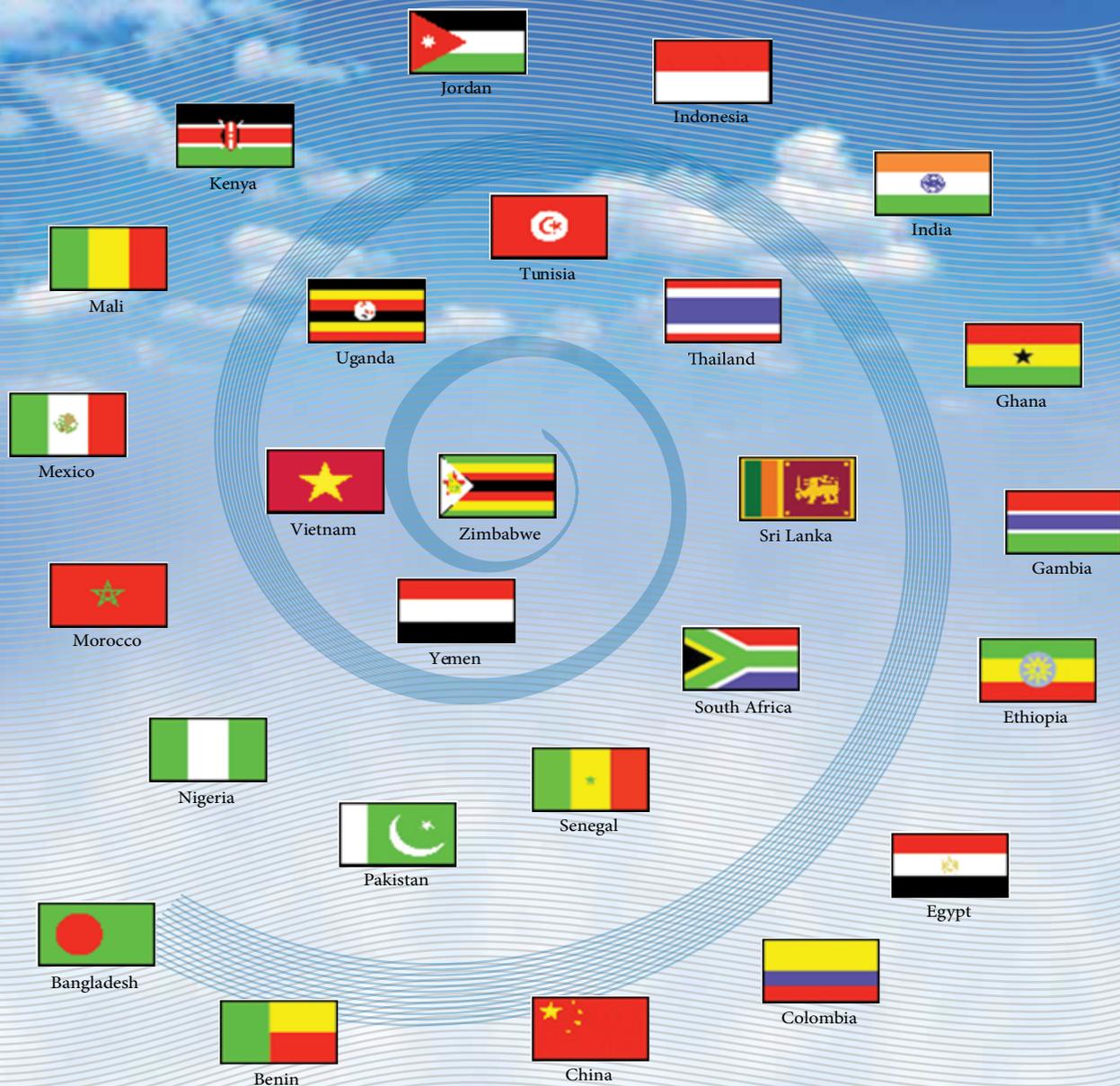


# Accelerating the gains, closing the gaps

## Strategic Plan 2015–19



**Partners in Population and Development (PPD)**  
An Inter-Governmental Organization  
for Promoting South-South Cooperation

# Sustainable Development Goals

26 Countries  
Governance

## Reproductive Health, Population and Development



## Accelerating the Gains, Closing the Gaps

### Strategic Plan 2015–19



**Partners in Population and Development (PPD)**

An Inter-Governmental Organization  
for Promoting South-South Cooperation

**Partners in Population and Development (PPD)**

**IPH Building, 2<sup>nd</sup> Floor, Mohakhali**

**Dhaka-1212, Bangladesh**

# Accelerating the Gains, Closing the Gaps

## Strategic Plan 2015–19

### **Partners in Population and Development (PPD)**

An Inter-Governmental Organization  
for Promoting South-South Cooperation

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## Abbreviations

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AIDS	:	Acquired Immune Deficiency Syndrome
ARO	:	Africa Regional Office
BRICS	:	Brazil, Russia, India, China and South Africa
DALY	:	Disability Adjusted Life Year
EWEC	:	Every Woman, Every Child
EXCO	:	Executive Committee
GB	:	Governing Board
HIV	:	Human Immunodeficiency Virus
ICPD	:	International Conference on Population and Development
ICT	:	Information and Communication Technology
IPAC	:	International Program Advisory Committee
MC	:	Member Country
MDG	:	Millennium Development Goal
MMR	:	Maternal Mortality Ratio
PCC	:	Partner Country Coordinator
PI	:	Partner Institution
PoA	:	Program of Action
PPD	:	Partners in Population and development
PRSP	:	Poverty Reduction Strategy Paper
REC	:	Regional Economic Communities
RH	:	Reproductive Health
SRH	:	Sexual and Reproductive Health
SSC	:	South-South Cooperation
SWAp	:	Sector-Wide Approach
U5M	:	Under-five Mortality
UN	:	United Nations
UN-DESA	:	United Nations- Department of Economic and Social Affairs
UNESCAP	:	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	:	United Nations Population Fund
UNGA	:	United Nations General Assembly
UNSG	:	Secretary-General of the United Nations
USAID	:	United States Agency for International Development
WHA	:	World Health Assembly
WHO	:	World Health Organization

# MESSAGE FROM THE PPD MEMBERS OF EXECUTIVE COMMITTEE

With more than 20 years of the implementation of the ICPD Program of Action (PoA), the international community has realized that South-South Cooperation (SSC) is needed more than ever before to tackle the unfinished ICPD agenda and the new emerging issues in Reproductive Health (RH), population and development.

The SSC arena is rapidly changing with availing new players and the emerging economies such as the BRICS. However, since its inception in 1994, an opportunity to take a pro-active role and become agenda setters to make a real difference through SSC, Partners in Population and Development (PPD), an Inter-Governmental organisation representing over 59% of the world population has remained at the forefront in promoting South-South Cooperation (SSC) for RH, population and development since its inception in 1994.

PPD concedes that as the MDGs transit to SDGs, there is compelling evidence that a lot has been achieved but yet more needs to be done, providing an enormous opportunity for deepening SSC. With the intention of positioning the Alliance and its partners to expand SSC for contributing to transformational measurable change in RH, population and development in its 26 Alliance Member Countries (MCs), PPD has purposefully developed a resourceful

5-year (2015–19) Strategic Plan that would uphold the ICPD core values and acknowledges dignity and human rights as pre-conditions for sustainable development.

PPD Strategic Plan emphasizes the advantages of SSC in sustainable development. This includes the global south having same goals with similar challenges in RH and population; rich experiences for sharing; same language in future strategic development; common voice for the benefit of southern countries; and self-support of each other in the realisation of the ICPD agenda and the post-2015 agenda.

Nevertheless, the SP also highlights the challenges to SSC that include imbalanced development between the north and the south and among the southern countries; insufficient funding for SSC; and the need to further enhance the effectiveness and efficiency of SSC initiatives.

**The SP prioritizes three areas for SSC over the next five years namely to:**

- \* complete the unfinished ICDP PoA and MDG business with particular focus on reducing maternal mortality, addressing unmet family planning need for modern contraception methods and ensuring universal access to reproductive health care and services;
- \* speed up and better integrate population and development issues within national, regional and global dialogue and development planning with particular focus on adolescents, aging, migration, urbanization, and environmental sustainability; and
- \* achieve gender equity and the elimination of all forms of violence against women and girls.

PPD will leverage the lessons learned from the implementation of the previous organisational strategies, the resources, capacity and opportunities within the MCs, PPD robust governance leadership, constituencies and Partners as well as regional and global level alliances for implementing the SP core SSC approaches specifically: advocacy and policy development; health and population diplomacy; capacity development and technical cooperation; knowledge management; institutional capacity building for SSC.

It is with an unparalleled enthusiasm that the PPD alliance is renewing the commitment to SSC through the approval of the PPD 5-year strategic plan to increase the programming modalities in the alliance member countries and impact on RH, population and development challenges and emerging priorities identified through the ICPD beyond 2014 and the SDG processes.

It is our profound pleasure and honor to present the Partners in Population and Development Strategic Plan for the period 2015–19 that has been approved at the 26th Executive Committee meeting held in Beijing China from 26–27 March 2015, in line with the recommendation from the 18th Board meeting held in November 2014, New Delhi India.

