



# **Consolidating the Gains-Closing the Gaps**

**Positioning PPD in the Post-ICPD era**

**August 2014**



*Consolidating the Gains – Closing the Gaps*  
*Positioning PPD in the Post-ICPD era*

## **Disclaimer**

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*Any reference/quotations used in the report that may not have been demonstrated and credited properly is not an intentional omission on behalf of the authors.*

# Table of Contents

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<i>Index - Tables &amp; Figures</i>	<i>iv</i>
<i>Partners in Population and Development – Member Countries</i>	<i>v</i>
<i>Acronyms &amp; Glossary</i>	<i>vi</i>
<i>Acknowledgments</i>	<i>viii</i>
Executive summary	ix
Introduction	1
Sections	
1: History and Context	7
2. Achievements, Challenges, Gaps	17
3. The Way Forward	21
4. Strategic Options for Equity	32
Annex	39

# Index

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## Figures

- Figure 1: Traditional donor countries stagnate and BRICS countries\* continue to grow. 15
- Figure 2: Progress of PPD member countries on MDGs 4 & 5 by 2010. Reduction of MMR and U5M rate as % of 1990 baseline 17
- Figure 3: Comparison between PPD and non PPD countries in reduction of deaths of infants and under five children (1990–2010) 18
- Figure 4: Projected actual year of meeting MDG targets by the PPD countries at the current rate 20
- Figure 5: Illustrators on interlinking of different MDG indicators and basis for focusing on core results and partnership in other areas of synergizers\* and enablers\* 22
- Figure 6: Comparison of Adult HIV Prevalence and MMR of South Africa and Thailand 23
- Figure 7: Comparison of different regions reaping the benefit of demographic dividend over a period of time 24
- Figure 8: Different stages of demographic dividend: Countries of South East Asia have already reached peaks of ratio in favor of more working people against non working people; Africa (except South Africa and Tunisia– latter not shown in the map) is yet to enter this positive ratio. South Asia and Latin America are catching up 25
- Figure 9: Three types of disparities to be addressed by three different strategies. 26
- Figure 10: India and China: two PPD countries increasingly show higher strength in supplying the global medicines and Active Pharmaceutical Ingredients (API) 29
- Figure 11: Supporting trained human resources from high density human resource country to hot spots is an important strategy to address equity 30

## Tables

- Table 1: Strategic Framework for South South (SS) and Triangular Cooperation 36

## Partners in Population and Development – Member Countries

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**B**angladesh

**B**enin

**C**hina

**C**olumbia

**E**gypt

**E**thiopia

**T**he **G**ambia

**G**hana

**I**ndia

**I**ndonesia

**J**ordan

**K**enya

**M**ali

**M**exico

**M**orocco

**N**igeria

**P**akistan

**S**enegal

**S**outh Africa

**S**ri Lanka

**T**hailand

**T**unisia

**U**ganda

**V**ietnam

**Y**emen

**Z**imbabwe

## Acronyms & Glossary

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### A

API	Active Pharmaceutical Ingredients
AU	African Union
AZT	Azidothymidine, also called Zidovudine

### B

BRICS	Brazil, Russia, India, China, South Africa
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### E

EWEC	Every Woman Every Child Initiative
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### G

GII	Gender Inequality Index
GNI	Gross National Income

### I

ICPD	International Conference on Population and Development
iERG	Independent Expert Review Group (reporting to the UN Secretary General)
IMR	Infant Mortality Rate

### K

KII	Key Information Interview
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### M

MC	Member Country
MDGs	Millenium Development Goals
MMR	Maternal Mortality Rate
MNCH	Maternal, Newborn and Child Health

### P

PMNCH	Partnership for Maternal, Newborn and Child Health (a WHO initiative)
PoA	Program of Action
PPC	Partner Country Coordinators/PPD Country Coordinators
PPD	Partners in Population and Development
PQ	Prequalification

**R**

RH Reproductive Health  
RMNCH Reproductive, Maternal, Newborn and Child Health

**S**

SDSN Sustainable Development Solution Network  
SRHR Sexual and Reproductive Health and Rights  
SSC South-South Cooperation  
STAS South Technical Advisory Services

**U**

U5M Under-5 Mortality  
UNAIDS Joint United Nations Program on HIV/AIDS  
UNESCAP United Nations Economic and Social Commission for  
Asia and the Pacific  
UNFPA United Nations Population Fund  
UNGA United Nations General Assembly  
UNICEF United Nations International Children’s Emergency Fund  
UNITAID First global health organization involved in innovative financing to  
increase funding for greater access to treatments and diagnostics  
for HIV/AIDS, malaria and tuberculosis in low-income countries  
USAID United States Agency for International Development

**W**

WHO World Health Organization

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**Joe Thomas, PhD**  
Executive Director

# Executive Summary

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## *1. History and Context*

### *1.1 ICPD beyond 2014 Review*

The United Nations and other agencies have undertaken to appraise the achievements made and challenges encountered during the two-decade-period of the International Conference on Population and Development (ICPD) Program of Action (PoA). Discussions have been initiated in different fora on the course of ICPD Beyond 2014. The review and the conclusions reached will significantly influence the future of population and development policies at national, regional and global levels.

Partners in Population and Development (PPD) is an Inter-Governmental organization formed during the ICPD in 1994. ICPD Beyond 2014 Review presents a ready-made opportunity to redefine and deliver a more equal, secure and sustainable future for the 4 billion people it represents.

### *1.2 PPD: Mission and Growth*

PPD was constituted in 1994 to augment the strengths of countries of the South through:

- ◆ Power of peer review
- ◆ Experience sharing
- ◆ Transfer of technology for enhancing quality of life among the member states.

Embodying the spirit of the South-South Cooperation (SSC) at its core, the PPD methodology involved sharing of expertise within the South through:

- ◆ Training programs
- ◆ Exchange of specialists and resources.

With 25 member countries representing over 58 percent of the world's population, PPD is the largest global platform facilitating SSC.

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<sup>1</sup>Number of maternal deaths in 100,000 live births

## ***2. Achievements, Challenges, Gaps***

### ***2.1 Progress since 1990***

Commendable progress has been posted by the PPD member countries to achieve all major MDGs. For example, during the period 1990 to 2015, MDG 5 has set a target for countries to reduce their Maternal Mortality Ratio (MMR)<sup>1</sup> by 75%. The overall MMR reduction among the 26 PPD countries was a remarkable achievement – 51% in 2010 compared to 1990. In 1990 the PPD countries accounted for 71% of global maternal deaths, but by 2010 this dropped to 60% of maternal deaths worldwide.

However, progress is uneven. Some member countries have done better than others. Paradoxically, a few PPD countries like India and Nigeria account for a disproportionately high number of both maternal and under-5 mortality (U5M) globally. In addition, there are hotspots or often a single district in these large countries where these deaths are concentrated. In several PPD countries the unmet needs of family planning and adolescent birth rates are high while skilled birth attendance remains average.

### ***2.2 Unfinished Agenda***

Given the enormity of the tasks to be completed and the paucity of resources available, PPD's agenda remains doubly challenging. It is time to take stock of the situation. The need of the hour is to work out strategic pathways for future action. This would enable PPD to realize its optimal potential for delivering tangible results for the benefit of its citizens. Time has come for PPD to stand on center stage and perform its role as an important and influential platform for population and development globally.

## ***3. The Way Forward***

### ***3.1 Focus on delivery of results***

The ICPD PoA has 92 action points while the Millennium Development Goals (MDGs) has 8 goals and more than 60 indicators to measure progress. This paper reflects on how PPD can establish a priority framework similar to the investment framework that has been developed globally for HIV/AIDS. PPD is a small organization. All it requires is to further sharpen its focus to a few key areas where it can impact optimally the resources at its command. For efficient and effective results, PPD should consider itself accountable to achieve targets that are part of MDGs 4 and 5 and relevant parts of MDG 6. Hence, PPD should:

- ◆ Commit to ensure tangible and measurable achievements of Reproductive, Maternal, Newborn and Child Health (RMNCH) through actual support of policies, commodities and human resource support

- ◆ Remain comprehensive by addressing the requirement of information and guidance on other ICPD and MDG themes and play the role of an enabler
- ◆ Put in place among its member countries robust census and data collection systems
- ◆ Prepare regular alerts to enable them to reap the fruits of the demographic dividend, without being responsible for development activities necessary for bringing about the dividend
- ◆ Advocate for gender issues in order to achieve MDGs 4, 5 and 6 but without being mainly responsible for changing gender norms on all spheres of life in member countries.

### ***3.2 Uphold equity as the central theme for the post-2014 period***

Equity, at different levels, is a key area for PPD to focus on. Any improvements here will have considerable spin-off benefits for all other areas of focus and work. In particular, greater efforts are needed by PPD as a global platform to close the gaps:

- ◆ Between the North and the South
- ◆ Between PPD countries
- ◆ Within PPD countries.

### ***3.3 Build on PPD's unique advantage***

PPD's unique strength is scaffolded into SSC. Unlike other global or regional development and support mechanisms, the core value of SSC remains in the fact that it is not based on any political, religious, economic agenda or viewpoint. Instead, it encourages mutual and collective solidarity solely based on the merits of specific developmental needs of individual countries and the global South at large. In the context of PPD's area of work, SSC implies that all countries, irrespective of their political, economic, cultural and religious practices, have the potential to enjoy the highest level of reproductive and sexual health status.

### ***3.4 Partnership for leveraging***

PPD has potential to form partnerships with a variety of international institutions like World Health Organization (WHO), Joint UN Program on HIV/AIDS (UNAIDS), the first global health organization involved in innovative financing to increase funding for greater access to treatments and diagnostics for HIV/AIDS, malaria and tuberculosis in low-income countries (UNITAID) and the UN Population Fund (UNFPA) to address key ICPD PoA and MDG themes. For example, partnering with the Every Woman

Every Child (EWEC) initiative, spearheaded by the UN Secretary-General Ban Ki-moon, PPD could mobilize and intensify global action to improve the health of women and children around the world.

## ***4. Strategic Options for Equity***

### ***4.1 Lobbying and international advocacy***

- ◆ PPD recommendations need to be sent to the next UN General Assembly (UNGA) for post- ICPD review as well as post-MDG discussions.
- ◆ PPD could host meetings of ICPD reviews as was done by the Africa regional office. Such opportunities should also be considered in the future.

### ***4.2 Streamlining global efforts***

- ◆ UN agencies need to redefine their mandates and division of labor. All agencies must work with a similar investment framework and set of standards of interventions with indicators for monitoring.
- ◆ PPD could start diagnostics based on examples from member countries on fracturation, duplication and compartmentalization.
- ◆ PPD could put together an inventory of these packages, unit costs, effectiveness and outcomeanalyses.

### ***4.3 Ensuring PPD participation***

- ◆ Demand official presence of PPD in all relevant international fora to reflect the voices of countries and the majority population of the South.
- ◆ Create an inventory of all international events and initiate a single voice for the South through either organizing member countries or having Secretariat presence.

### ***4.4 Offering solutions to member countries***

- ◆ Peer review of a country program on areas ranging from policy, implementation challenges, strategic plans
- ◆ Analysis of pockets of higher burdens, gaps in achievements/implementation, and support for smart management solutions, scaling up mechanisms, procurement and logistics.

### ***4.5 Commodities and diagnostics***

- ◆ Consider commodities and diagnostics as common areas of collaboration for increasing availability, accessibility, affordability and quality assurance.

- ◆ Work on a common commodity list in collaboration with the UN Commission on Commodity Security.
- ◆ Introduce a common pooling mechanism to create volume and reduction of prices.
- ◆ Create country-wise information based on drug licensing, registration, pricing and patenting.

#### ***4.6 Considering human resource exchange***

- ◆ PPD could put together an inventory (yellow pages) of relevant experts and develop capacity within the organization to broker for such services.
- ◆ On high priority sensitive and policy issues, PPD could consider appointing a multicountry senior officials mission to another country.

#### ***4.7 Transferring of knowledge and good practises***

- ◆ Ongoing facilitation of training and institutional collaboration.
- ◆ Further enhance documenting and sharing of good practices from each country
- ◆ Support scale-up of good practices.

For such an important grouping of nations accounting for more than half of the globe's population, PPD needs to optimize its profile as an influential game changer in the global arena and multilateral policy platforms.

The urgent need of the hour is for a bolder and stronger PPD that asserts itself on the global stage proportionate to the large global population and economy it represents.

## Introduction

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Year 2014 is a historical juncture. It is the 20<sup>th</sup> anniversary of PPD and ICPD and the world is observing the significance of the International Conference on Population and Development (ICPD) in the future development framework. The ICPD agenda is still an unfinished agenda. However, we can expect the post ICPD agenda to be a significant paradigm shift in the global approach towards development implications of population challenges. The Cairo agenda is about respect and promotes reproductive rights as human rights. Under these conditions, women especially, enjoy better health and live fuller lives. Boys and girls alike grow up knowing that they can make their own choices in life. Girls whose rights are understood and protected within the family become women with a strong sense of autonomy, who value themselves, their partners and the rights of others.

These are essential conditions for girls to finish school, marry later and have the children they want. Large families are no longer the norm, and population growth slows down in most of the member countries, providing a window for investment and economic development. The ICPD consensus was the result of wide consultations in countries and regions, with active participation of civil society. The birth of Partners in Population and Development (PPD) is a sterling example of the ICPD consensus. As we are in the post ICPD dialog, it is natural for PPD to be actively involved in the global dialog on the possible outcome of ICPD. It is also an opportunity for PPD to rediscover its relevance and scope in the post ICDP era by exploring the unfinished agenda of ICPD.

Many girls do start but do not complete schooling. Many adolescents are so ignorant of the basic facts of sexuality and reproduction, including how to protect themselves from HIV and AIDS. Many girls are married while they are still in their childhood. So many women, married and unmarried, continue to be vulnerable to gender-based violence. Many women still suffer and die from complications of pregnancy and childbirth. Unsafe abortion is still a major cause of maternal mortality and disability. Many of our member countries are still far from the goal of universal access to affordable and appropriate sexual and reproductive health services. Most services are still directed at married women with children, including sexually transmitted diseases and AIDS prevention, gender-based violence and cervical cancer screening. They do not reach the unmarried, the childless, adolescents – whether married or not – or most men. They do not reach people who

may be outside mainstream society – young people out of school, injection drug users, sex workers or the lesbian, gay, bisexual, transgender community.

We know these are some of the unmet agenda of ICPD. To meet these conditions, we have to recommit to the goal of gender equality with full human rights. There has certainly been a welcome surge in global contraceptive prevalence. However, this was truer for a handful of large countries, and elites in most countries. Women in many countries do not experience that their reproductive life has changed very much since their mothers' or grandmothers' times. Affordable modern contraception is still hard to find and many women accept that unintended pregnancy and the risk associated with it are normal. Unsafe abortion still remains a major cause of maternal death in many countries. Very little progress has been made to address the underlying issues of ideology, prejudice and subsequent policy and program vacuum.

PPD's relevance in the post ICPD era depends on our ability to address some of the salient issues related to universal access to reproductive health, including family planning, population and development. It is increasingly clear that emphasis on the Maternal and Child Health (MCH) delivery model is at the expense of Sexual and Reproductive Health (SRH) needs. MCH programs in most countries are very effective. However, they are oriented almost entirely to married women with children. Women in other categories, including childless married women and unmarried women, and of course men, are effectively excluded.

The best way is to introduce an integrated health system combining curative and preventive services, including MCH. Countries will arrive at their own best practices, but it is a perfectly practical solution – provided there is the will to do it. One of the core consensus of ICPD, was to ensure that family planning was available to everyone who needed it. However, family planning information and services have slid far down the public policy agenda, both in the donor community and among medium- and low-income countries.

Recent efforts to restore focus, such as the London Summit on family planning, are very welcome, but the fact remains that the demand among women of reproductive age is outstripping the ability of countries to meet it. Programs are at best, marking time. In many places they are falling behind.

Since total fertility and population growth rates have gone down globally, in many countries people assume that the urgent need has passed. Majority of the 69 poorest countries constitute the PPD member countries where 73% of the women with

unmet needs reside. In spite of major gains in contraceptive prevalence globally and improved technologies for safe abortion, the unmet needs for Family Planning (FP) and safe abortion services persist, especially in sub-Saharan Africa and South Asia, particularly among the poor, newly married couples, sexually active youth and those in vulnerable situations namely people living with HIV/AIDS, engaged in sex work and exploitative employment, and living in violent relationships. The estimated unmet need for modern methods is 215 million women in the developing world, accounting for about 15% of all women aged 15–49 years. Unmet need for FP is a key indicator for Millennium Development Goal (MDG) 5 and is a critical indicator of human rights and for assessing the burden of maternal and newborn morbidity and mortality.

Sexuality education in adolescence is the foundation of a healthy sexuality in adult life. Yet only a third of adolescents worldwide know how to prevent HIV, for example. Millions of young women go into marriage without even the most basic knowledge of sexuality and reproduction. Lack of involvement of men in family planning and reproductive health dialog is currently fully inadequate. Some of our member countries have even stopped their effort to involve men in family planning, sexual and reproductive health dialog. While post ICPD challenges address the unfinished agenda of ICPD, newer challenges are emerging. The overall challenges of population dynamics, including changes in fertility, mortality and morbidity, migration, population distribution, nuptiality, population growth and decline, and the causes and consequences of demographic change are indeed complex.

However, PPD member countries have achieved remarkable progress in the ICPD/MDG goals. Population stabilization goals that a decade ago seemed unimaginable to achieve are now reality. The rate of population growth has fallen in most parts of the world; a record number of people are accessing modern contraceptives and family planning services. This progress has been achieved in a rapidly changing development framework. 2014 and 2015 are key milestones in the global development goals. A new global development paradigm will be in place in continuation of ICPD and MDGs. South-South Collaboration (SSC) is a key component of this development paradigm. In line with the evolving population and development challenges, the PPD secretariat is equipped to pursue a catalyst role in the global population and development dialogue within the following three overarching objectives:

- ◆ Ensuring human and financial resources are aligned with the core mandate of the organization and supporting the member countries to address post ICPD/MDG challenges
- ◆ Continuing strengthening country focus
- ◆ Lowering overall operating cost and demonstrating value for money.

## *Initiative for strengthening PPD Secretariat*

The on-going realignment of the PPD secretariat on a series of strategic initiatives, based on the significant external review findings is helping to guide the Secretariat in driving changes across all areas of its work. There are three specific secretariat wide initiatives in the area of human resources, administration and organizational design.

For the Secretariat to evolve today into a strong and solid knowledge-based organisation, special attention has been given to strengthen the program team – the annual performance assessment will identify the areas for further strengthening and the proposed revised personal policy manual will serve as a robust guide. Similarly, the annual work plan, the monthly deliverables of the staff and robust internal and external Monitoring & Evaluation framework will all be contributory factors. Gender equity has been given special emphasis while organizational strengthening is being carried out. The Secretariat is also exploring the possibility of attracting voluntary human resources from various other global stakeholders to meet the increasing organisational representational needs. UN bodies in Geneva and regional UN bodies such as the UN Economic and Social Commission in Asia and the Pacific (UNESCAP in Bangkok) and the African Union (AU in Addis Ababa) require greater representational attention from PPD.

- While efforts are being made to ensure greater administrative effectiveness, additional efforts are needed to ensure that PPD has a single administrative system in place. Alignment of governance practices under the single policy framework is to be carried out in the PPD Africa Regional office as well.

Financial oversight and the fiduciary function of the PPD Secretariat are under the constant attention of the Executive Director. Disciplinary action has been initiated against some of the staff for noncompliance of higher accounting standards. PPD is in dialogue with the auditors towards implementing International Public Sector accounting standards.

Designing an appropriate organizational structure is an on-going challenge. Based on the feedback from the Beijing PPD Board Meeting, the organizational design was strengthened and a representational organogram also has been finalised.

## *Strength, weaknesses and opportunities of PPD*

### *Strengths*

- ◆ Derives its mandate from the Charter of Member States.
- ◆ An institution of permanent nature
- ◆ Provides a forum for discussion and inter-ministerial peer review process on population and development issues
- ◆ Concerns of PPD are specific
- ◆ Generates and provides information and knowledge
- ◆ Provides opportunity for multilateral South to South and Triangular cooperation
- ◆ Based in the Global South to address the concerns of Global South.

### *Weaknesses*

- ◆ Membership is limited only for Global South
- ◆ Prohibits membership of private citizens and civil society
- ◆ PPD mandates often overlap with other international organizations resulting in a complex network
- ◆ Weak resource base – in relation to the expectation and the mandate of the organization.

### *Opportunities*

- ◆ A credible voice of Global South on Population and Development issues
- ◆ An agency mediating South-South Cooperation in the area of Population and Development
- ◆ Convening capacity. Annual, International Inter-Ministerial Conference on Population and Development
- ◆ Fostering population and health diplomacy
- ◆ A catalytic opportunity in global developmental dialog on Population Dynamics, Population Stabilization, Family Planning, Sexual and Reproductive Health Rights, Gender, Equity and Rights and its implication on population dynamics.

Against this backdrop PPD has initiated a comprehensive assessment in its 26 developing countries to document the achievements, challenges and lessons learned from the implementation of the ICPD PoA (Program of Action) through SSC and to explore a strategic framework for PPD to address these challenges and opportunities and ensure delivering on the Global Post ICPD/MDG Agenda. PPD strategic plan 2014–20 would address these challenges and provide a robust leadership in the post ICPD and MDG development paradigm. Such a plan also should redefine PPD’s relevance in the new scheme of events.

### *Methodology*

The methodology used in preparing this Position Paper has been desktop research combined with Key Informant Interviews (KIIs) involving specialists in the field and compilation of information through detailed questionnaires sent to all PPD Country Coordinators (alias Partner Country Coordinators or PCC). The response to the questionnaires was over 42 percent. Personal and face-to-face meetings were also held with PCC and others wherever possible.

This publication is divided into 5 sections. Section 1 provides introductory information and relevance of the study. It also focuses on the strength, weakness and opportunity of PPD for meeting the challenges of post ICPD and MDGs agenda. Section 2 presents history in the context of PPD. Achievements, Challenges and Gaps are discussed in Section 3. Section 4 presents the way forward and examines the strategic options for equity.

# Section 1

## History and Context

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### *1.1 International Conference on Population and Development*

2014 will mark the completion of 20 years of the Program of Action (PoA) and agenda, committed to by over 179 governments at the landmark International Conference on Population and Development (ICPD) held in 1994.

The ICPD PoA set out to:

- ◆ Provide universal access to family planning and sexual and reproductive health services and reproductive rights.
- ◆ Deliver gender equality, empowerment of women and equal access to education for girls.
- ◆ Address the individual, social and economic impact of urbanization and migration.
- ◆ Support sustainable development and address environmental issues associated with population changes.

The ICPD PoA approaches these objectives not only from the perspective of universal human rights, but also as an essential step towards eradicating poverty and stabilizing population growth. The PoA, along with benchmarks added at the ICPD+5 review, informs the eight Millennium Development Goals (MDGs) introduced at the Millennium Summit in 2000. Five of the MDGs dealing with poverty reduction, gender equality and the empowerment of women, child mortality, maternal health (including reproductive health) and HIV/AIDS are directly related to the ICPD PoA.

### *1.2 Partners in Population and Development: History, Mandate and Evolution*

Partners in Population and Development (PPD) conceived in 1994 at the landmark ICPD, stands to promote South-South Cooperation (SSC) and facilitate implementation of the PoA by countries of the South. With a membership of 26 countries around the world, PPD is today the foremost international effort that is totally dedicated to promoting and improving the transfer of expertise in population and reproductive health within developing countries. One of the key ideas behind forming the PPD in 1994 was to augment the strengths of countries of the South through the power of peer review. This involved sharing of expertise within the South through training programs, exchange of specialists and resources. The statement of PPD member countries made at the PPD Board Meeting in Mexico City in 1998 reads:

*“There is much work to do. While developing country family size has come down from over six to under four, it is estimated that well over one hundred million couples wish to delay or avoid the next birth, but lack the information or means to do so. Maternal mortality remains at a disturbingly high level in many countries, and the spread of STDs and HIV/AIDS is an increasingly serious reproductive health issue. Also, with a larger proportion of the developing world population 20 under 20 years of age, the number of individuals of reproductive age is increasing dramatically. This is the reason Cairo called for a quick doubling in provision of services, citing the need for even more rapid increases in donor assistance or reproductive health and family planning, as well as for girls’ education and other relevant programs. The Partners Population and Development represent a wide range of experience, expertise and success. We join together with other developing countries, NGOs, and donors to implement the Cairo Program of Action which will improve the health and wellbeing of women and their families, enhance living standards and contribute to sustainable development.”*

The critical mandate of PPD is to create a ***South-South Inter-Governmental Partnership*** in the field of Reproductive Health (RH), Population and Development that includes:

- ◆ Expanding and improving South-South Collaboration in the field of Reproductive Health, Population and Development
- ◆ Strengthening institutional capacity to undertake South-South Collaboration (SSC) and exchanging activities at member country level
- ◆ Collaborating for South-South assistance among member countries on a long-term basis
- ◆ Advocating globally for South-South funding and innovation in the field of reproductive Health (RH), Population and Development.

PPD started with 10 founding Member Countries (Bangladesh, Colombia, Egypt, Indonesia, Kenya, Mexico, Morocco, Thailand, Tunisia and Zimbabwe). Currently, PPD has a membership of 26 developing countries (Bangladesh, Benin, China, Colombia, Egypt, Ethiopia, The Gambia, Ghana, India, Indonesia, Jordan, Kenya, Mali, Mexico, Morocco, Nigeria, Pakistan, Senegal, South Africa, Sri Lanka, Thailand, Tunisia, Uganda, Vietnam, Yemen and Zimbabwe), representing 59% close to 4 billion of the world’s population and making it the largest SSC effort of its kind. In 1994, 7% of the world’s Gross National Income (GNI) was accounted for from the PPD countries and 52% of the GNI of all low- and middle-income countries. By 2010, PPD countries accounted for 19% of global GNI and 63% of the GNI of all low and middle income countries.

Since its inception, PPD has effectively contributed to the implementation of the ICPD PoA within the broader framework of the MDGs through high level advocacy, policy dialogues, exchange of knowledge, best practices, technical cooperation, capacity building and operations research in its member and non-member countries. PPD reflects the international acceptance of South-South Cooperation (SSC) as a vital means towards attainment of universal access to Sexual and Reproductive Health and Rights (SRHR) and sustainable development. Today, with a membership of 26 countries around the world, PPD is the foremost international effort that is totally dedicated to promoting and improving the transfer of expertise in population and reproductive health within developing countries.

### ***PPD's Experiences and Capacity in South-South Cooperation***

PPD mandate is to promote SSC for Population, Reproductive Health and Development. It has built a well acknowledged and documented credible reputation for high level advocacy, policy dialogues, and exchange of knowledge, best practices, technical cooperation, capacity building and operation research to assist both its member and non-member countries in implementing the ICPD PoA within the broader framework of the MDGs.

### ***South-South Cooperation for increased political commitment, training and grooming global leaders as voices of the South***

PPD organizes policy dialogues on global, regional and national level priority issues of importance related to Population, Development and Reproductive Health (RH) including HIV/AIDS, Family Planning (FP) and adolescents in the form of international and regional fora for member and non-member countries. The international fora outcomes are Declarations that are statements of commitments by PPD Member Countries that serve as useful guidelines in addressing Population, RH, FP, HIV/AIDS and development issues.

These fora have been excellent opportunities for PPD to advocate for political goodwill, policy, financial, technical and program commitments and support to address SRHR, Population and Development issues in PPD member countries and other developing countries.



PPD Board Members attend 17<sup>th</sup> Board Meeting held in Dhaka, Bangladesh



Advocacy Meeting with Parliamentarians for integration of Human Rights Based Approach to maternal health, Uganda

PPD trains southern leaders including parliamentarians, senior government officials and youth representatives to be strong advocates for SRHR in their own countries, regionally, and globally. PPD's SRHR champions have influenced national policies and programs as well as the international development agenda.

### *Transfer of knowledge, best practices and resources*

PPD documents from Member Countries (MCs) the good practices in the area of RH/FP, population policy and HIV/AIDS. These are then published and circulated to all MCs. PPD advocates and facilitates technical cooperation for transfer of knowledge and technical expertise, and for replicating these good practises.



## *Exchange of RH/FP commodities and technologies*



Honorable Health Minister of Bangladesh receives RH/FP commodities and equipment from H.E. the Ambassador of the Republic of China

PPD has been involved in facilitating transfer of RH/FP commodities and technologies from one emerging global economy MC (Republic of China) to other MCs (Bangladesh, Kenya, Mali, Nigeria, Uganda and Zimbabwe). This has contributed to increased access and affordability of RH/FP services for the poorest in the recipient countries.

## *Capacity building of new generation managers and leaders for SRHR and Population Programs*



Fellows from PPD MCs attend Scholarship Program held in ICMH, Bangladesh – a Partner Institution of PPD

PPD works through governments to build leadership, technical and managerial capacities to ensure that appropriate, locally owned and locally driven policies and programs are implemented.



Senior Government Officials from PPD MCs in a consultative meeting held in Beijing, China

PPD facilitates scholarships (fully funded by the MCs) offered by PPD Partner Institutions for young professionals and government officials from its Member Countries. Hundreds of professionals and government officials in the field of population, demography, HIV/AIDS, RH and Family Planning have benefitted from the scholarship program, in the last five years. PPD organizes capacity building programs for senior government officials in advocacy and utilization of evidence for policy and programmatic change. PPD has also pioneered the South-South Technical Advisory Support Services (STAS) initiative that created and expanded opportunities for developing countries to benefit from each other's expertise and experiences in the areas of reproductive health, population and development through SSC in 2002.

