Mr Chair, I would like to start on a very positive note and talk briefly about the progress we have made to date. If I don't do this, I will not be doing justice to this community which has been working tirelessly for so many years.

When I joined the Family Planning world some 25-30 years ago, I was told by my demographer friends that if we could achieve a 1.5 percentage point increase per year in CPR I should be happy.

Today many countries in this region surpassed 2, 3, even 4 percentage point increases in CPR per year. Ethiopia, Rwanda, Malawi, Madagascar, Niger and others have made substantive increase. Improvements which previously were not considered possible.

And in many other countries political commitment is so strong as we heard in this conference from Ministers and other distinguished partners from Senegal, Burkina Faso, Mali, Sierra Leon, Kenya and others. I am very hopeful that the next 4-5 years will bring further substantive and sustainable progress.
The second success is that now the stars are aligned: we have heard from donors of their commitment, particularly from the governments of The United Kingdom and The Netherlands – and we are deeply thankful to them. We have also heard about global and regional level initiatives. For example, the RH Supplies Coalition, foundation partners as well as the good job done at country level by many NGO, civil society groups, social marketing agencies and technical agencies. Even small organization, such as UAFC, has done a good job in promoting female condoms.

I remember the African saying “if you walk alone you may be fast but if you walk together you walk far.” We have now learned to walk together.

In spite of this progress there remain big challenges: Today maternal, newborn and child mortality is one of the largest health inequities in the world, both between and within nations.

The family planning movement has a long history. In 1974 in Bucharest, we agreed that "all couples and individuals should have the basic right to decide freely and responsibly the number and spacing of their children and should have the information, education and means to do so."
In 1994 in ICPD, we further placed FP as part of sexual and reproductive health and reproductive rights, gender and sustainable development.

In 2007 we added the new target to MDG 5 of "universal access to RH " and included the targets CPR and unmet need.

We are on the sound footing. So what do we need to do more of now?

First, to look at the equity issue: why is unmet need 33 percent in the poorest quintile and only 15 percent in the richest? Similarly, how can we address high unmet need among youth, HIV positive couple and hard to reach population groups.

A recent study in Swaziland shows that there is an unmet need for family planning among all women of 24 percent yet the number of unintended pregnancies among women living with HIV is 63.2 percent.

Second, we have to start linking unmet needs with maternal mortality, poverty reduction and social development, as this conference is trying to do.

Thirdly, we need to better serve the needs of youth, ensuing more education, also improving gender dynamics.
Forth, we need to go the last mile, go beyond the district, to community participation where we have to integrate services of family planning, maternal and child health, STI and HIV prevention and treatment and PMTCT.

Fifth, is my favorite topic, logistics management, where we need to continue to improve forecasting, procurement and distribution – broadly speaking, health system strengthening.

Sixth, we need to introduce innovative mechanisms such as: "husband schools" developed in Niger involving men; using mobile phone; task shifting; innovative finance.

Seventh, we need additional investment both from governments and partners not only for contraceptives but also to strengthen the national health supply system – in general, a masterplan is needed for this.

And the final point: although the political commitment is first and foremost important for the progress, the other important factor is the choice that people are given when they go for family planning – what we call the method mix. If you give people a broader choice they are more likely to accept it. Recent DHS shows that Ethiopia has increased implant use from 0.2 per
cent to about 4 percent. And it could have increased further if resources were available. Similar patterns are seen in Mali, Rwanda, Sierra Leone and many other countries. It is therefore important to provide the choice which we have not been able to provide due to upfront cost factors.

So I will call upon the partners and government together to expand choice and this should not be compromised with costs. Indeed this is an investment not cost. Let me remind us all. Family Planning is our right: it is the right of every individual so we should not compromise with cost and we should not focus merely on the numbers.

I thank you.