## **MEMBERS OF EXECUTIVE COMMITTEE**

### **1. Chair – China**

**H.E. Dr. Li Bin**

Honorable Minister

National Health and Family Planning Commission (NHFPC)

Government of the People's Republic of China

### **2. Vice Chair – India**

**H.E. Mr. Jagat Prakash Nadda**

Honorable Minister of Health and Family Welfare

Government of India

### **3. Secretary – South Africa**

**H.E. Ms. Bathabile Olive Dlamini**

Honorable Minister for Social Development, Government of the  
Republic of South Africa

### **4. Treasurer – Tunisia**

**Dr. Ridha Gataa**

President/Director-General

National Board for Family and Population, Ministry of Public Health

Government of Tunisia

**5. Member – Bangladesh**

**H.E. Mr. Mohammed Nasim**

Honorable Minister, Ministry of Health and Family Welfare (MOHFW)

Government of the People's Republic of Bangladesh

**6. Member – Benin**

**H.E. Professeur Dorothee GAZARD**

Honorable Minister Ministry of Health,

Republic of Benin

**7. Member – Mexico**

**Ms. Patricia Chemor**

Secretary-General, National Population Council

Ministry of the Interior

Government of Mexico

**8. Member – Zimbabwe**

**H.E. Dr. David Parirenyatwa**

Honorable Minister

Ministry of Health and Child Welfare

Government of Zimbabwe

## FOREWORD BY PPD EXECUTIVE DIRECTOR

Year 2014 is the 20th anniversary of the Partners in Population and Development (PPD) and International Conference on Population and Development (ICPD). The world has observed the significance of the ICPD in the future development framework. The ICPD1994 in Cairo has provided a global Program of Action on Population and Development. This has provided an inter-governmental framework for diplomatic opportunities in the arena of Population and Development that has resulted in the institutionalization of South-South Cooperation. Starting its journey with 10 founding Member Countries (MCs), today it has a membership of 26 countries from the developing world. They represent almost 59% that is close to 4 billion of the world's population. Totally dedicated to promote and improve the transfer of expertise in population and reproductive health within the member developing countries, in contemporary times, PPD is positioned as the foremost international endeavor. PPD can take great credit and pride for its inter-governmental strength, strong political commitment of member states, organizational capacity, skills and expertise.

For the first time in PPD's history of 20 years establishment, the UN Secretary General acknowledges PPD's contribution towards promoting South-South Cooperation (UN Resolution 69/2014).

*“An example of a South-South and triangular initiative enabling national institutions to promote horizontal cooperation in areas related to the Program of Action is the intergovernmental organization Partners in Population and Development, established to promote South-South cooperation in the field of reproductive health, population and development. Over the past two decades the organization's annual inter-ministerial conferences have provided a peer review mechanism for the member countries on all aspects of population and development issues.”*

South-South Cooperation is a broad framework for partnerships between sovereign nations from the Global South. PPD member countries use this framework to promote their core mandate of knowledge and experience sharing; promote policy debate and dialogue in the field of population and development; scholarship exchange; reproductive and FP commodity supply and management of particular projects and programs.

PPD Strategic Plan 2015–19 is an operational document about what PPD plans to do, to achieve and how it will arrive there over the next 5 years. The SP was developed through a collective process of consultation, involving PPD member countries, Board Members, Partners Country Coordinators, Secretariat staff and other offices' staff, partners, particularly UNFPA, WHO/PMNCH, Every Women Every Child and IPPF and donors and approved by the 26th Executive Committee – the highest decision-making body of PPD held in Beijing, China in March 2015 in consensus with the 19th Board Meeting held in New Delhi, India in November 2014. This strategy response to the south-south framework include:

- \* Advocacy and policy development;
- \* Health and population diplomacy;
- \* Capacity development and technical cooperation;

- \* Knowledge management ;
- \* Institutional capacity building for SSC;
- \* Partnerships and relationships.

The strategic plan 2015–19 is guided by a 5-year action plan and a 5-year resource mobilization plan for its effective implementation.

The priority areas of the next 5-year plan:

- \* **Achieve** the unfinished ICDP-PoA and MDG agenda with particular focus on reducing maternal mortality, addressing unmet family planning need for modern contraception methods and ensuring universal access to reproductive health care and services;
- \* **Integrate** population dynamics and development issues within national, regional and global dialogue and development planning with particular focus on: ageing, adolescents, migration, urbanization and environmental sustainability;
- \* **Ensure** gender equity and the elimination of all forms of violence against women and girls, including trafficking, sexual and other forms of exploitation and harmful practices, such as child, early and forced marriage and female genital mutilation.

Progress of the implementation of the Strategic Plan will be measured through a set of prescribed monitoring indicators and accountability mechanism at the national and south-south global levels.

With this 5-year Strategic Plan, PPD is equipped with a strong and bold tool to move forward to meet global challenges towards the population, RH and development area and deliver south-south promises.

I hold all our members countries, Board Members, Partner Country Coordinators, Staff Members, UNFPA, PMNCH, Every Women and Every Children and IPPF in high esteem and appreciate their exemplary professional support to make this plan in the context of post 2015.

With best wishes,



**Dr. Joe Thomas**  
Executive Director

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## EXECUTIVE SUMMARY

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This Strategic Plan, 2015–19 builds on PPD's strengths, in particular on a robust system of governance with a Board consisting of Ministers from Member Countries (MC), a focal Partner Country Coordinator (PCC) in all 26 MCs, a network of 23 Partner Institutions (PIs) in 14 countries, a Secretariat in Bangladesh, regional office in Uganda, program office in China, liaison offices in New York, Geneva and Bangkok; and expertise gained from a successful track record of facilitating South-South Cooperation (SSC) by way of senior level peer review and policy dialogue, capacity building and transfer of knowhow.

### VISION, MISSION AND GUIDING PRINCIPLES

PPD's vision is “An Intergovernmental Alliance leading the promotion of South-South Cooperation towards the attainment of the global population and reproductive health agenda for sustainable development”. PPD's Mission is “To achieve its vision through sustained advocacy, capacity building, networking, knowledge management/sharing and transfer of technology in the field of reproductive health and rights, population and development within the framework of south-south cooperation”.

To fulfill its Mission, PPD's MCs have agreed to a set of common values and principles including people centered development, alignment with member countries' priorities, equity, mutual respect and solidarity, and accountability and transparency.

### STRATEGIC PRIORITIES

PPD remains committed to fulfilling the ICPD agenda agreed in 1994 and the “Framework of Actions for the follow up to the Program of Action of the ICPD beyond 2014”. Within the medium term, i.e., 2015–19, PPD would intensify efforts to:

- \* **Complete** the unfinished ICDP-PoA and MDG business—with particular focus on reducing maternal mortality, addressing unmet family planning need for modern contraception methods and ensuring universal access to reproductive health care and services.
- \* **Speed up** and better **integrate** population and development issues within national, regional and global dialogue and development planning (with particular focus on: ageing, adolescents, migration, urbanization and environmental sustainability).
- \* **Achieve** gender equity and the elimination of all forms of violence against women and girls, including trafficking, sexual and other forms of exploitation and harmful practices, such as child, early and forced marriage and female genital mutilation.

## STRATEGIC INTERVENTIONS

As part of PPD's contribution towards achieving the above development results, all efforts will focus on the following five major areas of strategic interventions:

**1. *Advocacy and policy development:*** With the transition from the MDGs to the Sustainable Development Agenda over the 2015–19 period, particular attention will be devoted to ensuring that the priority of the ICPD post 2014 agenda is sustained and advanced, both at national and global levels. Towards this end, PPD will:

- (a) **Engage** policy makers (Ministers, parliamentarians, senior government officials) and present necessary evidence to ensure that reproductive health, population and development are positioned as high priorities in the national development agenda. Advocacy will also focus on the importance of SSC in meeting the interests and needs of developing countries: e.g., cooperation in human resources training, ICT transfer, RH commodity security;
- (b) **Encourage** greater accountability and oversight of the implementation of national RH, population and development strategies, through support for reviews, annual progress reports and discussion of these;
- (c) **Advocate** for increased domestic and international funding.

**2. *Health and population diplomacy:*** PPD will leverage established relationships, e.g., through its observer status at the UN General Assembly, diplomatic representations in Geneva (WHO) and Bangkok (UNESCAP) as well as close relations with the African Union and Africa's Regional Economic Communities to:

- (a) **Advocate** that the ICPD post 2014 priorities (as proposed in the Framework document) are agreed by UN member states and firmly embedded in the post 2015 Sustainable Development Agenda;
- (b) **Contribute** to health and population dialogue through strategic support to global commissions and working groups;
- (c) **Raise** the profile of PPD's work, particularly to communicate how SSC has helped influence and leverage better global decisions, and national policies and programs.

PPD will also explore the possibility of influencing the population policy of other countries—possibly through sensitization of diplomats on population related issues—for the benefit of the population of one's own country, particularly in the area of ageing and migrants.

**3. *Capacity development and technical cooperation:*** PPD will seek to deepen and broaden technical cooperation and capacity building efforts. More specifically, it will:

- (a) **Encourage** MCs and PIs to expand the number and range of fellowship-supported training opportunities with a focus on RH and population and development, leadership and policy, strategic planning, program management, monitoring and evaluation and the planning and management of SSC initiatives;

- (b) **Arrange** short-term training or technical consultations to introduce PCCs and PIs to new technologies, policy and programming approaches and guidance;
- (c) **Explore** opportunities and potential for PIs to strengthen their contributions to policy research on population dynamics – particularly policy research related to “youth bulge”, ageing, urbanization, migration and changing family structures;
- (d) **Explore** potential and **facilitate** enhanced technical cooperation and technology transfer in priority areas that respond to country partner needs and capacities, including reproductive health commodity security, population census and vital statistics data generation, analysis and use; and the development and adoption of innovative information and communication technologies that advance progress towards ICPD goals.

**4. Knowledge management:** PPD will:

- (a) **Identify**, document and disseminate good practices;
- (b) **Develop** and **maintain** a database (knowledge bank) of policy, programming and technical resources (resource institutions, technical networks, experts, training institutions and opportunities, new guidance, policy and programming tools, etc);
- (c) **Maintain** ongoing dialogue with PCCs and other stakeholders as to how PPD Secretariat could best facilitate and support knowledge management, networking and experience exchange.

**5. Institutional capacity building for SSC:** PPD will build institutional capacities to stimulate, deepen and strengthen SSC by:

- (a) **Enabling** SSC to be mainstreamed within the international cooperation components of national RH, population and development plans, budgets and coordination mechanisms;
- (b) **Promoting** the establishment and functioning of parliamentary committees;
- (c) **Encouraging** and facilitating peer-based experience exchange and technical cooperation;
- (d) **Requiring** PCCs to report annually on progress, plans and lessons learned in developing SSC institutional capacity. Such reports will be established as a standing item in annual PCC and PPD Governing Board meetings.