### ***1.3 Future course of ICPD and PPD***

In view of the ICPD PoA completing two decades, the United Nations (UN) and other agencies have undertaken a review of achievements made and challenges encountered during this period. Discussions have been initiated in different fora on the theme of ICPD Beyond 2014. The Review and conclusions arrived at will influence the future of the global population and development policy at national, regional and global levels.

For PPD, an institution born out of the original ICPD process, ICPD Beyond 2014 Review is an opportunity to define what needs to be done to deliver a more equal and sustainable world for the more than half the world's population that it represents.

More specifically, PPD and its member countries need to collectively decide their new strategic direction and operational plan that will be stated at the UN General Assembly meeting in 2014 to decide on the future course of action regarding the ICPD. This position paper aims to outline some of the possible strategic directions that PPD could adopt in order to strengthen its contributions to the ICPD Beyond 2014 process.

The question before PPD is very simply: ***“Does PPD wish to continue with its work as in the past or seek a new strategic direction to become increasingly effective on the ground and more influential on the global stage?”***

### ***1.4 Purpose of this Paper***

The purpose of this position paper is to:

- ◆ Take stock of progress, need and relevance of PPD.
- ◆ Inform PPD's strategic planning process and operational plan.

### ***1.5 Methodology***

The methodology used in preparing this Position Paper has been desktop research combined with Key Informant Interviews (KIIs) involving specialists in the field and compilation of information through detailed questionnaires sent to all PPD Country Coordinators. The response to the questionnaires was over 42%. Personal, face-to-face meetings were also held with PPD Country Coordinators and others wherever possible.

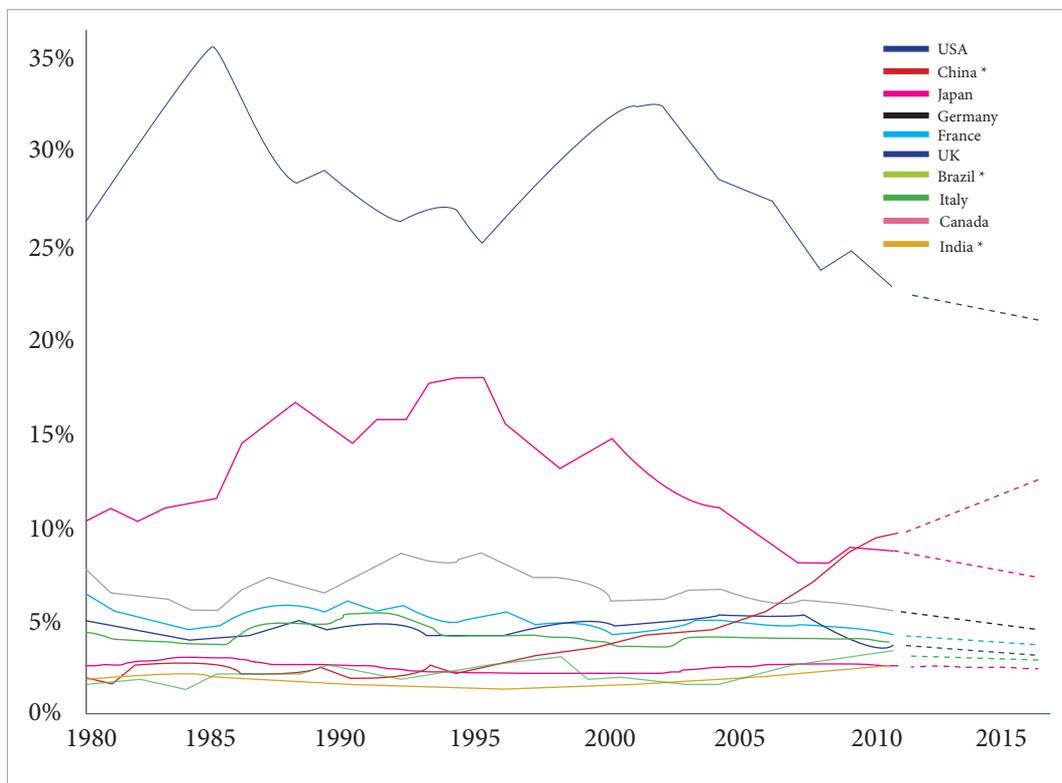
### ***1.6 The last two decades***

The last two decades have seen dramatic changes worldwide in everything from geopolitics to economy and the rise of new technologies and social trends. In 1994, when the ICPD was held in Cairo, Egypt, the Cold War had just ended, the Soviet Union dissolved, and East and West Germany had reunited.

Since then the world has witnessed many changes – the remarkable rise of 5 southern countries namely, Brazil, Russia, India, China and South Africa as economic powerhouses lifting millions of people out of poverty. These five countries, collectively labeled 'BRICS', are seen as a symbol of how global economy is shifting away from the traditional domination of the developed G7 countries comprising the United States of America, Japan, France, Germany, Italy, United Kingdom and Canada.

New communication technologies in the last decade have heralded an information revolution connecting up the remotest parts of the world. This has also made it possible for millions to benefit from the latest know-how. Enabling access to the mobile phone and transforming the economic and social status of rural women in Bangladesh has become legendary in the annals of modern development.

**Figure 1: Traditional donor countries stagnate and BRICS countries\* continue to grow.**



Proportion of world nominal GDP for the countries with the top 10 highest nominal GDP in 2010, from 1980 to 2010 with IMF projections until 2015. **Countries marked with an asterisk are non-G8 countries**, e.g., China, Brazil and India.

Grey lines show actual US dollar values.

\*Source: "IMF World Economic Outlook database"

The last 20 years have also witnessed the escalation of the global crisis of HIV/AIDS, with millions perishing due to the disease and leaving communities in the poorest parts of the world shattered. The response to the pandemic has also been large in scale with the Global Fund for HIV, TB and Malaria being the single largest development mechanism ever conceived. The UN developed a joint response to AIDS under the umbrella of UNAIDS.

Inspired by the ICPD process earlier, the MDGs emerged with world leaders setting for the first time ever, clear time-bound scheduled development goals in critical areas, costed programs and tangible indicators. This has been remarkable. The goals were set for both developed and developing countries. For example, further reduction of Maternal Mortality Ratios (MMRs) in countries already low on it to less than 1 per 1000, while those with high MMR had to reduce by two-thirds. ICPD too has continued reviewing its original mandate at year 5 (1999), year 10 (2004) and year 15 (2009).

### *1.7 PPD – its Mission and growth*

One of the key ideas behind forming the PPD in 1994 was to augment the strengths of countries of the South through the power of peer review. This involved sharing of expertise within the South through training programs, exchange of specialists and resources. There were only ten countries as members at that time, but by 2010 another 15 countries had joined PPD, making it the largest SSC effort of its kind. Starting with an office in Dhaka, Bangladesh, PPD expanded to set up a liaison office in New York in 2006 and a regional office in Uganda in 2007.

In 1994, PPD countries constituted 58% of the global population, accounted for 7% of the world's Gross National Income (GNI) and 52% of GNI of all low- and middle-income countries. By 2010, PPD countries accounted for 19% of global GNI and 63% of the GNI of all low and middle income countries of the world.

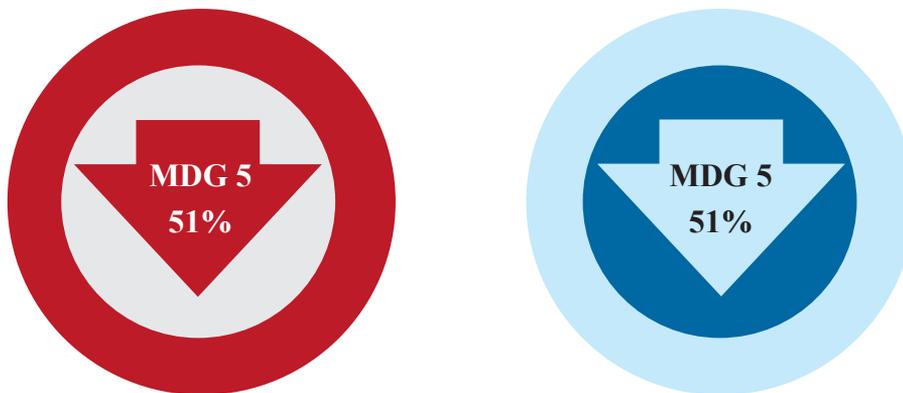
## Section 2

### Achievements, Challenges, Gaps

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#### 2.1 Progress since 1990

Major progress has been made by the PPD member countries to achieve all major MDGs. For example, MDG 5 has set a target for countries to reduce their MMR<sup>2</sup> by 75% from 1990 to 2015. The overall reduction in MMR among the 25 PPD countries was 51% in 2010 compared to 1990 and that is a great achievement. In 1990, the PPD countries accounted for 71% of global maternal deaths but by 2010 they only accounted for 60% of maternal deaths worldwide.



**Figure 2: Progress of PPD member countries on MDGs 4 & 5 by 2010. Reduction of MMR and U5M rate as % of 1990 baseline**

In the PPD countries, 387,400 maternal deaths occurred yearly in 1990 compared to 173,100 in 2010. Of these, around 61,000 died of hemorrhage, 31,000 of hypertension, 16,000 of unsafe abortion, 19,000 of other direct causes (e.g., complications) and 31,000 of indirect causes (e.g., malaria, HIV, cardiac disease).

MDG 4 seeks to reduce under-5 mortality (U5M) by two-thirds (67%) between 1990 and 2015. The PPD countries achieved a 51% reduction by 2010.

In 1990, 12.62 million children under-5 years of age died globally. Of these, 8.97 million (71%) were in PPD countries. In 2012, of the 6.55 million children under 5 years of age who died worldwide, 4.1 million (63%) were from PPD countries.

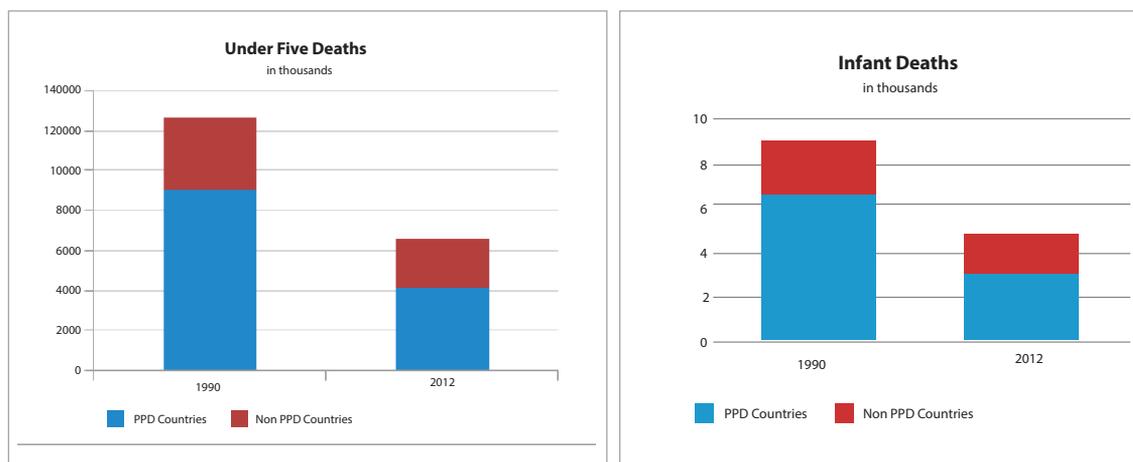
The progress on both the maternal mortality and U5M fronts is uneven among the PPD countries. While Vietnam has already reached the target of 75% reduction, Zimbabwe and South Africa have witnessed an increase in their MMRs.

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<sup>2</sup> Number of maternal deaths in 100,000, live births

Regarding the U5M front, some PPD countries have already achieved the target well in advance, for example, Egypt, China, Tunisia, Mexico and Bangladesh. Meanwhile, other PPD countries have had a much lower decline in mortality and will not be able to meet the MDG target.

**Figure 3: Comparison between PPD and non PPD countries in reduction of deaths of infants and under five children (1990–2010)**



PPD Countries show higher reduction of infant and under 5 deaths.

Source: <http://apps.who.int/gho/data/noe.main.childmort-1?lang=en>

A few PPD countries like India and Nigeria account for a disproportionately high number (34%) of both maternal and under-5 deaths globally. But there are hotspots in these large countries or often a single district where such deaths are concentrated. For example, two states in India account for 44% of the maternal deaths but only 25% of the population.

In many PPD countries, the unmet needs of family planning and adolescent birth rates are high, while skilled birth attendance remains average. Here too there is a wide variation between the various PPD countries.

#### *Range among the PPD countries*

Contraceptive prevalence rate, %	6–84
Antenatal visit, at least one, %	42–99
Skilled attendant at birth, %	10–100
Unmet need for family planning, %	2–40
Adolescent birth rate, per 1000 women	6–189

Summary country findings are included as **Annex A**.

## ***2.2 South-South Cooperation***

South-South Cooperation is a unique mechanism for fostering solidarity among the Global South through sharing of knowledge, experience and application of appropriate techniques, technologies and methodologies towards attaining holistic human development and common prosperity with a commonality of shared vision and collective coordinated action for delivering public goods. Specific South-South partnerships have helped successful implementation of programs. PPD fosters partnerships and supports member countries develop policies, share resources, exchange experience, transfer knowledge, technology and innovation for the global South. South-South Cooperation employs high level advocacy to galvanize coordinated collective action while aspiring to achieve quality of life at par with the global North.

Since inception, PPD has been a platform for countries of the South that stand together to lobby on the global stage and enable policies towards better resources and against discriminatory practices. Since 2008 there have been negative signs on the global stage with severe economic downturn gripping the major developed economies of Europe and North America. While middle and lower income countries of Asia, Africa and Latin America continue to grow, the new situation of paucity of funds for development work from the North makes it incumbent upon them to take the leadership in this field now.

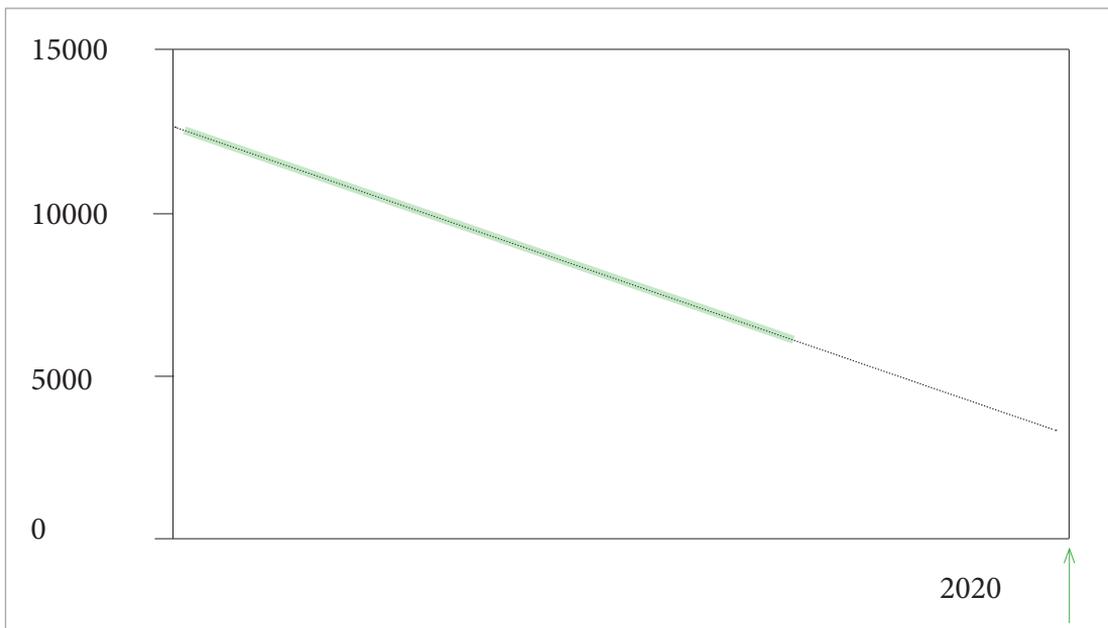
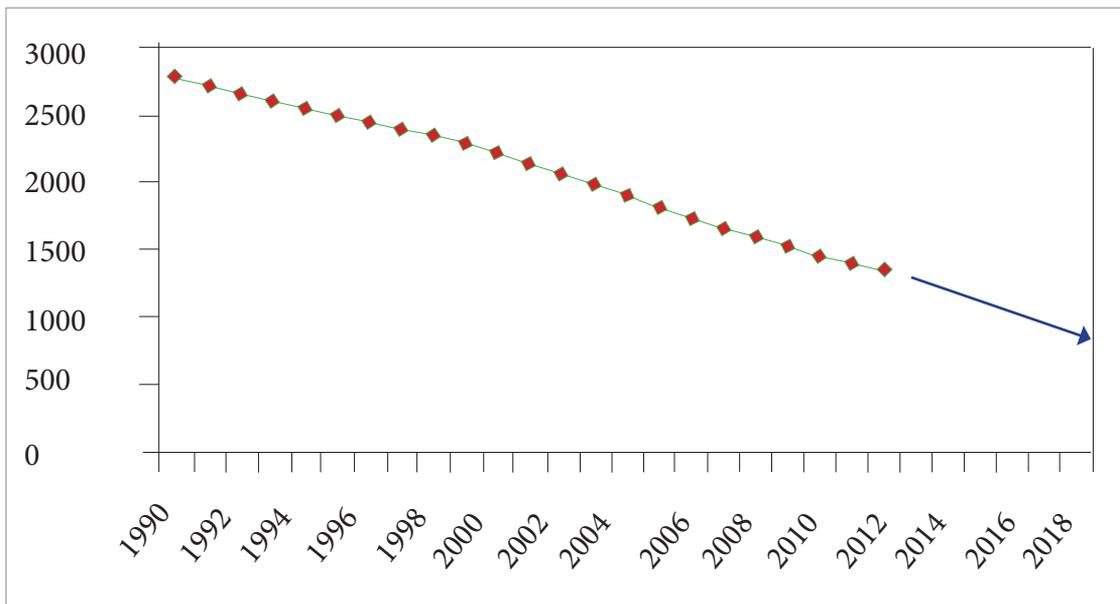
The current period is the perfect moment for PPD to step up its profile and activities to emerge as a major global player in its own right. Representing more than half the globe's population, it is indeed imperative that PPD takes the responsibility to pave the path in the field of development not just for its own constituents but for the rest of the world too.

## ***2.3 Unfinished Agenda***

Much has been achieved by PPD in its two decades of existence. However, given the enormity of the tasks to be completed and the paucity of resources available, PPD's agenda remains an unfinished one. It is time to take stock of the situation and work out a strategic direction for future action. This would enable PPD to realize its unfulfilled potential, deliver tangible results for the benefit of its citizens and most critically, emerge as an important and influential platform for development on the global stage.

If the current rate of implementation continues, then the MDG targets of the PPD countries would be reached only by 2018 and 2020.

**Figure 4: Projected actual year of meeting MDG targets by the PPD countries at the current rate**



Note: these extrapolations are based on linear projections using inbuilt Excel function

## Section 3

### The Way Forward

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#### *3.1 Focus for delivery of results*

The ICPD PoA has 92 action points while the MDG has 8 goals and more than 60 indicators to measure progress. In both agendas, the issues addressed cover a wide area ranging from hunger to environment.

However, given the fact that PPD being an inter-governmental organization of 26 countries, there is need to establish a priority framework similar to the investment framework that has been developed for HIV/AIDS. PPD needs to sharpen its focus further to few key areas where it can maximize the impact of the resources at its command.

#### *3.1.1 Results, Enablers and Synergizers*

More specifically, PPD needs to identify the results it wants to achieve and the enablers and synergizer issues that will help achieve these results efficiently.

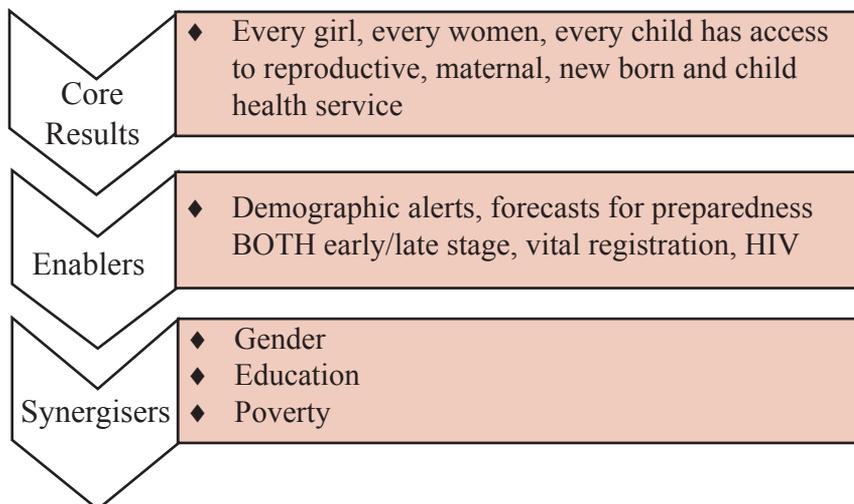
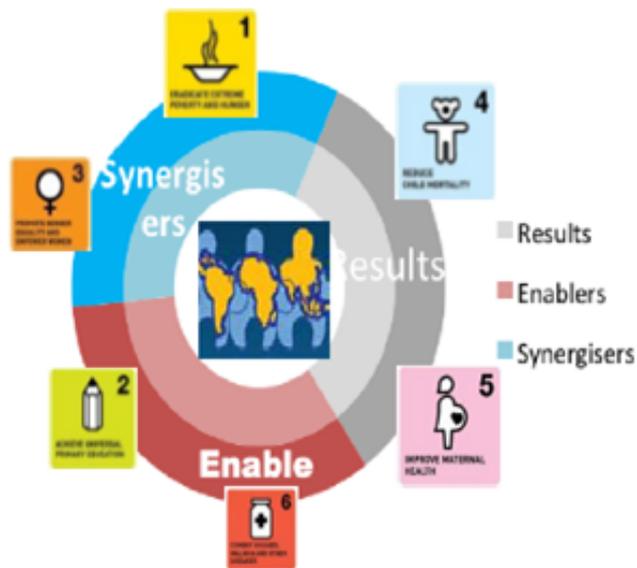
For constructive results, PPD should consider itself accountable for achieving targets that are part of MDGs 4 and 5 and including relevant parts of MDG 6. In other words, PPD should commit to ensure tangible and measurable achievements of Reproductive, Maternal, Newborn and Child Health (RMNCH) through actual support of policies, commodities and human resource support.

PPD can remain comprehensive by addressing the requirement of information and guidance on other ICPD and MDG themes and take on the role of an enabler. For example, to support its member countries, PPD can:

- ◆ Put robust census and data collection systems in place in each of the member countries.
- ◆ Prepare regular alerts to help them reap the fruits of the demographic dividend without being responsible for development activities necessary for bringing about the dividend.
- ◆ Advocate for gender issues in order to achieve MDGs 4, 5 and 6 without being mainly responsible for changing gender norms on all spheres of life in member countries.

Education is one synergizer issue example that PPD can work on to help achieve results in a mutually beneficial manner. However, it is obvious that education improves female literacy and can enhance and accelerate the results by acting as a stimulator.

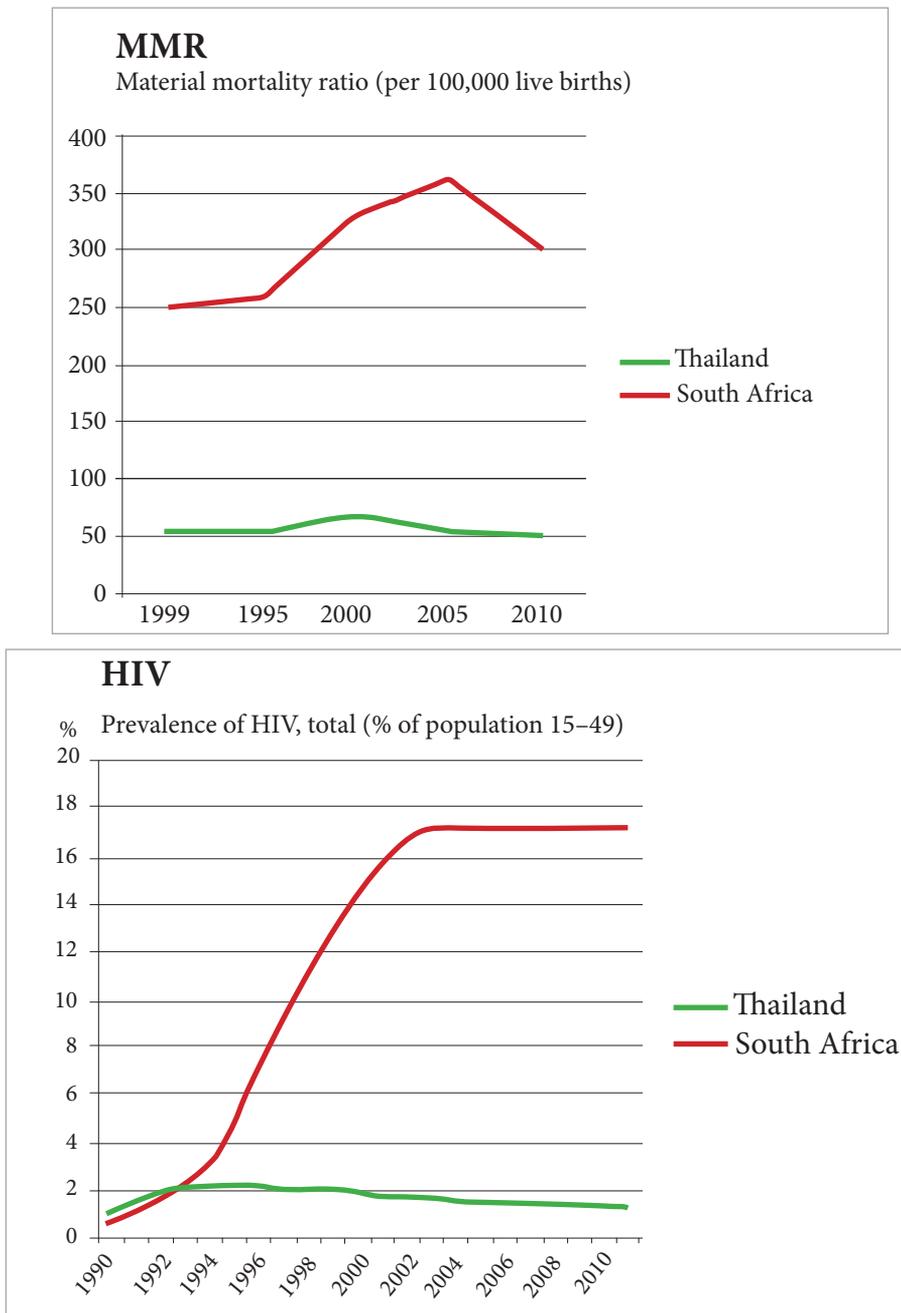
**Figure 5: Illustrators on interlinking of different MDG indicators and basis for focusing on core results and partnership in other areas of synergizers\* and enablers\***



*Example of key enabling activities*

**Figure 6: Comparison of Adult HIV Prevalence and MMR of South Africa and Thailand**

### Thailand and South Africa: Story of enablers in Reproductive health



(Note: Early effective tacking of HIV enabled Thailand to keep MMR lower while South Africa struggled to lower HIV and resultant MMR). Graphs based on the data.

Source: <http://mdgs.un.org/unsd/mdg/Data.aspx>

\*UNAIDS 2011

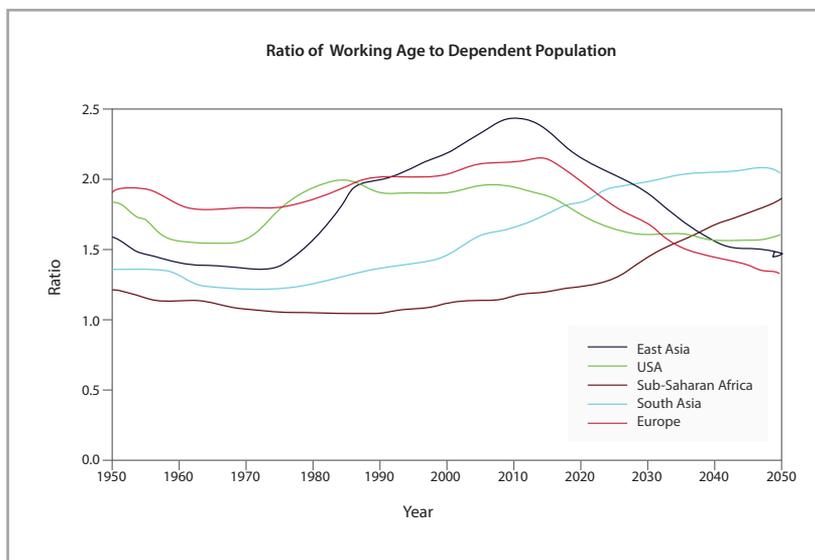
### 3.1.2 Demographic alerts as an enabler

PPD countries are poised to reap the benefits of a ‘demographic dividend’ with some countries showing a lower age dependency ratio than in the high income countries of the world. However, such benefits can be reaped only if there is a well-developed system of demographic alerts to enable countries to take advantage or be prepared with other necessary inputs.

The data shows that South East Asian countries have reached a high ratio of the working age group compared to the non-working age group of populations similar to that in highly industrialized countries. South Asia and Latin American countries are also about to take off to reach the same level. In Africa, excepting South Africa, most other countries are yet to reach the tipping point. China, on the other hand, is soon going to face a similar situation as the industrialized countries when this ratio would go down and the ageing population will increase significantly.

There is a need for demographic alerts on when a country is about to enter the demographic dividend phase and when it is exiting this. This information can then be integrated into the national planning system so that benefits and opportunities can be maximized through timely creation of jobs, necessary infrastructure and conducive environment for investments. Countries leaving the demographic dividend zone need to immediately initiate studies on ageing and its impact on social security.

