Integrating
The Cairo Agenda
with
Millennium Development Goals

Summary Report

of the International Forum on Integration of International Conference on Population and Development (ICPD) Goals and Millennium Development Goals,

Agra, India

21-22 November 2005

Partners in Population and Development
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IPH Building (2nd Floor),
Mohakhali, Dhaka-1212,
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GLOSSARY OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
API	Active Pharmaceutical Ingredient
ASHA	Accredited Social Health Activist
CHC	Community Health Centre
FP	Family Planning
GDP	Gross Development Product
GMP	Good Manufacturing Practices
HIV	Human Immune Virus
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IIPS	International Institute of Population Sciences
IMR	Infant Mortality Rate
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
NRHM	National Rural Health Mission
ODA	Overseas Development Assistance
PHC	Primary Health Centre
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PPD	Partners in Population and Development
RCH	Reproductive and Child Health
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RTI	Reproductive Tract Infections
STI	Sexually Transmitted Infections
UNFPA	United Nations Population Fund
USFDA	United States Food and Drug Administration
VCT	Voluntary Counselling Centre

FOREWORD

This publication contains the summary report of the International Forum on the Integration of the International Conference on Population and Development (ICPD) Goals and the Millennium Development Goals (MDGs), jointly organized by the Ministry of Health and Family Welfare, Government of the Republic of India and the Partners in Population and Development (PPD) in Agra, India on 21-22 November 2005. The International Forum was supported by the United Nations Population Fund (UNFPA) and the Hewlett Foundation.

The Forum was attended by more than 200 participants, including ministers and senior officials from PPD member governments, representatives of international agencies, non-governmental organizations and the media and also selected resource persons and experts.

The Agra Declaration, to be found in Annex 1, comprises the final outcome of the Forum. While welcoming the commitment of the heads of state and governments at the 2005 World Summit to' achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, it reaffirms the importance of integrating this goal of universal access into strategies to attaining the internationally agreed development goals, including those aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.' The Board of the Partners, which met immediately after the International Forum, fully endorsed the conclusions and recommendations of the Agra Declaration and agreed that these would guide the future policy and programme approaches of the Partners.

The Partners Secretariat would like to record its deep appreciation to the Ministry of Health and Family Welfare, Government of the Republic of India, for the generous financial and organizations support provided to the International Forum. The Secretariat is also very grateful to the United Nations Population Fund (UNFPA) and the William and Flora Hewlett Foundation for their support.

Sangeet Harry Jooseery
Executive Director
Partners in Population and Development 15 March 2006

EXECUTIVE SUMMARY

The International Forum on Integration of International Conference on Population and Development Goals (ICPD) and Millennium Development Goals (Mugs) was jointly organized in Agra, India on 21-22 November 2005 by the Partners in Population and Development (PPD) and the Ministry of Health and Family Welfare, Government of India. It was supported by the United Nations Population Fund (UNFPA) and the Hewlett Foundation.

The International Forum participants totalling more than 200 included ministers of health and senior officials from PPD member countries, representatives from international organizations, research institutions and NGOs, and selected experts and resource persons.

The Forum was organized to facilitate the sharing of information, knowledge and experience of various countries in integrating the ICPD goals and MDGs. It also provided a platform for giving recommendations through a mutually agreed Declaration for future follow up and implementation through South-South collaboration.

Through keynote speeches, presentation of background papers, sharing country experiences and discussions, the Forum prepared and later adapted The Agra Declaration which included the key recommendations, strategies and follow up actions for the Partners in Population and Development (PPD).

By the Declaration, the Forum reaffirmed its commitment to use effectively the available external and internal resources to achieve ICPD goals and MDGs. It recognized the importance of empowering people at the community level and putting them first with a focus on healthy life. It also urged the participants for paying special attention to the poor to achieve these goals.

The Forum reaffirmed the commitment to implement universal access to reproductive health by 2015 and to include it in the national strategies. While urging the developed countries to increase their Overseas Development Assistance (ODA) so as to reach the internally agreed target of 0.7 per cent, it committed itself to mobilize resources for attaining the ICPD goals and the MDGs.

It recognised the importance of improving human resources, developing institutional capacity and strengthening integration of reproductive health and HIV/AIDS programmes. The Forum called on the Governments to secure a political will to makeaccessible quality reproductive health commodities for its people, and committed itself to promote, follow up and monitor the implementation of the Agra Declaration.

CHAPTER 1: INTRODUCTON

Partners in Population and Development (PPD) is a South-South initiative which was officially launched during the International Conference on Population and Development (ICPD) in Cairo in 1994. Partners was created to help implement the ICPD Programme of Action, which called for strengthening the links between population and socio-economic development and was aimed at the provision of universal access to reproductive health services, including family planning and sexual health by 2015.

The mission of Partners is to help implement the Cairo programme of Action by quickly expanding and improving South-South collaboration in the fields of family planning and reproductive health.

It looks forward to a world in which countries are committed to strengthening their capacities and to creating supportive environments for South-South collaboration in reproductive health, in line with ICPD principles and guidelines.

BACKGROUND

The Partners in Population and Development and the Ministry of Health and Family Welfare of the Government of India jointly organized The International Forum on Integration of ICPD Goals & MDGs in Agra, India from 21 to 22 November 2005. The Forum which was supported by the United Nations Population Fund (UNFPA) was held at the Jaypee Palace Hotel & Convention Centre situated in Agra, the historic city of India.

The International Forum had the following three major themes:

Theme 1: Integration of ICPD Goals & MDGs

Theme 2: Integration of Reproductive Health and HIV/AIDS Services

Theme 3: Reproductive Health Commodity Security

The Themes were structured with keynote speeches, background paper presentations, exchange of country experiences and lessons learned, discussion and deliberations on the presentations followed by a summary of the entire session by the moderator.

The main objective of the International Forum was to share and exchange the knowledge, information and experiences achieved so far in the integration of the ICPD & Millennium Development Goals, Reproductive Health and HIV/AIDS Services as well as in accelerating the Reproductive Health Commodity Security as across-cutting dimension in support of the first two objectives. The Forum also reviewed and deliberated on the suggestions, guidance and visions from the eminent thinkers and professionals, and

formulated recommendations for further follow-up and implementation through South-South collaboration.

CHAPTER 2: COMBINED INAUGURATION OF THE INTERNATIONAL FORUM AND BOARD MEETING

The forum started with ***Mr A. P. Singh, Director, International Cooperation, and Mr S. S Brar, Joint Secretary, Ministry of Health and Family Welfare, Government of India*** welcoming the participants to the joint inauguration ceremony of the International Forum and the Tenth Annual Board meeting of Partners in Population and Development. They acknowledged the role of PPD as a facilitator in formulating and implementing strategic plans, using best practices to make reproductive health services accessible to all. They invited those on the podium to light the ceremonial lamp and declared the forum open.

Dr Timothee Gandaho, Executive Director, Partners in Population and Development, also welcomed the participants and expressed his gratitude to those who had the vision to initiate Partners ten years back. He thanked the organizers and UNFPA for the support they had provided for organizing the Forum.

He mentioned that the greatest challenge of the international community is to share their knowledge and wisdom on key issues of concern like HIV/AIDS and commodity security. South -South collaboration is the most effective modality to improve each other's programmes in population. He cautioned that South-South collaboration is not a substitute to North-South collaboration, but an additional mechanism to accelerate development process in these countries. Describing the problems being faced by members countries like that of the HIV/AIDS, linking reproductive health services with HIV/AIDS services, high Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR), he stressed the importance of sectoral collaboration and integration at all levels. He expressed his hope that the deliberations during the Forum would pave the way for appropriate integration strategies to ensure commodity to those who are poor.