**6. Partnerships and relationships:** The implementation of the 2015–19 strategic plan requires many, effective partnerships and relationships. PPD will focus on those partnerships and relationships that:

- (a) **Enable** PPD to contribute to and influence the global policy dialogue on RH, population and development;
- (b) **Fund** and technically **support** specific SSC initiatives related to commodity security, technology transfer, human resources development and technical cooperation;
- (c) **Invest** in and **build** institutional capacities for SSC – including support for PPD’s training and research Partner Institutions;

- (d) **Fund and support** the functioning of the PPD Secretariat.

**Priority will be placed to ensure that all partner agreements are:**

- (a) Well designed to serve PPD's mission, strategic priorities and interventions;
- (b) Closely monitored and managed, such that commitments made are delivered upon and fully reported;
- (c) There is a continuous effort to ensure better value for money.

## **MANAGING FOR CHANGE AND SUCCESS**

PPD recognizes the need for greater focus on results, i.e., outcomes and impact; mainstreaming and institutionalizing PPD's work at the country level; engaging PIs more effectively around PPD's strategic priorities; strengthening the joint identity, coordination and relationships between various PPD entities; and more effectively communicating PPD's progress and achievements to garner a greater degree of public support. Towards this end, and in order to take forward the Strategic Plan, a number of transformative changes are envisaged:

### **Unity of purpose**

- \* This Strategic Plan will guide the functioning of all PPD offices. The PPD Secretariat, ARO, China Office and other offices would prepare annual plans in line with the Strategic Plan. The PPD Secretariat will consolidate the annual plans and report progress to the Executive Committee. Necessary changes in the planning and reporting system will be made.

### **Increased emphasis on accountability**

- \* All PPD offices will work in accordance with the results framework as is an integral part of the Strategic Plan
- \* All MOU/agreements between PPD Secretariat and different offices would be updated/revised to reflect reporting relationships and indicators of performance. PPD Secretariat has an oversight and monitoring role over the ARO office.
- \* PPD's overall governance, policies and procedures documented in the form of manuals would be applicable to the Secretariat, ARO and other offices, with the exception of the China program office that is fully funded by the Government of China.

### **Larger role for Member Countries (MCs)/Partners Country Coordinators (PCCs)**

- \* Implementation of the Strategic Plan would be a joint effort of PPD and Member Countries. MCs are envisaged to promote the mainstreaming of SSC within the international cooperation components of national RH, population and development plans, budgets and coordination mechanisms.
- \* There would be at least two meetings of PCCs each year. PCC meetings will be used to report progress, identify best practice examples and explore potentials for peer support.

## Improved communications

- \* PPD will develop a communication strategy and plan clearly articulating target segments including MCs, communication objectives, and indicators for tracking progress. Progress against the communication plan will be tracked and reported to the EXCOM.

## Strengthening of PPD capacities

- \* Organisation structure and staffing of the Secretariat/other offices would be reviewed to ensure that it is fit for purpose and efficient. The resource mobilisation, communication and monitoring and evaluation functions will be strengthened.

## BUDGET AND RESOURCE MOBILISATION

### Financial trends 2010–14

During the 5-year period 2010–14, PPD had a total income of US\$10.3 million; membership fees from MCs and grants from donors accounted for 28% and 66% respectively. This does not include:

- (a) direct contributions from MCs by way of support to scholarships, full or partial coverage of office expenses, technical assistance, commodities, hosting various meetings, land for PPD building in Dhaka;
- (b) MC contributions towards construction of PPD building in Dhaka.

There has been a declining trend in total income primarily due to a decrease in support from donors from US\$1.64 million in 2010 to US\$0.84 million in 2014; however, contributions from MCs have shown a significant increase.

The total expenditure over the last 5 years is US\$10.7 million; salaries and consultancies, conference and meetings and travel accounted for 42%, 32% and 13% respectively.

### Key principles

#### Over the next 5 years, PPD will move towards:

- \* **Covering core expenses**, i.e., salaries, office expenses, costs of essential activities through own income, i.e., MC fees, interest from corpus (UNFPA trust fund);
- \* **Greater sustainability/decreasing dependence** on donors by exploring alternative options for raising funds, e.g., charging a fee for services rendered in a SSC initiative. Rental income from the building under construction in Dhaka would primarily be used for programmes.
- \* **Improved efficiency** through, e.g., managing personnel related expenditure to show better value for money.
- \* **Establishing common systems** across offices for capture and reporting of all sources of income and items of expenditure.

### **Financial projections, 2015–19**

In order to implement the strategic plan, PPD, including its offices in Kampala and New York, would need US\$16.58 million over the 5-year period 2015–19, i.e., about 55% more than the expenditure of US\$10.70 million incurred in the preceding 5- year period. Salaries and benefits, program activities and travel expenses would account for 38%, 37% and 14% respectively of the expenditure budget.

PPD expects to mobilise US\$16.58 million over the next 5 years primarily through funding for programs (70%), MC contribution (21%) and rental income (8%). To realize the rental income, PPD would need to mobilize an additional US\$6.07 million towards cost of construction of an office building in Dhaka, on land donated by the Government of Bangladesh.

### **Strategy to mobilize resources**

The above financial projections are indicative. PPD would prepare a comprehensive resource mobilization strategy identifying specific target segments, expected volumes/share and likely trends over the next five years.

# 1. INTRODUCTION

Partners in Population and Development (PPD), an inter-governmental initiative seeks to promote South-South Cooperation (SSC) in the fields of reproductive health, population and development. Launched at the 1994 International Conference on Population and Development (ICPD) by ten developing countries to support implementation of the Cairo Program of Action (POA), PPD has also been awarded Permanent Observer Status at the United Nations. With its membership having grown to 26 countries representing about 59% of the world population, PPD has established itself as a key global player in its areas of operation.

The year 2014 marks twenty years since the ICPD was held in Cairo. This has provided a historical opportunity for PPD to maintain priority and centrality of ICPD goals and principles through the transition from Millennium Development Goals (MDGs) to post-2015 Sustainable Development agenda. To this end, PPD's Beijing Declaration, October 2013 reaffirmed PPD's commitment to the goals and principles of the ICPD POA 1994 and ICPD+5 Review, 1999; focused on implementing the recommendations of the ICPD Beyond 2014 global review consultations; and requested the PPD Secretariat to accordingly prepare a 5-year strategic plan for 2015–19.

## **This Strategic Plan seeks to:**

(1) provide direction and a common framework including vision, mission, objectives, key principles, strategies, management arrangements and a results framework to all elements of PPD, i.e., member countries, governing board (Board Members, Executive Committee, Advisory Committees, Secretariat including UN representational offices, regional and country Offices (Africa Regional Office – ARO and China) and Partner Institutions (PIS);

*“An example of a South-South and triangular initiative enabling national institutions to promote horizontal cooperation in areas related to the Program of Action is the intergovernmental organization **Partners in Population and Development**, established to promote South-South cooperation in the field of reproductive health, population and development. Over the past two decades the organization's annual interministerial conferences have provided a peer review mechanism for the member countries on all aspects of population and development issues”.*

**UN Secretary General**

*United Nations General Assembly, Sixty-ninth session (A/69/62, pp 251). Framework of actions for the follow-up to the Program of Action of the International Conference on Population and Development (ICPD) beyond 2014.*

(2) reflect the consensus and joint commitment of its Member Countries (MCs);

(3) act as a means of communication to a wide range of stakeholders. The Strategic Plan would be operationalised through annual work plans to be prepared by PPD's entities including the Secretariat, various offices, MCs and PIs.

The Strategic Plan is based on an in-depth desk review, a situation analysis and recommendations as reflected in "Consolidating the Gains, Closing the Gaps: Positioning PPD in the post-ICPD era", PPD August 2014. This is a working consensus developed at a participatory strategic planning workshop held in Dhaka in September 2014 with comments received at a consultation meeting with Partner Country Coordinators (PCC) and other stakeholders in Taicang, China on March 2–3, 2015. The Strategic Plan was approved at the 26<sup>th</sup> meeting of the Executive Committee of PPD, held in Beijing on March 26–27, 2015.

## 2. GLOBAL REPRODUCTIVE HEALTH, POPULATION AND DEVELOPMENT CONTEXT

The year 2014 marks twenty years since the International Conference on Population and Development (ICPD) held in Cairo. Since then, strong economic growth in the developing world has lifted millions out of poverty and enabled increased investments in human development. As a result, the number of people living in poverty has been halved from 47% in 1990 to 22% in 2010: a reduction of 700 million people.<sup>i</sup> Maternal and child mortality rates have fallen by nearly half, global fertility rate fell by 23% and girls gained parity in primary education in a majority of countries.<sup>ii</sup>

Yet, despite this impressive overall progress, most developing countries will not achieve their MDG commitments by 2015, and aggregate improvements mask significant inequalities both between and within countries. In many countries, progress has been greatest among households in the upper quintiles of wealth, while remaining flat or marginal among the poor, rural and least educated. As a consequence, Sexual and Reproductive Health (SRH) conditions continue to contribute a significant part of the global burden of disease, representing some 14% of DALY's lost. Globally, this proportion remained unchanged between 1990 and 2010, though this burden declined in all regions except Africa (hard hit by AIDS since 1990) and south Asia. In both these regions, the burden of SRH conditions has been larger in 2010 than it was in 1990.<sup>iii</sup> This unevenness of progress highlights the critical importance of a commitment to ensuring universal access to SRH services with increased attention to addressing inequities in health service access and utilization.