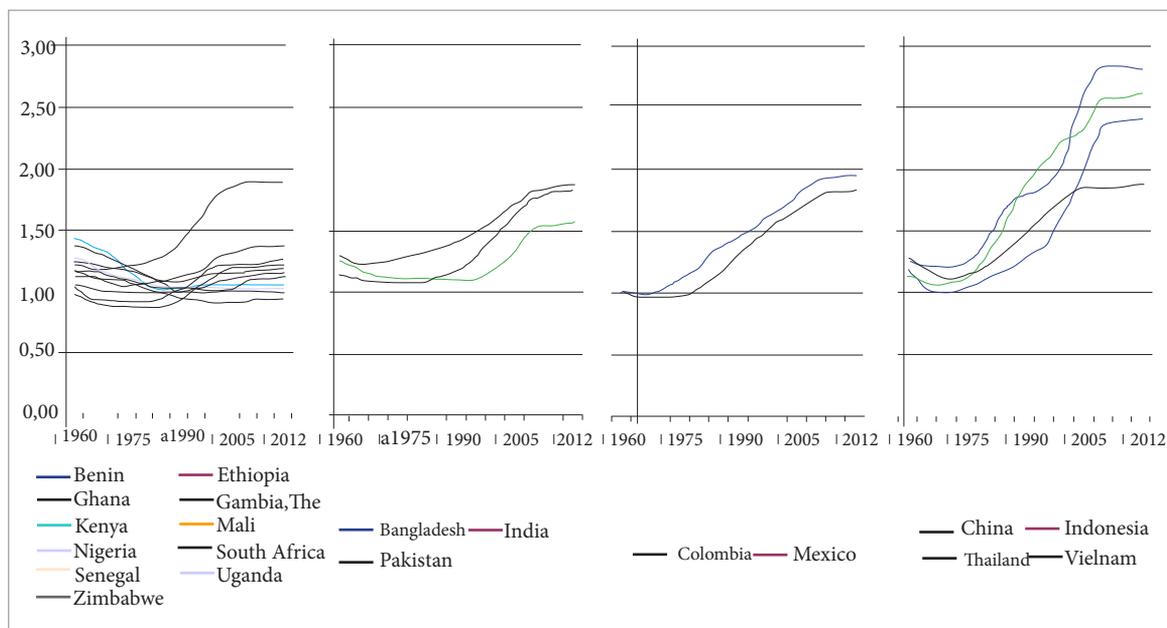
**Figure 7: Comparison of different regions reaping the benefit of demographic dividend over a period of time**



**Source:** David Canning, Harvard School of Public Health, [http://upload.wikimedia.org/wikipedia/commons/e/e6/Inverse\\_Dependency\\_Ratio\\_-\\_World\\_Regions\\_-\\_1950%E2%80%932050.png](http://upload.wikimedia.org/wikipedia/commons/e/e6/Inverse_Dependency_Ratio_-_World_Regions_-_1950%E2%80%932050.png)

## Proportion of working people to non working people in PPD countries by region

**Figure 8: Different stages of demographic dividend: Countries of South East Asia have already reached peaks of ratio in favor of more working people against non working people; Africa (except South Africa and Tunisia– latter not shown in the map) is yet to enter this positive ratio. South Asia and Latin America are catching up**



Source: Estimated based on the World Bank Data <http://data.worldbank.org/indicator/SP.POP.DPND>

### 3.2 Uphold Equity as central theme for post-2014 period

Equity at different levels is a key area for PPD to focus on, as any improvements here will have considerable spinoff benefits on all other areas of focus and work. In particular, greater efforts are needed by PPD as a global platform to close the gaps:

- ◆ Between the North and the South.
- ◆ Between PPD countries.
- ◆ Within PPD countries.

**Figure 9: Three types of disparities to be addressed by three different strategies.**

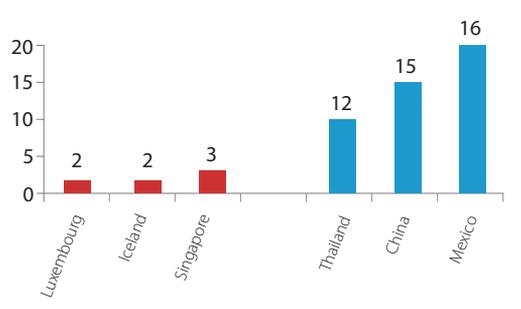
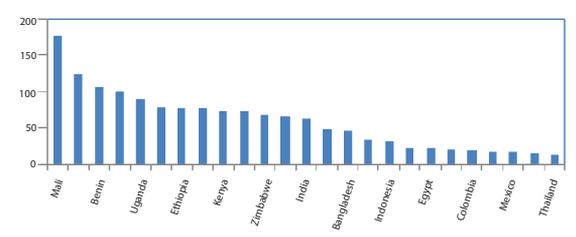
Disparity	Evidence	Comments																												
Disparity between North and South	 <table border="1" data-bbox="411 291 932 600"> <caption>PPD Rates by Country</caption> <thead> <tr> <th>Country</th> <th>Rate</th> </tr> </thead> <tbody> <tr> <td>Luxembourg</td> <td>2</td> </tr> <tr> <td>Iceland</td> <td>2</td> </tr> <tr> <td>Singapore</td> <td>3</td> </tr> <tr> <td>Thailand</td> <td>12</td> </tr> <tr> <td>China</td> <td>15</td> </tr> <tr> <td>Mexico</td> <td>16</td> </tr> </tbody> </table>	Country	Rate	Luxembourg	2	Iceland	2	Singapore	3	Thailand	12	China	15	Mexico	16	High achiever PPD countries still have rates much higher than the North countries														
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Disparity between PPD countries	 <table border="1" data-bbox="384 691 960 928"> <caption>Under-5 Mortality Rates</caption> <thead> <tr> <th>Country</th> <th>Rate</th> </tr> </thead> <tbody> <tr> <td>Mali</td> <td>180</td> </tr> <tr> <td>Benin</td> <td>120</td> </tr> <tr> <td>Uganda</td> <td>100</td> </tr> <tr> <td>Ethiopia</td> <td>80</td> </tr> <tr> <td>Kenya</td> <td>75</td> </tr> <tr> <td>Zimbabwe</td> <td>70</td> </tr> <tr> <td>India</td> <td>65</td> </tr> <tr> <td>Bangladesh</td> <td>50</td> </tr> <tr> <td>Indonesia</td> <td>35</td> </tr> <tr> <td>Egypt</td> <td>25</td> </tr> <tr> <td>Columbia</td> <td>20</td> </tr> <tr> <td>Mexico</td> <td>15</td> </tr> <tr> <td>Thailand</td> <td>10</td> </tr> </tbody> </table>	Country	Rate	Mali	180	Benin	120	Uganda	100	Ethiopia	80	Kenya	75	Zimbabwe	70	India	65	Bangladesh	50	Indonesia	35	Egypt	25	Columbia	20	Mexico	15	Thailand	10	Under-5 mortality rate in Mali is 18 times higher than that of Thailand
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Disparity within each PPD country	<p data-bbox="411 1001 932 1028"><b>50 % of new infection and disease burden from one geographic area-Nyanza/Kenya</b></p> <table border="1" data-bbox="411 1037 932 1346"> <thead> <tr> <th>Areas</th> <th>Proportional Area of the Country</th> <th>Proportion of people Living with HIV</th> </tr> </thead> <tbody> <tr> <td>Nairobi &amp; Nyanza</td> <td>Small yellow circle</td> <td>Large orange circle</td> </tr> <tr> <td>Western &amp; Central</td> <td>Small yellow circle</td> <td>Medium orange circle</td> </tr> <tr> <td>Rift Valley &amp; Coast</td> <td>Large yellow circle</td> <td>Medium orange circle</td> </tr> <tr> <td>East &amp; North-East</td> <td>Large yellow circle</td> <td>Small orange circle</td> </tr> </tbody> </table> 	Areas	Proportional Area of the Country	Proportion of people Living with HIV	Nairobi & Nyanza	Small yellow circle	Large orange circle	Western & Central	Small yellow circle	Medium orange circle	Rift Valley & Coast	Large yellow circle	Medium orange circle	East & North-East	Large yellow circle	Small orange circle	Nyanza, one small area of Kenya and Nairobi represent 50% of all Maternal/Child infections in the country													
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Figure for Kenya is based on UNAIDS unpublished data. Other figures are based on data sources from the UN database mentioned earlier

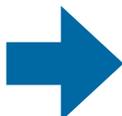
### *Few examples of how some of these disparities can be addressed.*

**Disparity between North and South**



Advocacy, lobbying international resources, similar standards, evidence base, IP issues on differential price of medicine, one voice of PPD countries must be ensured on all international issues, at meetings and fora.

**Disparity within PPD countries**



Support peer review of policy and programs of member countries and recommendation on policy and implementation issues through Smart solutions, making commodities available, accessible, affordable and increasing quality, human resources transfer through inter country and inter-governmental mechanisms replacing or in addition to current INGOs and UN services, optimized resource need and gap analysis for mobilization of resources in international fora.

**Disparity within country**



Identification of pockets of high burden and prioritization, Smart local solutions that often involve community and incentive based approaches possible within existing means.

### *3.3 Build on PPD's unique advantage*

PPD's unique strength is SSC. Unlike other global or regional development and support mechanisms, the core value of SSC remains in that it is not based on any political, religious, economic agenda or viewpoint. Instead, it encourages mutual and collective solidarity solely based on the specific developmental needs of individual countries. In the context of PPD's area of work, SSC implies that all countries, irrespective of their political, economic, cultural and religious practices have the potential to enjoy the highest level of reproductive and sexual health status.

This implies that PPD's assistance in terms of policy peer review of another country, and support through human, commodity and management solutions would be more accepted as it comes without judgment, political agenda or controversy.

This is particularly relevant in the light of the restrictions on sale of abortion-related medicine by several global funding agencies and a policy also reflected in the supply of reproductive health commodities by UN agencies.

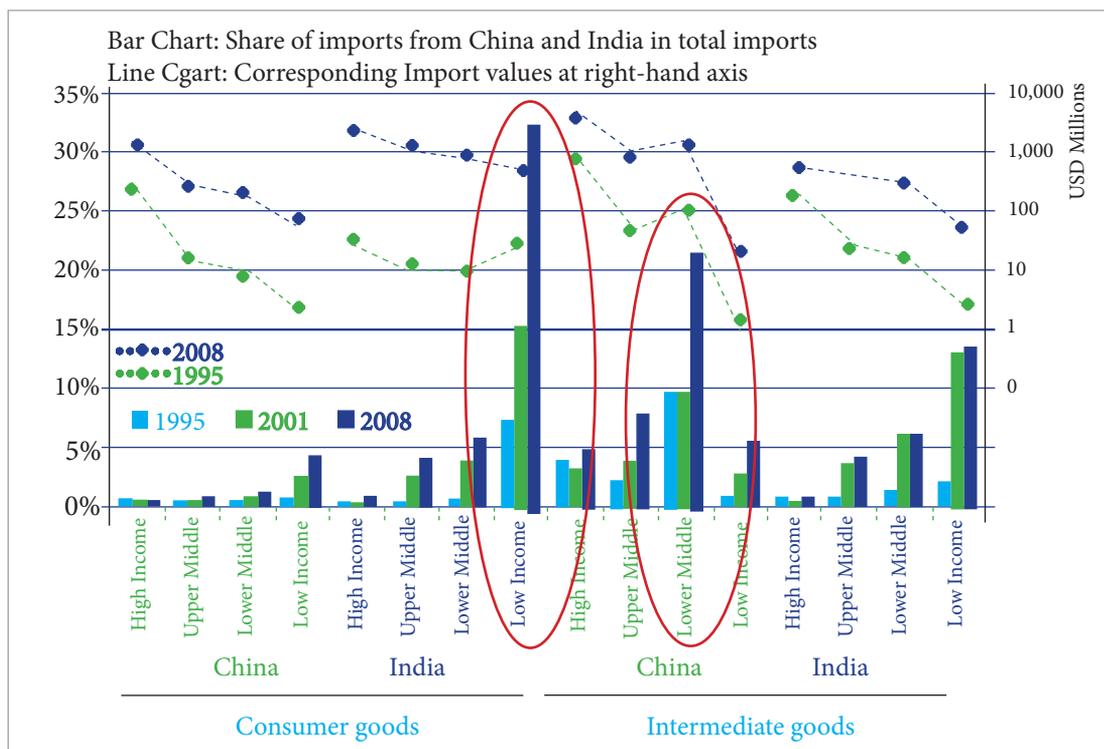
Further, PPD's priorities do not shift with the change of governments in member countries. This allows long-term perspective and consistent work. This is contrary to donor funding that has often been driven by agendas and prejudices, for example:

- ◆ AIDS money was increased while that for family planning reduced during the first decade of 2000.
- ◆ Skewed agendas and prejudice of some donors meant that the available money could not be spent on abortion services or support for sex workers.
- ◆ China was ineligible for Global Fund Resources.
- ◆ Mothers in countries of the North had Zidovudine (AZT) but this was not affordable in the South.

### ***3.4 Commodity supply and PPD***

PPD can play a major role in ensuring access to drugs and commodities within the member countries. Recently a list of 13 drugs/commodities for reproductive health has been suggested to become universally accessible. India is the major supplier of generic drugs to all the low income countries while China is the world leader in supply of the active pharmaceutical ingredients (API).(Fig.10)

**Figure 10: India and China: two PPD countries increasingly show higher strength in supplying the global medicines and Active Pharmaceutical Ingredients (API)**



Source: Kiriya N ( 2010) ‘Trade and Innovation Pharmaceuticals’, OECD working paper no 113, Paris, Organisation for Economic Cooperation and Development, p.32, p.33

### 3.5 Human resources options

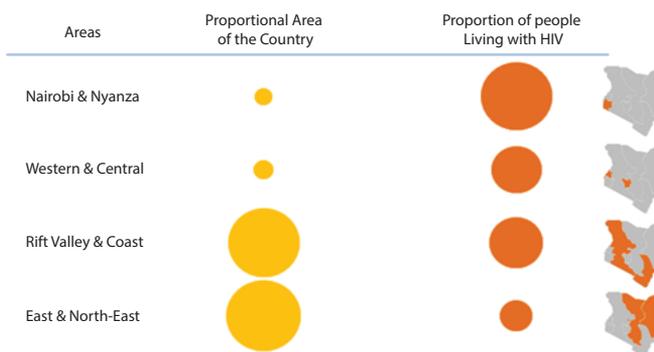
PPD could consider the option of promoting exchange of medical and health professionals among member countries to help overcome the shortage of skilled personnel, particularly in areas that are remote or ‘hotspots’ having high disease prevalence. While many professionals would not consider working in the rural areas of their own countries for a variety of reasons, they may be willing to proceed overseas if provided a reasonable income and suitable facilities. Such exchanges would be an example of creatively using South-South Cooperation to overcome a critical obstacle and achieve better results on a number of MDG goals. (Fig.11)

**Figure 11: Supporting trained human resources from high density human resource country to hot spots is an important strategy to address equity**

Figure 5: Relative density of doctors per 1,000 populations, latest available year<sup>58</sup>



50 % of new infection and disease burden from one geographic area-Nyanza/Kenya



### 3.6 Partnerships

There is potential for PPD to form partnerships with a variety of international institutions like WHO, UNAIDS, UNICEF, UNITAID and UNFPA to address key ICPD PoA and MDG themes. In addition, a number of initiatives are emerging driven by different UN agency and bilateral mandates. Few examples are:

- ◆ “A Promise Renewed”– by 2035 (led by UNICEF and USAID).

- ◆ “Family Planning 2020” (led by Gates, UK, UNFPA).
- ◆ “1 million community health workers” (Jeff Sachs and SDSN group).
- ◆ “Newborn action plan” (UNICEF).
- ◆ “PMNCH” (WHO).

Sometimes, these efforts overlap, causing fracturation and duplication and countries must demand for global governance and accountability in line with issues raised by the Independent Expert Review Group (IERG). PPD could also partner with the Every Woman Every Child (EWEC) initiative, spearheaded by the UN Secretary-General Ban Ki-moon, to mobilize coordination, division of labor and accountability.

PPD should make a commitment to accelerate progress towards MDGs 4 & 5. Strategic partnerships could be divided around core, enabler and synergistic areas.



### *Strategy 2: Innovative, Opportunistic & Strategic Partnership (S) including UN*

Partner	Theme	Area
UNFPA	Population, RH.	Core
PMNCH	MNCH	Core
UNAIDS	HIV	Core/enabler/TA
UNITAID/USAID/Govt of Norway	Drugsw Commodities	Core/ Synergy
Every Women Every Child	RMNCH	Core/
WHO / UN Women	Gender	Core/Enabler
BMGF/DFID	Family Planning	Core

**Global Governance and Investment Framework:** to avoid fragmentation, duplication and inefficiency, to identify cost effective interventions, critical enablers, civil registration and health, Accountability: Lancet Emerging health issues: Resource mobilization and allocation

**Ref:** LANCET Emerging Health Issue, 2012

[http://gamapserver.who.int/gho/interactive\\_charts/health\\_workforce/PhysiciansDensity\\_Total/atlas.html](http://gamapserver.who.int/gho/interactive_charts/health_workforce/PhysiciansDensity_Total/atlas.html) Kenya data is from unpublished paper of UNAIDS (personal communication, sarkars@unaids.org)

## Section 4

### Strategic Options for Equity

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#### *4.1 Lobbying and international advocacy*

- ◆ PPD should strongly express support for international efforts to achieve current MDGs and continued commitment till these gains are materialized
- ◆ PPD's comments need to be sent to the next UNGA for post-ICPD review as well as post-MDG discussions
- ◆ PPD could host meetings of ICPD reviews as was done by the Africa Regional Office. Recently a meeting for Asia was hosted by UN-ESCAP. PPD could have easily bid for it and hosted it. Such opportunities should be considered in the future.

#### *4.2 Streamlining global efforts*

- ◆ Demand architecture, governance and division of labor to optimize, synchronize and avoid duplication between different global agencies and initiatives
- ◆ Different UN agencies need to redefine their mandates and division of labor and all agencies must work with a similar investment framework and set standards of interventions with indicators for monitoring
- ◆ PPD could start a diagnostics based on examples from member countries on fracturation, duplications, and compartmentalization
- ◆ PPD could create an inventory of these packages, unit costs, effectiveness and outcome analysis
- ◆ PPD could also consider solution options in a few areas.

#### *4.3 Ensure PPD Participation*

- ◆ Demand official presence of PPD in all relevant international fora to reflect the voices of member countries and majority of the population of the South
- ◆ Create an inventory of all international events and organize a single voice through either member countries or Secretariat presence.

#### *4.4 Offer solutions to member countries*

- ◆ Peer review of a country program on areas ranging from policy, implementation challenges, strategic plans

- ◆ Analysis of pockets of higher burdens, gaps in achievements/implementation
- ◆ Member countries can be encouraged to identify such problem areas and ask for assistance from PPD for necessary diagnostics and advice
- ◆ Consider support for management solutions, scaling up mechanism, procurement and logistics.

#### ***4.5 Commodities and diagnostics***

- ◆ Consider commodities and diagnostics as common areas of collaboration for increasing availability, accessibility, affordability and quality assurance
- ◆ Work on a common commodity list in collaboration with the UN Commission on Commodity Security
- ◆ Examine completeness, comprehensiveness of existing product lists, and identify issues related to neglected existing products as well as need for newer products that are costly and need market interventions or low cost solution of product modifications for better uptakes. For example, abortion drugs, and pregnancy kits are missing from the list
- ◆ Common pooling mechanism to create volume and reduction of prices
- ◆ Sharing of database on price of drugs
- ◆ Create country-wise information based on drug licensing, registration, price and patenting
- ◆ Consider regulatory authority that can speedily screen a drug for diagnostics without waiting for WHO Pre-qualification (PQ) mechanism that takes a long time.

#### ***4.6 Consider human resource exchange***

- ◆ PPD could put together an inventory (yellow pages) of relevant experts and develop capacity within the organization to broker for such services
- ◆ On sensitive and high priority policy issues, PPD could consider appointing a multi-country senior officials mission to another country.

#### ***4.7 Transfer of knowledge and good practices***

- ◆ Continue facilitation of training and institutional collaboration
- ◆ Enhance documenting and sharing of best practices from each country
- ◆ Support scale-up of best practices.

A bolder and stronger PPD that asserts itself on the global stage proportionately with the size of the global population and economy it represents is what is strongly recommended. This vision document should be translated into an operational plan reflecting the new leadership challenges and strategies to successfully implement the post 2015 agenda.

The vision document to be converted into an operational plan encompassing specific strategic options by thematic, geographic and development needs of the countries would have a three-fold process:

- ◆ Peer Review
- ◆ Presentation to the board and adoption
- ◆ Development of operational plan and country adaptation.

The peer reviewed vision document will be finalized and presented to the board for information and adoption by the board. Following this, it will then be transformed into an operational plan to be customized by the countries as per their specific needs.

PPD, in the changed global scenario, faces the uniquely advantageous position to foster South-South Cooperation among its member countries and represent this collective constituency within the northern hemisphere to get equitable representation and allocations for the South. By pooling its vast human resource base, knowledge and technical expertise to enhance the health and standards of living among its citizens, PPD is poised to herald a new deal for the region. This would be a value added deal that will optimize the benefits for its people, enhance program delivery and assure high-end program outcome in a sustainable program environment and assured political leadership commitment. In the process, PPD will be achieving global governance by ensuring the interests of the South are protected and its voice is heard prominently across global platforms.

At the Secretarial level, PPD can deliver a lot. As the custodian of the South-South Cooperation, representing 58% of the population, PPD holds the key to any global achievement. Thus, PPD should position itself for expanding the SSC cooperation to add the next dimension to make it a triangular cooperation by leveraging its leadership in delivering the global agenda. For example, strategic partnership with new initiatives such as Every Mother Every Child would be very rewarding in terms of reaching the mother and child centric MDGs, in the PPD countries. Similarly, initiatives of the Global Fund and Bill Gates Foundation and the bilateral and multi-lateral support can be optimized when PPD acts as the third dimension to augment the triangular cooperation.

In the development of the operational plan, PPD will build in elements of awareness, branding and image among the key stakeholders and within the countries. Member countries will also demonstrate political commitment by providing necessary financial and human resource allocation to enable this development. Programmatically, the enablers and synergizers would be employed to enhance the outcomes. For example, demographic alerts, census registration and health statistics and population profiling will be very useful in population planning and health management. Similar and appropriate invoking of synergizers and enablers will have a catalytic effect programmatically and enhance the program delivery and outcomes.

Thus PPD emerges as ultimate value addition for the Post 2015 global agenda in terms of geographic spread, programmatic capability, capacity to create economies of scale through South-South Cooperation and Triangular Cooperation for achieving global governance and equitable resource allocation and flow. PPD thus emerges as the single largest constituency and player that could lead globally by playing a significant role through its concerted efforts to save millions of lives through a people centric response. PPD is placed in a unique position to potentially deliver new hope for humankind. It is time PPD played that role and delivered the dividends of development and hope to humanity.

The vision document is an effort to bring PPD closer to people, their aspirations and their hope and is also the roadmap to hasten the process. Considering the mandate and post-ICPD era, the next generation of PPD's strategic framework for South South (SS) and triangular cooperation in the field of Reproductive Health (RH) Population and Development are given in Table 1:

**Table 1: Strategic Framework for South South (SS) and Triangular Cooperation**

	<b>Domains</b>	<b>Methods</b>	<b>Outcome</b>
1	Knowledge sharing	<ul style="list-style-type: none"> <li>Identify best practices, documents,data, and evidence sharing and dissemination.</li> <li>Advocacy and facilitation for technical cooperation to transfer of knowledge and adopt &amp; replication in MCs</li> <li>Joint research/studies with Partners Institutions</li> </ul>	<ol style="list-style-type: none"> <li>Strengthened PPD as hub or clearinghouse/ think tank of knowledge (best practices, lessons learned, RH commodities &amp; Technology and commodity procurement)</li> <li>Established mechanism for documentation of best practices/lessons learned and evidence based knowledge uptake at country level</li> <li>Best Practices documented, capacity of the south to shape policies strengthened, southern needs and context integrated into global policies and achievement of ICPD and MDGs agendas accelerated</li> </ol>
2	Capacity building	<ul style="list-style-type: none"> <li>Facilitate scholarships program offered by MCs for young professionals and government officials relevant to RH, Population and Development field.</li> <li>Organization of training programs for senior government officials and young parliamentarians for addressing issues related to international commitments (ICPD/ MDGS) and translates them into national agenda as</li> </ul>	<ol style="list-style-type: none"> <li>Strengthened institutional capacity of each MC to undertake SS exchange activities</li> <li>South South leadership built, technical and managerial expertise in RH, population and development increased</li> <li>Partner Institutions (PI)</li> </ol>

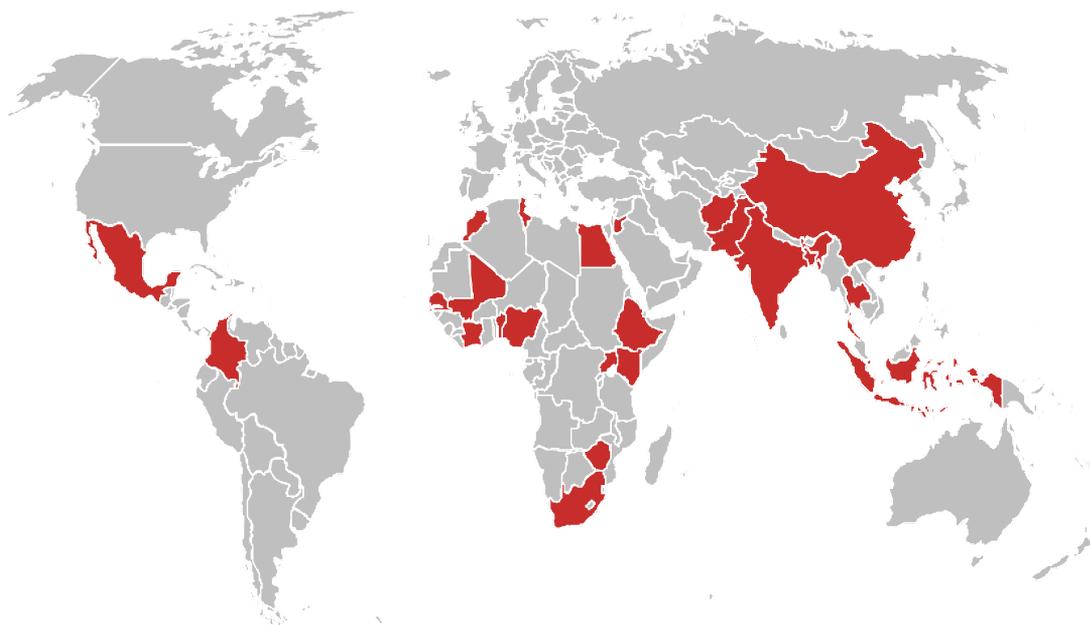
		<p>well as utilization of evidence for policy &amp; program change and strengthen South-South Technical</p> <ul style="list-style-type: none"> <li>• Advisory Services (STAS) in RH Population and Development. Facilitate study tours/exchange visits for policy makers to know how, adopt and scale up best practices.</li> </ul>	
3	Commodity & technology transfer	<ul style="list-style-type: none"> <li>• Identify low cost commodities, technology and IT/software and facilitate transfer of commodities/technology and joint commodity procurement among MCs</li> </ul>	<ol style="list-style-type: none"> <li>1. MoUs signed with MCs for exchanging commodities/technology and joint commodity procurement</li> <li>2. Access and affordability of RH/FP services increased</li> </ol>
4	Shaping RH Commodity Market and Regulatory Institutions	<ul style="list-style-type: none"> <li>• Identify opportunities for impacting the RH Commodity market</li> <li>• SSC opportunities for strengthening regulatory institutions</li> </ul>	<ol style="list-style-type: none"> <li>1. Explore pooled procurement opportunities among member countries</li> <li>2. Create opportunities for strengthening regulatory institutions among member countries</li> </ol>
5	Policy and Advocacy/ dialogue	<ul style="list-style-type: none"> <li>• Facilitate international inter-ministerial conference, policy dialogue and consultative discussions at international, regional and national levels, combined/joint statement in UNGA, WHA, BRICS, Inter-Ministerial peer review mechanism and other international events</li> </ul>	<ol style="list-style-type: none"> <li>1. Increased global reach for SS funding and innovation in RH, population and development</li> <li>2. South South Voices increased for greater commitments &amp; investment in addressing post ICPD and MDGs agendas</li> </ol>
6	Partnership and resource mobilization	<ul style="list-style-type: none"> <li>• Enhance partnership, organization of joint events, mobilize resources and liaison with UN agencies and other development organizations</li> </ul>	<ol style="list-style-type: none"> <li>1. Increased long term SS Collaboration/commitments and assistance among MCs</li> <li>2. Resource mobilized for sustainable development</li> </ol>

7	Health/ population diplomacy	Identify global diplomatic arena as a platform for articulating critical population policy issues and policy challenges through, PPDs diplomatic presence in UN, Bilateral forums and of emerging venues such as BRICS.	<ol style="list-style-type: none"> <li>1. Increased global reach and innovation for SSC in RH, population and development</li> <li>2. Increased PPD's access for SSC in RH, Population and Development at global high level arenas</li> <li>3. Reduced global south and national health inequities (demographic and population dynamic indicators)</li> </ol>
8	Monitoring and accountability	Assess the implementation progress of SSC Declarations and other South-South Activities for achieving ICPD/MDGs agendas, document and disseminate	<ol style="list-style-type: none"> <li>1. Documented SSC implementation status and progress accelerated</li> <li>2. MC accountabilities and common position in UN and other forums</li> <li>3. Incorporate PPD's position in global diplomatic forum.</li> <li>4. Member countries spoke person in global forum</li> <li>5. Declaration adopted by member countries</li> </ol>