H E Mr Zhang Weiqing, Chair, Partners Board, started by expressing his gratitude to the initiators of Partners in Population and Development. He recognized that Partners has been concerned with developmental issues in many countries and has been making efforts to eradicate poverty, making reproductive health services accessible to poor, fighting HIV/AIDS, reducing Infant Mortality Rate (IMR) etc. He suggested reinforcing high level dialogue, repositioning self-priorities of the countries and capacity building as ways to brighten the future. Mentioning his delight at being a part of the Forum, he wished all the participants great success and a pleasant stay in Agra.

Mr Kunio Waki, Deputy Executive Director, UNFPA expressed his pleasure to be able to participate in the Forum. He called it a unique moment of opportunity for the member countries to express their commitment to work towards internally agreed goals of making reproductive health services and products accessible to all. He suggested documenting competent strategies, facilitating knowledge sharing and capacity building among countries and re-examining policy and support to South –South collaboration as ways for upscaling social programmes. It is important to link the HIV/AIDS programme with other reproductive health programmes, provide leadership training for young people, working towards making treatment accessible to all. He stressed the need for better-disaggregated data, indicators, robust MDG monitoring mechanisms, and sector- wise approach to be able to deal with these issues of concern. He reiterated UNFPA's commitment to support activities relating to these issues.

H E Mrs Panabaka Lakshmi, Minister of State for Health and Family Welfare, Government of India, who was the Chief Guest for the Forum emphasised the importance of integration of ICPD and MDGs, and of reproductive health and HIV/AIDS programmes. PPD aims at promoting transfer of knowledge and expertise in population and development and since the signing of Cairo Conference, countries have taken steps to integrate these into their policies. Ten years ahead of the internationally agreed time-period of 2015, it is time to review future strategies. The government of India has taken steps to reinvigorate its Reproductive and Child Health (RCH II) programme and is committed to achieving MDGs. By launching the National Rural Health Mission Programme (NRHM), the Government of India aims to provide accessible, reliable and effective health care to poor and vulnerable population in all parts of the country. The key aspect of this highly ambitious programme is the provision of Accredited Social Health Activist (ASHA), or a community health worker to provide health care to the village community at their doorstep.

CHAPTER 3: THEME 1- INTEGRATION OF ICPD GOALS AND MDGs

The first theme for the Forum was **"Integration of ICPD Goals and Millennium Development Goals"**. The session was chaired by ***Mr Kunio Waki, Deputy Executive Director, UNFPA*** and co- chaired by ***Prof. P N Mari Bhat, Director, International Institute of Population Studies (IIPS), Mumbai***. The chair opened the session and called upon the keynote speakers to provide the opening comments.

KEYNOTE SPEECH

The key note speech was made by ***Prof. Dr. Haryono Suyono from Indonesia***. He presented statistics indicating the world population growth, especially increases in the numbers of youth and old age population in Indonesia. He also pointed out the demographic transition that had taken place from an "agrarian community" characterised by high birth rate, and low status of women to "technological development" characterised by an urban community, declining fertility and mortality and a lower population growth. Pointing out the rapid population growth in India and China whom he called 'the two giants', he compared their development indicators from 1950- until now.

Prof Haryono suggested three integrated approaches to eradicate extreme poverty among people, namely, improvements in health, education, and generating economic activities. In order to attain these goals, some of the strategies that he suggested were: improving income of young women, providing micro credit to help young mothers, improving quality of schooling, increasing participation in schools, practical business training for out-of-school youth, promoting gender equality, preparing midwives for providing efficient services to the people, providing contraceptives at the local level, improving maternal health, ensuring environmental sustainability, developing facilities for under privileged women, and maintaining and improving international cooperation and networking.

BACKGROUND PAPER PRESENTATION

The background paper on the theme "Integration of ICPD Goals and MDGs" was provided by ***Dr. S.L.N Rao, Senior Adviser, Partners New York Liaison Office***. In his presentation, he highlighted lessons learned by the PPD countries in implementing the ICPD Programme of Action and MDGs, present scenario in Integration of ICPD goals and MDGs, and recommendations for future action by PPD.

Some of the successful approaches in integration have been the existence of strong and sustained political commitment at all levels within the country by successive governments, involvement of civil society, NGOs and private sector, mobilizing domestic resources and providing coordination for external resources, and delivering client – oriented and broad choices in family planning services. Focus on the quality of services, social expenditure programmes for the poor, financial support to pregnant women and use of micro credit have also been successful strategies used by the member countries.

Scaling of programmes in member countries and tackling the 'dragging effect' of rapid population growth on their interventions are some of the challenges that were outlined by Dr Rao.

For MDGs implementation, political will, strong legal frameworks and effective policy, flexible programmes, monitoring and evaluation capacities including data collection and analysis and evidence based approaches, targeting poverty reduction programmes in poor regions have proven to be some of the successful approaches. As far as challenges are concerned, regional disparities, adverse impact of demographic dynamics, challenges in mobilizing resources and lack of strong analytical capacity for research, have proved to be the constraints for the member countries.

Dr Rao pointed out the following issues in integration of ICPD and MDGs: commitment by all stakeholders, broadening the process of designing the Poverty Reduction Strategy Papers (PRSPs) to mainstream population, reproductive health and gender perspective; these agenda to be treated as policy priority, inadequate capacity to undertake needed research, weak analytical capacity and lack of institutionalised and stable systems of statistical data collection and analysis.

Finally, he gave several recommendations for the action by PPD. Higher commitment for population dynamics and reproductive health issues; integration of reproductive health and HIV/AIDS related services; greater attention towards improving maternal health and adolescent issues, need for training of future experts and program professionals and recognizing the significance of capacity building.

COUNTRY EXPERIENCE- INDONESIA

The country experience of Indonesia in integrating ICPD goals and MDGs was presented by ***Dr. Sumarjati Arjoso, MPH, Partners Board Member and Chairperson of BKKBN (National Family Planning Coordinating Board, Indonesia).***

Indonesia has considered population as a key issue in its National Development Strategy. This includes the targets given in MDGs and the ICPD Plan of Action. The Indonesian government has launched a programme in which primary health service and education have been linked with poverty reduction strategy. Also, the National Policies and Programmes for Reducing Maternal Mortality are based on "Making Pregnancy Safer" and Essential Reproductive Health Initiatives. The aim of implementation of these two

initiatives is to strengthen the health systems within the country and identify actions at the community level to ensure that women and their newborns have access to the care that they need. Some measures are: improving skill attendance and quality services, establishing legal aspect and policies of reproductive rights, assuring universal access of reproductive health through primary health care system, integrating family planning into reproductive health services and maximizing access and quality of family planning.

For fighting HIV/AIDS, there are ten priority programs being implemented: IEC (Information, Education and Communication) for adolescents, using condom and dual protection approach and auto destruct syringes, Voluntary Counselling Centre (VCT), education and training for health workers, research and development, monitoring and evaluation, international cooperation, program institutionalisation and laws and regulation.

The measures that have been taken for improving gender equality are: formulating legal aspect of protecting girls and women, gender based violence, trafficking, conducting gender mainstreaming in six major sectors like law, economics, politics, etc, establishing and strengthening women's organizations and women officials through capacity building; implementation of a concept "zero tolerance policy" to eliminate violence against women, law on discrimination against girls, enhancing men's support to women's rights and empowerment, particularly reproductive health and family planning.