### KEY CHALLENGES

#### Sexual and reproductive health

The challenges ahead are clear, and largely relate to keeping the pressure on to deliver on the reproductive health and rights commitments made in the ICPD Programme of Action (PoA) and the unfinished MDGs agenda. Key challenges include:

- \* **Maternal mortality:** Despite a 47% decrease in the maternal mortality ratio (MMR) between 1990 and 2010, an estimated 800 women die each day from pregnancy or child birth related complications, and developing countries have accounted for 99% of maternal deaths globally. Women in the developed world have only a 1 in 3,800 risk of dying of causes related to maternity, while the lifetime risk for those in developing countries is 1 in 150, and in sub-Saharan Africa this risk jumps to a staggering 1 in 39.<sup>iv</sup> Worldwide, 33% of births in developing countries take place without skilled attendance; and twenty-six countries have experienced an increase in maternal deaths, largely in sub-Saharan Africa where HIV and maternal causes are the two predominant causes of premature death among women.<sup>v</sup>
- \* **Unmet family planning need for modern contraception methods:** Global unmet need declined only modestly between 1994 and 2012, from 20.7% to 18.5%. Worldwide, it is estimated that 222 million women have an unmet need for modern contraception – 90% live in developing

countries – and the needs are greatest where the risks of maternal mortality are highest. According to WHO's 2012 estimates, providing access to contraception to all women in low and middle income countries who currently have an unmet need for modern methods of contraception would prevent 54 million unintended pregnancies, 26 million abortions and 7 million miscarriages. Such action would also prevent 79,000 maternal deaths and 1.1 million infant deaths.<sup>vi</sup>

- \* **Unsafe abortion:** In 2008, 22 million unsafe abortions were estimated to have occurred, accounting for half of all induced abortions that year; and approximately 47,000 pregnancy-related deaths (13%) were attributable to complications of unsafe abortion. Nearly all (98%) unsafe abortions occur in low and middle income countries and the rate of unsafe abortions has remained relatively constant at about 4 per 1000 women aged 15–44 years. Young women are particularly vulnerable where access to effective contraceptive methods is restricted to married women and where the incidence of non-consensual sexual intercourse is high – e.g., in Africa where young women below 25 years account for nearly two-thirds of unsafe abortions.<sup>vii</sup>
- \* **Young people's SRH:** Young people's needs for SRH services are largely overlooked. An estimated 16 million births occur to young women aged 15–19 years, representing 11% of all births, and reflect generally low levels of access and use of SRH services by young people. About 12% of adolescent girls in low and middle income countries are married before they turn 15 years and as many as 30% are married by the age of 18 years, enhancing their risk of adverse health consequences of early pregnancy. Of the estimated 22 million unsafe abortions that occur every year, 15% occur in young women aged 15–19 years and 26% occur in those aged 20–24 years. In Africa alone, an estimated 3 million girls are at risk of undergoing female genital mutilation every year. Young people aged 15–24 years are at the forefront of the HIV epidemic with 41% of all new HIV infections among adults in 2009.<sup>viii</sup>
- \* **Gender based violence:** An estimated one-in-three women worldwide report that they have experienced physical and/or sexual abuse, mostly at the hands of an intimate partner, making this form of violence against women and girls one of the most prevalent forms of human rights violations worldwide. Globally, intimate partners are responsible for about 38% of all murders of women; and non-fatal intimate partner violence is associated with increased risk of HIV and sexually transmitted infections, higher rates of induced abortion and poor birth outcomes, including low birth weight and preterm births.<sup>x</sup>

## Population dynamics

The dramatic decline in global fertility since 1994 has led to a decrease in the rate of population growth. However, the world's population crossed the 7 billion mark in 2011 and projections anticipate a global population of 9.6 billion by 2050. Much of the projected growth in population in the coming decades is expected to take place in least developed and developing countries where, if unplanned and poorly managed, it is likely to exacerbate poverty and add pressure on the economy, basic health, social services and the environment.

Population trends and dynamics are diverse across different countries and regions and reflect significant demographic changes that have taken place over the past decades. While many developing countries are

experiencing a “youth bulge” and the potentials of benefiting from a “demographic dividend” fuelled by an increased productive population and reduced dependency ratios, most developed countries are experiencing fast growing ageing populations. In sub-Saharan Africa, countries with high fertility rates are driving a rapid increase in the population of 15–24 year olds that is expected to grow from 173 million (2014) to 362 million by 2050 – providing an unprecedented opportunity for economic betterment if these young people have benefited from good health,

*“Population trends will shape the post-2015 UN development agenda. Increased knowledge and understanding of demographic changes is key to develop and carry out a successful post-2015 development agenda, and for achieving internationally agreed goals.”*

*47<sup>th</sup> Session of the Commission on Population and Development, Secretary-General’s report on World demographic trends*

education and an enabling environment that creates employment and economic opportunity. In contrast, in the developed world, older people constitute the fastest growing population. Globally, people over 60 years are expected to grow from 810 million in 2014 to over 2 billion by 2050, and this will strain family support systems and have implications for health care and social security.

The search for economic opportunity has fuelled migration, nationally and internationally, and rapid urbanization. Today about half of the world’s population live in urban areas and nearly all of the population growth in coming decades is projected to occur in the cities and towns of developing countries. If planned for and managed well, urbanization provides opportunity to rapidly expand people’s access to housing, education, health services and economic opportunity. However, if urbanization is rapid and unplanned, the outcome is likely to be a deepening of poverty, a worsening of human development indicators, and increased inequality. And with this comes the likelihood of increased crime, challenges to governance and a loss of social cohesion. Importantly, the challenges of deepening poverty and inequality are no longer only the challenges for the world’s least developed countries – as more than 70% of the world’s poorest people today live in middle income countries.

## **PPD MEMBER COUNTRIES**

### **Reproductive health**

PPD MCs have fared better in comparison to other countries in terms of progress towards MDGs. Between 1990 and 2010, the overall reduction in MMR among the PPD countries was 51%; in 2010, the PPD countries accounted for 173,100 maternal deaths or 60% of the world-wide total, the corresponding figures for 1990 being 387,400 and 71% respectively. Similarly, between 1990 and 2010, PPD countries achieved a 51% reduction in under-5 mortality (U5M); in 2010, the PPD countries accounted for 4.1 million U5 deaths or 63% of the world wide total. This in sharp contrast to 8.97 million deaths or 71% of the world wide total in 1990.<sup>xi</sup>

Nevertheless, PPD member countries need to continue to focus on the unfinished MDGs agenda. Progress has been uneven:

- \* While Vietnam has already reached the target of 75% reduction in MMR, Zimbabwe and South Africa have witnessed an increase;
- \* While some countries such as Bangladesh, China, Egypt, Mexico and Tunisia have achieved the U5M MDG target, some of the other MCs are unlikely to do so;

- \* Country averages typically mask wide intra-country variations. For example, two states in India account for 44% of maternal deaths, but only for 25% of the population.
- \* There are again wide variations across PPD MCs in terms of key underlying indicators:<sup>xii</sup>

Range among the PPD countries	Rate
Contraceptive prevalence rate, %	6–84
Antenatal visit, at least one, %	42–99
Skilled attendance at birth, %	10–100
Unmet need for family planning, %	2–40
Adolescent birth rate, per 1000 women	6–189

Ref: PPD, *Consolidating the Gains Closing the Gaps: Positioning PPD in Post-ICPD era, 2014* <http://www.partners-popdev.org>

## Population dynamics

As of 2014, youth (age 10–24) constituted more than one-fourth of the population of all PPD countries with the exception of China, Sri Lanka, Thailand and Tunisia. While a large young productive population is a boon, it also presents certain challenges. Apart from the need to provide social support—including health, education and employment opportunities—a key issue is that many of these are young girls and women who face particular challenges in adverse socio-economic contexts. The UNDP’s Gender Inequality Index<sup>1</sup> reflects a wide variation in progress along gender-related indicators across PPD countries, ranging from a low inequality of 0.213 (China) to a high of 0.747 (Yemen).<sup>2</sup> These gender inequalities need to be addressed to meet the specific needs of young girls and women in order for countries to truly reap the benefits of the present “demographic dividend”.

PPD countries are undergoing critical shifts in age demographics, with repercussions for future social structures. The good news is that nearly all PPD countries have experienced declines in overall dependency ratios since 1990 that translate into reduced pressure on the working-age population to provide for a large number of dependents. This trend can confer many benefits: in the most immediate sense, there will be a rise in the relative number of household earners. This can in turn lead to an increase in the average savings and investment rate of these countries, as working-age populations tend to save more than dependent-age populations. Women may also move into employment, increasing the size of the overall workforce.

The declining dependency ratios across PPD countries are driven by reductions in youth dependency, in large part due to decreasing fertility rates through all PPD countries with the exception of Uganda and Mali over the past two decades. For example, the burden of young dependents that was as large as 115% of the working-age population in Yemen and 101% in Kenya as of 1990,<sup>xiii</sup> reduced significantly to 72.1% and 77% respectively in 2012.

<sup>1</sup> A composite measure reflecting inequality in achievements between women and men in reproductive health (measured by MMR and adolescent health), empowerment (measured by secondary school attainment and share of national parliament seats), and the labour market (measured by labour force participation rate).

<sup>2</sup> Note: Ethiopia and Nigeria not ranked. Source: UNDP Human Development Report 2013.

But not all PPD countries are there yet. Some countries are at an earlier stage of transition, as youth dependency has begun to decrease relatively recently, i.e., Pakistan (1992), Ethiopia (1996), and Uganda (2002). And while the decline has been acute in many countries (Vietnam, 51% decline between 1990–2012; Tunisia, 50%; Thailand, 45%; Morocco, 43%; Jordan, 40%), it has been gradual in others (Gambia, 1% decline; Nigeria, 3%). Finally, youth dependency has actually grown in Mali and Uganda between 1992 and 2012 despite periodic episodes of decline, and in Sri Lanka and Nigeria, initial trends have reversed and youth dependency has increased over the past decade.<sup>xiv</sup>

*Even as youth dependency ratios decrease across most PPD countries, higher life expectancy in some countries is resulting in an ageing population, although to very different levels and with varying degrees of intensity.* This creates a new set of opportunities and challenges that will be accelerated as the demographic transition advances. The population above 60 years old presently constitutes at least 10% of the national population in Thailand, China, Sri Lanka, Tunisia, Vietnam, Columbia and Mexico. On the other hand, across sub-Saharan Africa, the share of the elderly population is currently much lower, at around 4–6%, with the exception of South Africa (9%).