# Annex

## PPD COUNTRIES

### List of PPD Countries



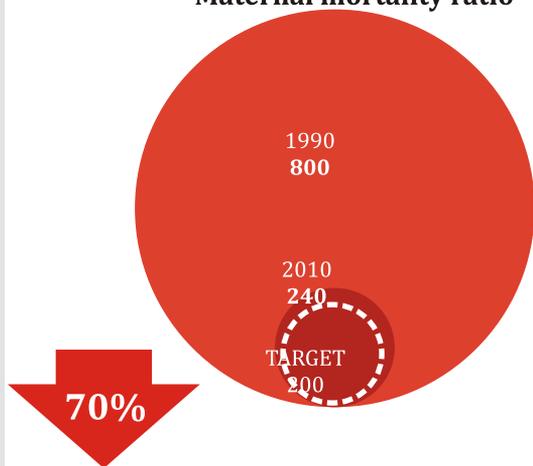
Countries	Population	Countries	Population	Countries	Population
Bangladesh	150494	Indonesia	242326	South Africa	50460
Benin	9100	Jordan	6330	Thailand	69519
China	1347565	Kenya	41610	Tunisia	10594
Colombia	46927	Mali	15840	Uganda	34509
Egypt	82537	Mexico	114793	Viet Nam	88792
Ethiopia	84734	Morocco	32273	Yemen	24800
Gambia	1776	Nigeria	162471	Zimbabwe	12754
Ghana	24966	Pakistan	176745		
India	1241492	Senegal	12768		

*\*population in thousands 2011, total*

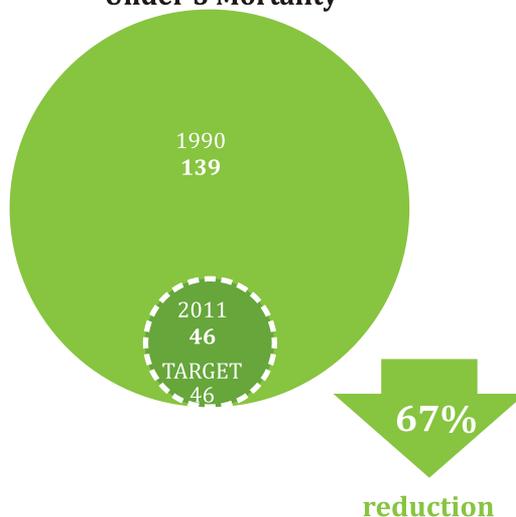
# COUNTRY HIGHLIGHTS

# BANGLADESH

### Maternal mortality ratio



### Under 5 Mortality



## Universal access to reproductive health

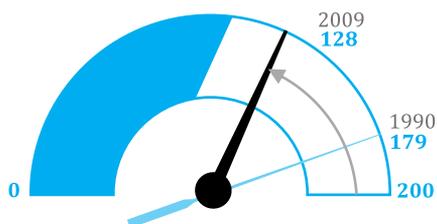
### Contraceptive prevalence rate, modern



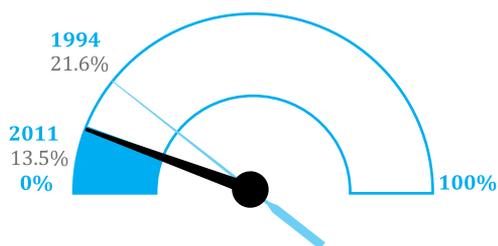
### Antenatal care coverage, at least 1 visit



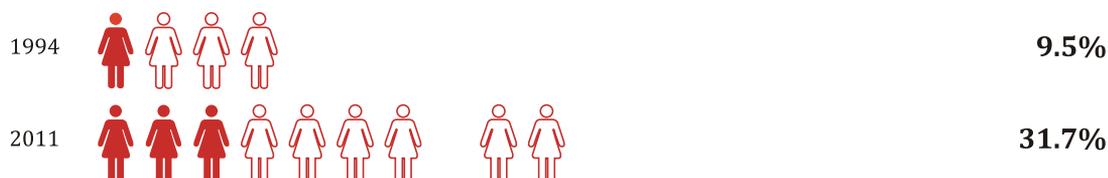
### Adolescent birth rate (per 1000)



### Unmet need for family planning

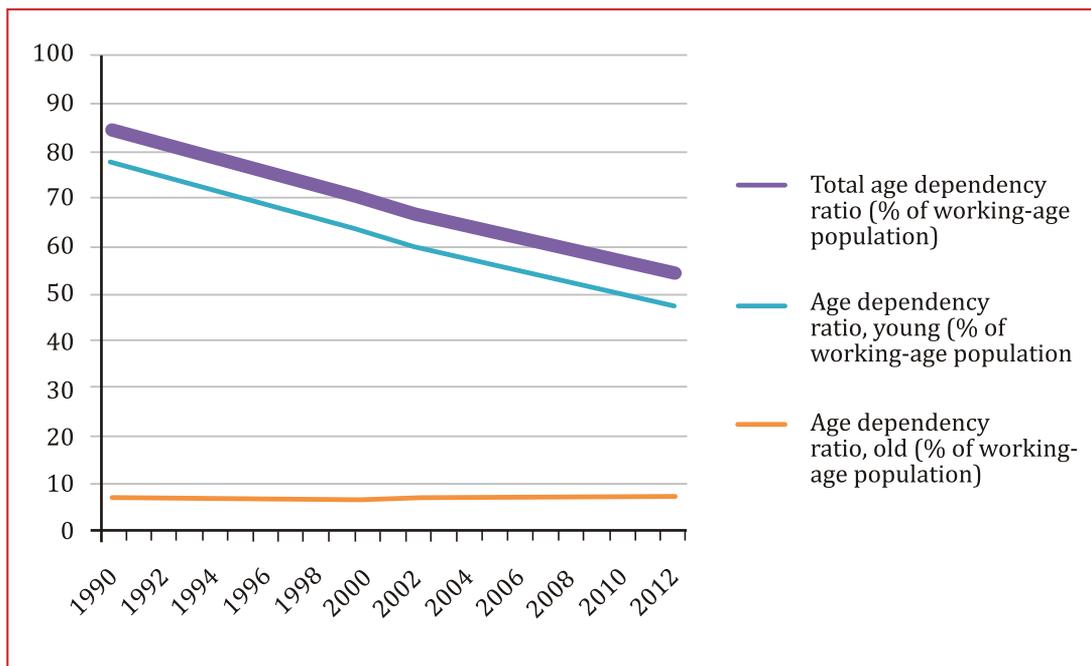


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



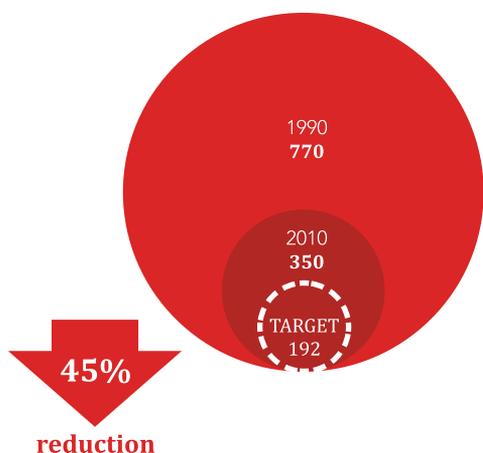
Source: <http://databank.worldbank.org>

Life expectancy at birth (years)	69.2
GNI per capita in PPP terms (constant 2005 Int \$)	1,785
Human Development Index 2012	0.515
HDI Ranking among PPD countries	16
HDI Ranking 2012	146
Gender Inequality Index. value	0.518
GII Ranking among PPD countries	12

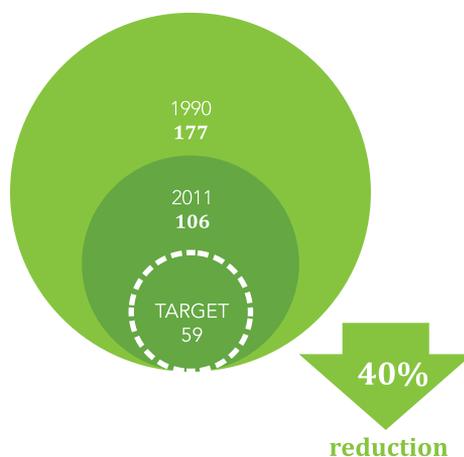
Source: UNDP <http://hdr.undp.org>

# BENIN

Maternal mortality ratio

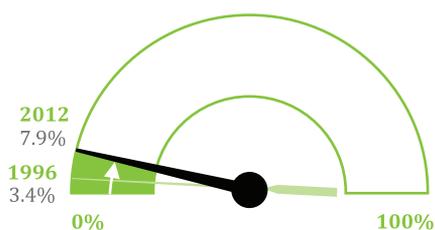


Under 5 Mortality



## Universal access to reproductive health

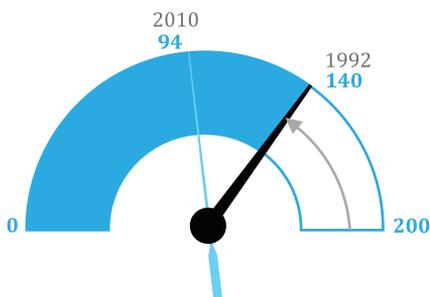
Contraceptive prevalence rate, modern



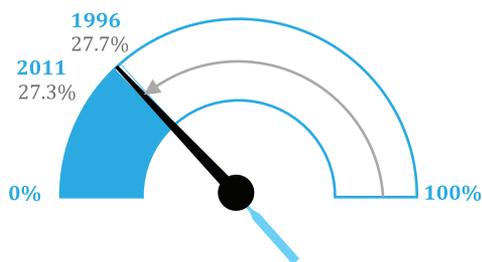
Antenatal care coverage (at least one visit)



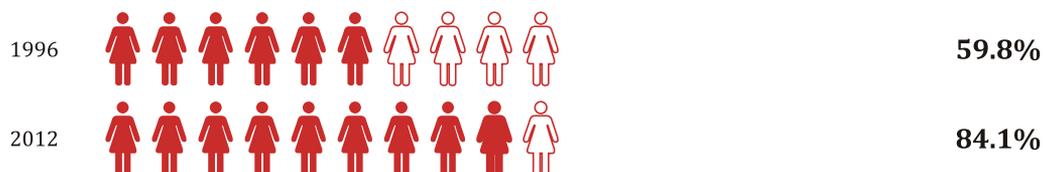
Adolescent birth rate (per 1000)



Unmet need for family planning

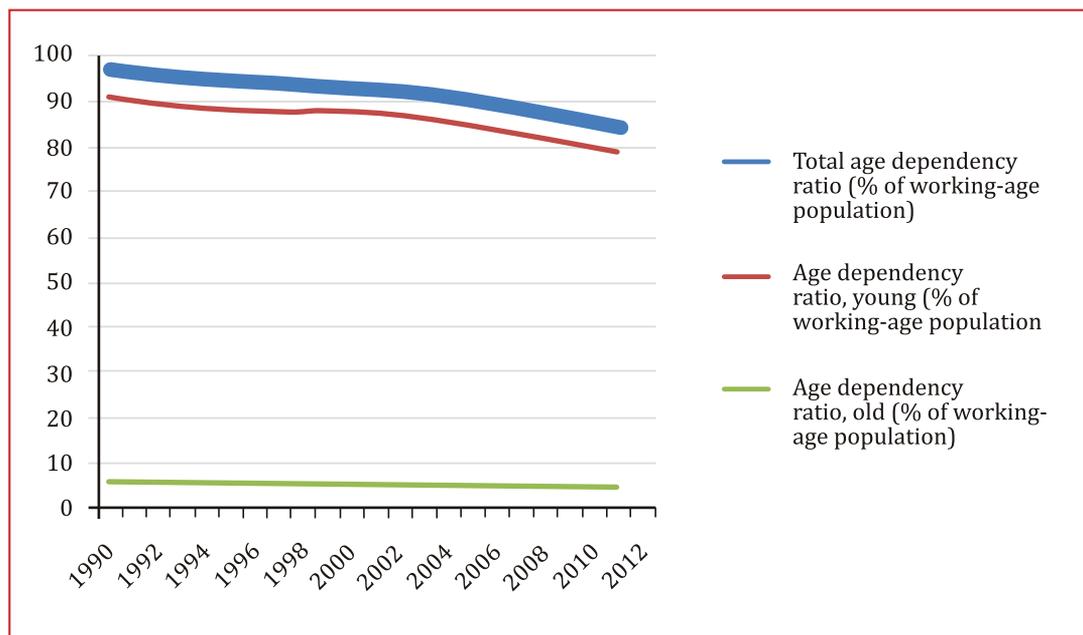


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



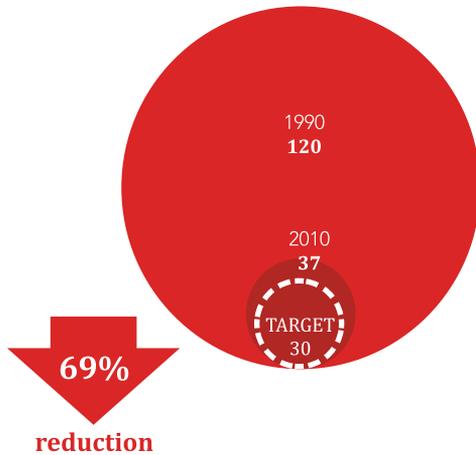
Source: <http://databank.worldbank.org>

## Country Profile

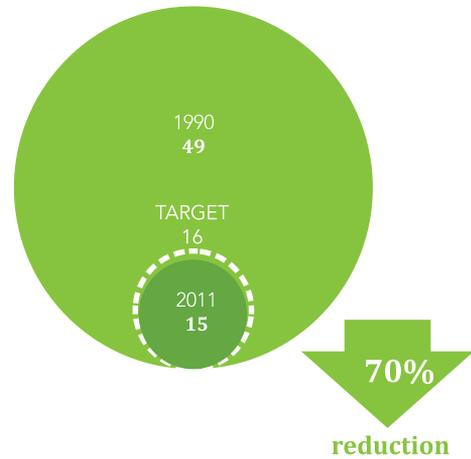
Population (millions)	9.4
Life expectancy at birth (years)	56.5
GNI per capita in PPP terms (constant 2005 Int \$)	1.439
Human Development Index 2012	0.436
HDI Ranking among PPD countries	22
HDI Ranking 2012	166
Gender Inequality Index. value	0.618
GII Ranking among PPD countries	21

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio



### Under 5 Mortality

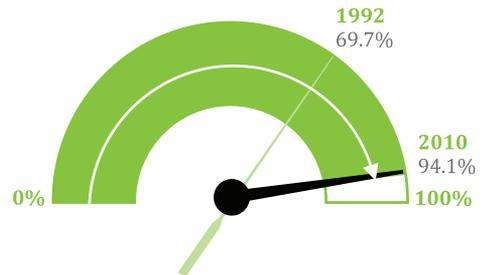


## Universal access to reproductive health

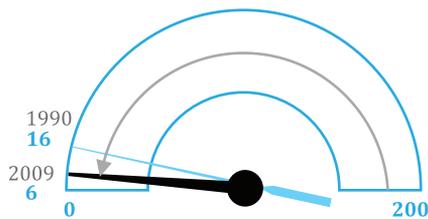
### Contraceptive prevalence rate, modern



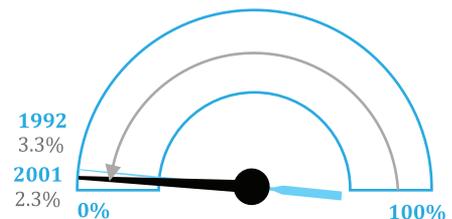
### Antenatal care coverage (at least one visit)



### Adolescent birth rate (per 1000)



### Unmet need for family planning

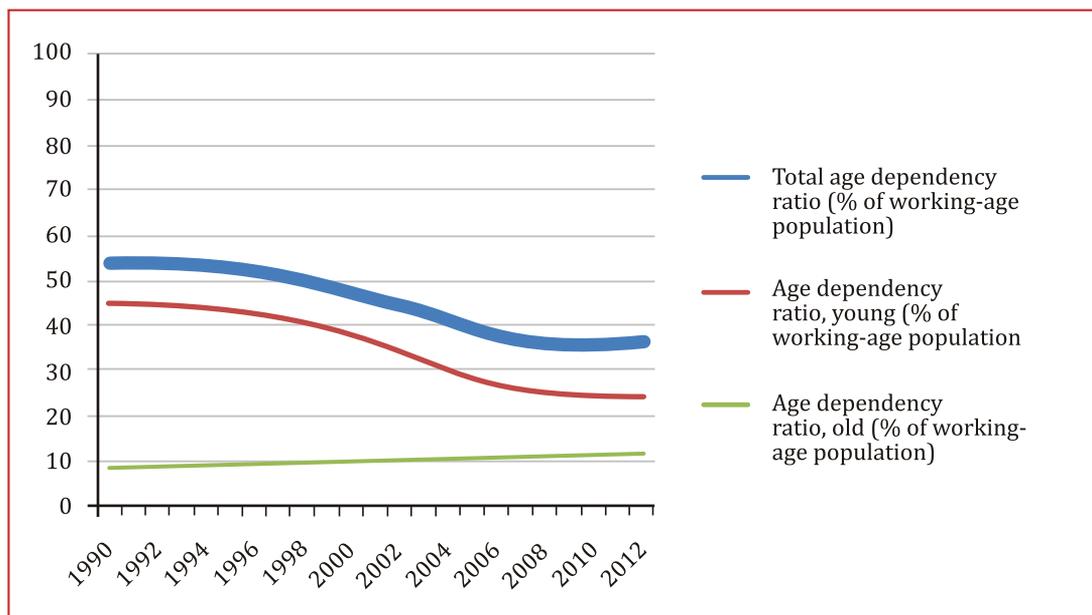


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

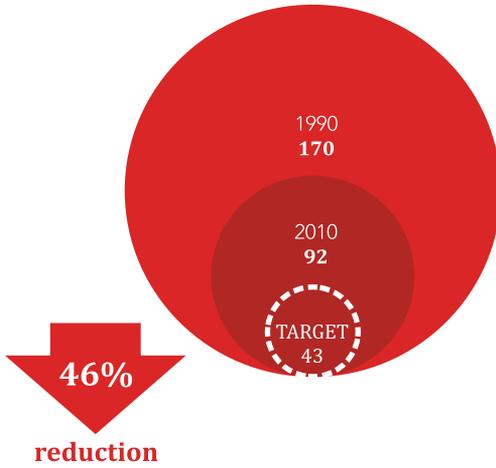
## Country Profile

Population (millions)	1.353.6
Life expectancy at birth (years)	73.7
GNI per capita in PPP terms (constant 2005 Int \$)	7,945
Human Development Index 2012	0.699
HDI Ranking among PPD countries	5
HDI Ranking 2012	101
Gender Inequality Index. value	0.213
GII Ranking among PPD countries	1

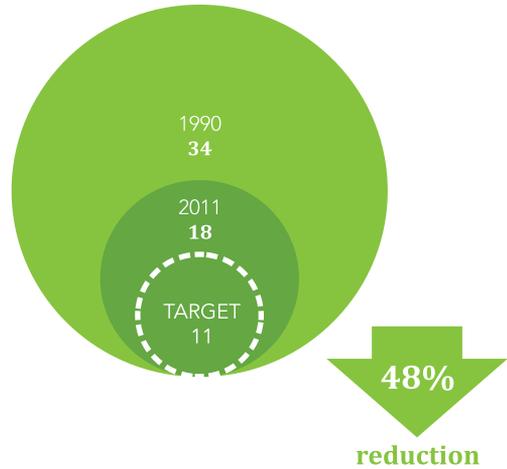
Source: UNDP <http://hdr.undp.org>

# COLOMBIA

Maternal mortality ratio



Under 5 Mortality

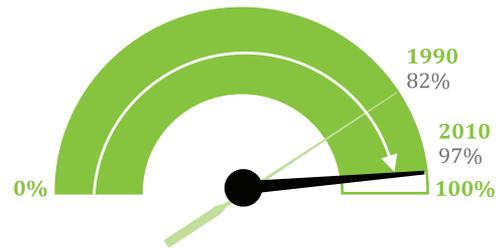


## Universal access to reproductive health

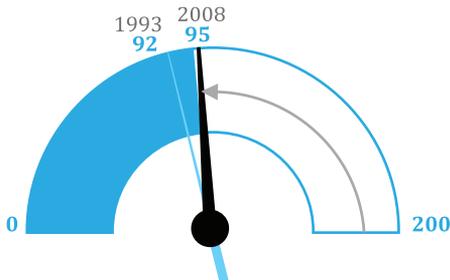
Contraceptive prevalence rate, modern



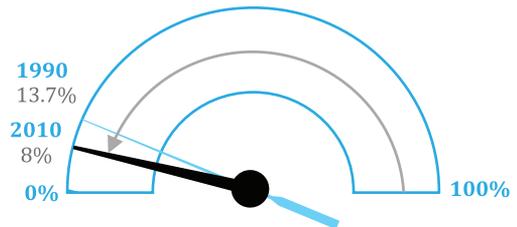
Antenatal care coverage (at least one visit)



Adolescent birth rate (per 1000)



Unmet need for family planning

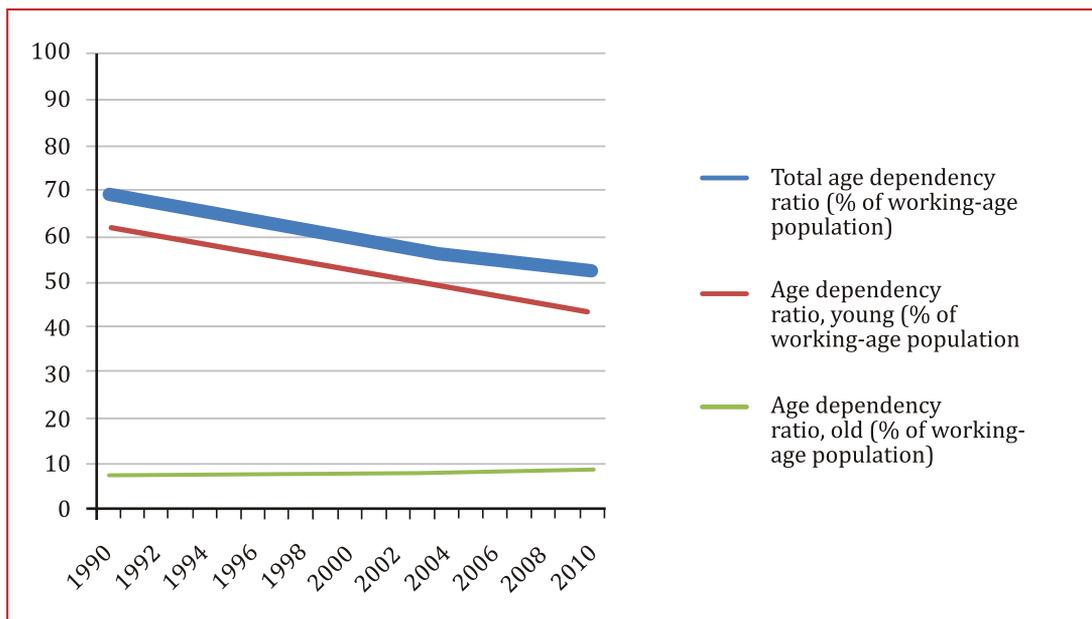


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

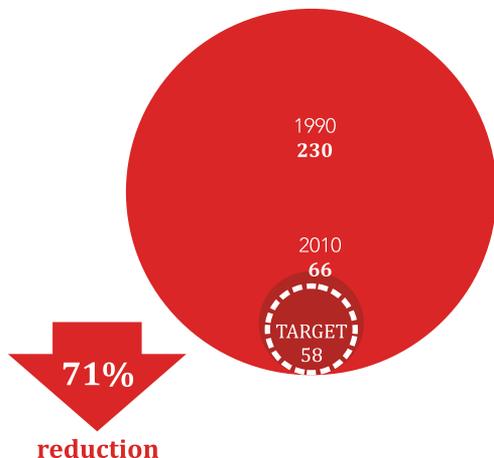
## Country Profile

Population (millions)	47.5
Life expectancy at birth (years)	73.9
GNI per capita in PPP terms (constant 2005 Int \$)	8,711
Human Development Index 2012	0.719
HDI Ranking among PPD countries	2
HDI Ranking 2012	91
Gender Inequality Index. value	0.459
GII Ranking among PPD countries	7

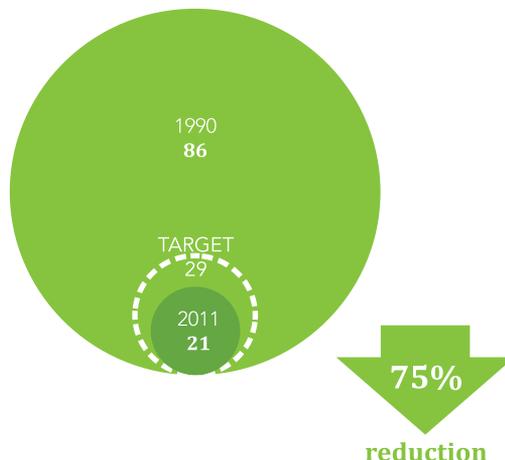
Source: UNDP <http://hdr.undp.org>

# EGYPT

### Maternal mortality ratio



### Under 5 Mortality



## Universal access to reproductive health

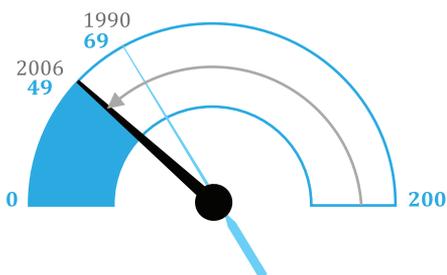
### Contraceptive prevalence rate, modern



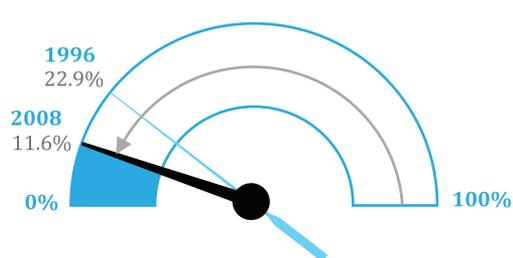
### Antenatal care coverage (at least one visit)



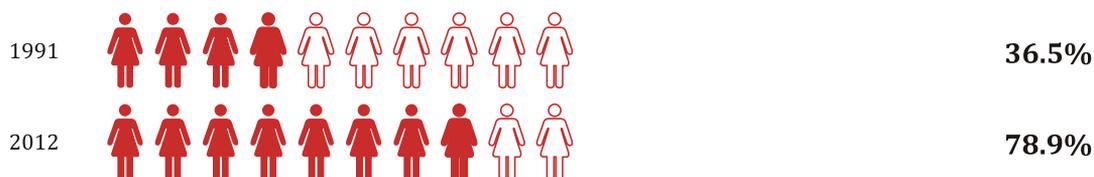
### Adolescent birth rate (per 1000)



### Unmet need for family planning

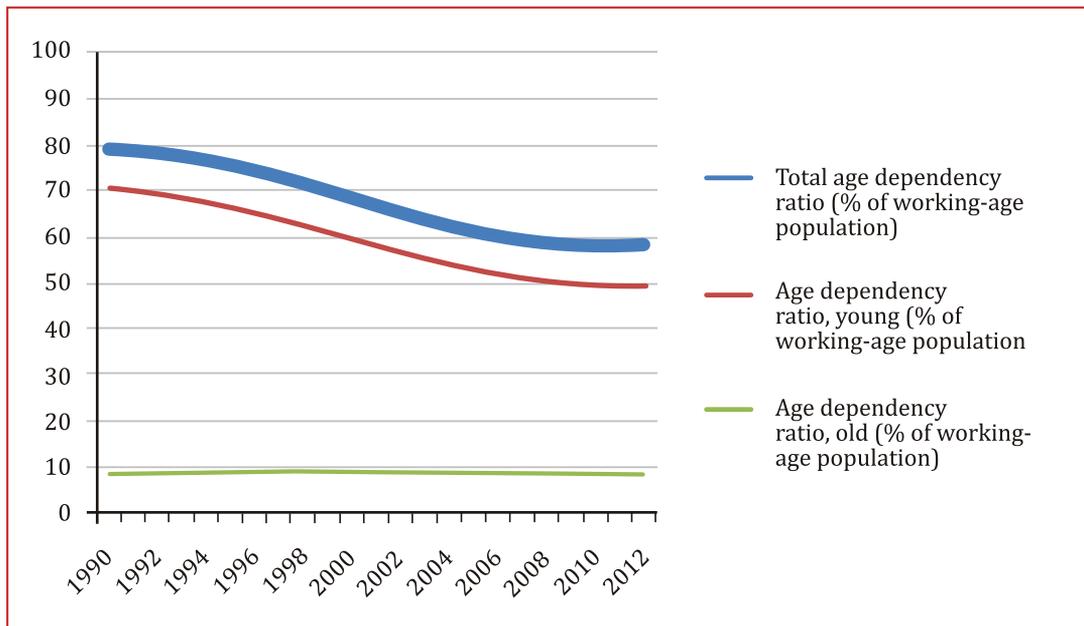


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

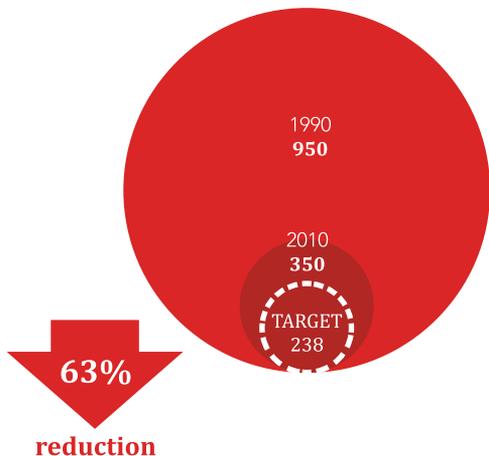
## Country Profile

Population (millions)	84.0
Life expectancy at birth (years)	73.5
GNI per capita in PPP terms (constant 2005 Int \$)	5,401
Human Development Index 2012	0.662
HDI Ranking among PPD countries	7
HDI Ranking 2012	112
Gender Inequality Index. value	0.590
GII Ranking among PPD countries	17