The success story of the family planning programme in Indonesia showed the long and cohesive commitment of all stake holders in the country since early 1970s to population programme, particularly for stabilizing population growth.

Following the ICPD 1994, Indonesia made serious efforts to shift the paradigm of population, reproductive health and family planning programmes. Unfortunately the economic crisis in 1997 followed by changes in socio- political scenario and governance 1998 made these efforts more challenging.

Indonesia has offered several modalities for sharing with developing countries. In line with the efforts to improve various aspects of reproductive health and family planning programme in Indonesia, the government of Indonesia has encouraged senior and middle level managers to visit other countries to obtain lessons learned in RH/FP.

The challenges that the Indonesian experience has faced are: decentralization process, building capacities of regional government to plan and implement programs accordingly, obtaining support from international community and providing good governance to the people.

COUNTRY EXPERIENCE 2: PAKISTAN

The country experience on Pakistan's efforts for integration of ICPD and MD goals was shared by ***Dr Mumtaz Esker, Director General, Technical Ministry of Welfare,***

Government of Pakistan. She started by providing an overview of ICPD goals and MDGs. Some of the policy initiatives for integration of ICPD and MDGs in Pakistan have been the Education Policy 1998, National Health Policy 2001, Population Policy 2002 and Population Sector Perspective Plan (2001- 2011), Policy for Development and Empowerment of Women 2002, Poverty Reduction Strategy Paper 2003 and Education for All- 2003.

The Population Policy 2002 of Pakistan envisions limiting population growth and achieving 'population replacement level' by 2020 through expeditious completion of demographic transition. Various initiatives have been undertaken in Population Sector like the National Population Commission, Strengthening of Mobile Service Units, Social Marketing of contraceptives, National Ulema (Muslim religious leaders) Conference etc. The mobile units have been very successful and have achieved near doubling of family planning clients. Community involvement in health has increased; there is greater acceptance of service providers by communities and increased contraceptive prevalence rate among rural women.

In Pakistan, some major issues in integration of ICPD and MDGs are: vicious cycle of high fertility, socio-economic disparity and low human indices, addressing high unmet need for contraception, large adolescent population entering reproductive life, gender inequality, patriarchal society and the difficulty in reaching remote and marginalized community.

The constraints faced in implementing these efforts have been many. The social constraints like the growth of urban slums, migration, persistently high poverty rates, early marriage practices and low female literacy are the major constraints in achieving these goals. Added to these are the traditional and cultural norms, misconceptions and doubts about family planning and contraception, maintaining fertility transition and lowering maternal and infant mortality rates.

Some suggestions provided by Ms Esker for future action are: Mainstreaming of Population Factor in all socio economic development process, ensuring gender equality by educating and empowering women, targeting youth as an asset and promoting public private partnership.

ISSUES:

- What is the impact of implementing social safety nets on family size?
- The developing countries are facing various challenges in population and development, and hence what kind of public-private partnerships could be formed to tackle these challenges?
- Various faith- based organizations resist promoting condoms, how can this problem be addressed?

- In today's times when there is so much focus on 'private' enterprise, how can we still provide 'free distribution of services'?
- What have been the approaches used for social marketing of female contraceptives in Pakistan?
- When we say the term 'good governance' what can be actually done other than advocacy?
- How can the other countries learn from the experience of mobilizing internal resources, which is still a challenge for most of the countries?
- There is an issue of manpower resource crunch and not having enough sensitive staff. What kind of salaries, awards could be considered to motivate people to work towards a better life?
- It is important to have robust monitoring and assessment mechanisms, and there is a need to ensure that proper health information systems are in place. It is not possible to take decisions about policies etc unless there is enough reliable data
- The role of religious leaders in shifting the opinions of youths is very important. Other countries can learn from their experience of working with religious leaders

COMMENTS FROM THE PANEL

Dr. Sumarjati Arjoso responded to some of the above issues by mentioning that in Indonesia extensive condom promotion was done despite a large Muslim population. Some religious leaders are against the use of condoms. The strategy that has been used is to promote condoms as a method of dual protection- to avoid pregnancy as well as RTI/STI and HIV/AIDS. It is not always easy to collaborate with religious leaders, but efforts have to be made. In Indonesia, they have provided condom vending machines in localities of commercial sex workers, near industries, factories, in military dormitories, clinics etc. They also encourage formulation of Memoranda of Understanding (MOU) with military officials, police, and religious organizations and encourage them to attend their meetings and conferences.

Responding to a comment on the role of Primary Health Centre (PHC), Dr. Esker mentioned that the MDG, PHC is a key point. PHC in Indonesia focuses on health programs, education for midwives, decentralization of health services, providing free contraceptive for poor people.

Dr. Mumtaz Esker shared her positive experience of having worked with religious leaders at Ulema (Muslim Leaders) Conference organized by the Ministry of Pakistan. These leaders also visited other countries, gained fresh knowledge and had a good experience of working with the government on population issues.

They have been helped a lot by Greenstar in social marketing of condoms. Through electronic and print advertisements, they were able to break many taboos. She also acknowledged the support by UNFPA which provided them with Mobile Service Units through which they could reach areas that were earlier inaccessible.

Responding to a comment on monitoring systems, she mentioned that the district level monitoring systems have improved over time and the management and flow of information is now more consistent than earlier.

Responding to comment on manpower constraint, Professor Haryono mentioned the difficulty of recruiting personnel in remote areas. In Indonesia earlier, there was a rule under which the medical doctors needed to practise in villages for two- three years, only then they could get their certificate of specialization. This had helped in some way in tackling the issue of manpower resource crunch. The same rule does not stand today and again there is a lack of doctors in the villages. This points out how there is a need for the MDGs to be translated into policy decisions and for seeking political commitment from leaders.

Responding to comment on public- private partnership, Dr Rao recommended two countries which though poor, have done well in mobilizing support from private sphere- Mexico and Egypt. Other countries could learn from their experience.

Before the session was to be concluded, Co-chair of the session Dr Mari Bhat gave research based evidence on how in India, reducing family size in poor families had led to reduction in poverty levels. This meant that just providing Reproductive and Sexual Health Services (one of the ICPD goals) has led to reduction in poverty (one of the key MDGs). This shows that it is necessary to address the ICPD goals in order to achieve the MDGs.

He also gave an interesting example (based on research done by International Institute of Population Studies, IIPS) of illiterate couples who send their children to school, the first generation of school goers- the transition from not sending to school to sending them is marked by the use of contraceptives. That means, having a small family and using contraceptives by the couple, which leads to reduction in fertility, has been shown to have links with the enrolment of the first girl in the family to school. Thus it also has a link with female literacy.

Summing up: Mr Jyoti S Singh, Permanent Observer, Partners in Population and Development at the United Nations

In order to learn from the example provided by Dr Mari Bhat and to translate it into action, researchers and NGOs should explore this relationship further to increase gender equality and broadening choices for women, reducing IMR and maternal mortality, and alleviating poverty so that the general prosperity of population can be ensured.

PPD has developed a publication based on the country experiences on integration of ICPD goals and MDGs. Although it documents the successes and challenges, achieving this integration in reality is even a greater challenge. It needs partnership among government, private agencies, NGOs and civil society. The policy dialogue also needs to strengthen at the level of the national governments. Higher the level of participation, greater the chances of people accepting integration of ICPD goals and MDGs.

Resource mobilization still remains a challenge. Although consistent demands are being made, to

make sure that these yield results, it is necessary to make higher level representations to bilateral and multilateral donors, and to provide them with data that will attract their attention. Demands made by the countries and organizations need to be better articulated. We must also aim at generating more resources at local level and not always depend on external aid.

