and I think that we need to recognize that.

For me, it demonstrates the importance of leadership of institutions, of all of us here gathered around here in advocating for standards, for best evidence in supporting policy, and I think

ultimately recognizing that a lot of what we do is rather intuitive and based on vision and principle and expectation and not necessarily what we can produce for today or tomorrow in the way of evidence, although recognize that we need to be producing that stuff.

So I am not sure if that helps at all, but I think it is kind of how I feel sometimes within DFID with a budget which is fairly modest in terms of what we can directly do to support research and knowing the kind of ammunition that we need to have to talk to those who do manage more resources than my team in terms of ensuring that we pay our contribution in supporting research that ultimately will make a difference.

MS. BIRDSALL: Thank you very much, John. I think we should remember tomorrow what are the top three research priorities.

Sara.

MS. SEIMS: Thank you.

I have the dubious honor of being the last speaker of a very long and intense day, and I want to thank you all for staying for this.

I thought what I would do just very quickly is revisit why the Hewlett Foundation wanted to drag you here in the first place.

I am a non-economist, and I bring that up now because after I have gone through the Hewlett Foundation why we asked you to come here, I want to share with you those elements of the research agenda that came out this morning that resonated with me, with apologies in advance for the way I would express it which might drive the economists here up the wall. Then I want to say a few words about capacity-building.

So why did the Hewlett Foundation want to do this? That was basically when we were revising our program last year, very conscious of the particular moment in history where family planning and reproductive health was, we felt that we wanted to try to support those activities which would have family planning and reproductive health investments

judged on their merits because we happen to agree with Nancy's diagnosis that there is a whole range of factors of why investments, whether it is the marginal dollar or the absolute dollar, for family planning and reproductive health are complicated. They are the issues of the voice of women, the fact that this area is a nuisance for a lot of policy-makers, the fact that it is so ideologically driven, but also because this is a very complicated area.

Many of you around this table have struggled with this question for a long, long time. If it were easy to answer, it would already have been answered.

So we phrased it. In my non-economist way, I want to have what I hope will come out of this working group. I think enormous progress has been made, and a lot of progress in my mind was made today. It is to answer the question, what is the relationship of the status of reproductive health and household poverty and economic growth.

There are major knowledge gaps. Not all of them can be filled with research funded by the

Hewlett Foundation or even DFID or the Gates Foundation, but let's initially map out what those major knowledge gaps are, and then we can work from there to see how to address them.

We felt by doing so that we would help recapture that compelling idea that drove our field for so long and which seems to be lacking in the field now. If we could find some way to help family planning and reproductive health and its purpose and its benefits link to the broader struggle of poverty alleviation and economic growth, then we would have recovered some of that nobel high ground that we seemed to have lost over the years.

We recognized as we went to this that there are multiple audiences, that there are limits to evidence, but without evidence, then we have no way to navigate the political process, and without evidence, we have no way of combatting ideological attacks. We know it is not sufficient, but we really do believe that it is necessary.

So that being said, as a non-economist, what are my impressions of the document and the

discussion this morning? I have to confess, I was delighted that others besides myself felt that the spider web was a little bit too much, very hard to follow, not quite clear why and why it couldn't be more direct. I am so pleased that no less a personage than Dr. Canning seemed to agree with that sentiment. So I hope that there can be some de-mazing the maze when you meet again.

What I heard over and over again from this morning and the wonderful case studies that colleagues from Kenya and Ghana provided us is if you could have had answers to the following questions, your life would have been a little bit easier. So one was what really is the impact of family planning and reproductive health on health, and then what is the impact on health on household poverty and economic growth.

I think Tom's reminding us of issues of morbidities, that we should not forget maternal morbidity, it is a neglected area, there is a parallel activity that Tamara and I have already

launched to look at abortion-related morbidity and its impact on household poverty.

I think that the suggestion also would have been helpful to colleagues from Ghana and Kenya, which is what was the impact of a reproductive health-linked death on vulnerable households several years later. Was it the tipping point that really got to them? You are saying your earlier research indicated it was extremely important.

I think the whole issue that John raised and Steve seconded on ideational change is very important.

The package business, we have kind of gotten on a package bandwagon, but it is a very complicated thing because it is not just what is in the package and what type of package, but it is the timing of this. I am looking forward to the working group's further deliberation on this, but I hope the working group will keep in mind that at the end of the day, we have to figure out if you do judge it as very important, what exactly are the tractable research questions here.

The "roads not taken" comment, which is something being worthy of research, I think is really important, but I don't know how it can be done. If that bad event didn't happen, if that maternal death or maternal morbidity did not occur, what the impact would be, that was mentioned implicitly or explicitly by a couple of you. I don't know how that can be done. I think it could be a very useful piece of work if it could be done.