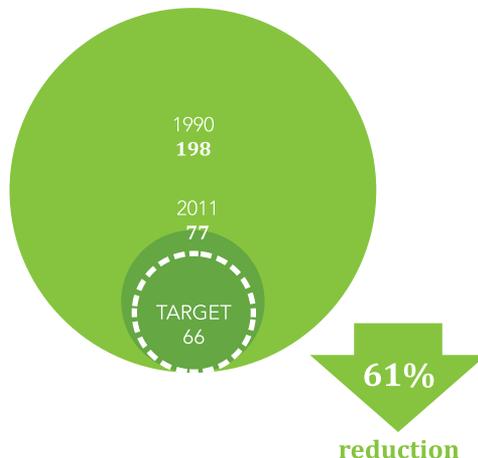
Source: UNDP <http://hdr.undp.org>

# ETHIOPIA

### Maternal mortality ratio

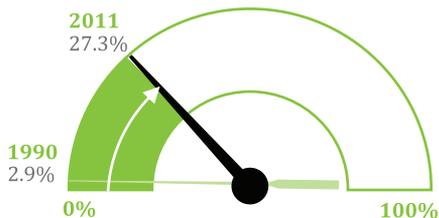


### Under 5 Mortality

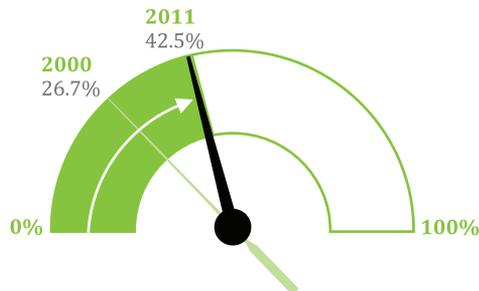


## Universal access to reproductive health

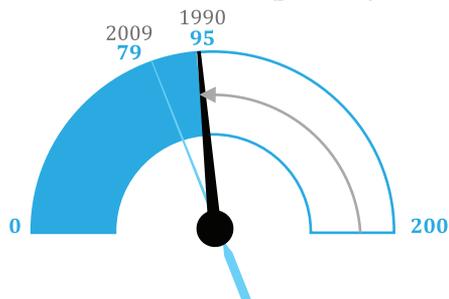
### Contraceptive prevalence rate, modern



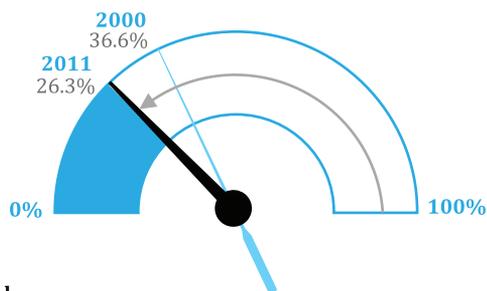
### Antenatal care coverage (at least one visit)



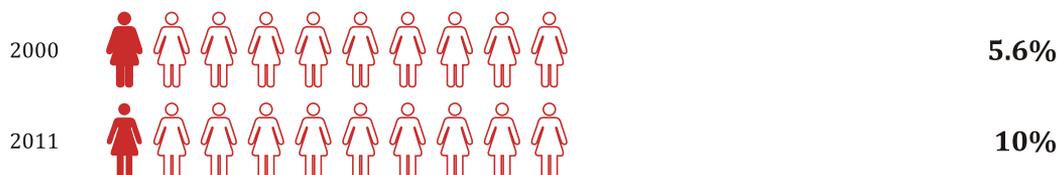
### Adolescent birth rate (per 1000)



### Unmet need for family planning

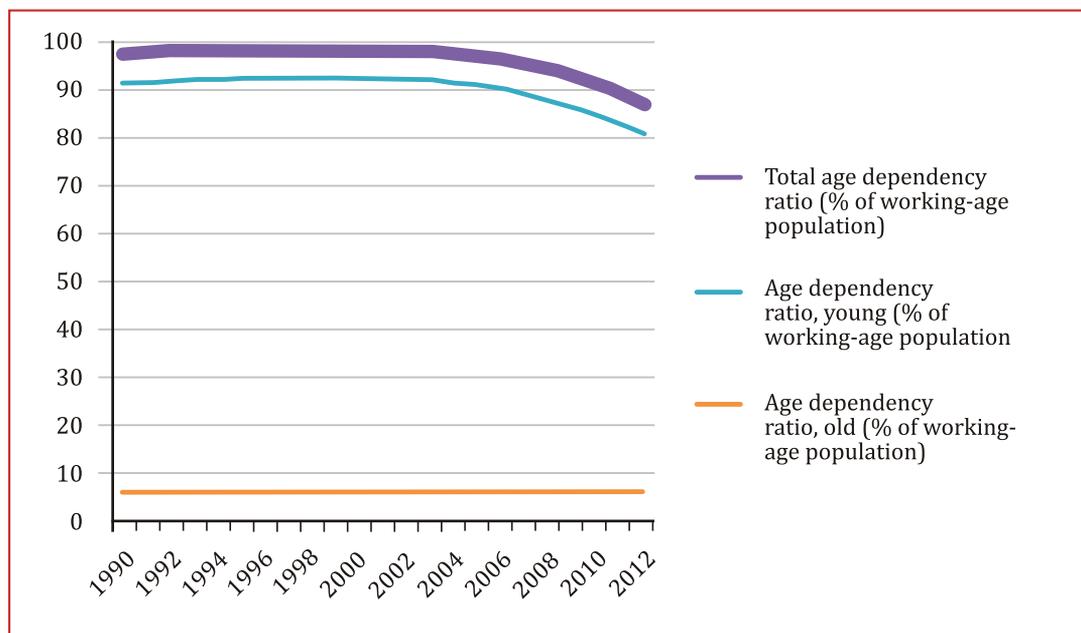


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

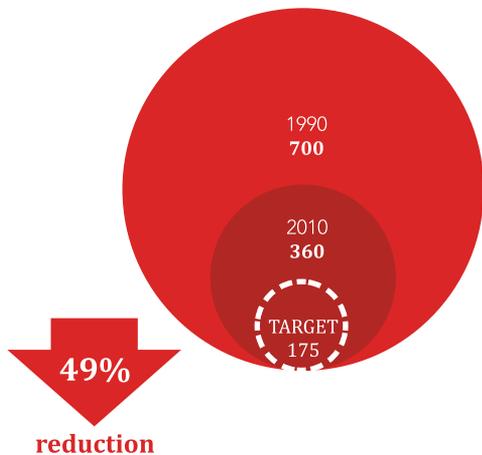
## Country Profile

Population (millions)	86.5
Life expectancy at birth (years)	59.7
GNI per capita in PPP terms (constant 2005 Int \$)	1,017
Human Development Index 2012	0.396
HDI Ranking among PPD countries	24
HDI Ranking 2012	173
Gender Inequality Index. value	Na
GII Ranking among PPD countries	Na

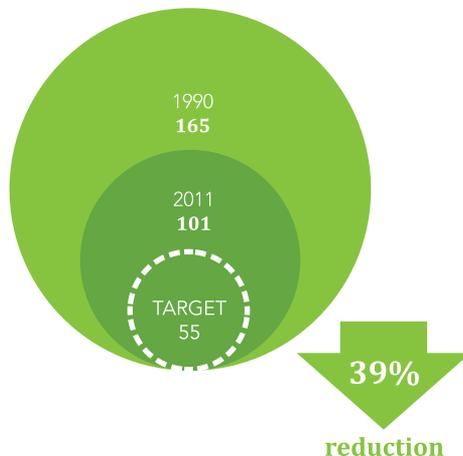
Source: UNDP <http://hdr.undp.org>

# THE GAMBIA

### Maternal mortality ratio

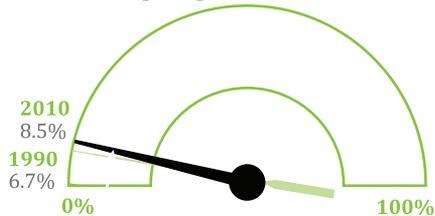


### Under 5 Mortality

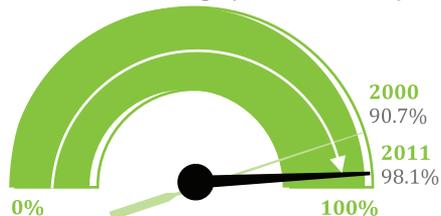


## Universal access to reproductive health

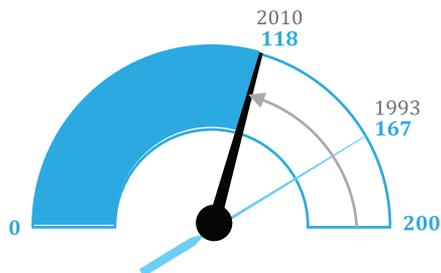
### Contraceptive prevalence rate, modern



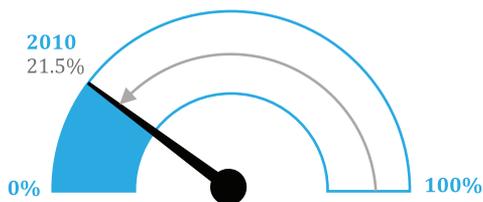
### Antenatal care coverage (at least one visit)



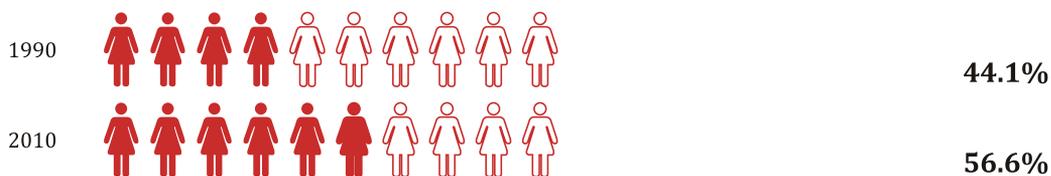
### Adolescent birth rate (per 1000)



### Unmet need for family planning

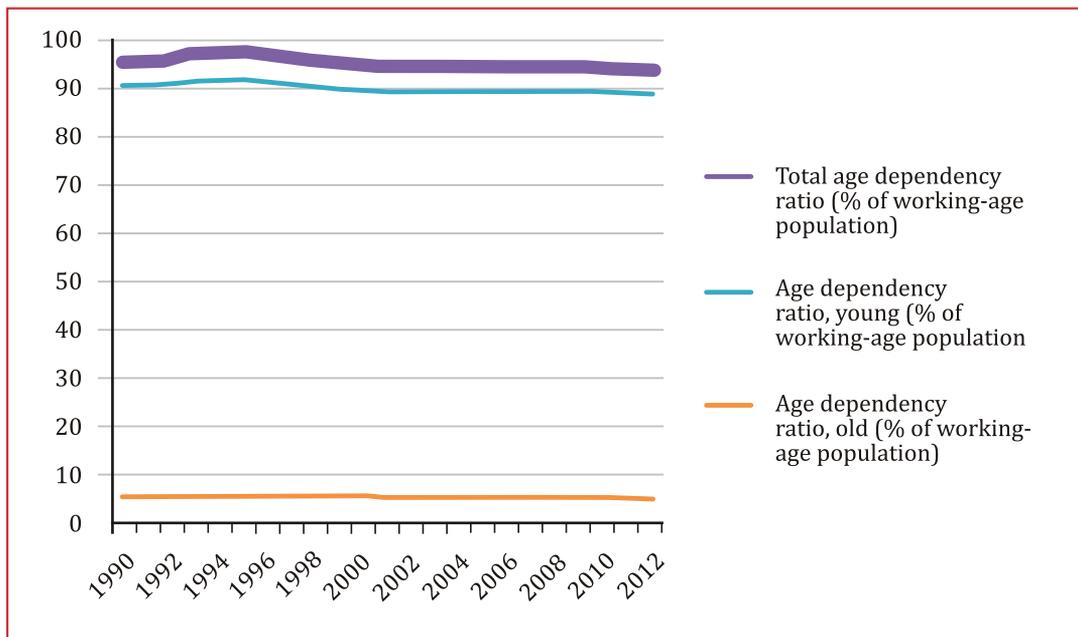


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



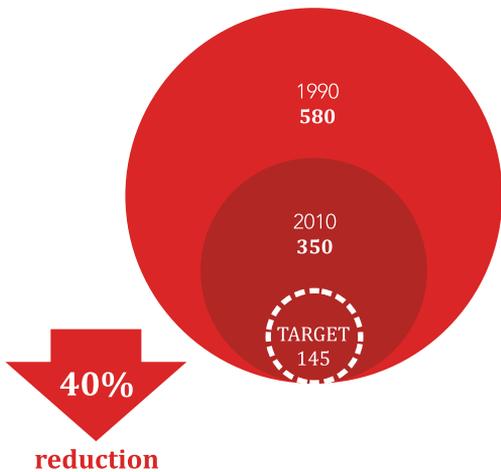
Source: <http://databank.worldbank.org>

## Country Profile

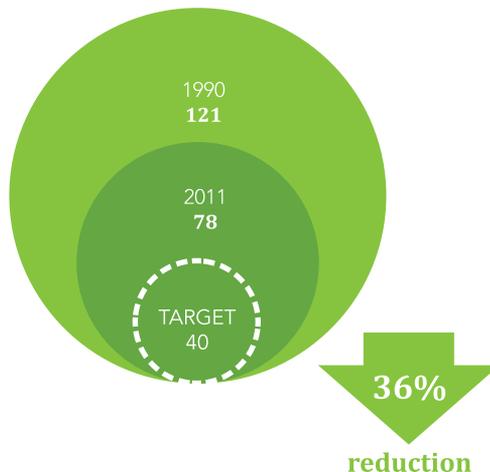
Population (millions)	1.8
Life expectancy at birth (years)	58.8
GNI per capita in PPP terms (constant 2005 Int \$)	1.731
Human Development Index 2012	0.439
HDI Ranking among PPD countries	21
HDI Ranking 2012	165
Gender Inequality Index. value	0.594
GII Ranking among PPD countries	18

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio



### Under 5 Mortality

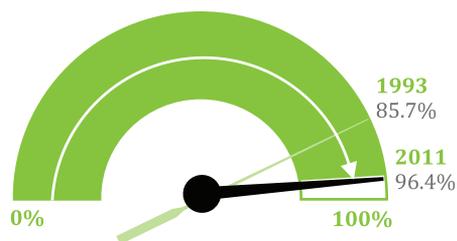


## Universal access to reproductive health

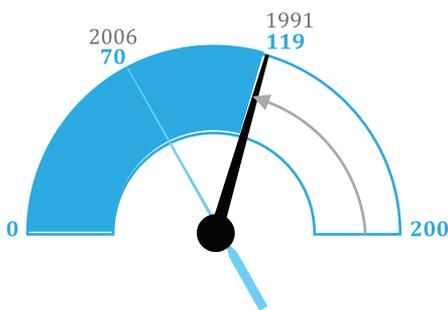
### Contraceptive prevalence rate, modern



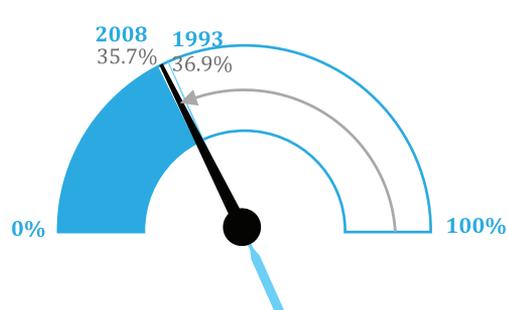
### Antenatal care coverage (at least one visit)



### Adolescent birth rate (per 1000)



### Unmet need for family planning

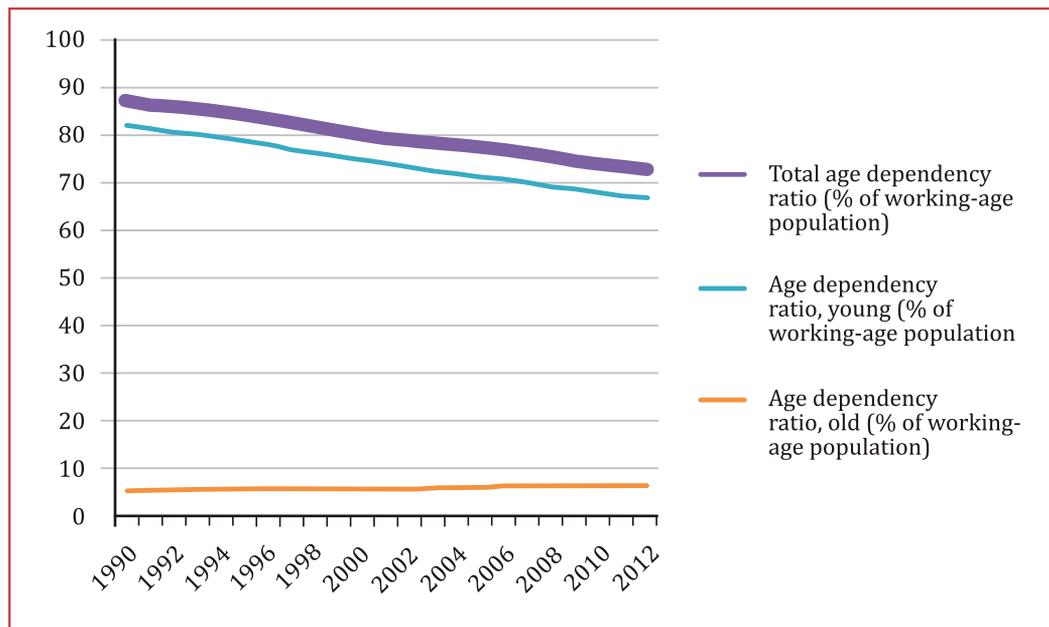


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



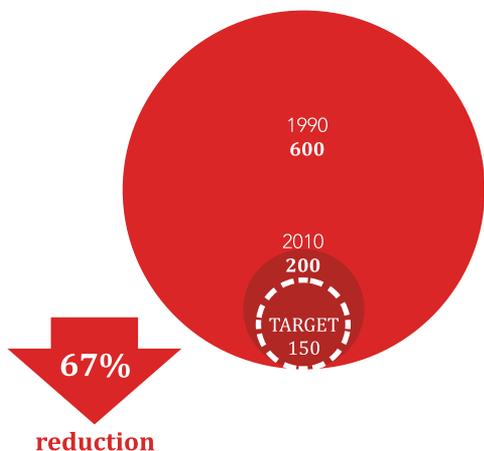
Source: <http://databank.worldbank.org>

## Country Profile

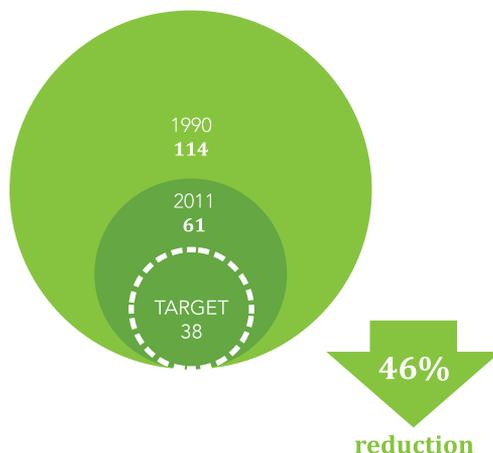
Population (millions)	25.5
Life expectancy at birth (years)	64.6
GNI per capita in PPP terms (constant 2005 Int \$)	1,684
Human Development Index 2012	0.558
HDI Ranking among PPD countries	12
HDI Ranking 2012	135
Gender Inequality Index. value	0.565
GII Ranking among PPD countries	15

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio



### Under 5 Mortality



## Universal access to reproductive health

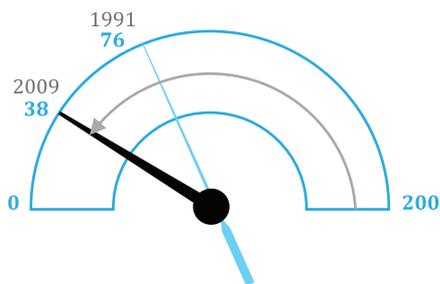
### Contraceptive prevalence rate, modern



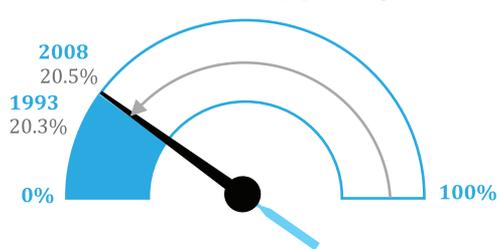
### Antenatal care coverage (at least one visit)



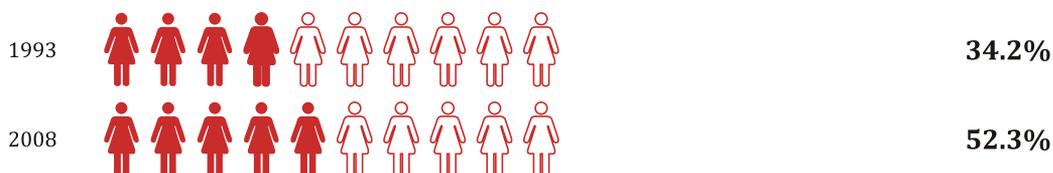
### Adolescent birth rate (per 1000)



### Unmet need for family planning

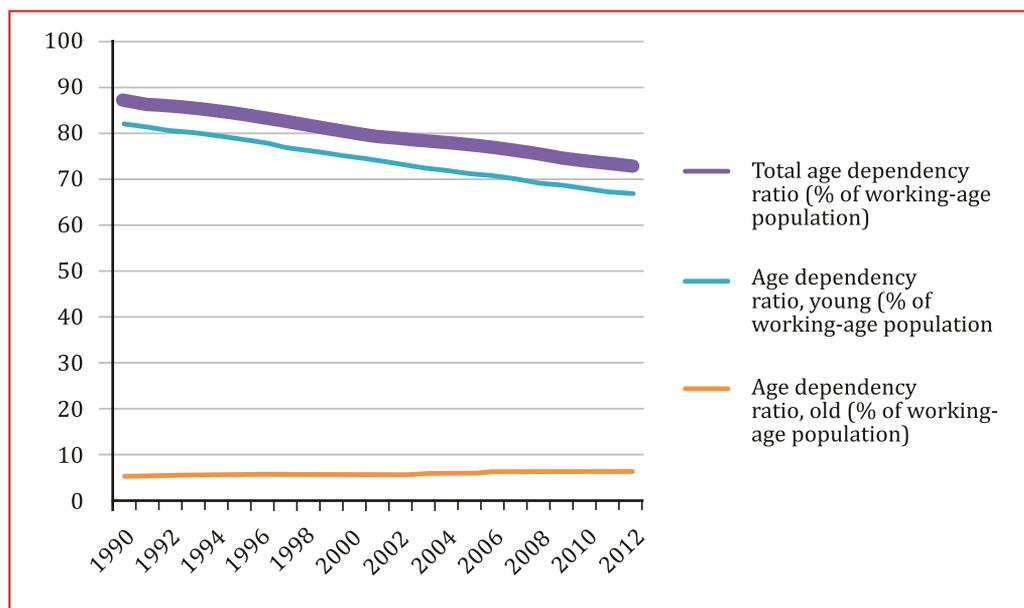


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

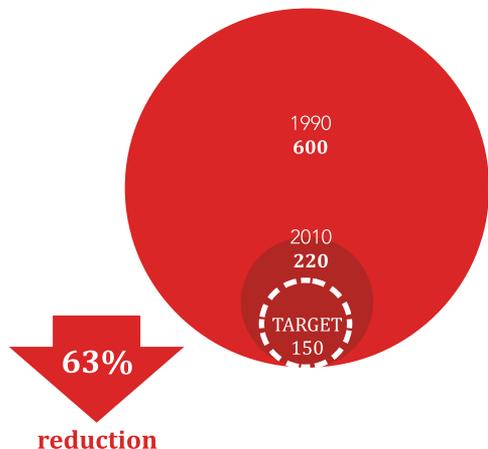
## Country Profile

Population (millions)	25.5
Life expectancy at birth (years)	64.6
GNI per capita in PPP terms (constant 2005 Int \$)	1,684
Human Development Index 2012	0.558
HDI Ranking among PPD countries	12
HDI Ranking 2012	135
Gender Inequality Index. value	0.565
GII Ranking among PPD countries	15

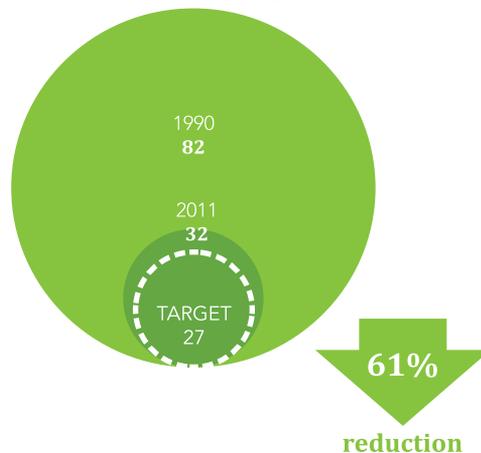
Source: UNDP <http://hdr.undp.org>

# INDONESIA

Maternal mortality ratio

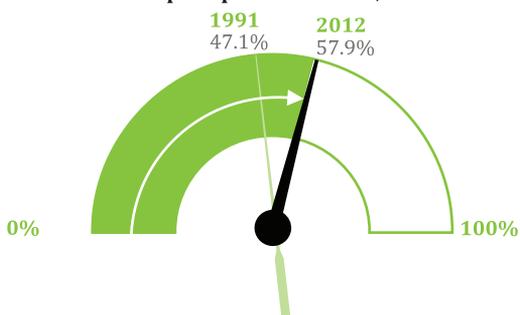


Under 5 Mortality



## Universal access to reproductive health

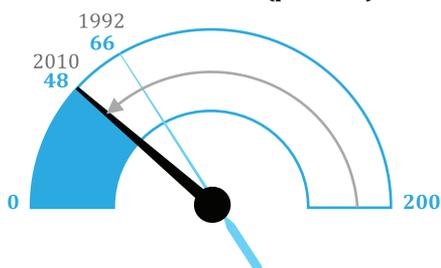
Contraceptive prevalence rate, modern



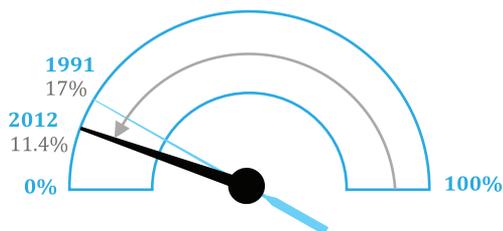
Antenatal care coverage (at least one visit)



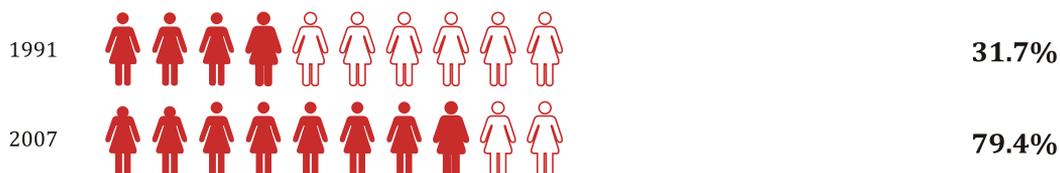
Adolescent birth rate (per 1000)