CHAPTER 4: THEME 2- INTEGRATION OF REPRODUCTIVE HEALTH AND HIV/AIDS SERVICES

The second theme for the day was "Integration of Reproductive Health and HIV/AIDS Services". ***H.E. Dr Khandekar M Hossain, Minister, Health and Family Welfare, Bangladesh,*** chaired the session. It was Co- chaired by ***Ms S. Jalaja, Additional Secretary, Ministry of Health and Family Welfare, Government of India***.

KEYNOTE ADDRESS

The keynote address for the second session was given by ***Dr Nafis Sadik, United Nations Secretary General's Special Envoy for HIV/AIDS in Asia and the Pacific***.

The World Summit at the United Nations in September 2005 gave a new impetus to the international consensus on sexual and reproductive health, in the context of Millennium Development Goals. It is hoped that the World Summit marks the turning point and Governments, donors and civil society should now implement sexual and reproductive health and rights as a routine part of primary health care, and as a critical element in the basic and anti-poverty package. Research and data shows that sexual and reproductive health rights have not receive this kind of importance till now. The maternal mortality rates have hardly changed since 1980s, adolescent pregnancy outside marriage is becoming rampant, family planning is beyond the reach for many young women and in the last ten years, HIV/AIDS has added further risk to the lives of women in poor countries. Research shows that in urban Africa young women are five to six times more likely to be HIV positive than men their age; among a sample of HIV positive married women in India, 90% said that they had no sexual partner other than their husbands. These two examples indicate the greater vulnerability of women to HIV/AIDS.

There is no cure for HIV/AIDS. For many countries with low but rising prevalence, preventing infection offers only chance of escaping a full blown epidemic. So far the tendency has been to treat HIV/AIDS as a separate and special threat to health, and to set up specialised, stand- alone programs for prevention and treatment. Integrating reproductive heath and HIV/AIDS services will help to end the stigma surrounding HIV/AIDS and encourage everyone to see prevention and treatment as a mainstream public health problem; it will apply expertise, human and financial resources efficiently.

Integration promotes efficient use of resources and allows synergy in resource mobilization. The need for treatment and prevention in most seriously affected countries still outstrip resources, and needs for prevention in non- crisis countries are not being met, especially among high- risk groups. The needs are both situational and systemic. There is also a need for more emphasis on services such as strengthening surveillance, testing laboratories and prevention outreach and follow up services. Devoting more

resources, national and international, for the fight against HIV/AIDS will help to reverse this mistaken order of priorities.

Donors should encourage preventive action, before countries are seriously affected. They should make the connections among the MDGs, including women's empowerment and gender equality and HIV/AIDS prevention. Increasingly, donors should encourage integration wherever possible; encourage stronger reproductive health services and improve HIV/AIDS surveillance systems; build up condom supply systems; and strengthen women's organizations and networks. Donors should support governments to concentrate on high risk groups with information and services, and support leaders who take strong positions to end stigma and discrimination.

They should remember that HIV/AIDS is a public health issue, and make their funding decisions with this in mind. The levels of commitment and the flows of resources must increase over the long term, in a reliable, predictable way. HIV/AIDS is preventable. Integrating sexual and reproductive health services and information now, and supplying the necessary resources to do it will minimise human tragedy, help fight poverty and increase human security in the coming decades.

Finally, it was suggested that a high-level dialogue to integrate HIV/AIDS and RH services be set up bringing successful partners together. In addition to this, meeting MDGs is possible through private-public, and international organizations partnerships.

BACKGROUND PAPER PRESENTATION

The background paper on the second theme was presented by ***Dr Angela Akol, Head of Family Health Department, Population Secretariat, Uganda***

Ms Angela Akol started her presentation by highlighting key concerns in integration. Although there had been significant progress in the decline of HIV prevalence, while most of the reproductive health indicators remain poor, are stagnating or in some cases worsening. HIV/AIDS programs are fairly well funded but implementation approach remains vertical. The reproductive health programmes are poorly funded, poorly coordinated and implemented through weak delivery structures and funding for both of these is almost entirely provided by donors. Although the Ministry of Health houses AIDS control programme and RH division they do not plan together. Political leadership demonstrated for HIV/AIDS is lacking for other aspects of RH.

For working purposes, integration is being defined as "delivery of two or more types of services which previously provided separately, as a single, coordinated, and combined service". There are several rationales for integration; many HIV infected women are likely to need reproductive services; women seeking reproductive health services are likely to require HIV prevention, diagnosis and treatment services; RH and HIV/AIDS programmes share several critical components. Some of the opportunities for integration could be: Family Planning services for HIV positive women, diagnosis and treatment of

sexually transmitted infections (STIs), sexual risk reduction counselling, programmes for combating sexual and gender based violence, condom promotion and logistics management.

At the same time, there are various challenges to integrating the two- shortage of manpower, poor remuneration, untrained staff, weak logistics systems, persistence of vertically run programs, stigma and discrimination associated with HIV/AIDS and difficulty in adopting successful models of integration, even when found, because these might need changes in policies and governance.

Changes could be made at various levels for enhanced programme integration. At the policy level, stakeholders can advocate for policies that support integration, implementers can undertake research to provide evidence on the benefits of integration, government health systems need to be strengthen. At the systems level, flexible implementation and galvanizing support for condom programming can be made. At the level of the community, increased community participation, and focus on stigma and discrimination will be needed.

Finally, Ms Akol made the point that integrated approaches should not lead to lower priority for HIV/AIDS, and neither should it compromise the effectiveness of existing HIV/AIDS programmes.

COUNTRY EXPERIENCE 1- THAILAND

The background paper presentation was followed by two country presentations on experiences of integrating HIV/AIDS and reproductive health services.

The first presentation was made by ***Dr Somsak Patarakilwanich, Director, Bureau of Health Promotion, Thailand***. After going through the statistics on HIV/AIDS in his country, he outlined the intervention made in Thailand in dealing with the pandemic. Modified existing family planning and MCH services, Prevention of Mother to Child Transmission (PMTCT) programme, counselling, short courses on ARV and formula feeding had been the key interventions in Thailand. He felt that the poor quality of voluntary counselling, excessive workload of the staff and inadequate counselling skills are some of the challenges being faced.

Thailand's experiences brought out some key lessons- reduce costs by eliminating overlap in services; consider other related dimensions of HIV/AIDS, need of training and team building.

Finally, he recommended South-South collaboration training and workshops on HIV/AIDS prevention and control, observation and study tours from several countries on RH and HIV/AIDS and regional PMTCT training programmes for health care worker.

COUNTRY EXPERIENCE 2-SENEGAL

The Senegal experience in integrating the ICPD and MDGs was shared by ***Mr Abdou Issa Dieng, Population Technical Adviser, Ministry of Health, Senegal***.

In Senegal after the International Conference on Population and Development in 1994 (ICPD), the concept of maternal and child health was replaced by the concept of reproductive health. This concept has been operationalized in the Declaration of Population Policy in Senegal. Reproductive health has been integrated through various components like maternal mortality, risk monitoring, family planning, pregnancy monitoring, exclusive breastfeeding, vaccination, fighting sexual violence and providing services for genital mutilations, reproductive health of young people, and reproductive health of refugees and displaced people.

In terms of services, there exists a division of reproductive health, a national committee to fight against AIDS, and a department for vaccination. In terms of legislation, a law has been enacted on reproductive health in Senegal.