But population dynamics in other countries are gradually aligning with this trend. Old-age dependency ratio has been increasing consistently since 1990 in Thailand, Mexico, Indonesia, India, Colombia, China); Benin, Nigeria, and Kenya have begun to experience consistent decline in old age dependency, more recently, in the past decade. Other countries, such as Yemen, Tunisia, Sri Lanka, South Africa, and Egypt, have been transitioning towards an ageing population since 1990, but at an uneven pace, with periodic episodes of declining old age dependency.

On the other hand, there are a number of countries that are outliers given their diminishing proportion of elderly population. The old-age dependency ratio has been decreasing since 1990 in Mali, and the initial trend in an ageing society has reversed over the past fifteen years. Elderly dependency is now decreasing in the Gambia, Senegal, Uganda, Vietnam, Morocco and Zimbabwe.

As populations grow older across PPD countries, there may be increases in overall dependency ratios. This can already be seen in some countries such as China, South Africa and Sri Lanka. China saw a slight increase in the dependency ratio from 36% to 36.4% between 2010–2012; in South Africa the dependency ratio increased from 53.7% to 53.8% during the same period. In Sri Lanka, the overall age-dependency ratio has increased from 48.1% in 2006 to 50.1% in 2012.<sup>xv</sup> Such increases in dependency ratios due to an ageing population will create demands on the economy to provide adequate pension and social security systems, as well as on the healthcare system to respond to changes in the burden of disease, especially an increase in the burden of non-communicable diseases.

## **OPPORTUNITIES AND TRENDS**

### **Changing international relations**

The growing economies of the developing world, and the sluggish response to the global financial crisis by the developed world, are changing international relations. Currently, one half of global growth is being generated by developing countries and it is expected that they will contribute about 60% of the world gross domestic product by 2030. Trade between the south and north have grown rapidly and are vital

to the global economic health; developing countries have taken the initiative to strengthen south-south trade and cooperation (e.g., BRICS) and to encourage new thinking on development cooperation (e.g., Busan) as more traditional forms of official development assistance have stagnated.

#### Information and communication technology for development

The full potential of information and communication technology including social media in the area of reproductive health and population is yet to be realised. There is considerable scope for use of information and communication technology to facilitate more rapid progress by way of promoting health seeking behaviour, improving access to quality health products and services, as well as promoting accountability.

#### Global policy dialogue

The transition from MDGs provides a historical opportunity to maintain priority and centrality of ICPD goals in the post-2015 Sustainable Development Agenda. Other opportunities to contribute to policy dialogue and leadership mobilization include Every Woman Every Child, Family Planning 2020, Partnership for Maternal, Newborn and Child Health (PMNCH), A Promise Renewed, etc.

#### Alliance partners

There is considerable potential to expand PPD membership. While the PPD alliance has grown to 26 countries, there are a number of other developing countries (e.g., Brazil, Peru, Nepal) that may find PPD membership to be beneficial, both in terms of providing a voice in international fora as well as South-South Cooperation.

### 3. PPD'S EVOLUTION, ACHIEVEMENTS AND EXPERIENCE

Partners in Population and Development (PPD) is an inter-governmental initiative created specifically for the purpose of expanding and improving SSC in the fields of reproductive health, population and development within the framework of ICPD PoA. This was subsequently reinforced by the MDGs and adopted by the world community in 2000. PPD was launched at the 1994 ICPD by ten developing countries from Asia, Africa and Latin America to help implement the Cairo PoA. It has Permanent Observer Status since 2002 at the United Nations and its membership has grown to 26 countries representing about 59% of the global population.

#### PPD Member countries



## KEY ACHIEVEMENTS

### Robust governance system

Over the years PPD has established a robust system of governance and management arrangements including a well functioning:

- \* Governing Board (GB)—consisting mainly of Ministers of Health, Population and Social Development from all 26 member countries. It ensures the highest policy level commitments. Annual meetings of the GB culminate in a “Declaration” reflecting a consensus amongst members.
- \* Executive Committee, consisting of the Chair, Vice-Chair, Secretary, Treasurer and elected members. It provides guidance to the GB and oversight to the functioning of PPD. The EC meets once between the annual GB meetings and is supported by Advisory Committees for Program, Planning and Development and Finance and Risk Management.
- \* Partner Country Coordinator (PCC), a senior government official in each Member Country provides support for south-south activities at the country level
- \* Operational base consisting of a permanent Secretariat based in Dhaka, Bangladesh, regional office in Uganda, programme office in China, and liaison offices in New York, Geneva and Bangkok. The day-to-day functioning of PPD is guided by long term strategic plans and annual work plans approved and monitored by the EC.

### DELHI DECLARATION 2014

*“We the delegates representing the member countries and stakeholders of the Partners in Population and Development (PPD) gathered here in New Delhi acknowledge the strategic value of Partners in Population and Development, which currently includes 26 member countries currently representing nearly 60% of the world’s population, to the attainment of national, regional and global goals on health, population and sustainable development through South-South Cooperation.”*

## Strengthening South-South Cooperation

PPD has played an increasingly effective and valued role in mobilizing leadership and strengthening SSC:

### Advocacy and policy dialogue

- \* PPD has maintained RH, population and development issues high on the leadership and political agenda of PPD member states. Emphasis has been given to raising the overall priority of RH, population and development issues within national development plans and budgets, including full integration into PRSPs, SWApS and donor support programs. Through its high level advocacy and policy dialogue—facilitated through annual Governing Board meetings and Inter-Ministerial Forums attended by a wide range of stakeholders including government, civil society and development partners—PPD has provided a unique and valued platform for developing countries to review progress, discuss common concerns among peers, and agree to common commitments for follow up nationally and at the global level. These commitments have been communicated in the form of Declarations following each Governing Board meeting and Inter-Ministerial Forum. PPD’s advocacy and policy dialogue initiatives would have contributed to increased allocation in the government budget

for RH and its integration into poverty reduction policies by 17 and 19 MCs respectively; and enacting legislation banning child marriage in Malawi.

- \* PPD has increasingly leveraged its global advocacy influence through its Permanent Observer status at the UN General Assembly and representation at the regional level inter-governmental meetings convened by the Africa Union, ESCAP and SAARC. Opportunities have also been created to contribute to the global policy dialogue regarding RH, population and development through PPD's active support for the establishment of the Commission on ageing in Developing Countries (WHO, 2013), and PPD's participation at the World Health Assembly and Executive Boards of UNFPA, UNDP and UNAIDS.

### *Capacity development and technical cooperation*

- \* PPD has contributed to the strengthening of country level capacities to plan and manage SSC initiatives. With PPD support, PCCs have been established in all member countries; national Task Forces have been formed to mobilize and coordinate cross-sectoral planning for SSC in 12 countries; and the PPD partnership has helped facilitate an increasing number of bilateral and trilateral exchanges and agreements. PCCs are convened annually to share plans, experiences and explore opportunities for strengthened south-south cooperation.
- \* PPD facilitated the establishment of a network of 23 premier training and research PIs in 14 member countries, and through this has encouraged increased technical, training and research cooperation between developing countries. Needs assessments have been conducted to ensure that the training addresses country priorities and needs, and core curricula have been agreed to assure consistency and quality of training.
- \* PPD supported the establishment of a scholarship program, largely (80%) funded by PPD member states that has benefited over 2700 professionals in the fields of reproductive health and family planning, demography, maternal and child health. Over the past two decades, this scholarship program has expanded from one (Egypt) to nine countries, i.e., Egypt, Bangladesh, China, India, Indonesia, Tunisia, South Africa, Morocco and Thailand. In addition, 1300 senior-level officials have been trained in sexual and reproductive health and population through the PPD China office.
- \* PPD has nurtured and facilitated SSC to contribute to reproductive health commodity security, including the brokering of commodity security cooperation agreements between China and nine member countries; the creation of the Reproductive Health Supply Coalition to strengthen communication and coordination among organizations involved in reproductive health commodity security; and the establishment of a Memorandum of Understanding between UNITAID and PPD.
- \* PPD helped to develop a progress assessment tool to hold countries accountable for their commitments to the Maputo Plan of Action in partnership with the African Union, resulting in heads of states to extend their respective plan from 2010 to 2015 to coincide with the MDGs review.
- \* PPD has supported strengthening of the health system through task shifting/sharing in Uganda; prioritizing family planning in the local development plans in two districts in Uganda and in two Regions in Ethiopia; assisted the government of Uganda to develop and launch its

own national Demographic Dividend Model as well as a National Family Planning Costed Implementation Plan; and enhanced transparency for family planning and reproductive health expenditures by tracking the respective government's funding for reproductive health commodities in Uganda and Tanzania .

### *Knowledge management*

- \* PPD has been instrumental in documenting and disseminating best practice experiences, including the monograph series of 10 Best Practices on Family Planning, Reproductive Health and Population issues and the series of 9 country case studies on “Population Trends and Policy Options in Selected Countries”.

## **SCOPE FOR IMPROVEMENT**

While much has been achieved, PPD stakeholders sense that the partnership is currently performing at a level less than its potential. In particular, concerns have been expressed that PPD needs to fully grasp the window of opportunity to embed ICPD post 2014 recommendations within the post MDG Sustainable Development agenda. This will require PPD member states to develop consistent positions on priorities and effectively articulate these as global commitments to the Sustainable Development Agenda as negotiated in 2015. PPD should then take a key role in helping translate agreed goals and targets into operational strategies, and ensure that south-south cooperation is fully leveraged to realize these commitments.