Unmet need for family planning

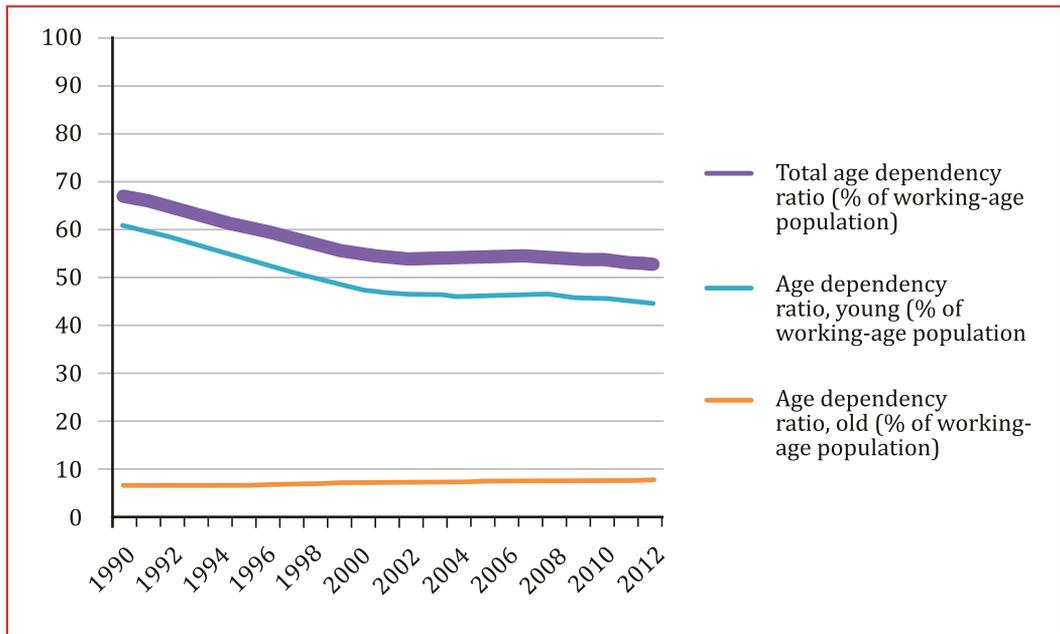


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



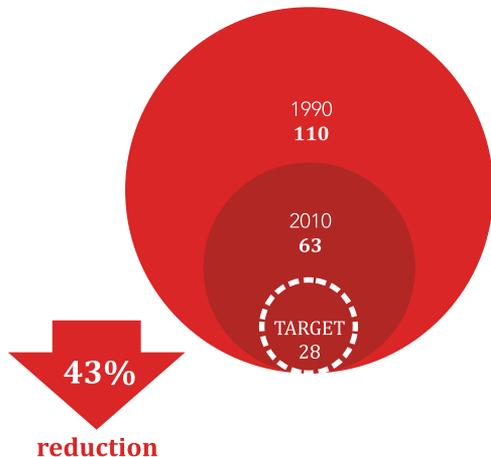
Source: <http://databank.worldbank.org>

## Country Profile

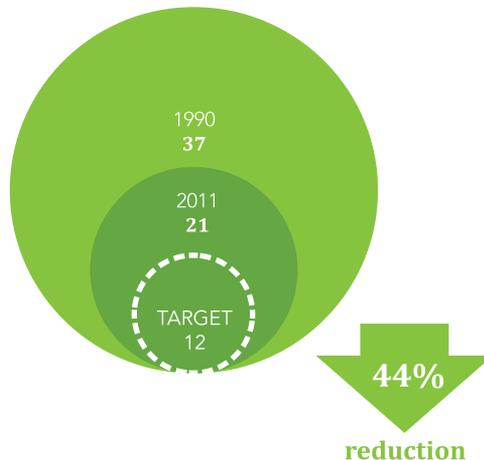
Population (millions)	244.8
Life expectancy at birth (years)	69.8
GNI per capita in PPP terms (constant 2005 Int \$)	4,154
Human Development Index 2012	0.629
HDI Ranking among PPD countries	9
HDI Ranking 2012	121
Gender Inequality Index. value	0.494
GII Ranking among PPD countries	10

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio



### Under 5 Mortality

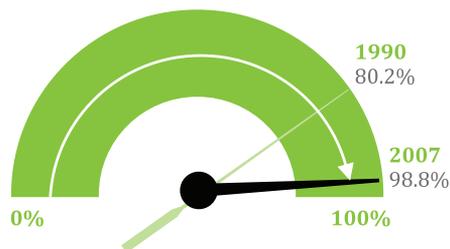


## Universal access to reproductive health

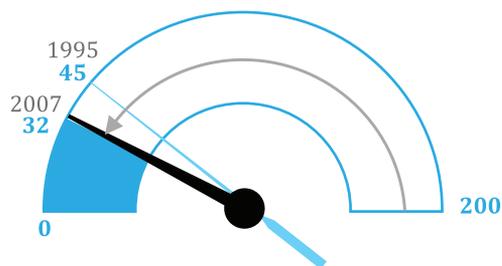
### Contraceptive prevalence rate, modern



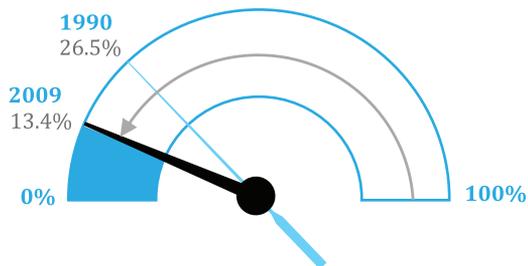
### Antenatal care coverage (at least one visit)



### Adolescent birth rate (per 1000)



### Unmet need for family planning

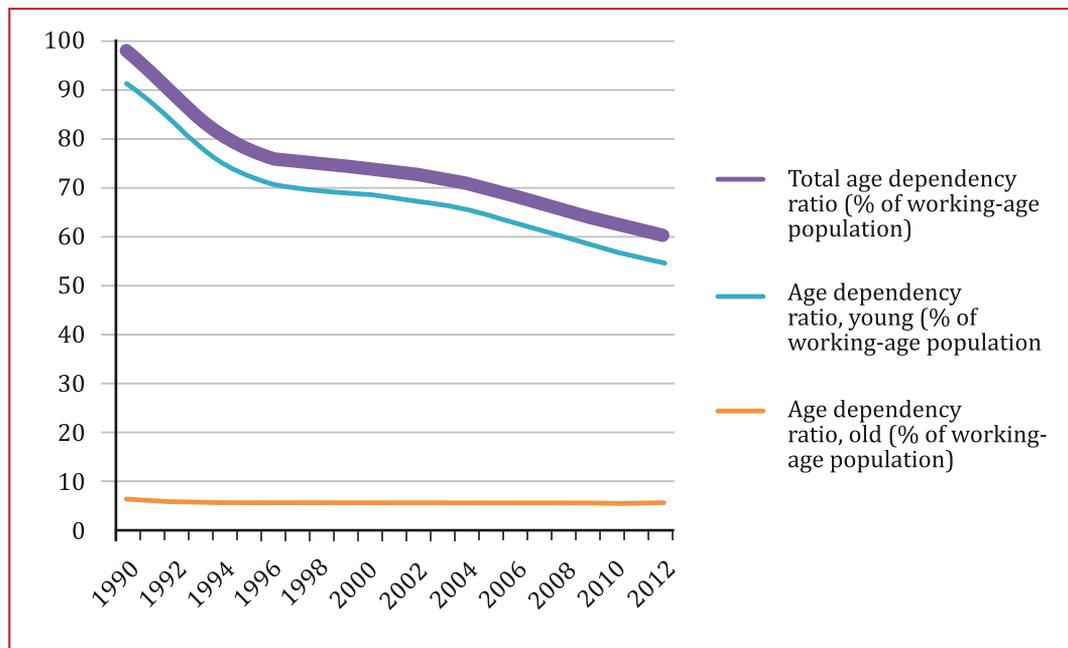


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

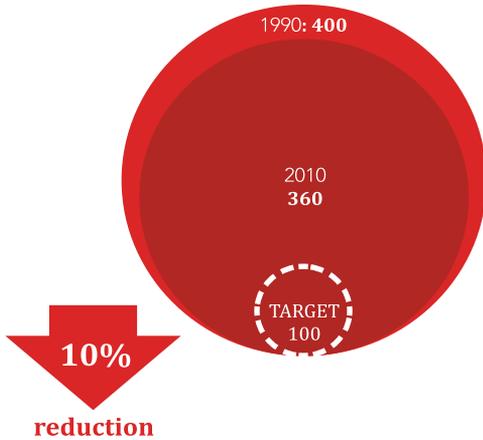
## Country Profile

Population (millions)	6.5
Life expectancy at birth (years)	73.5
GNI per capita in PPP terms (constant 2005 Int \$)	5,272
Human Development Index 2012	0.700
HDI Ranking among PPD countries	4
HDI Ranking 2012	100
Gender Inequality Index. value	0.482
GII Ranking among PPD countries	9

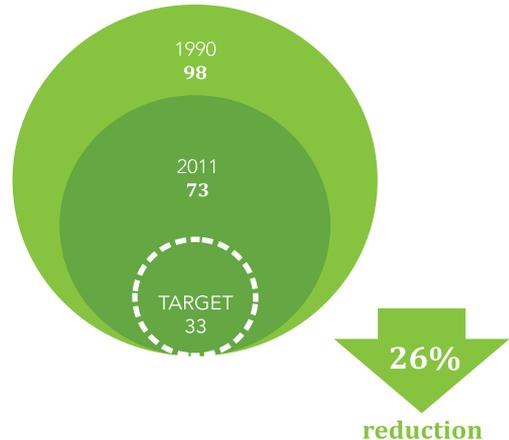
Source: UNDP <http://hdr.undp.org>

# KENYA

Maternal mortality ratio

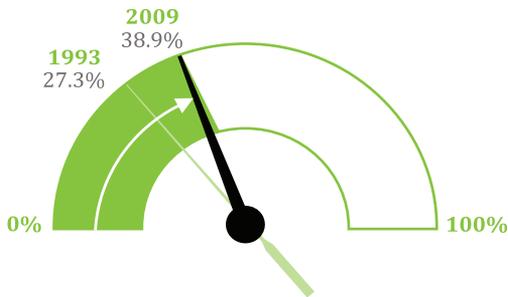


Under 5 Mortality

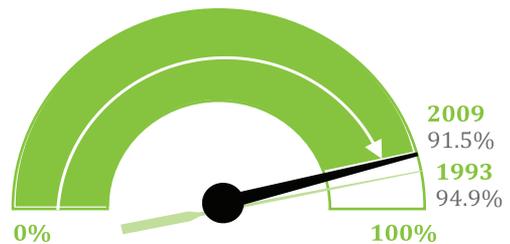


## Universal access to reproductive health

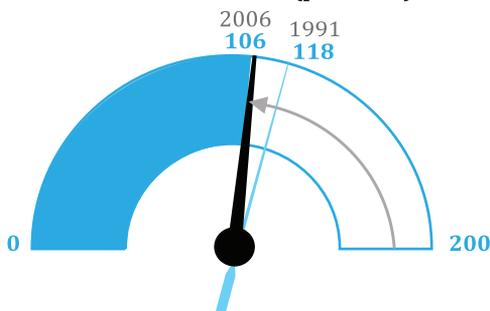
Contraceptive prevalence rate, modern



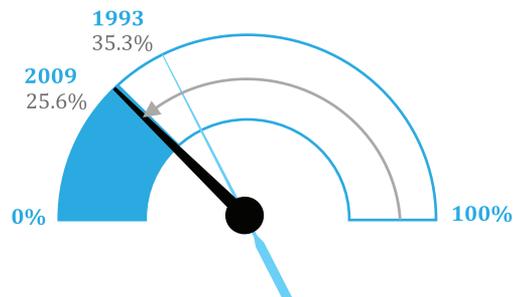
Antenatal care coverage (at least one visit)



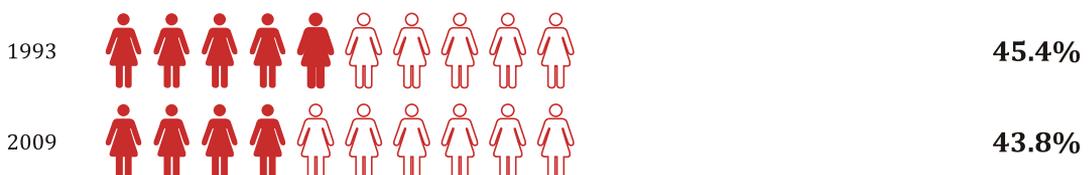
Adolescent birth rate (per 1000)



Unmet need for family planning

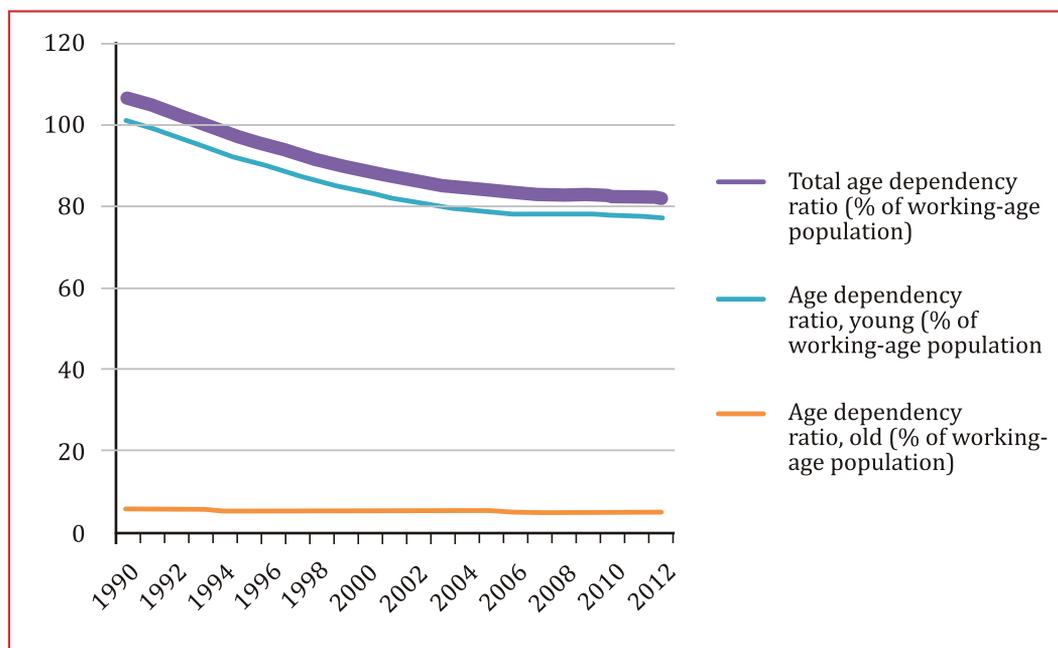


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



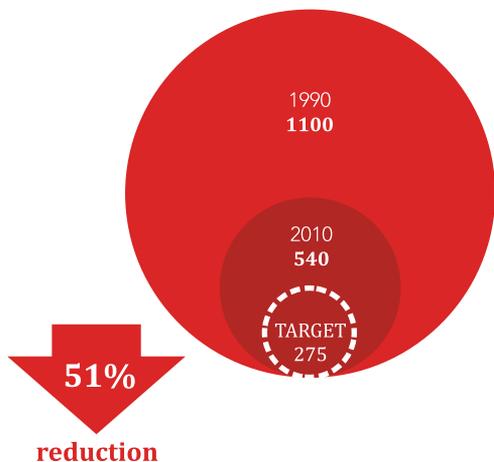
Source: <http://databank.worldbank.org>

## Country Profile

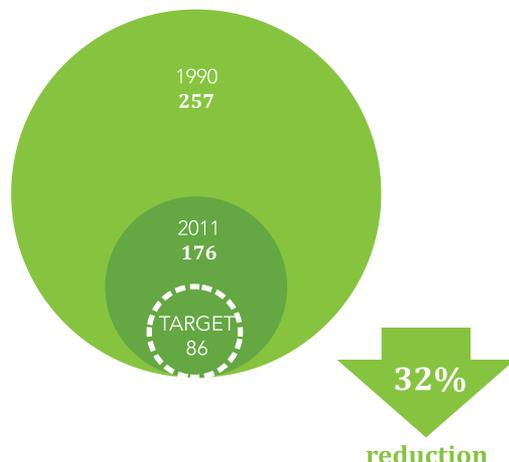
Population (millions)	42.7
Life expectancy at birth (years)	57.7
GNI per capita in PPP terms (constant 2005 Int \$)	1,541
Human Development Index 2012	0.519
HDI Ranking among PPD countries	14
HDI Ranking 2012	145
Gender Inequality Index. value	0.608
GII Ranking among PPD countries	19

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio

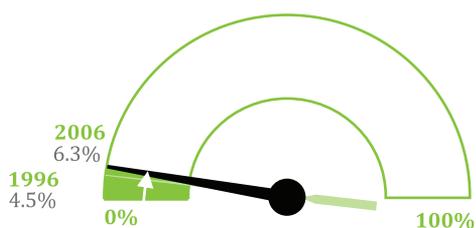


### Under 5 Mortality



## Universal access to reproductive health

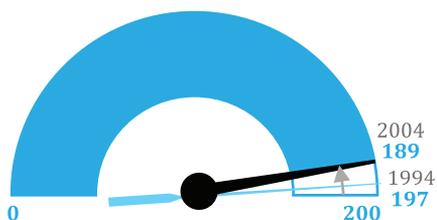
### Contraceptive prevalence rate, modern



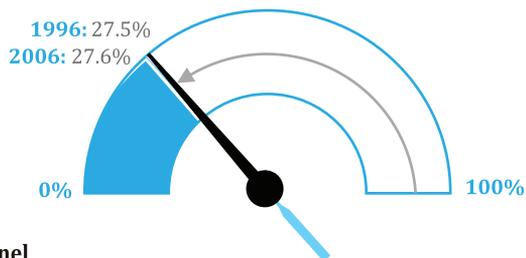
### Antenatal care coverage (at least one visit)



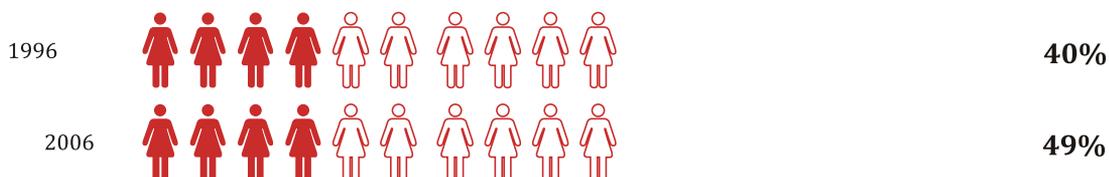
### Adolescent birth rate (per 1000)



### Unmet need for family planning

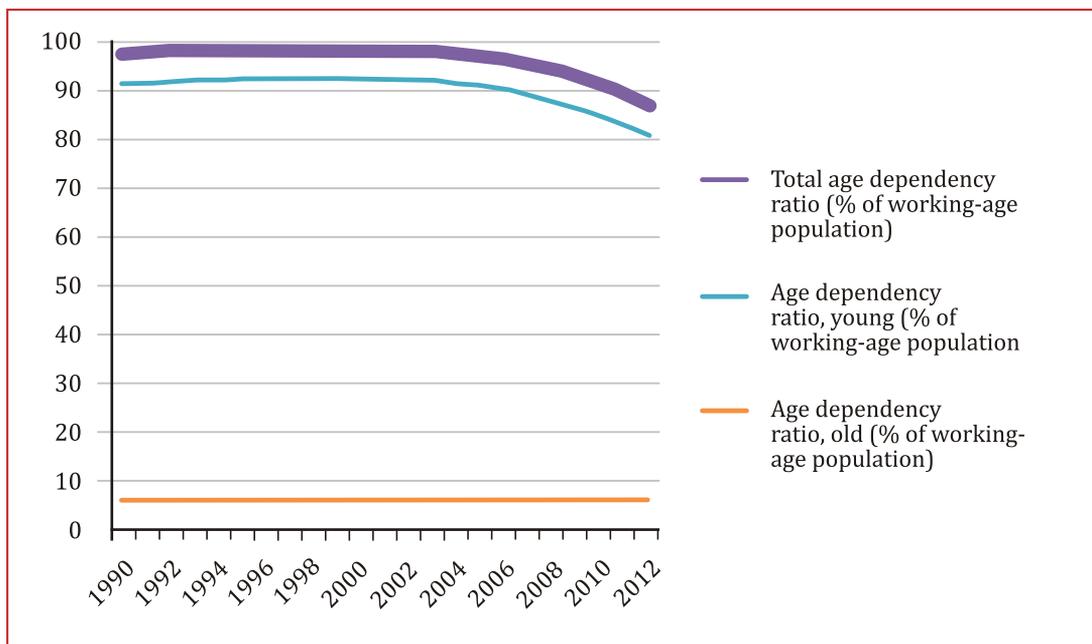


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

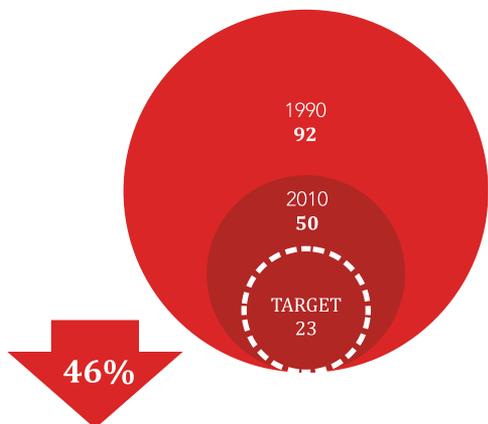
## Country Profile

Population (millions)	86.5
Life expectancy at birth (years)	59.7
GNI per capita in PPP terms (constant 2005 Int \$)	1,017
Human Development Index 2012	0.396
HDI Ranking among PPD countries	24
HDI Ranking 2012	173
Gender Inequality Index. value	Na
GII Ranking among PPD countries	Na

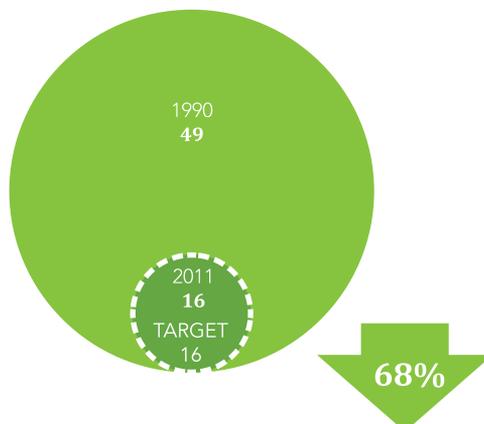
Source: UNDP <http://hdr.undp.org>

# MEXICO

Maternal mortality ratio



Under 5 Mortality

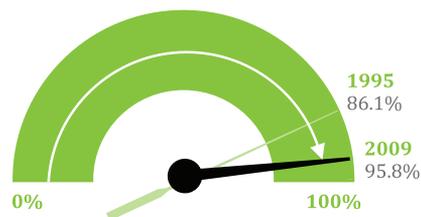


## Universal access to reproductive health

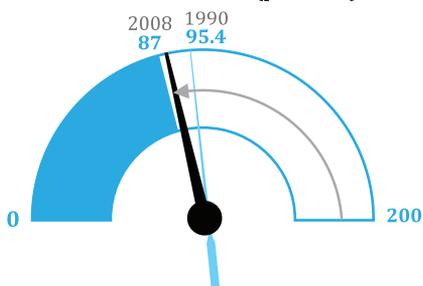
Contraceptive prevalence rate, modern



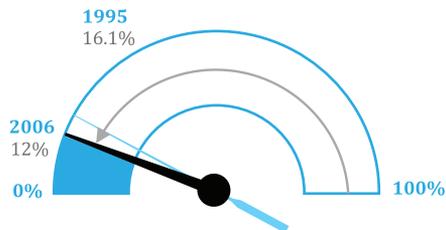
Antenatal care coverage (at least one visit)



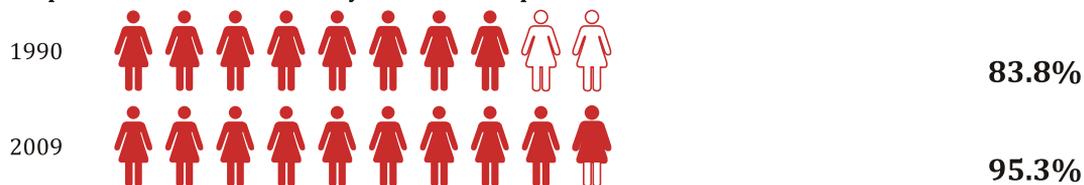
Adolescent birth rate (per 1000)



Unmet need for family planning

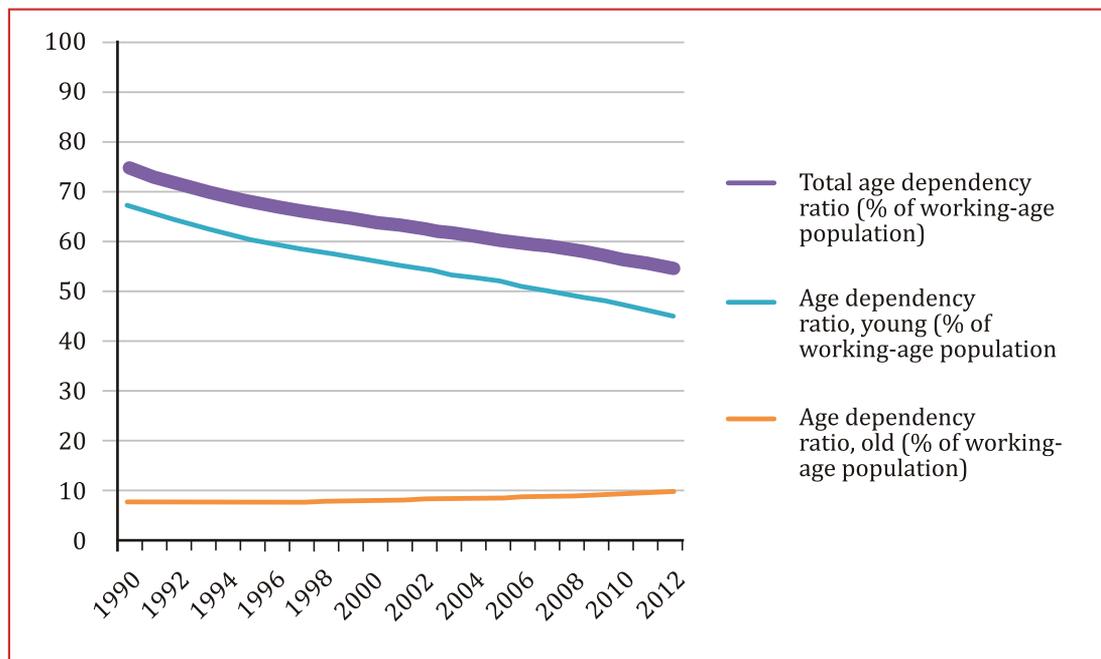


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

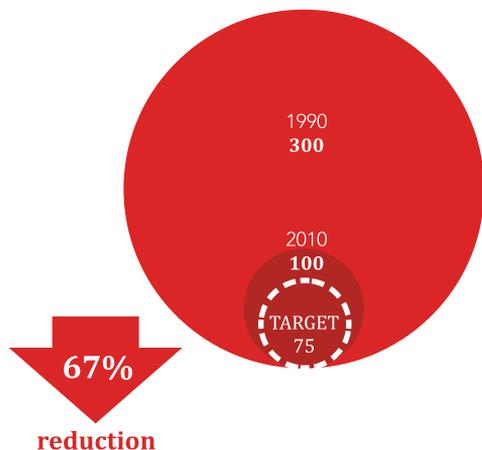
## Country Profile

Population (millions)	116.1
Life expectancy at birth (years)	77.1
GNI per capita in PPP terms (constant 2005 Int \$)	12,947
Human Development Index 2012	0.775
HDI Ranking among PPD countries	1
HDI Ranking 2012	61
Gender Inequality Index. value	0.382
GII Ranking among PPD countries	5

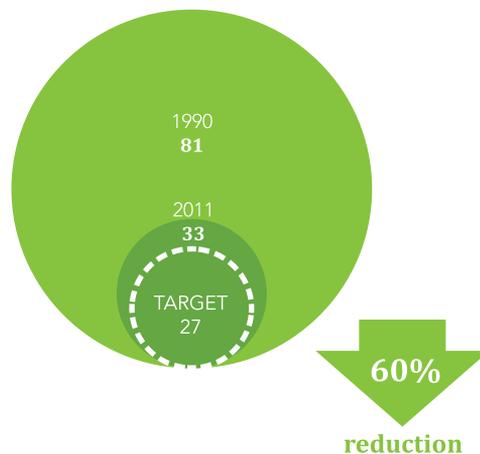
Source: UNDP <http://hdr.undp.org>

# MOROCCO

Maternal mortality ratio



Under 5 Mortality

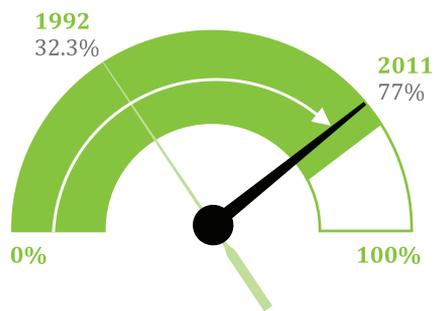


## Universal access to reproductive health

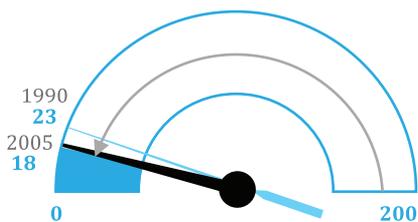
Contraceptive prevalence rate, modern



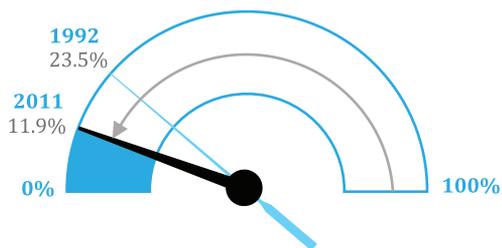
Antenatal care coverage (at least one visit)



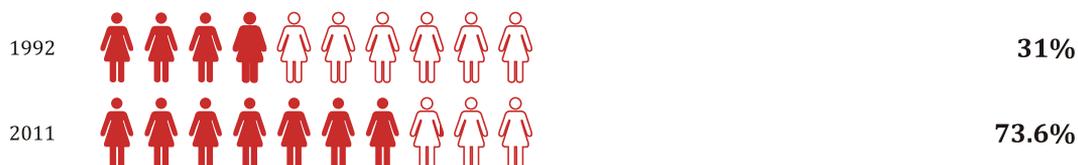
Adolescent birth rate (per 1000)