I was really intrigued by David's comments that he made several times about how important it is to separate the impact of a mortality-related event and a fertility-related event and its impact on age structure, on family size, on the whole demographic continuum.

David, I really think that you are on to something, and I hope when the working group meets, if that can be deconstructed a little because I sense within it--I don't know, David, how you saw this, in its macro dimensions or its household dimensions, but I as a non-economist see it has

salience for both levels in ways that could be very compelling.

I would also like the working group's opinion on the viability of some of the macro issues of looking at population size and structure on these broader questions of peace and security and the environment. That has been tried before, and it hasn't really had that much traction. I don't know whether it is worth trying again.

Just a few words on capacity-building and the short, medium, and long term. Clearly, capacity-building is an investment in the medium and long term, but we heard over and over again today--and I think specifically what is demonstrated in the Kenya and Ghana case studies--how important local voice is, that the policy dialogue now more than ever with PRSPs has to be led by the countries most directly affected.

I am just very privileged during the time that I will be at the Hewlett Foundation that we, even with our modest resources, will be trying to address the capacity question through investments in

strengthening postgraduate training in a few countries in Sub-Saharan Africa in our continuing partnership with what I think is the most exciting African-based health think-tank ever, headed by my good friend over there, but we know that that is a long-term strategy. There are short-term needs. A lot of this work, even though in 20 years time, a whole different set of people, except Tamara, may be around this table trying to figure it out.

There is some of this work that can and needs to be done quickly, and I would like to have some sense of that from the group.

I am going to stop here and invite Tamara who is an economist to say a few words either to correct me, if I have said something wrong, or just opine on what I might have left out that you would have liked said.

MS. FOX: Maybe I can just ask you to add a little bit about what the Hewlett Foundation is going to do in the coming near term.

MS. SEIMS: All right. What the Hewlett Foundation is going to do in the coming near term is

rely very heavily on you all to answer some of these questions from which we will continue to interact with you and bug you until we understand the answers, and then working with partners, we hope--many of these partners are represented in the room today--to identify a tractable practical research agenda which can be funded. We will fund part of it. We hope others will fund the rest of it. We hope it can be a continual process that will involve partners in the north and the south, and that we hope that we can get to it expeditiously.

MS. BIRDSALL: Great. Thank you both, John and Sara.

I think that those of us who are members of the working group will have a big agenda tomorrow to kind of get our arms around.

Before we close and have cocktails, I want to repeat my thanks to Ruth Levine and Suba for the tremendous work they have done in organizing the working group, helping the working group put something down for all of you to mull over today, and putting together this very good group of people.

I think the conversation has been very rich and helpful.

Sara?

MS. SEIMS: I would just like to also propose a vote of thanks to our chair, to second your--

MS. BIRDSALL: Your confused chair.

MS. SEIMS: --acknowledgements of the excellent work of Ruth and Suba here.

MS. BIRDSALL: Thank you.

MS. SEIMS: But also, I also want to acknowledge, from the Hewlett Foundation side, the real force behind this. It hasn't been Paul. It hasn't been me. It has been Tamara, and to thank Tamara. Ninety-five percent, if not 99 percent, of the Hewlett Foundation contribution to this has come from Tamara.

MS. BIRDSALL: I don't think it is a coincidence that as far as I can figure out, Tamara and Ruth have a mutual admiration society.

Actually, let me say at the end, before we get up, what a privilege it has been for the Center

for Global Development to have been able to play this role so far and how much we will continue to need all of your help in order to bring it to some sort of fruition along the lines that John and Sara outlined at the very end.

So my thanks to Ruth. She wants to tell us something not very important, but probably urgent.

MS. LEVINE: That is what I specialize in: urgent, but not important.

Just a reminder to working group members that we will be convening tomorrow at 9:00 with coffee available around 8:30 at the Center for Global Development offices next door to try to figure out what to do with this input and to respond to the mandate that has been set before us.

If I could just be indulged in thanking the small working party that put together the meeting, Tamara and Elizabeth, thank you so much.

Hans-Martin and John Worley have been very helpful in organizing the meeting.

I want to thank the CGD events team, particularly Sarah Dean [ph] for a tremendous amount

of work, and Suba Nagaranjon, without whom really, literally none of this would have happened. Nobody would be here. There would be no paper. Nothing would exist. So thank you, Suba, for your exemplary organizational skills. Suba is on the leading edge of the next generation of researchers in this field. So keep an eye on her.

MS. BIRDSALL: She will be in the room in 20 years.

MS. LEVINE: She will be in the room in 20 years.

One more thank you, and that is to Judith Helzner of the MacArthur Foundation because MacArthur has over the past several months commissioned a set of background papers that have fed in very much to the work of this working group, and so we have had a free ride on that contribution and I want to acknowledge that.

MS. BIRDSALL: Okay. We are all liberated. Thank you very much.

[End of the conference.]

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