Other areas in which there is expectation for improvement include:

- \* Strengthening PPD's focus on supporting country level capacities to nurture, plan and manage south-south cooperation – with particular attention to mainstreaming and building institutional capacities to support SSC;
- \* Tightening the results focus of the PPD Secretariat's planning and budgeting, and its accountability to the Governing Board for results;
- \* Developing a clearer and more strategic and evidence informed advocacy agenda to be carried forward at the level of the UN by PPD Board members (Ministers) and PPD observers;
- \* Building confidence and cultures of SSC by expanding the number of concrete SSC initiatives and platforms, including expansion of the training and leadership development fellowship programs, increasing technology transfer and technical cooperation, and expanding current commodity security initiatives to include a broader range of medicines, diagnostics and family planning supplies;
- \* Improving PPD's communications about its own priorities and work with the aim of building stronger appreciation and support for PPD's efforts.

For these changes to be successfully implemented, there is also a need for PPD to ensure that PPD Secretariat functions and capacities are fit for purpose; that the roles of the Dhaka Secretariat, Africa regional office and diplomatic representations in New York, Geneva and Bangkok are well defined and coordinated; and that renewed attention be given to developing stronger relationships with strategic partners and resource mobilization.

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## 4. VISION, MISSION AND GUIDING PRINCIPLES

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### VISION

“An Intergovernmental Alliance leading the promotion of South-South Cooperation towards the attainment of the global population and reproductive health agenda for sustainable development.”

### MISSION

“To achieve its vision through sustained advocacy, capacity building, networking, knowledge management/sharing and transfer of technology in the field of reproductive health and rights<sup>3</sup>, population and development within the framework of south-south cooperation.”

### GUIDING PRINCIPLES

In order to fulfill its Mission, PPD’s member countries have agreed to common values and principles to guide relationships and the work of the Governing Board, Executive Committee, PPD Secretariat staff and partners. Key among these are PPD’s commitments to:

- \* **People centered development:** PPD recognizes the interconnectedness between sexual and reproductive health and rights, population and economic growth for the attainment of sustainable development. This principle leads PPD to value people as the most critical resource for development.
- \* **Alignment with member countries’ priorities:** PPD will align and be responsive to Member Countries’ priorities in reproductive health and rights, including Family Planning and HIV/AIDS, and population and development.
- \* **Equity:** PPD is committed to equality and equity among people in all countries, particularly gender equality and the empowerment of women and girls. PPD strives to build equity within member states, between developing countries and between developing and developed countries.
- \* **Mutual respect and solidarity:** All member countries—regardless of size, political system, economic strength, religious beliefs or cultures—have the same rights and responsibilities, and equal say in PPD’s affairs.
- \* **Accountability and transparency:** PPD upholds high standards of good governance, transparency and accountability to stakeholders. These standards are recognized as the bedrock for PPD’s relevance and sustainability.

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<sup>3</sup> “Reproductive health and rights” includes family planning and sexual health in accordance with the ICPD POA, 1994.

## 5. STRATEGIC PRIORITIES AND INTERVENTIONS

### STRATEGIC PRIORITIES

PPD remains committed to fulfilling the ICPD agenda agreed in 1994 and the “Framework of Actions for the follow up to the Program of Action of the ICPD beyond 2014”. Within the medium term context of 2015–19, PPD’s strategic priorities are threefold. These are to intensify efforts to:

- \* Complete the unfinished ICPD-PoA and MDG business, with particular focus on reducing maternal mortality, addressing unmet family planning need for modern contraception methods and ensuring universal access to reproductive health (RH) care and services;
- \* Speed up and better integrate population and development issues within national, regional and global dialogue and development planning (with particular focus on: ageing, adolescents, migration, urbanization, and environmental sustainability);
- \* Achieve gender equity and the elimination of all forms of violence against women and girls, including trafficking, sexual and other forms of exploitation and harmful practices, such as child, early and forced marriage and female genital mutilation.

An overview of PPD’s “strategic priorities” is presented in Table 1. This framework is based upon the “recurrent themes and key elements” that emerged from the 47th session of the Commission on Population and Development (2014) and seeks to be broad enough to reflect the diversity of country contexts and needs, while at the same time provide a sense of common priorities and concerns. This framework is expected to evolve further in 2015 as the UN General Assembly moves forward with the definition of the post 2014 Sustainable Development Agenda, including its goals and targets.

### Potential impact

Through action in these priority areas, PPD aims to contribute to:

- \* Reducing infant and maternal morbidity and mortality;
- \* Improving reproductive health, including averting unintended pregnancies;
- \* Gender equity and the elimination of all forms of violence against, and exploitation of women and girls;
- \* Reducing poverty and development inequities and the achievement of sustainable development.

Impact indicators for PPD’s three strategic priorities are shown in Table 2.

**Table 1: PPD's post 2014 Strategic Priorities**

Ensure universal access to reproductive health care and services	Integrate population dynamics in development planning at national, regional and international levels	Advance gender equality and the empowerment of women
Stop maternal deaths due to preventable causes – by ensuring access to high quality and comprehensive prenatal, delivery and post natal care, including of post abortion care.	Strengthen national capacities to produce, analyze and use disaggregated data on population and development: including vital statistics, census, demographic research.	End all forms of violence against women and girls, including trafficking and sexual and other forms of exploitation. Support states to adopt and implement legislation, policies and measures that prevent, punish and eradicate gender-based violence within and outside the family and ensure treatment and support for the victims of violence.
Eliminate unmet needs for family planning and ensure universal access to a wide range of modern, quality contraceptive methods.	Increase priority for adolescents and youth in national development plans and programs with particular focus on: education, sustainable job creation, access to SRH services, and participation.	End harmful practices such as child, early and forced marriage, teenage pregnancy and female genital mutilation.
Ensure universal access to sexual and reproductive health information, commodities and services – with particular attention to the most vulnerable, poor, migrants, disabled, youth and adolescents.	Promote healthy ageing and economic wellbeing in old age with particular focus on sustaining productive and remunerative employment, access to appropriate health care services, and social protection and security.	Ensure equal opportunity for women to contribute to society as leaders, managers and decision-makers, enabling them access to positions of power equal to that of men in all sectors of public life.
Integrate HIV and STI diagnostic, treatment and care services within routine health services and remove legal and discriminatory barriers affecting key populations, particularly sex workers and their clients, people who inject drugs, men who have sex with men.	Prioritise planning for internal migration and urbanization – including investments in infrastructure, services (health, education), social protection, and the strengthening of urban-rural linkages.	

<p>Strengthen health system capabilities to design and deliver quality SRH services, with particular focus on human resources, commodity security, information systems, technology transfer.,</p>	<p>Promote international cooperation to facilitate mobility and the protection of migrant's rights – in particular between sending and receiving countries to ensure that migration occurs in safe and legal conditions, to simplify and reduce the costs of remittance transfers, and stop exploitation and trafficking, stop including</p>	
<p>Protect and fulfill the rights of adolescents and youth to accurate information, comprehensive sexuality education and health services for their sexual and reproductive wellbeing and lifelong health.</p>		
<p>Eliminate inequities – within developing countries (among poor or vulnerable groups); between developing countries and between developing and developed countries</p>		

**Table 2: ICPD Beyond 2014 Impact Indicators for PPD's Strategic Priorities**

Ensure universal access to reproductive health care and services	Integrate population dynamics in development planning at national, regional and international levels	Advance gender equality and the empowerment of women
<p><b>Family Planning</b></p> <ul style="list-style-type: none"> <li>◆ Unmet need for family planning</li> <li>◆ Contraceptive prevalence rate</li> </ul> <p><b>Maternal Health</b></p> <ul style="list-style-type: none"> <li>◆ Antenatal care coverage (1 and 4 visits) by wealth quintile</li> <li>◆ Proportion of births attended by skilled health personnel by wealth quintile</li> <li>◆ Number of deaths due to unsafe abortion</li> <li>◆ Maternal Mortality Ratio</li> <li>◆ An indicator on STI prevalence*</li> <li>◆ Maternal morbidity indicators including rate of obstetric fistula, rate of uterine prolapse and rate of severe anaemia</li> <li>◆ Percentage of adults 15-49 who received a HIV test in the past 12 months and know their results</li> <li>◆ ARV coverage</li> </ul> <p><b>Child health</b></p> <ul style="list-style-type: none"> <li>◆ Neonatal mortality</li> </ul>	<p><b>Strengthen capacity to effectively use population and reproductive health data and projections</b></p> <ul style="list-style-type: none"> <li>◆ Indicators to improve tracking of resources committed to population categories; family planning services, basic reproductive health services, sexually transmitted diseases/ HIV/ AIDS activities; data and population and development policy analysis</li> </ul> <p><b>Adolescents/young people</b></p> <ul style="list-style-type: none"> <li>◆ Proportion of adolescents who achieve recognized and measurable learning outcomes</li> <li>◆ Number of young people neither in education nor employment (NEET rate) by sex</li> </ul> <p><b>Internal migration/ urbanisation</b></p> <ul style="list-style-type: none"> <li>◆ Proportion of urban population living in slums</li> </ul>	<ul style="list-style-type: none"> <li>◆ Proportion of women 20–24 years who were married or in union before age 18</li> <li>◆ Proportion of women aged 15–49 subjected to physical or sexual violence in the last 12 months</li> <li>◆ Proportion of women 15–49 years old who have undergone FGM/C</li> <li>◆ Primary school completion rate (female)</li> <li>◆ Adjusted net enrolment ratio in secondary education (female)</li> <li>◆ Share of women in parliament</li> <li>◆ Share of women among persons in managerial positions</li> <li>◆ Proportion of women and men in wage employment</li> <li>◆ Proportion of adult population owning land by sex</li> </ul>

<p><b>Adolescents /young people</b></p> <ul style="list-style-type: none"> <li>◆ Adolescent birth rate</li> <li>◆ Proportion of women 20–24 years who had a pregnancy before age 18</li> <li>◆ Proportion of never married women and men aged 15–24 using a condom at last sex</li> <li>◆ Percentage of young women and men age 15–24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV</li> <li>◆ Youth HIV prevalence rate</li> </ul> <p><b>Health systems</b></p> <ul style="list-style-type: none"> <li>◆ An indicator on quality of SRH services*</li> <li>◆ An Indicator of access to health facilities and essential medicines*</li> <li>◆ Mother to child HIV transmission rate</li> </ul>	<p><b>International migration</b></p> <ul style="list-style-type: none"> <li>◆ Proportion of international migrants accessing health services</li> </ul>	
<p>* To be developed/improved for indicators where data is available for a very limited number of countries.</p> <p>Notes: (1) Data to be segregated by urban/ rural/ vulnerable areas including those affected by humanitarian crisis; age; wealth quintile and by sex, where applicable. (2) Above indicators have been extracted from “Framework of Actions for the follow-up to the Programme of Action of ICPD beyond 2014”, Annex IV, Monitoring Framework.</p>		

## PPD's Strategy – a Glance

### Vision

An Intergovernmental Alliance leading the promotion of South-South Cooperation towards the attainment of the global population and reproductive health agenda for sustainable development.