Unmet need for family planning

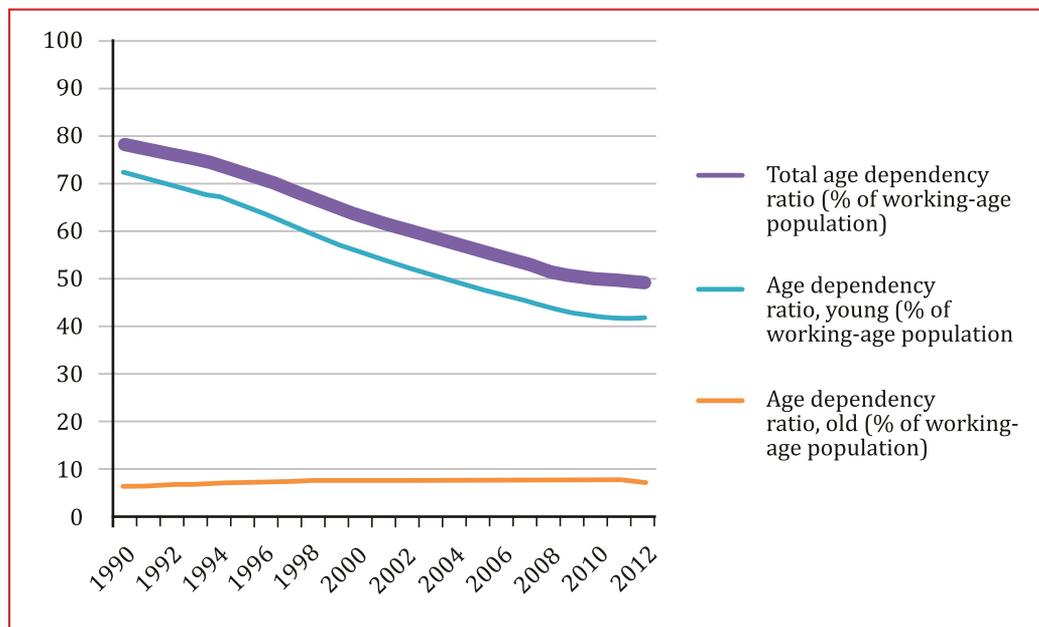


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

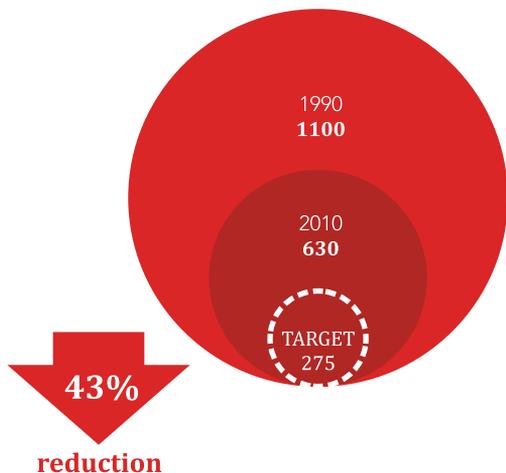
## Country Profile

Population (millions)	32.6
Life expectancy at birth (years)	72.4
GNI per capita in PPP terms (constant 2005 Int \$)	4,384
Human Development Index 2012	0.591
HDI Ranking among PPD countries	11
HDI Ranking 2012	130
Gender Inequality Index. value	0.444
GII Ranking among PPD countries	6

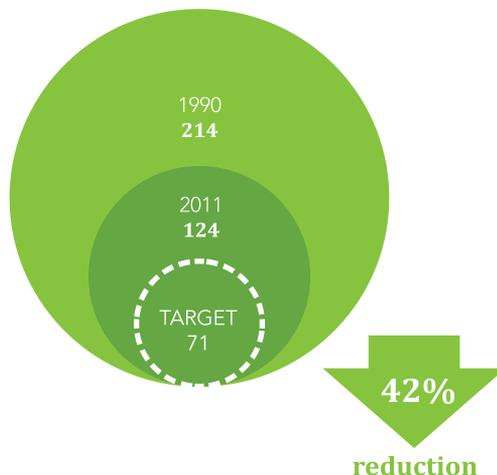
Source: UNDP <http://hdr.undp.org>

# NIGERIA

Maternal mortality ratio

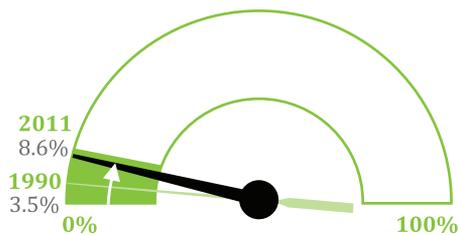


Under 5 Mortality

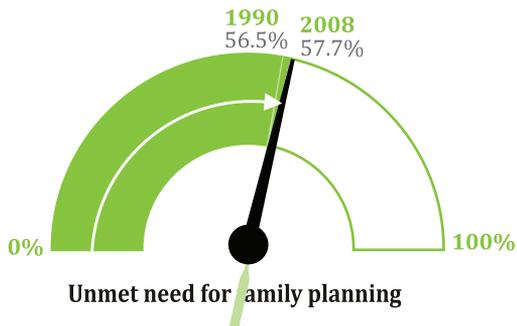


## Universal access to reproductive health

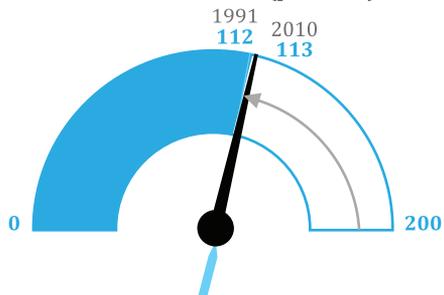
Contraceptive prevalence rate, modern



Antenatal care coverage (at least one visit)



Adolescent birth rate (per 1000)

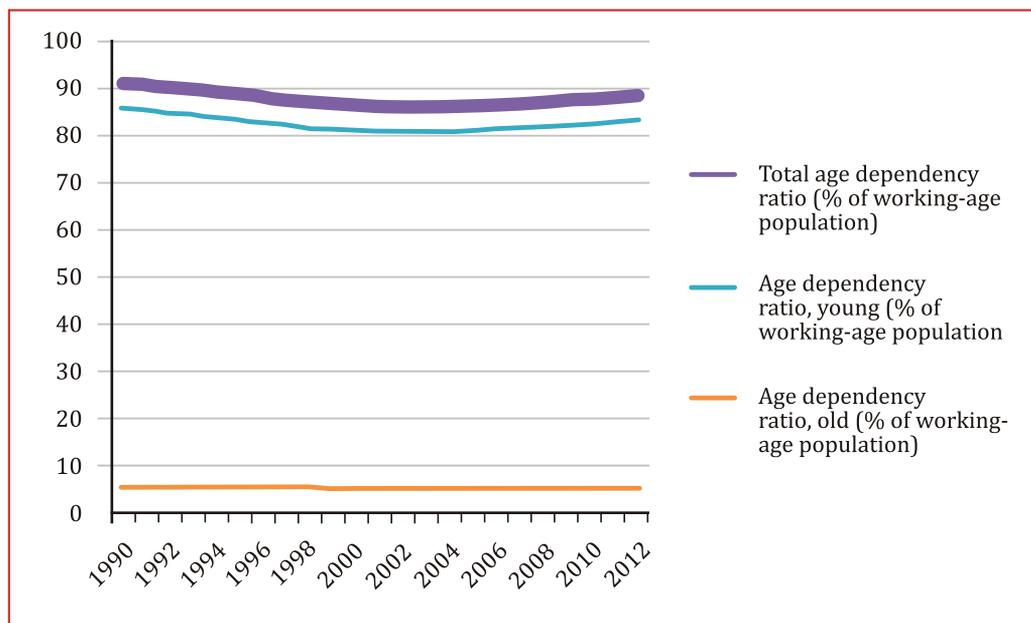


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

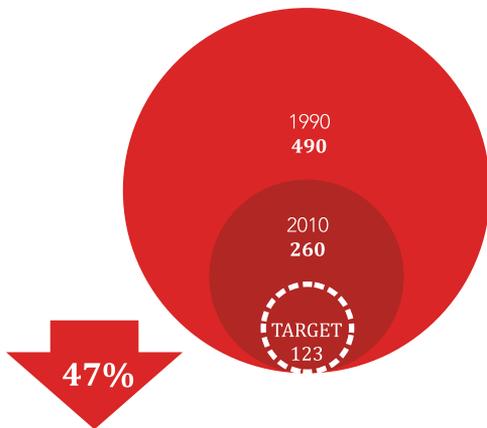
## Country Profile

Population (millions)	166.6
Life expectancy at birth (years)	52.3
GNI per capita in PPP terms (constant 2005 Int \$)	2,102
Human Development Index 2012	0.471
HDI Ranking among PPD countries	17
HDI Ranking 2012	153
Gender Inequality Index, value	Na
GII Ranking among PPD countries	Na

Source: UNDP <http://hdr.undp.org>

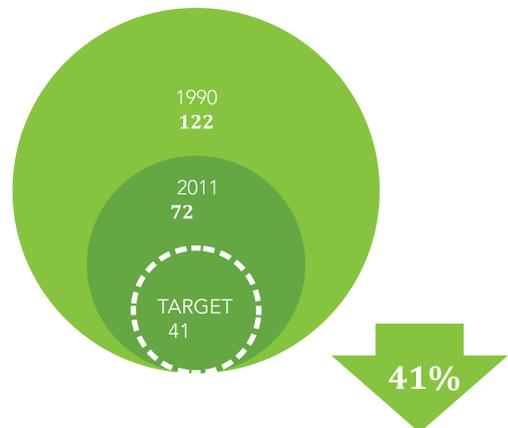
# PAKISTAN

Maternal mortality ratio



reduction

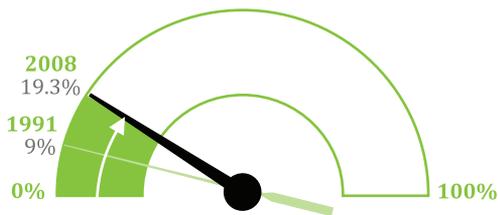
Under 5 Mortality



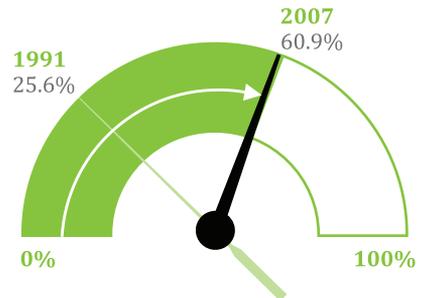
reduction

## Universal access to reproductive health

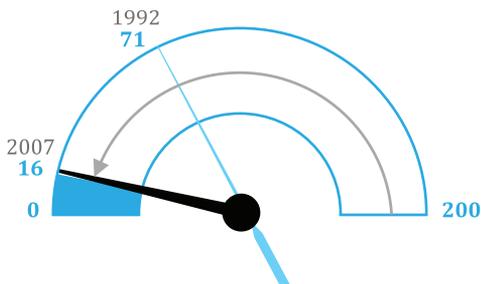
Contraceptive prevalence rate, modern



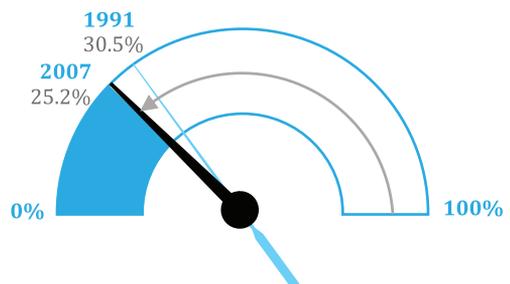
Antenatal care coverage (at least one visit)



Adolescent birth rate (per 1000)



Unmet need for family planning

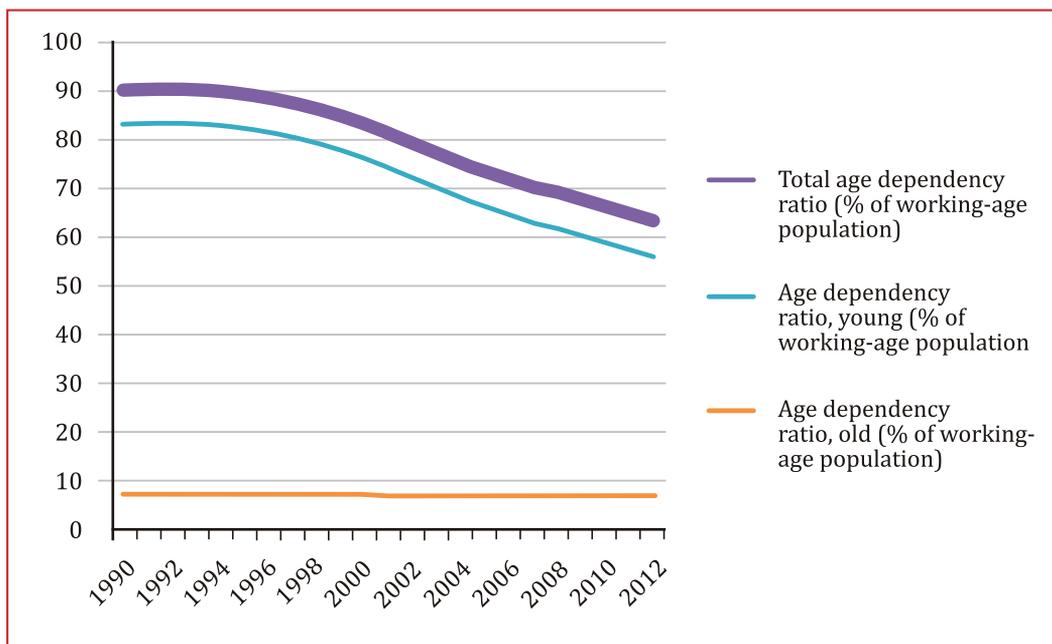


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

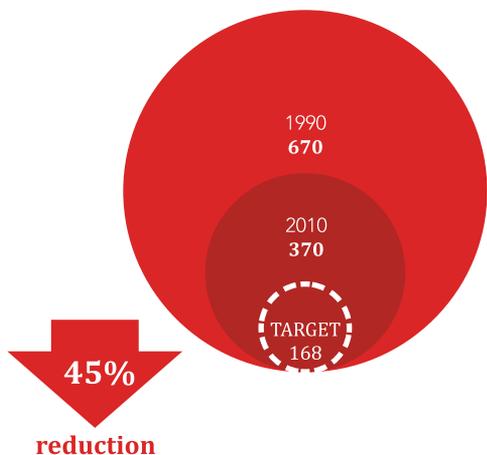
## Country Profile

Population (millions)	180.0
Life expectancy at birth (years)	65.7
GNI per capita in PPP terms (constant 2005 Int \$)	2,566
Human Development Index 2012	0.515
HDI Ranking among PPD countries	15
HDI Ranking 2012	146
Gender Inequality Index. value	0.567
GII Ranking among PPD countries	16

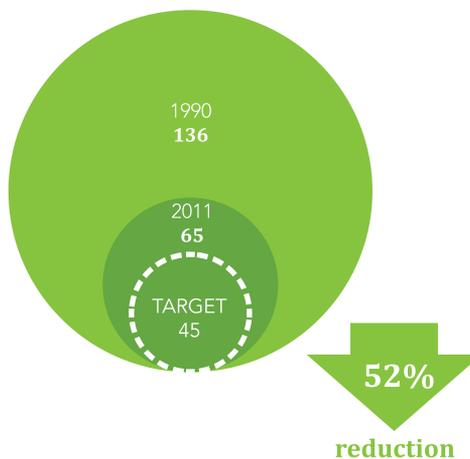
Source: UNDP <http://hdr.undp.org>

# SENEGAL

### Maternal mortality ratio

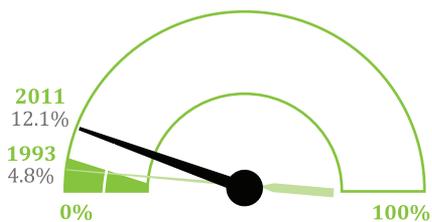


### Under 5 Mortality

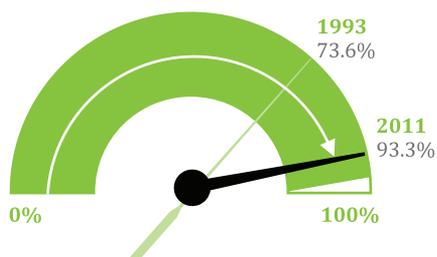


## Universal access to reproductive health

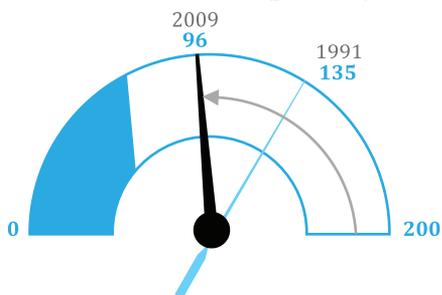
### Contraceptive prevalence rate, modern



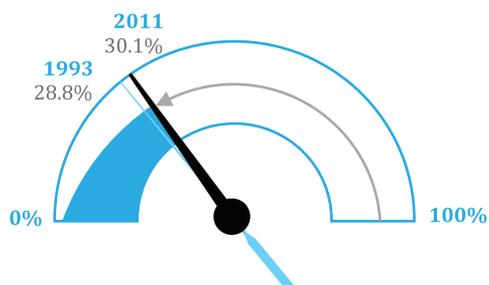
### Antenatal care coverage (at least one visit)



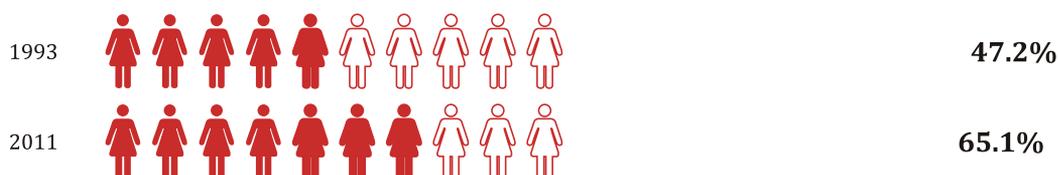
### Adolescent birth rate (per 1000)



### Unmet need for family planning

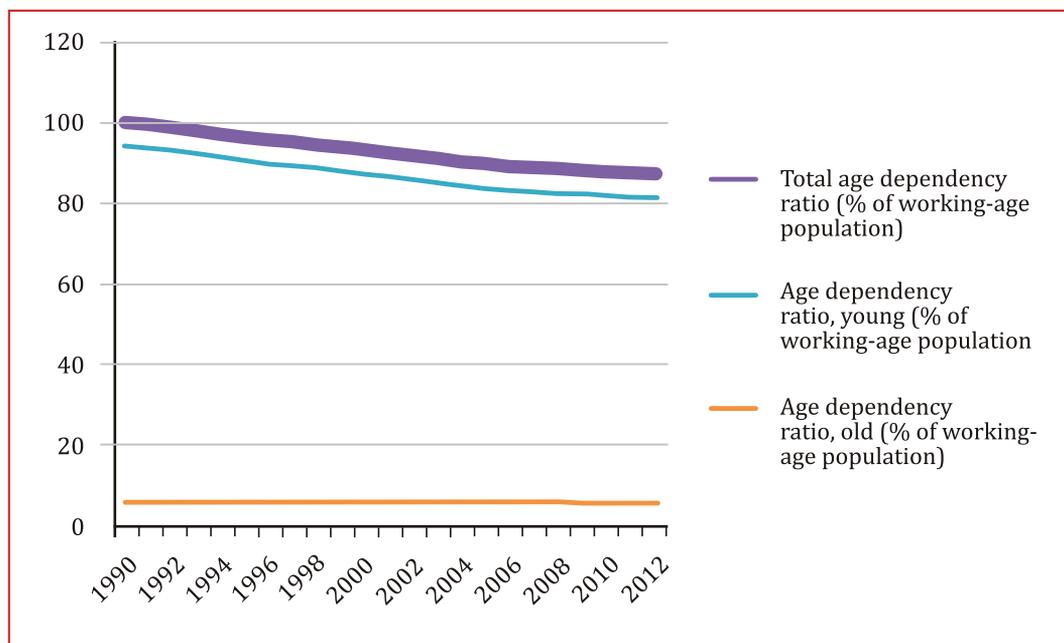


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

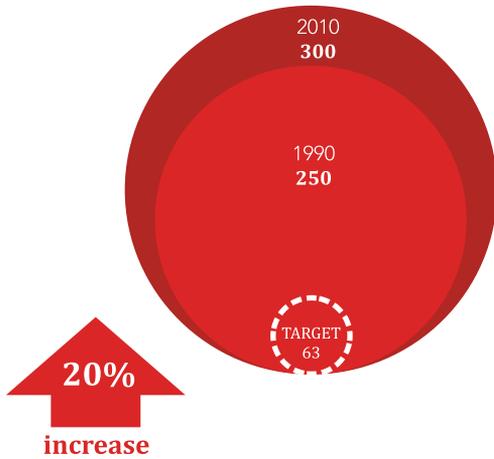
## Country Profile

Population (millions)	13.1
Life expectancy at birth (years)	59.6
GNI per capita in PPP terms (constant 2005 Int \$)	1,653
Human Development Index 2012	0.470
HDI Ranking among PPD countries	18
HDI Ranking 2012	154
Gender Inequality Index. value	0.540
GII Ranking among PPD countries	13

Source: UNDP <http://hdr.undp.org>

# SOUTH AFRICA

Maternal mortality ratio



Under 5 Mortality

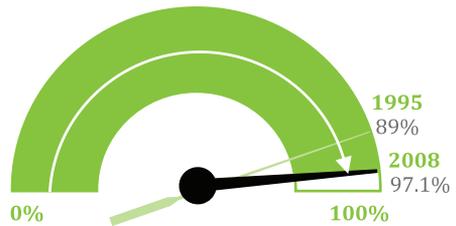


## Universal access to reproductive health

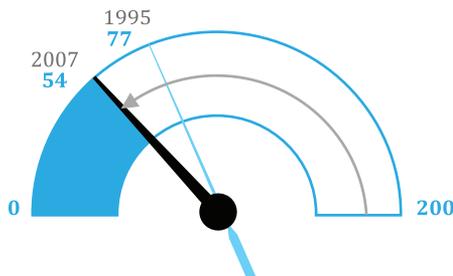
Contraceptive prevalence rate, modern



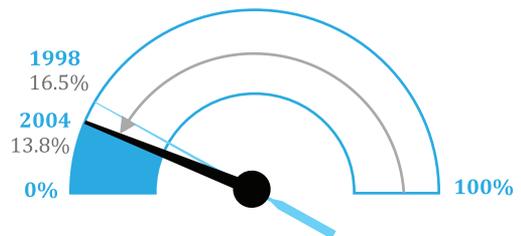
Antenatal care coverage (at least one visit)



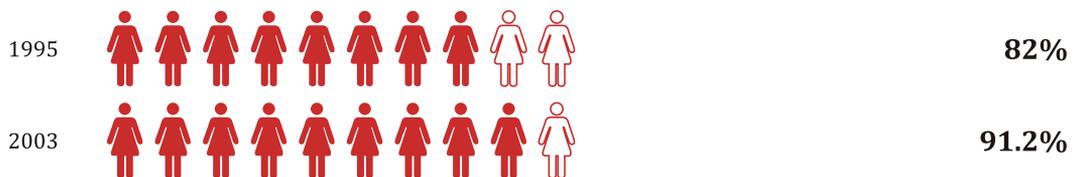
Adolescent birth rate (per 1000)



Unmet need for family planning

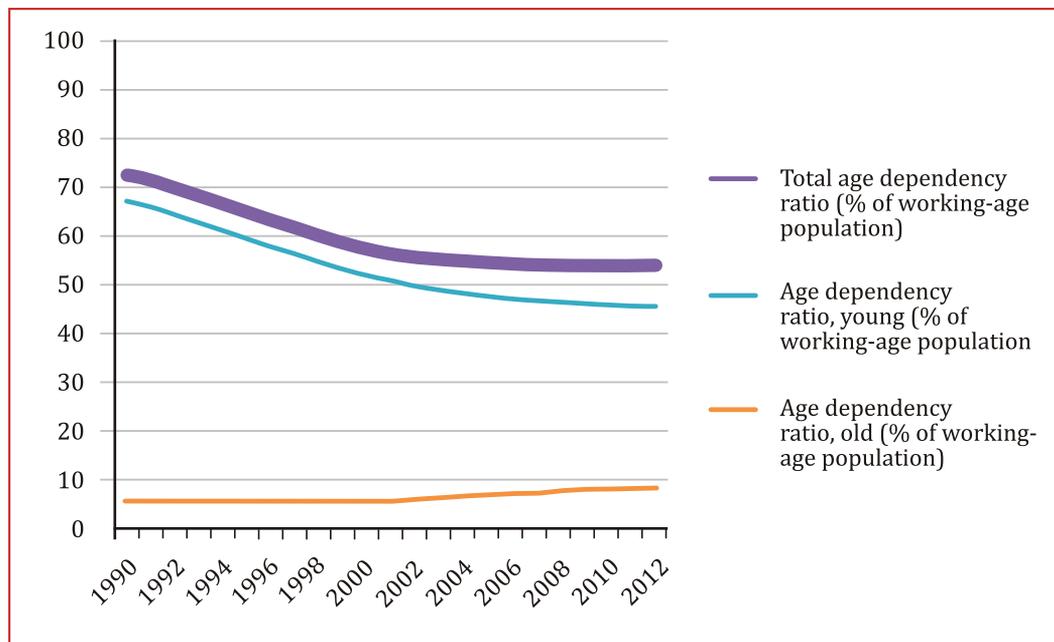


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

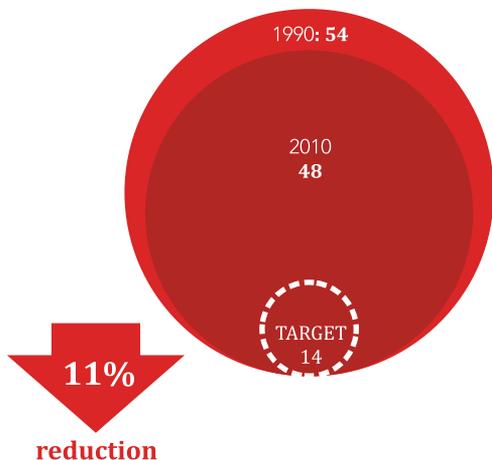
## Country Profile

Population (millions)	50.7
Life expectancy at birth (years)	53.4
GNI per capita in PPP terms (constant 2005 Int \$)	9,594
Human Development Index 2012	0.629
HDI Ranking among PPD countries	8
HDI Ranking 2012	121
Gender Inequality Index. value	0.462
GII Ranking among PPD countries	8

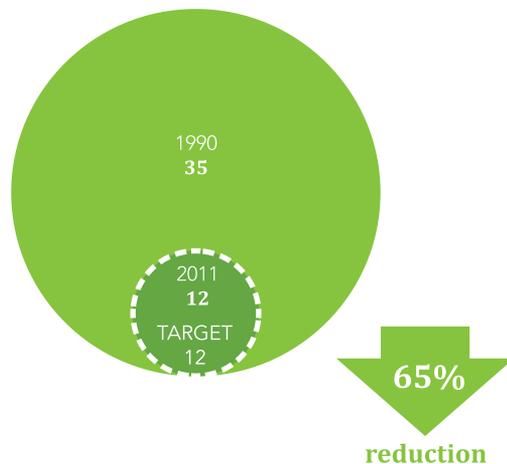
Source: UNDP <http://hdr.undp.org>

# THAILAND

**Maternal mortality ratio**



**Under 5 Mortality**

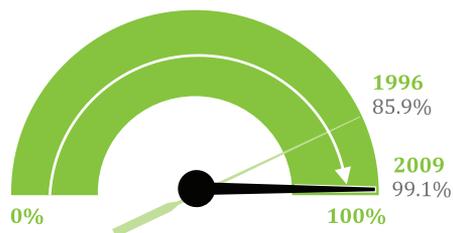


## Universal access to reproductive health

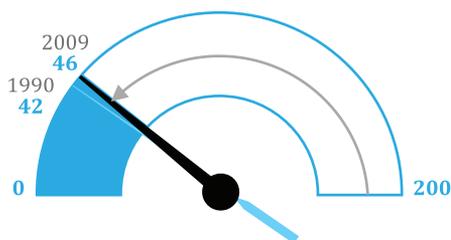
**Contraceptive prevalence rate, modern**



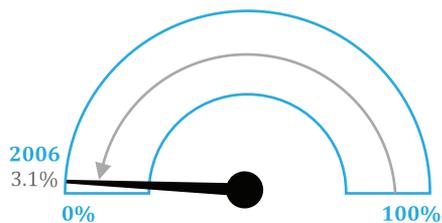
**Antenatal care coverage (at least one visit)**