Integration should happen in terms of activities, personnel and there should be the involvement of the civil society in the programmes. The experience of Senegal would help in South -South collaboration. But the model can only be reproduced when there is a political will and conditions conducive to integration.

ISSUES:

- While talking about integration, it is of utmost importance to keep in mind the people for whom the planning and implementation is being taken up. It is necessary that they participate in the decisions being made and have an equal stake in the system.
- The health system in India is already too over burdened, and to tackle this issue, the Government has launched the National Rural Health Mission (NRHM) which seeks to reduce IMR, MMR and provide space for HIV/AIDS intervention. It brings all the various schemes and programmes which were earlier provided in rural India separately, under one umbrella.
- The involvement of People Living with HIV/AIDS (PLHA) cannot be neglected when making programmes. When they disclose their status to other in the society, the threat of HIV/AIDS becomes real to more number of people, as only true experience can make many people believe the real threat of HIV/AIDS. Many a times even the health workers do not want to deal with PLHA. Exposing them to the issue through interaction with PLHA can sensitise them in an effective manner.
- It is important to remember that the point is to integrate HIV/AIDS with Reproductive Health (RH) and not to compromise on the focus that HIV/AIDS is receiving already. Vertical programmes have the advantage of working well because of unique, uninterrupted planning and well -coordinated financial

resources. How can these be retained while integrating the two is the key question.

- This forum can become an opportunity for Partners and various Governments to chalk out a road map for policies and programs, and a commitment can be obtained. It is time that some concrete steps are taken towards these and we go beyond the rhetoric.
- Social problems go beyond service delivery to behaviour change. It is necessary to communicate with people from grassroots so that real change in the attitudes and behaviour can take place rather than very superficial ones

RESPONSES FROM THE PANEL

Ms Jalaja brought out the importance of effective IEC material in dealing with HIV/AIDS pandemic providing correct information to people and aim at behaviour change.

Mr Abdou Issa Dieng, Population Technical Adviser, Ministry of Health shared the experience of his government in involving PLHA in their programmes. The Senegal programme takes into consideration the needs of PLHA at all levels, and also mentioned that it is necessary to inform even the health professional about the need to involve PLHA.

Responding to the comment on vertical management systems, Ms Angela Akol said that there are situations and programmes where vertical management can be the only way. If the same logistical system is used, then just adding the component of HIV/AIDS will not slow down the effectiveness of the health system.

Dr Somsak said Southern countries can provide political support, ongoing training and health workers and provide information- these can be the factors for successful integration.

Dr Nafis Sadik mentioned that the point about the health worker's unwillingness to deal with PLHA is an important one. They may not be fully aware about the implications and ways of spread of the disease, they need to be given proper equipment to protect themselves at all levels. The question of vertical Vs integrated services is a complicated one. While vertical programmes are being planned, it should be clearly express what capacities would they be leaving behind when the programmes stop functioning? Specific issues about integration should be discussed in great detail.

COMMENTS FROM THE CHAIR

The chair Mr Hossain pointed out the utility of the speeches made during the session. Reproductive health and family planning are complementary to each other, just like it is to HIV/AIDS. Government and NGO collaboration and country-tailored programmes are

needed to respond to the pandemic. People should be made aware about the implications of HIV/AIDS, political commitment is necessary, steps need to be taken to make treatment cheaper, medicines should be made more affordable, and donor perception needs to be changed. South-South collaboration is important in this context as these countries have similarity of experiences. Piloting projects in all the countries can be expensive, member countries can learn from the experience of each other.

Commitments need to be made at this meeting so that one can go beyond the rhetoric and make concrete plan of actions. Though the prevalence rate in Bangladesh is low, it cannot afford to be complacent about HIV/AIDS. Steps are being taken in Bangladesh to deal with HIV/AIDS in a big way. Safe blood transfusion mechanisms are being created, screening centres made available, seven different blood tests including HIV/AIDS is being made available to the public, training have been done with religious leaders (Imam) which has yielded good results.

Summing up: HE Dr David Parireneyatawa, Minister of Health and Child Welfare, Government of the Republic of Zimbabwe *summarised the above presentations. He thanked Dr Sadik for bringing out the concern on donor funding. It needs to be worked out how one programme integrating the various components on HIV/AIDS and RH can be designed. Donors are mostly funding HIV/AIDS programmes and it is the responsibility of the Partners to make it more fruitful by integrating these with RH programmes. The leadership and support should come from the Governments and they should even allocate local funds for these programs.*

All the plans and programmes being designed should be people- centric and PLHA should be important stake holders in all program implementation.

SPECIAL ADDRESS BY H E ANBUMANI RAMADOSS, UNION MINISTER HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA

Dr Ramadoss expressed his delight at being able to participate in the Forum. He mentioned that greater efforts at all levels are essential to achieve the MDGs. MDGs are closely related to ICPD goals and the two complement each other.

Reproductive health is central to women's health and for attaining greater gender equity. In the last five decades major strides have been made on this front- more women are entering the workforce and there has been a significant reduction in IMR and MMR.

He expressed his hope that with the launch of the new National Rural Health Mission (NRHM) of the Government of India, greater synergy between the various health services in India would be achieved. It includes programs related to safe drinking water, sanitation, reproductive health and many other components. The aim is to achieve 2.2 % GDP spending on health than the present 0.9%. Decentralised health delivery systems, management at the level of the district, community ownership, induction of village level personnel are the key components of the NRHM. It is first being launched in the 18 regions with the poorest public health indicators. ASHA (Accredited Social Health Worker) will be provided for a population of per 1000 people, and a total of 250 000

ASHAs would be recruited from the villages so that health care can be provided at the doorstep of the villagers.

The focus of the government is to address the regional inequities within the country for which time- bound action plans are needed. The way ahead is a shared vision to reach every child and mother, to address poverty and gender iniquity. The vision is that of a world free of diseases and takes bolder steps which can transfer knowledge into actions.

CHAPTER 5: THEME 3- COMMODITY SECURITY

The panel for this theme was chaired by ***HE Anbumani Ramadoss, Union Minister of Health and Family Welfare, Government of India***. It was co- chaired by ***Mr Jyoti Singh, Permanent Observer to the UN, Partners Liaison Office, New York***

KEYNOTE SPEECH

The keynote speech on the topic of Commodity Security was given by ***HE Dr Zhao Baige, Vice Minister, National Population and Family Planning Council(NPFPC), China***

She started with defining Reproductive Health Commodity Security as ensuring a secure supply and choice of quality contraceptives and other reproductive health commodities to meet every person's need at the right time and in the right place.

The challenges in ensuring commodity security have been mentioned in ICPD Programme of Action. Pointing out the interrelations between Reproductive Health Commodity Security (RHCS) and RH goals, she mentioned that RHCS is essential to achieve the goals of universal access to reproductive health by 2015.

Reviewing the Global Programme to enhance RHCS, she suggested advocacy to build a global political commitment to supply commodities, building national capacity to deliver reliable supplies, financing for enduring sustainable flow of material and coordination of procedures to simplify them as methods to attain commodity security.

Recommending South-South collaboration, she suggested establishment of South -South coordination mechanism, forming technical requirements and products, establishing licensing criteria, sharing experiences, promoting development of related intellectual property and establishing international market as strategies for future action.

BACKGROUND PAPER PRESENTATION

The Background Paper on the topic of Commodity Security was provided by ***Dr Peter Hall, Consultant, Generic Drugs Study sponsored by PPD.***

He began with reminding Partners of the commitment to share resources including reproductive health qualities. He outlined the reasons for contraceptive commodity crisis as increase in the number of people of reproductive age, increased demand for contraceptives, insufficient donor funding and inadequate management capacity.