### Mission

To achieve its Vision through sustained advocacy, capacity building, networking, knowledge management/sharing and transfer of technology in the field of reproductive health and rights, population and development within the framework of South-South Cooperation.

### Strategic priorities (results)

The strategic results that PPD strives for are:

1. Ensure universal access to reproductive health care and services.
2. Integrate population dynamics in development planning at national, regional and international levels.
3. Advance gender equality and the empowerment of women

### Strategic interventions

1. **Advocacy & policy development.** Conduct evidence-based advocacy for sound policies, budgets and programs.
2. **Health and population diplomacy.** Contribute to and influence the global policy dialogue to encourage inclusive approaches that sustain global human development, reduce inequalities, and respond to the priorities and interests of developing countries
3. **Capacity development and technical cooperation.** Facilitate needs-based, demand-driven technical and capacity building support to both member and collaborating countries.
4. **Knowledge management.** Facilitate the sharing of information, experiences and expertise through South-South cooperation.
5. **Capacity building for south-south cooperation.** Build institutional capacities to stimulate, deepen and strengthen south-south cooperation.
6. **Partnerships and relationships.** partnerships for contribute to and Influence the global policy dialogue on RH, population and development; fund and technically support specific SSC initiatives related to commodity security, technology transfer, human resources development and technical cooperation; build institutional capacities for south-south cooperation – including support for PPD's training and research Partner Institutions.

## STRATEGIC INTERVENTIONS

To contribute to achievement of the above development results, PPD will focus its efforts in 6 major areas of strategic interventions:

### 1. Advocacy and policy development

A central purpose of PPD is to engage senior political and government leaders to ensure that reproductive health care and services, and population and development priorities retain national priority, and are fully integrated into national policies, development plans and budgets and are effectively implemented. With the transition from the MDGs to Sustainable development agenda over the 2015–19 period, particular attention will be devoted to ensuring that the priority of the ICPD post 2014 agenda is sustained and advanced, both at national and global levels. This will require action on a number of fronts over the 2015–19 period. Specifically, PPD will:

- \* Engage policy makers (Ministers, parliamentarians, senior government officials) to ensure that RH care and services and population and development are positioned as high priorities in the national development agenda. PPD will actively advocate with countries to set policies and plans in place to achieve universal access to RH care and services; integrate population and development issues within national development planning; and eliminate gender based violence and achieve gender equity. This advocacy will be strongly informed by evidence, and make a compelling case as to why investments in RH care and services, population and development make sense, with strong social benefits, economic and nation-building returns. Advocacy will also focus on the importance of south-south cooperation, and provide compelling examples as to how SSC has accelerated progress or responded significantly to the interests and needs of developing countries: e.g., cooperation in human resources training, ICT technology transfer or on RH commodity security.
- \* Encourage greater accountability and oversight of the implementation of national RH, population and development strategies through support for strategy reviews, annual progress reports and discussion of these. PPD will encourage and facilitate the use of PPD based mechanisms, particularly using the Inter-Ministerial Forums as a platform for Ministerial level peer review of progress and discussion of SSC collaboration opportunities. Similarly, the annual PCC meetings will be utilized to discuss and review country progress in leveraging SCC for RH, and PCCs will be encouraged and enabled to participate in “other-country” program reviews.
- \* Advocate for increased domestic and international funding. PPD will liaise closely with national authorities to identify resourcing gaps and concrete opportunities as to how these could be addressed through south-south and trilateral cooperation arrangements.

## 2. Health and population diplomacy

Health has become increasingly dominant in the growing discussions on national security, trade and the global diplomacy agenda. Governments, UN agencies and international organizations are increasingly embracing health diplomacy as a tool to simultaneously carry out programs and improve health and international relations. It is evident that a nation's health risk not only affects its national boundaries and those of its neighbors but also those of the whole world. The outbreak of SARS in 2003, H1N1 influenza in 2009 and Ebola virus in 2014 demonstrated how fragile our defenses are to curtail the rapid spread of these diseases, costing lives, impacting human health, and restraining travel and trade among interdependent economies. World Health Organization (WHO) has been working on promoting health diplomacy. The aim is to bring together the disciplines of public health, international affairs, management, law and economics and strengthen the capacity of negotiations that shape and manage the global policy environment for health. Through these efforts, health ministries are identifying how they can best inform pre-negotiation trade positions, provide input during negotiations, analyse the health costs and benefits of proposed compromises and monitor the health impacts of trade agreements.

The term 'diplomacy for health and population' frequently refers to the efforts of partnerships, interactions and negotiations between and among institutes, governments, UN agencies, international agencies and multi-disciplines. All this within and beyond the health and population sciences that are responsible for dealing with transnational health and population issues, contributing to and influencing the global policy dialog to sustain development, healthy lives, reduce inequalities and promote well-being for each one at all ages and respond to the priorities and interests of nation building. They refer to the role of the global diplomatic arena like UNGA, WHA, AU, EU, and BRICS (grouping of emerging economies) towards addressing health and population issues that cross national boundaries. Diplomacy for health and population can be seen as a policy-shaping process through which state, non-state and other institutional actors negotiate responses for health and population challenges. This will accentuate the promotion of healthy populations by supporting sexual and reproductive health and reproductive rights, voluntary family planning, equity, women's empowerment, development, and efforts to combat HIV/AIDS and achieve other political, economic or social benefits.

Given the enormity of the tasks to be completed and the paucity of resources available, PPD's south south agenda remains doubly challenging as it has failed to advance effectively:

- \* South-South diplomacy among the countries involving vital ministries like foreign affairs, finance, planning, commerce/industrial and head of the states;
- \* Relationship among the international diplomatic and political platform like UNGA, UNSC, UNCPD, WHA, BRICS, G20, G8, European Union, African Union and different regional bodies.

The need of the hour is to work out strategic pathways for advancing south-south diplomacy. This would enable PPD to realize its optimal potential for delivering tangible results for the benefit of its member countries as well as other developing countries.

South-South diplomacy for health population and development should focus on 3 different levels of interaction and negotiation around health and population issues.

- a) south-south diplomacy: formal negotiations or interaction between and among developing nations to enact formal agreements;

- b) multi-levels diplomacy: negotiations between or among north-south nations, and other actors like WHA, WTO (TRIPS), UN CPD, UNSC, EWEC, Bill and Melinda Gate Foundation, PEPFAR, Global Fund, GAVI Alliance, etc.;
- c) informal diplomacy: interactions between international population and health actors and their counterparts in the field, including host country officials, nongovernmental organizations, private-public sector, etc.

*During the coming five years (2015–19) PPD will:*

- \* **Advocate** that the ICPD post-2014 priorities (as proposed in the Framework document) are agreed upon by UN member states and firmly embedded in the post-2015 Sustainable Development Agenda. PPD Secretariat will work with PPD partner states to coordinate their positions on goals and targets, monitoring and reporting arrangements, and highlighting the critical need to sustain high levels of donor support and expanded support for south-south and trilateral cooperation.
- \* **Contribute** to health and population dialogue through strategic support to global Commissions and working groups. It would perhaps use the co-lead (WHO/PPD) “Commission on Ageing” as a model, and additional working groups could be considered to provide developing countries with a global platform to participate in the dialogue on other “population dynamics” issues: particularly maximizing benefit from the “youth bulge” demographic dividend; planning for growth; managing national and international migration, etc. PPD Secretariat will consult with PPD partner countries on their priority concerns and develop proposals to be approved by the PPD Governing Board, before taking it up with other international partners.
- \* **Raise** the profile of PPD’s work, particularly to communicate how SSC has helped influence and leverage better global decisions, and national policies and programs. PPD will also explore the possibility of influencing the population policy of other countries for the benefit of the population of one’s own country, particularly in the area of migrants. This could be attempted through sensitization of diplomats on population related issues.

### **3. Capacity development and technical cooperation**

Over the past twenty years PPD member countries have developed impressive expertise, institutional capacity and resources to support policy and programmatic advances in the areas of RH, population and development. By end 2014, 23 Partner Institutions (PIs) in 14 MCs have been registered with PPD – providing a broad range of research, training and expert advisory services in the fields of population and development, sexual and reproductive health. PPD fellowship programs have expanded to involve nine PIs and have provided graduate and postgraduate training for over 2700 professionals working in the areas of RH and population and development. Initiatives have been taken to leverage south-south and trilateral cooperation to improve reproductive health commodity security, program management and delivery. While considerable progress has been made, there is a strong sense that the potential contributions of SSC for capacity development and technical cooperation are not being fully realized. Responding to this concern, under the 2015–19 plan period, PPD will seek to deepen and broaden technical cooperation and capacity building efforts. Specifically, PPD will:

- \* **Encourage** Partner Countries and Institutions to expand the number and range of fellowship-supported training opportunities with a focus on RH and population and development

leadership and policy development, strategic planning, program management, monitoring and evaluation and the planning and management of south-south cooperation initiatives. In particular, PPD Secretariat will work with PCCs and PIs to define training needs and demands; to develop or strengthen relevant courses in response to current and emerging needs; and strengthen quality assurance, course evaluation and participant feedback on the value and relevance of training.