**Adolescent birth rate (per 1000)**



**Unmet need for family planning**

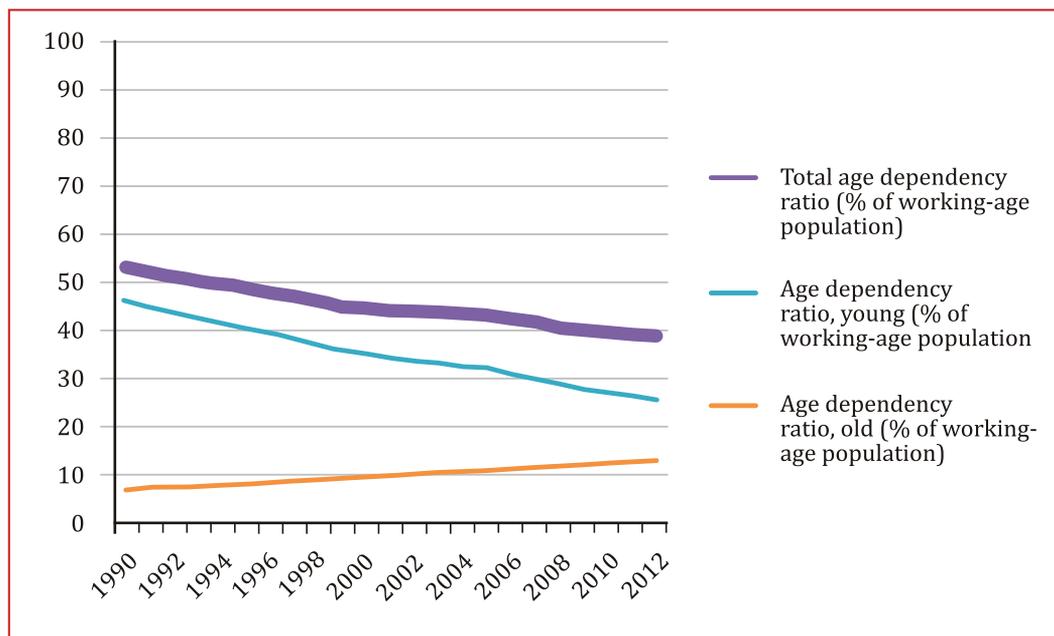


**Proportion of births attended by skilled health personnel**



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



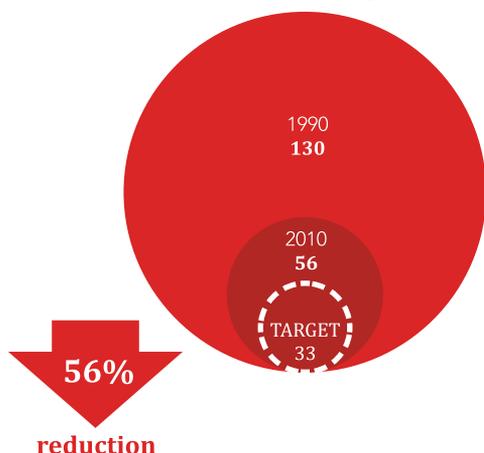
Source: <http://databank.worldbank.org>

## Country Profile

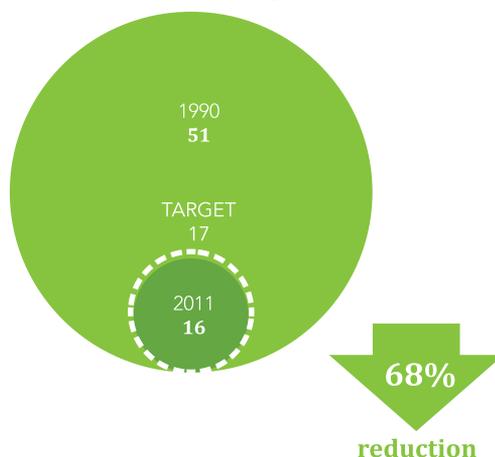
Population (millions)	69.9
Life expectancy at birth (years)	74.3
GNI per capita in PPP terms (constant 2005 Int \$)	7,722
Human Development Index 2012	0.690
HDI Ranking among PPD countries	6
HDI Ranking 2012	103
Gender Inequality Index. value	0.360
GII Ranking among PPD countries	4

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio

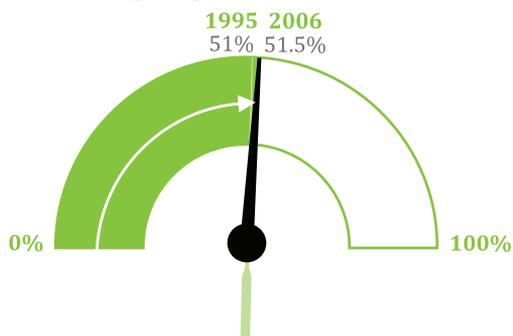


### Under 5 Mortality

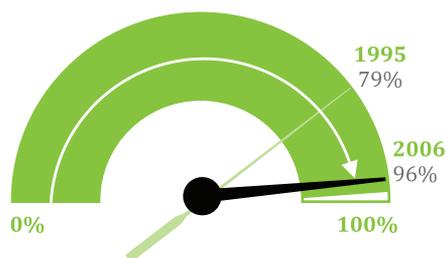


## Universal access to reproductive health

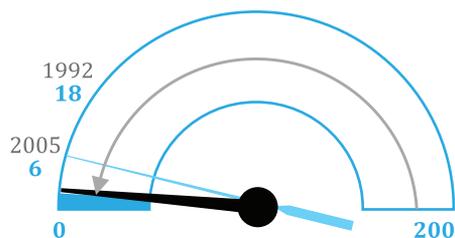
### Contraceptive prevalence rate, modern



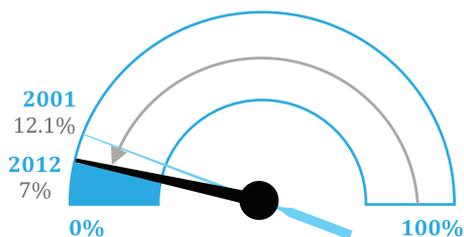
### Antenatal care coverage (at least one visit)



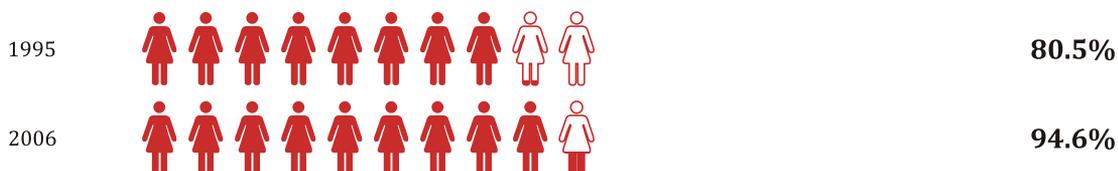
### Adolescent birth rate (per 1000)



### Unmet need for family planning

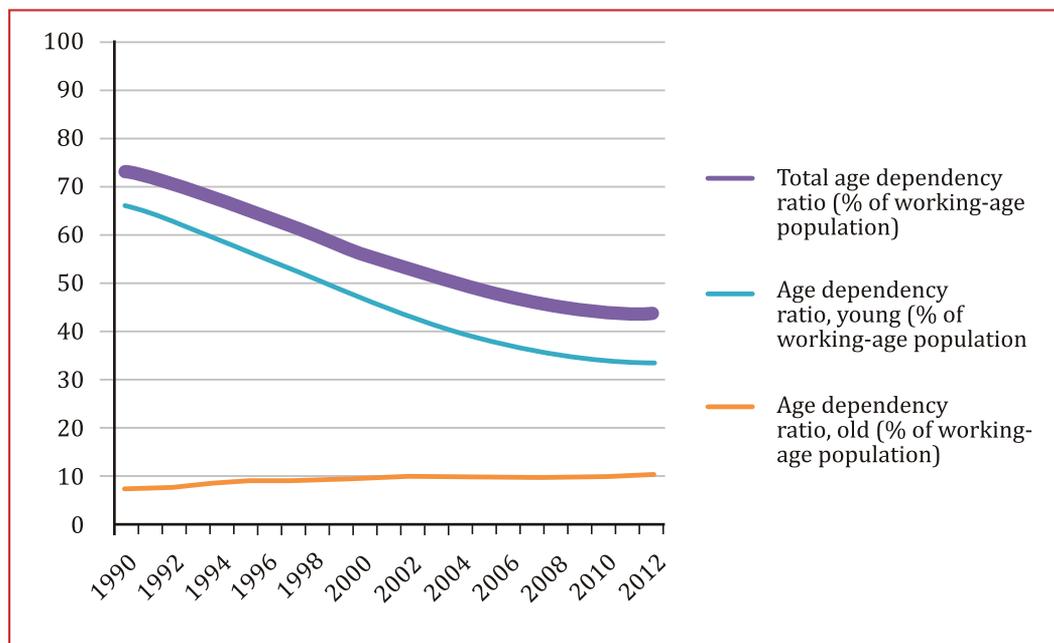


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

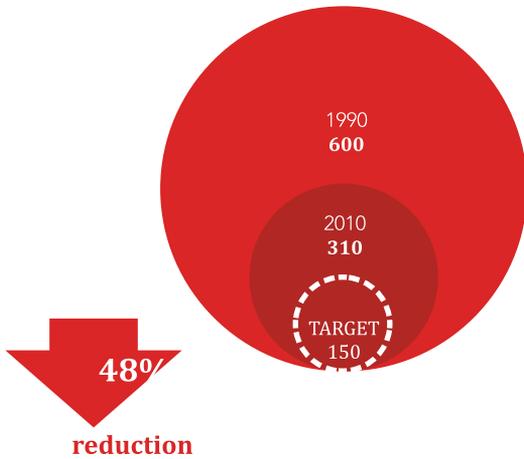
## Country Profile

Population (millions)	10.7
Life expectancy at birth (years)	74.7
GNI per capita in PPP terms (constant 2005 Int \$)	8,103
Human Development Index 2012	0.712
HDI Ranking among PPD countries	3
HDI Ranking 2012	94
Gender Inequality Index, value	0.261
GII Ranking among PPD countries	2

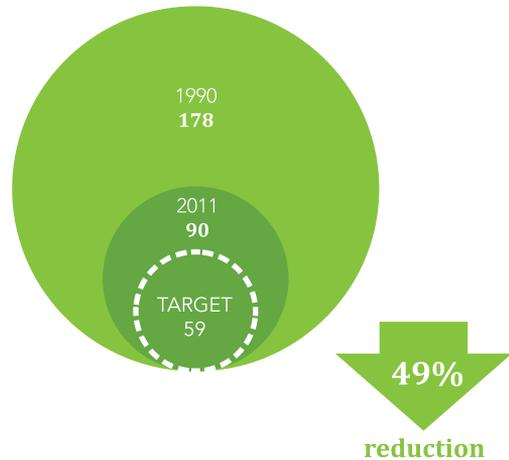
Source: UNDP <http://hdr.undp.org>

# UGANDA

Maternal mortality ratio

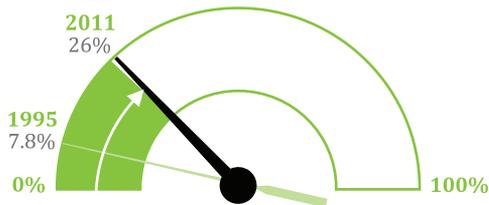


Under 5 Mortality



## Universal access to reproductive health

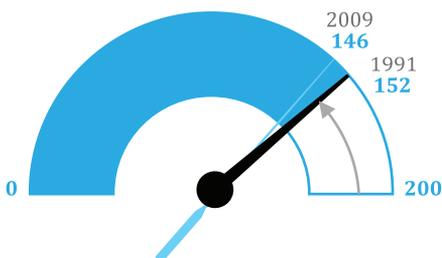
Contraceptive prevalence rate, modern



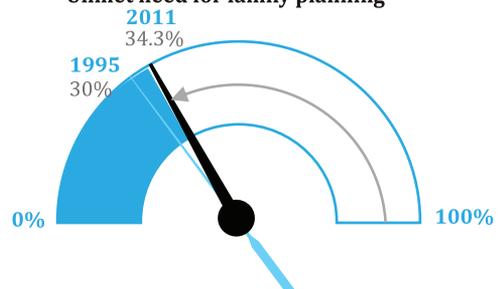
Antenatal care coverage (at least one visit)



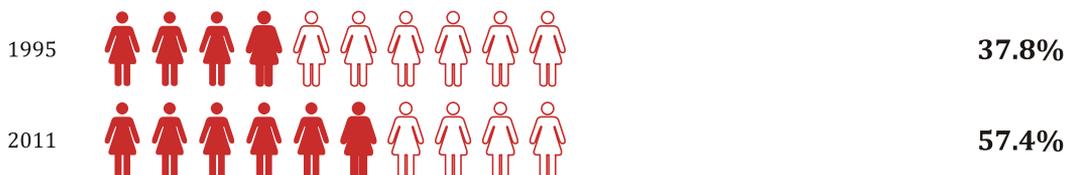
Adolescent birth rate (per 1000)



Unmet need for family planning

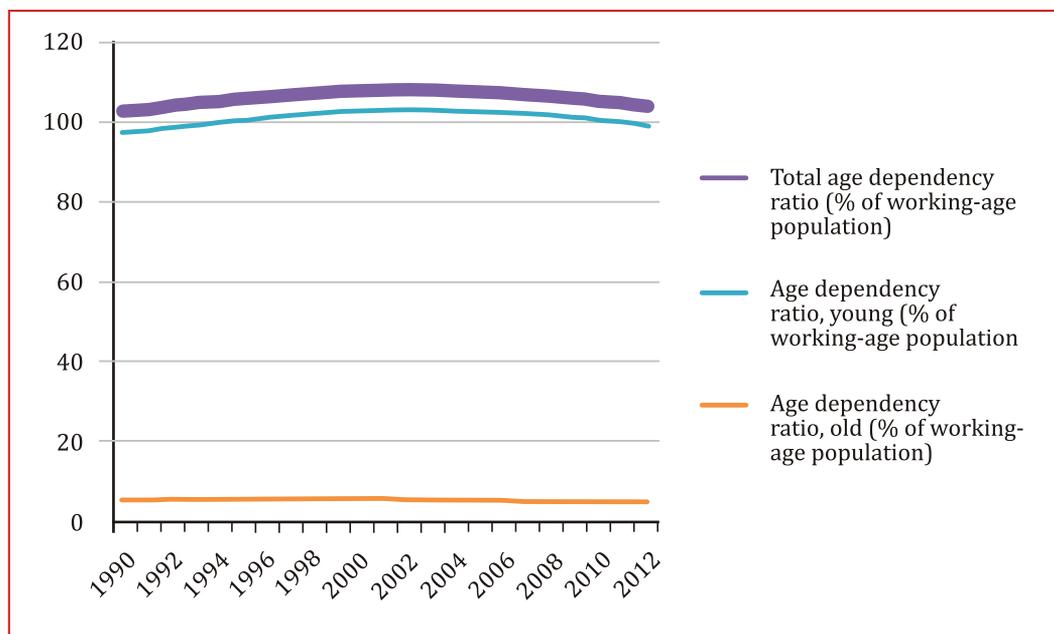


Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



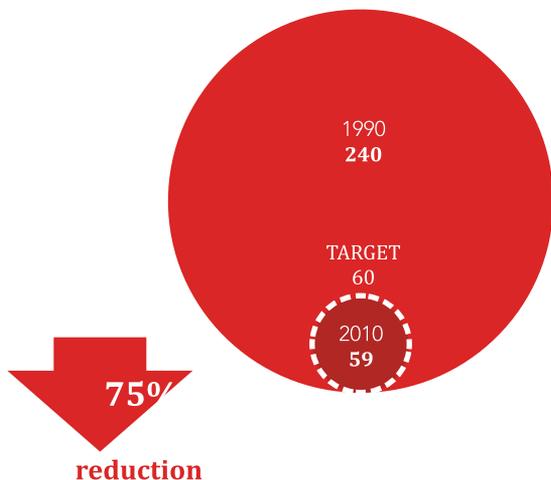
Source: <http://databank.worldbank.org>

## Country Profile

Population (millions)	35.6
Life expectancy at birth (years)	54.5
GNI per capita in PPP terms (constant 2005 Int \$)	1,168
Human Development Index 2012	0.456
HDI Ranking among PPD countries	20
HDI Ranking 2012	161
Gender Inequality Index. value	0.517
GII Ranking among PPD countries	11

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio



### Under 5 Mortality

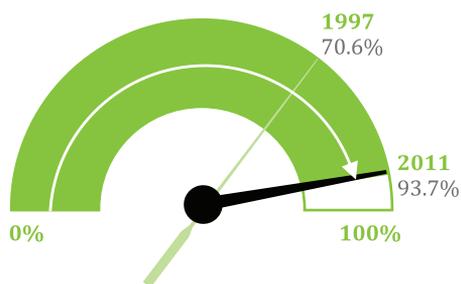


## Universal access to reproductive health

### Contraceptive prevalence rate, modern



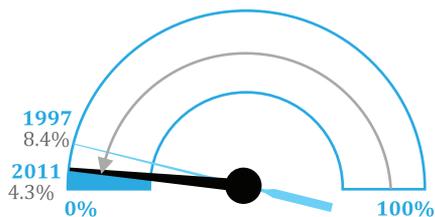
### Antenatal care coverage (at least one visit)



### Adolescent birth rate (per 1000)



### Unmet need for family planning

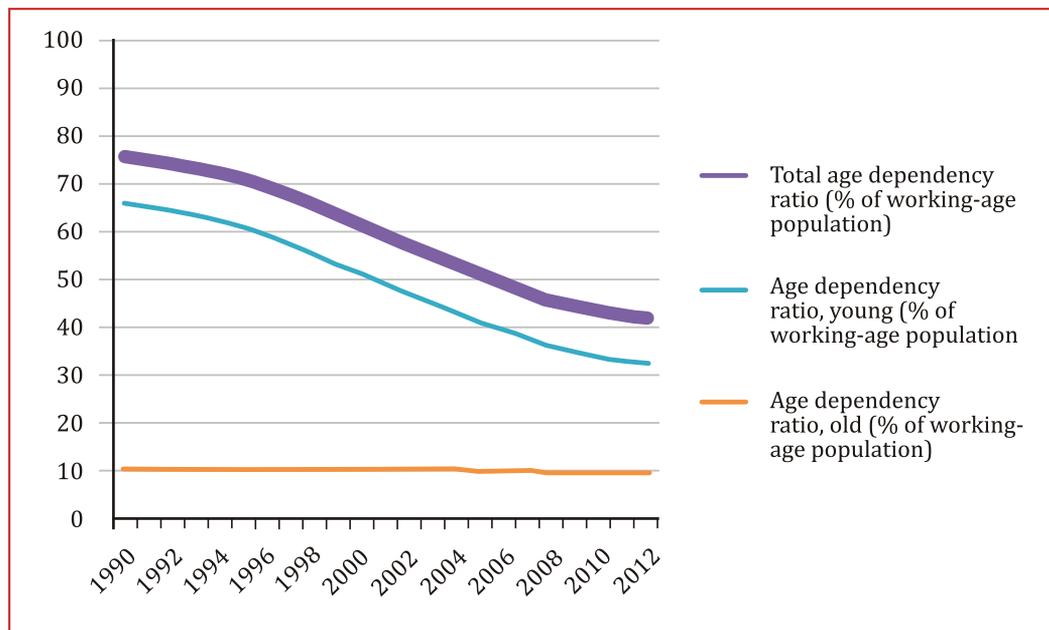


### Proportion of births attended by skilled health personnel



Source: UN STATIS <http://mdgs.un.org>

## Dependency ratio



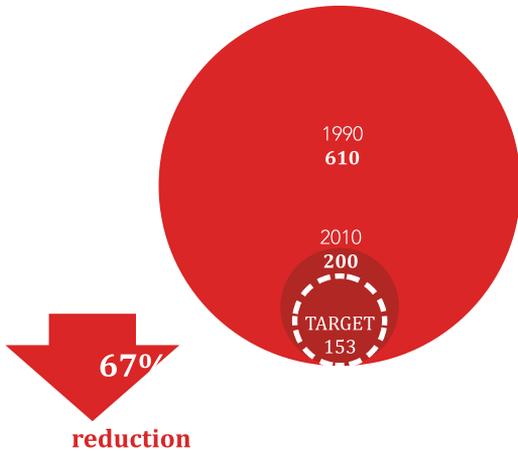
Source: <http://databank.worldbank.org>

## Country Profile

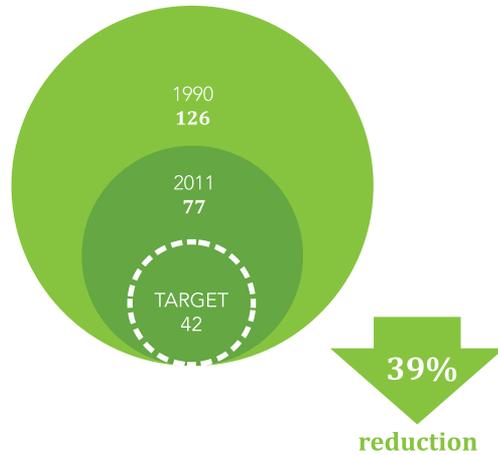
Population (millions)	89.7
Life expectancy at birth (years)	75.4
GNI per capita in PPP terms (constant 2005 Int \$)	2,970
Human Development Index 2012	0.617
HDI Ranking among PPD countries	10
HDI Ranking 2012	Na
Gender Inequality Index. value	0.299
GII Ranking among PPD countries	3

Source: UNDP <http://hdr.undp.org>

### Maternal mortality ratio

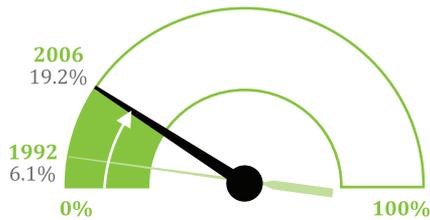


### Under 5 Mortality



## Universal access to reproductive health Yemen

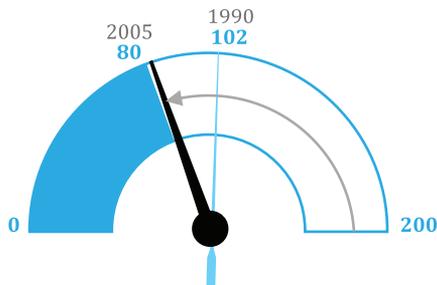
### Contraceptive prevalence rate, modern



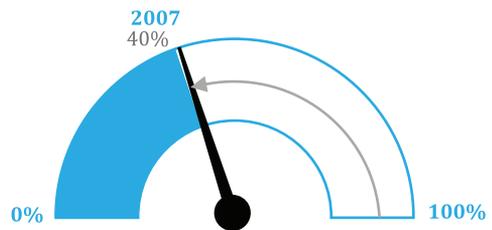
### Antenatal care coverage (at least one visit)



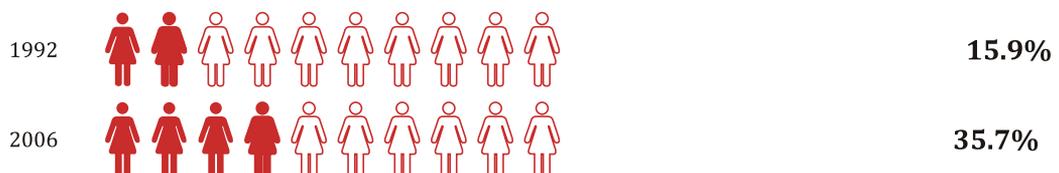
### Adolescent birth rate (per 1000)



### Unmet need for family planning

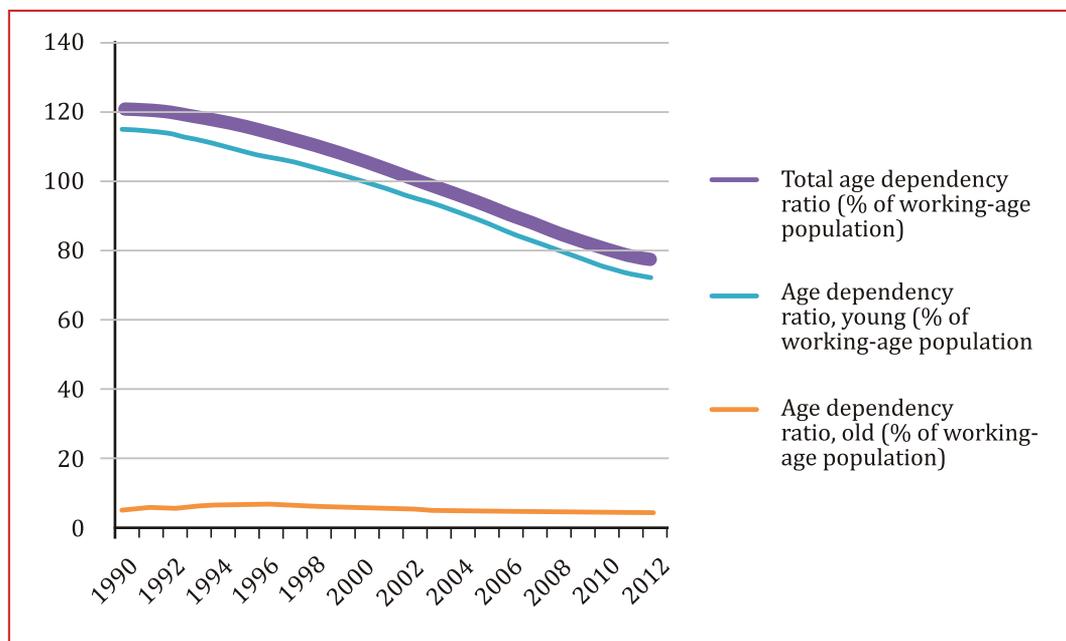


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

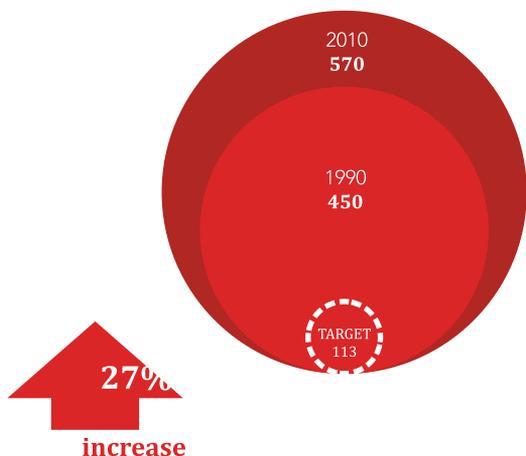
## Country Profile

Population (millions)	25.6
Life expectancy at birth (years)	65.9
GNI per capita in PPP terms (constant 2005 Int \$)	1,820
Human Development Index 2012	0.458
HDI Ranking among PPD countries	19
HDI Ranking 2012	Na
Gender Inequality Index. value	0.747
GII Ranking among PPD countries	23

Source: UNDP <http://hdr.undp.org>

# ZIMBABWE

### Maternal mortality ratio

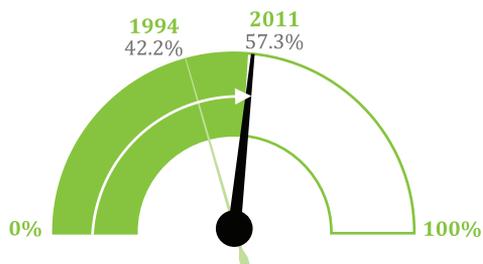


### Under 5 Mortality

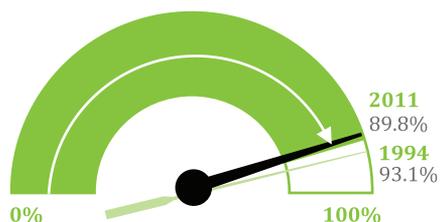


## Universal access to reproductive health Zimbabwe

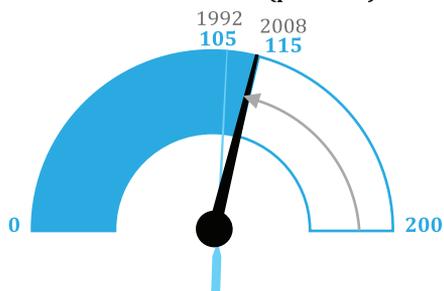
### Contraceptive prevalence rate, modern



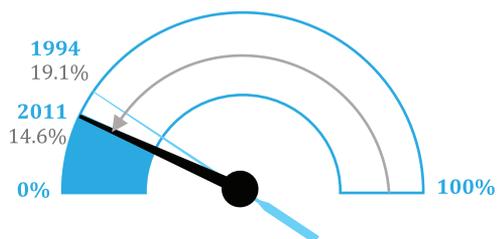
### Antenatal care coverage (at least one visit)



### Adolescent birth rate (per 1000)



### Unmet need for family planning

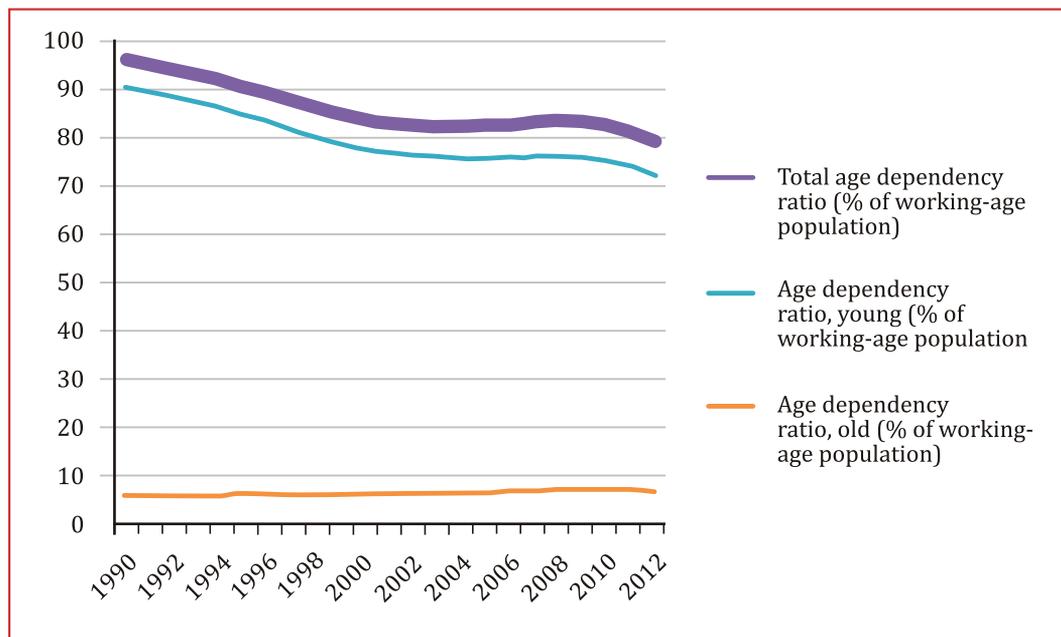


### Proportion of births attended by skilled health personnel



Source: UN STATS <http://mdgs.un.org>

## Dependency ratio



Source: <http://databank.worldbank.org>

## Country Profile

Population (millions)	13.0
Life expectancy at birth (years)	52.7
GNI per capita in PPP terms (constant 2005 Int \$)	424
Human Development Index 2012	0.397
HDI Ranking among PPD countries	23
HDI Ranking 2012	Na
Gender Inequality Index. value	0.544
GII Ranking among PPD countries	14

Source: UNDP <http://hdr.undp.org>