In most developing countries, the public sector remains the principal supplier of contraception. The use of contraception is cost dependent and hence the government must

be able to purchase quality products for the public sector or social marketing programmes at the lowest possible price.

Although generic drugs are identical in dose, strength, safety and efficacy, and despite there being tremendous capacity for production in developing countries, there are obstacles to their export. Their production facilities do not conform with modern standards, lack of access to active pharmaceutical ingredients and inability to develop full registration dossiers. World Health Organization (WHO) is also pre-qualifying manufacturers of drugs for the treatment of HIV/AIDS, malaria and Tuberculosis (TB) as a precondition for procurement by UN agencies and related groups. This is also being applied to hormonal contraceptives soon.

Quality generic drugs can help address the commodity supply and security needs of lower and middle income countries if Active Pharmaceutical Ingredients (APIs) and production facilities conform to internationally accepted Good Manufacturing Practices (GMP) standards. This is where South-South collaboration can have significant economic advantages. Partners should pressurise WHO to begin prequalification activities on RH commodities and particularly hormonal contraceptives now. International donors and governments must continue to focus on the need to supply contraceptives to meet the needs of the more than two billion people living on less than two Dollars a day.

He concluded by emphasizing that quality generic drugs can indeed help address commodity security if they are of adequate quality and they are cheaper in South!

COUNTRY EXPERIENCE 1: BANGLADESH

The country experience on commodity security was provided by ***Dr Md Serajuddowla, Joint Secretary, Ministry of Health and Family Welfare, Government of Bangladesh.***

In Bangladesh, there is an enormous and increasing demand for modern contraceptives. Government of Bangladesh has taken up major steps in forecasting, procurement, warehousing and distribution of commodities to the end users. He suggested strategies in population policy to deal with commodity crisis- uninterrupted supply of required medicines, special attention to young and newly married couples with unmet needs for contraceptives, freedom and right to choose contraceptive methods, home visits to ensure contraceptives supply and free distribution to poor communities.

The constraints and challenges faced by the Bangladesh Government are: obtaining financial resources and declining donor funds in the light of increasing demand for commodities. He proposed that under South–South collaboration, exchange of ideas, increasing resource allocation, strengthening capacity of procurement can help in dealing with the crisis.

Finally, he stressed that achieving commodity security is a long term effort and various parties need to work together to understand the problems inherent in achieving commodity security.

COUNTRY EXPERIENCE 2: CHINA

China's experience was presented by ***Mr Hu Hongtao, Deputy Director General, Department of International Cooperation, NPFPC, China.***

The major steps that the Chinese Government has taken to ensure commodity security are: strengthened legislation, increased government budget, improved service and delivery network, strengthened science and research network, well established RH enterprises network and production capacity and greater exchanges in RHCS with developing countries.

They have faced the challenge of enormous disparity between regions in providing RH/FP services, increase in migrant population in the country and the fact that most of them are young and in the sexual-active age period, under served in reproductive health for migrant and adolescent population.

Mr Hongtao suggested advocacy to improve RH/FP services to meet the unmet needs, attention to poor areas, and improved quality of commodities, social marketing and improvement in management system and coordination mechanisms as the future strategies to deal with the challenge.

COUNTRY EXPERIENCE 3: INDIA

The country experience of India on reproductive health commodity security was presented by ***Mr B P Sharma, Joint Secretary, Ministry of Health and Family Welfare, Government of India.***

The reproductive health commodities under the Reproductive and Child Health (RCH II) programme are basic contraceptives, family planning supplies, maternal health commodities, and diagnostic kits for Sexually Transmitted Infections (STIs) and drugs. The Indian pharmaceutical industry is the fourth largest producer of drugs by volume and 11th by value in the world. More than 60 establishments in India have been approved by United States Food and Drug Administration (USFDA).

The institutional mechanisms that are in place are forecasting, ensuring quality of commodities, procurement strategy, award of contract and monitoring and distribution plans.

The department procures contraceptives from manufacturers and supplies to the states. These are distributed free of cost through hospitals, dispensaries, Community Health

Centre (CHCs), and Primary Health Centre (PHCs). Social marketing of condoms was also introduced in 1968 under which contraceptives are procured by the Central Government from indigenous manufacturers and supplied to social marketing organizations at highly subsidized rates. They are also given incentives and packaging subsidy.

He concluded by saying the adequate manufacturing capacity exists for contraceptives and other supplies in India. Elaborate procurement system is in place and strategies under NRHM will address the delivery mechanism and aim to make them more effective.

ISSUES:

- How can we do sufficient advocacy within the country to generate demand for contraceptives? It will be interesting to learn from Bangladesh's experience that has been able to create sufficient demand within the country?
- Can capacity within the countries be build so that condoms could de made locally?
- How has India made possible the transition from traditional medicines to modern methods of contraceptives and general health care?
- Setting of a central product procurement centre would be of immense help in coordinating the various processes undertaken to ensure commodity security
- Good experiences of various countries have been shared, and that of others has not been that good. How could others benefit from the successful partners? There was a recommendation to the Forum that sharing of information and best practices be undertaken so that there would be no duplication of efforts and more success stories could be replicated.

RESPONSES FROM THE PANEL

Dr. Zhaio Baige responded to the comments by saying that need for contraceptive has increased dramatically over the past years. On the other hand, investment in reproductive health has gone down. This poses a challenge for Partners which should act as a bridge between the two by showing political commitment to resolve these issues. She gave three suggestions for PPD: One, cooperation mechanisms should be created, there should be sustainable mechanisms under which people can get together and share their experiences. Two, capacity building, not just for the decision makers but also for the manufacturers. And third, resource mobilization is needed not just internationally, but also at the national level for reproductive health commodity security.

Dr Ramadoss responded on the comment about traditional medicines by mentioning that traditional medicine, though popular till now in India, is now being integrated with modern medicine. India will try its best to share commodities, technology and research, especially within the South countries.

Summing up: Dr Dinesh Agarwal, UNFPA Technical Support Group Manager and Technical Advisor-Reproductive Health, India

Dr Agarwal mentioned the need for the member countries to think in terms of six basic rights of the people when commodity security is concerned- quantity, quality, time, place, cost and kind of contraceptive. It means that the people should be allowed to choose what contraceptive to use, when to use it, at what cost, where to get it from, what quality, and how much quantity. When they achieve this, it will mean that commodity security has been met.

The demands for contraceptives has increased over the years, ad more young people are entering the reproductive age group, more women are accessing options available to them and meeting these needs is a challenge to the member countries.

Since the resources are either stagnating or decreasing, there is a strong case for advocating for increased allocation of resources. Focus should also be at local level capacity building within the countries for manufacturing. Countries like India and China can made good use of generic drugs since they have immense capacity for manufacturing and as most medicines are now a part of the new Patent Rule.

PRESENTATION AND DISCUSSION OF AGRA DECLARATION

The Agra Declaration was presented by Mr Jyoti Shankar Singh. He responded to several questions and agreed to a number of suggestions from the floor. The Declaration as revised was then approved by acclamation. Annex 1 contains the final text of the Agra Declaration.

CHAPTER 6: CLOSING COMMENTS

HOST COUNTRY OF THE SECRETARIAT: HE DR. KHANDAKER MOSHARRAF HOSSAIN

Dr Hossain expressed his hope that the participants had a meaningful discussion on the ways and means to strengthen programmes and strategies. They would have reviewed the existing skills and expertise in developing countries for disseminating knowledge and transfer modes of best practices. Identifying technical and training needs may create a new generation of leaders and planners to develop realistic and people oriented programs in developing countries.

The meeting of PPD marks a historical event for integration of ICPD and MDGs and is entering into the next stage of commitments. The discussion about how to strengthen a strategy for South -South programme of action through the Partners Secretariat for further period of its operations will be beneficial for everyone. On behalf of the Government of Bangladesh, he appreciated this inter-government alliance of 21 member countries having a strong commitment to family planning, reproductive health and development programs.

He urged the board members to make a firm decision on the activities and cooperation in the fields of family planning and reproductive health.

UNITED NATIONS POPULATION FUND- MR KUNIO WAKI, DEPUTY EXECUTIVE DIRECTOR, UNFPA

After thanking the organizers, Mr Kunio Waki expressed his confidence that there is a clear direction that this forum has shown towards which the Partners should be heading, following this Forum. Many countries are moving towards spending almost 7% of health budget on HIV/AIDS and there is enough funding to support these programmes. However, there is a resource crunch in the field of reproductive health. The challenge is to be able to successfully integrate the two.

Integrating the two has also proved to be cost effective at a time when the resources are few. Migrants and young people need special attention in the fast globalising world. There is a need to provide integrated mother and child health care, care for HIV/AIDS infected mother and child, and low- cost reproductive health services.

To meet the unmet demands we need to be more strategic, give priority to cost effective programmes, undertake advocacy with the Government and other decision makers and finally mobilize resources at all levels.

He mentioned that he is looking forward to working with PPD further and committed UNFPA’s constant support to all its initiatives.

CHINA- H E ZHAO BAIGE, VICE MINISTER, NPFPC CHINA

In her concluding comments, Ms Baige gave several useful suggestions. She said that the participating countries should commit to providing universal access to reproductive health services by 2010. It should be integrated into the overall health programme of the countries. PPD and South-South collaboration should start by dialoguing at the country level to achieve this goal. They should also commit to mobilise domestic resources to attain MDGs and ICPD goals. The developed countries, through the United Nations, increase their Official Development Assistance (ODA) to reach international target of 0.7% Gross Development Product (GDP) to developing countries. And finally, they should work together with national and international society to implement funding linkages.

She also pointed out some suggestions for PPD follow up. One, commit to share lessons learned through high level policy dialogue; two, commit to address capacity development issues on not just resource mobilization but also about human development and other related areas; three, commit to further promote South–South collaboration by integrating with national projects.

INDIA- MS JALAJA, ADDITIONAL SECRETARY, MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA

Ms Jalaja reiterated India's commitment to provide improved health status for India's people, to provide a sensitive health system, strive towards greater gender equity and mobilizing more resources for health sector. She also emphasised the importance of building valuable partnerships and reaffirm India's commitment to such partnerships.

ANNEX 1:

THE AGRA DECLARATON

International Forum on Integration of ICPD Goals and MDGs
Agra, India, 21-22 November 2005

We, the members of an alliance of developing countries, Partners in Population and Development, accounting for more than half of the population of the world, and many other developing countries attended the 2005 International Forum on Population and Development. The meeting took place in Agra, India on the banks of the River Jamuna, where the Great Taj Mahal stands as a testimony to the artistic glory of the Mogul Empire. The Forum was convened in order to exchange the experiences on integrating the goals of the International Conference on Population and Development (ICPD) with the Millennium Development Goals (MDGs), based on the implementation in our countries of the ICPD Programme of Action and of the MDGs. At the end of two days of deliberation, we adopted this Declaration. We commit ourselves to honour, promote, respect and implement this Declaration for the cause of peace, cooperation, poverty reduction and sustainable development everywhere. We therefore:

PREAMBLE

1. ***Reaffirm*** our strong commitment to the principles, objectives and actions contained in the ICPD Programme of Action as strategic to attaining the MDGs.

2. ***Welcome*** the commitment of Heads of State and Government at their largest ever gathering in adopting the 2005 World Summit Outcome Document to:

"Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development."

3. ***Reaffirm*** the importance of integrating this goal of universal access into strategies to attain the internationally agreed development goals, including those aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty.

4. ***Reaffirm*** our commitment to use effectively external resources made available to us to achieve the ICPD goals and the MDGs.

5. ***Recognize*** that population-poverty dynamics are subtle and complex. In poor families and under-served communities, the dynamics combine to create conditions that are likely to perpetuate poverty, ignorance, ill health, poor reproductive health, high fertility, high infant and maternal mortality and a host of other negative

population and gender imbalances, and further recognize that empowering women, supporting reproductive choices and providing appropriate reproductive health services to poor individuals and households will break the population-poverty vicious cycle.

6. ***Recognize*** that key to achieving the ICPD goals and MDGs is empowering people and community for better knowledge, attitude, and full participation. Putting people first with a focus on a healthy life, education, and improvement of income, with special attention to the poor is likely to achieve these goals.

7. ***Recognize*** with concern that the reduction of stigma, using all approaches including cultural and religious approaches, is a critical element for the promotion of integrated reproductive health and HIV/AIDS programmes.

8. ***Recognize*** the responsibility of Governments to ensure the availability of quality, affordable and essential drugs and commodities, particularly those required for reproductive health.

9. ***Recognize*** that in some of the poorest communities the unmet need for contraception continues to rise, while excess manufacturing capacity exists for contraceptive production in several developing countries.

10. ***Recognize*** that information systems in our countries require strengthening to meet the demands of formulating, implementing and monitoring MDGs.

COMMITMENTS

1. ***Commit*** to implement universal access to reproductive health by 2015 and to include it in comprehensive national development strategies to attain the agreed international development goals including the MDGs and to report on it in MDG monitoring.

2. ***Commit*** ourselves to do our utmost to mobilize our own domestic resources for attaining the ICPD goals and the MDGs.

3. ***Urge*** developed countries to increase their Official Development Assistance (ODA) so as to reach the internally agreed target of 0.7 per cent of GDP of OECD countries by 2015, while acknowledging our appreciation to those countries that have already reached the target and to those that have recently agreed to reach it in the near future.

4. ***Further urge*** the developed countries to cancel or provide greater relief to debt owed by the poorest countries.

5. ***Request*** multilateral and bilateral donors to continue funding HIV/AIDS programmes and to support initiatives that promote linkages between reproductive health and HIV/AIDS.

6. ***Appreciate*** the continued support and assistance provided by UNFPA to all our countries, and request the Fund to further increase its support to South-South cooperation activities inn our countries as also to the Partners in Population and Development.

7. ***Urge*** international donors to provide support to Partners Secretariat for launching programmes to build the capacity of programme professionals of Member Countries in line with ICPD.

8. ***Urge*** Governments, the multilateral and bilateral donors, civil society organizations and other partners to promote stronger linkages between reproductive health and HIV/AIDS to:

(i) enhance synergy;
(ii) improve resource efficiency;
(iii) expand access to and improve the quality of services.

9. ***Call on*** Governments and their development partners to facilitate stronger linkages and integration through strengthened health systems by:

(i) improving human resource capacity and availability;
(ii) developing institutional capacities and availability;
(iii) strengthening the coordination of planning and management cycles for reproductive health and HIV/AIDS programmes.

10. ***Urge*** stakeholders to take all possible measures to eliminate stigma and discriminatory attitudes against persons infected with, or affected by, HIV/AIDS.

11. ***Call on*** partners to build the evidence base and to commit to the integration of reproductive health and HIV/AIDS and Operational research should be strengthened.

12. ***Call on*** governments and international donors, as a matter of urgency, to secure firm political commitment for ensuring the availability and accessibility of affordable and quality reproductive health commodities, especially for the poor, the disadvantaged and underserved groups.

13. ***Encourage*** the use of quality generic drugs, to help address the commodity supply and security needs of lower and middle income countries, provided that the active pharmaceutical ingredients (APIs) and production facilities conform to internationally accepted Good Manufacturing Practices; that data are available to comply with regulatory requirements; and their cost remains significantly lower than other branded products.

14. ***Urge*** South-South collaboration to maximize economic advantages, while ensuring that government tenders include quality criteria. In this context, we urge the rapid development of prequalification criteria and their implementation for reproductive health commodities and particularly hormonal contraceptives.

15. ***Encourage*** South-south collaboration in the transfer of manufacturing technology of appropriate reproductive health commodities particularly to Africa

PPD FOLLOW UP

1. ***Commit*** ourselves to share with each other lessons learned and experiences gained in our countries through high-level policy dialogues in key areas of significance to achieve the ICPD goals and MDGs.

2. ***Commit*** ourselves to address the capacity development issues through effective global and other partnerships.

3. ***Commit*** ourselves to further promote South-South cooperation by incorporating it in our national strategies and national projects.

4. ***Commit*** ourselves to develop a concrete action plan for projects on South-South programmes

5. ***Seek*** commitment by larger and more developed countries of the Partners Alliance to strengthen the capacities of needy member countries particularly least developed countries of alliance in areas that are vital to them.

6. ***Urge*** follow up action by WHO on various recommendations contained in this Declaration.

7. ***Strongly*** commit ourselves to promote, execute, follow up and monitor the implementation of this Agra Declaration that will immensely contribute to the attainment of ICPD goals and MDGs, particularly in low income and the least developed countries.

ANNEX 2

Agenda and Programme of Work

International Forum on Integration of ICPD Goals and MDGs

Agra, India

21-22 November 2005

Venue: Jaypee Palace Hotel and Convention Centre
Fatehabad Road, Agra 282003, India
Tel: (91-562) 233080, Fax: (91-562) 2330850

Jointly organized by

Ministry of Health and Family Welfare
Government of the Republic of India
Nirmal Bhawan, New Delhi-110011
Tel/Fax: (91-11) 23061262

And

Partners in Population and Development (Partners)
IPH Building (2nd Floor), Mohakhali, Dhaka- 1212, Bangladesh
Tel: (880-2) 988 1882, 882 9475, Fax: (880-2) 8829387

Supported by UNFPA and the William and Flora Hewlett Foundation

Sunday, 20 November 2005

Arrival of board Members, Partner Country Coordinators (PCCs), Country delegations and Participants of the International Forum

1700-1900 Registration of Participants

1900-2100 Dinner hosted by Partners in Population and Development

Monday, 21 November 2005

0800- 1000 Registration of Participants Continues

1000- 1010 Lighting lamp Ceremony

1010- 1115 **Combined Inauguration of the International Forum and Board Meeting**

Key Speakers:

- Mrs S. Jalaja, Additional Secretary, Ministry of Health and Family Welfare, Government of India
- H E Mr. Zhang Weiqing, Chair, **Partners** Board
- Dr. Timothee Gandaho, Executive Director, **Partners** Secretariat
- Mr Kunio Waki, Deputy Executive Director, UNFPA
- H E Mrs. Panabaka Lakshmi, Chief Guest, Minister of State for Health and Family Welfare, Government of India

1115- 1130 Tea/Coffee break

1130- 1330 Theme 1: Integration of ICPD Goals and MDGs
Chair: Mr Kunio Waki, Deputy Executive Director, UNFPA
Co-Chair: Prof. P N Mari Bhat, Director, IIPS, Mumbai, India

1130- 1145 Keynote speech: Prof. Dr. Haryono Suyono, Indonesia
Background Paper Presentation- Dr S L N Rao, Senior Adviser, Partner New York Liaison Office

1215- 1300 Country Experiences

Indonesia: Dr. Sumarjati Arjosi, MPH, Partners Board Member

	Pakistan: Dr Mumtaz Esker, Director General, Technical Ministry of Welfare
1300- 1400	***Lunch Break***
1400-1430	Discussion
1430- 1500	Summing up by: Mr Jyoti S. Singh, Permanent Observer of PPD to the UN, Partners New York Liaison Office
1500- 1715	**Theme 2: Integration of Reproductive Health and HIV/AIDS Services**
	Chair: H E Dr. Khandaker M Hossain, Minister, Health and Family Welfare, Bangladesh **Co Chair: Mrs S. Jalaja, Additional Secretary, Ministry of Health and Family Welfare, Government of India**
1500- 1515	Keynote speech: Dr Nafis Sadik, UN Secretary General's Special Envoy for HIV/AIDS in Asia and the Pacific
1515- 1545	Background Paper Presentation: Ms Angela Akol, Head of Family Health Department, Population Secretariat, Uganda
1545- 1615	Country Experiences
	Thailand: Dr Somsak Pattarakulwanich, Director, Bureau of Health Promotion Senegal: Mr Abdou Issa, Population Technical Adviser, Ministry of Health
1615- 1645	Discussion
1645-1715	Summing up by: H E Dr David Parirenyatwa, Member, Partners Board, Minister of Health and child Welfare Government of the Republic of Zimbabwe
1715-1730	***Tea/Coffee Break***
1900-2100	**Dinner and cultural night by the host country-India**

<u>Tuesday, 22 November</u>

0600- 0800	Visit to the Taj Mahal Site
0900- 0915	**Special address by H E Dr. Anbumani Ramadoss, Union Minister of Health and Family Welfare, Government of India**
0915- 1130	**Theme 3: Commodity Security** **Chair: H E Dr. Anbumani Ramadoss, Union Minister of Health and Family Welfare, Government of India**

	Co-Chair: Mr Jyoti S Singh, Permanent Observer to the UN, Partners Liaison Office, New York
0915- 0930	Keynote Speech: H E Dr Zhao Baige, Vice Minister, NPFPC, China
0930- 1000	Background Paper Presentation: Dr. Peter Hall, Consultant, Generic Drug
1000- 1045	Country Experiences Bangladesh: Dr Md Serajuddowla, Joint Secretary, Ministry of Health and Family welfare China: Hu Hongtao, Deputy Director General, department of International Cooperation, NPFPC, China India: Mr B P Sharma, Joint Secretary, Minister of Health and Family Welfare, Government of India
1045- 1115	Discussion
1115-1130	Summing up by: Dr Dinesh Agarwal, UNFPA Technical Support Group, Manager and technical Advisor, Reproductive Health, India
	Tea/Coffee break
1130- 1200	Presentation of the Draft Agra Declaration by Mr Jyoti S. Singh Discussion and Adoption of Agra Declaration
1200- 1300	Closing Ceremony India: Ms S. Jalaja, Additional Secretary, Ministry of Health and Family Welfare, Government of India UNFPA: Mr Kunio Waki: Deputy Executive Director, UNFPA Host Country of the Secretariat: H E Khandaker M Hossain, Minister, Health and Family Welfare, Bangladesh Hair: H E Mr Zhang Weiqing, Partners Board, Minister, NPFPC, China
1300- 1400	**Lunch**
	Conclusion of International Forum
	Tenth Annual Board Meeting of Partners in Population and Development to begin in the afternoon and to be concluded on 23 November 2005
1900- 2100	**Dinner hosted by the Ministry, India**