- \* **Arrange** short-term training or technical consultations to introduce PCCs and PIs to new technologies, policy and programming approaches and guidance.
- \* **Explore** opportunities and potentials for PI to strengthen their contributions to policy research on population dynamics – particularly policy research related to “youth bulge”, ageing, urbanization, migration and changing family structures. Recognizing that virtually all partner countries are grappling with the implications of population growth and demographic change, there is a critical and urgent need to strengthen capacities within and between developing countries to develop evidence informed policies that proactively respond to these demographic changes. PPD would play an active role in this area: by helping triangulate PPD partner country interests with current and planned policy research; exploring opportunities for south-south and tri-lateral collaboration on policy research; and utilizing platforms such as the PPD Inter-Ministerial Forum, UN global meetings (e.g., UNGA, WHA, UNFPA EB) and task forces (e.g., Commission on Ageing) to facilitate high level policy dialogue on population dynamics involving parliamentarians, senior government officials, experts, researchers and other stakeholders.
- \* **Explore** potential and facilitate enhanced technical cooperation and technology transfer in priority areas that respond to country partner needs and capacities, including: a) reproductive health commodity security (medicines, family planning commodities, diagnostics); b) population census and vital statistics data generation, analysis and use – that have been highlighted as areas of high priority among members; and c) the development and adoption of innovative information and communication technologies that advance progress towards ICPD goals.
- \* **Explore** the feasibility of promoting SSC in reducing regulatory barriers and improve regulatory efficiency in the procurement of life saving commodities. The UN Secretary-General’s Global Strategy for Women’s and Children’s Health (2010) called on the global community to work together to save 16 million lives by 2015. This challenge was taken up by the UN Commission on Life-Saving Commodities for Women and Children. It identified and endorsed an initial list of 13 overlooked life-saving commodities, if more widely accessed and properly used, could save the lives of more than 6 million women and children. The Commission recommended 10 time-bound actions including the need for improved global and local markets for life-saving commodities, innovative financing, quality strengthening, and regulatory efficiency, improved national delivery of commodities and better integration of private sector and consumer needs.

#### 4. Knowledge management

The principles of learning from each other and drawing upon other developing country experiences and resources have been foundational principles underpinning PPD’s role and work. Most developing

countries have experience of good practices and competencies in the areas of RH, population and development; most prefer to learn from other countries experiencing similar development contexts and experience; and most perceive a mutual benefit from cooperation and are willing to contribute their experience and expertise to support other developing countries. The challenge is to link the supply and demand of these opportunities, and that is a critical role for PPD.

The mechanisms for facilitating these exchanges are many and varied, ranging from opportunities provided by conferences, workshops and technical meetings; engagement with professional networks; drawing upon relationships built with peers and mentors through participation in training programs; the gaining of new ideas and perspectives through the sharing of research, policy and program reviews and the documentation and dissemination of best practices; and through networking that takes place as part of technical cooperation arrangements. During the 2015–19 period, PPD will work to speed up and strengthen these knowledge resources and networks. Specifically, PD will:

- \* **Identify and document** good practices in RH, population and development. PPD will work with PCCs to identify promising practices, provide quality assurance support to PCCs in the preparation of best practice briefs, and to disseminate best practices briefs through the PPD newsletter, emails/alerts, website and other means.
- \* **Promote** knowledge and recognition of best practices developed by PPD member states among key policy makers and program managers by arranging briefing sessions, presentations at major global and regional conferences, and ensuring references to positive experiences in high level speeches and statements.
- \* **Facilitate** study-tours and experience exchange visits between partner countries. Particular priority will be given to linking countries with demonstrable progress, innovation or success (e.g., reducing maternal mortality, reducing unmet FP needs, implementing effective approaches to reduce FGM or child marriage, etc.) with other countries facing more challenging contexts. The aim of these exchange visits will be to design and operationalise ongoing technical cooperation between partner countries.
- \* **Develop and maintain** a database (knowledge bank) of policy, programming and technical resources (resource institutions, technical networks, experts, training institutions and opportunities, new guidance, policy and programming tools, etc.) in the field of RH, population and development.
- \* **Maintain** ongoing dialogue with PCCs and other stakeholders as to how PPD Secretariat could best facilitate and support knowledge management, networking and experience exchange.

## 5. Institutional capacity building for south-south cooperation

While many countries have benefited from various forms of SSC, most report that such cooperation is often ad hoc focused mainly on training, information and experience exchange, and that the full potentials of SSC are not being realized. This relative underdevelopment of SSC is partly explained by its relative newness—as recent rapid economic growth and technological innovation in developing countries has bolstered developing country capacities and confidence to contribute to development cooperation—and partly by the relative weakness of institutional capacities to nurture and manage SSC. As a consequence and in contrast to the well developed and politically connected institutional capacities to manage bilateral and multilateral cooperation (that have been benefitted from decades of investment in institutional capacity

and relationships with international development partners), capacities for nurturing and managing SSC are more nascent in their formation and less institutionally strong.

Noting that the demands for South-South Cooperation will likely grow rapidly over the coming decades—in part fuelled by the need for middle income countries to adopt new forms of development cooperation as many become ineligible for ODA from developed countries—it will be critically important to invest more in developing these institutional capacities, and utilize SSC modalities to do so. During the 2015–19 period, PPD will build institutional capacities to stimulate, deepen and strengthen south-south cooperation in the field of RH, population and development. Specifically, PPD will:

- \* **Promote** the mainstreaming of SSC within the international cooperation components of national RH, population and development plans, budgets and coordination mechanisms. This includes: (1) establishing SSC components within RH and population and development work-plans and line items within national budgets; (2) establishing or supporting the functioning of cross-sectoral coordination mechanisms (including National SSC Task Forces); and (3) strengthening of the human and institutional capacities within lead Ministries to act as focal point, facilitate and report on SSC work related to RH, population and development.
- \* **Promote** the establishment and functioning of parliamentary committees on RH, population and development to support the development of national policies and legislations, and provide parliamentary oversight and support for the implementation of national RH, population and development strategies.
- \* **Encourage and facilitate** peer-based experience exchange and technical cooperation between PCCs and International Cooperation Departments and staff responsible for SSC. Annual PCC meetings will be used to report progress, identify best practice examples and explore potentials for peer support. Recognizing that many countries have experienced high turnover of staff responsible for SSC, priority will also be given to improving the orientation and mentoring of new staff, particularly PCCs. For this there will be a need to update PCC briefing packs (including Terms of Reference), and encourage “twinning” and mentoring arrangements linking less with more experienced PCCs.
- \* **Engage** with United Nations agencies and bilateral partners to mobilize technical and financial support to strengthen national capacities to plan, manage and report on SSC initiatives.
- \* **Require** PCCs to report annually on progress, plans and lessons learned in developing SSC institutional capacity. Such reports will be established as a standing item in annual PCC and PPD Governing Board meetings.

To undertake this work, the PPD Secretariat and Africa Regional Office, will work closely with PCCs to assess institutional development needs; tailor their own, country specific, action plans to build SSC institutional capacity; assist in mobilizing donor and peer support for their implementation; and engage both PCCs and Board members in an ongoing review of progress and dialogue of what next needs to be done to strengthen SSC.

## 6. Partnerships and relationships

The implementation of the 2015–19 strategic plan requires many, effective partnerships and relationships. While the range of partners engaged around RH, population and development is broad, and the number of initiatives to accelerate action in these fields is many, PPD will focus its partnering strategy to focus

on those relationships that will best leverage PPD's strategic aims. Specifically, PPD will focus on those relationships and partnerships that: (1) enable PPD to contribute to and influence the global policy dialogue on RH, population and development; (2) fund and technically support specific SSC initiatives related to commodity security, technology transfer, human resources development and technical cooperation; (3) invest in and build institutional capacities for south-south cooperation – including support for PPD's training and research Partner Institutions; (4) fund and support the functioning of the PPD Secretariat and other offices.

At the level of global policy dialogue and leadership mobilization, PPD will actively engage with and support a number of partner mobilization and coordination initiatives including Every Women Every Child (UNSG), Family Planning 2020 (Gates Foundation), Partnership for Maternal, Newborn and Child Health (WHO), A Promise Renewed (UNICEF, USAID), etc. It will continue to work closely with the United Nations system, particularly platforms provided by the UN General Assembly for high-level policy engagement around sexual and reproductive health and rights, population and development, and the post 2015 Sustainable Development agenda. This will include close engagement with the UN Commission on Population and Development; the Executive Boards of UNFPA, WHO, UNICEF, UNDP, UN Women and UNAIDS; and the technical departments of Population Division of the UN Department of Economic Affairs, UNFPA and UNDP's unit on South-South Cooperation.

PPD will also engage in partnerships with parliamentary organisations to build political will and support for reproductive health, population and development; with non-governmental and civil society organisations, to tap into community experience, needs and perceptions; and increasingly, the private sector.

While PPD's work has benefitted from considerable donor support—from bilateral and multilateral donors and private foundations—there is now less, and less predictability of future funding. Clearly also, as many middle-income countries become less eligible for donor funding, there is a critical need to adopt more innovative resourcing approaches.

This priority will ensure that all partner agreements are: (1) well designed to serve PPD's Mission, strategic priorities and interventions; (2) closely monitored and managed, such that commitments made are delivered upon and fully reported; and (3) there is a continuous effort to ensure better value for money.

## **THEORY OF CHANGE**

The theory of change underlying PPD's Strategic Plan is shown schematically in Exhibit 3. The current status amongst MCs in terms of access to RH care and services, population dynamics and gender equality and empowerment of women could be assessed through appropriate indicators (refer earlier Exhibit 2). While the underlying cause would vary across PPD MCs, these are likely to be a combination of weaknesses in policy, legislation and programs; insufficient funds and indifferent implementation capacity. PPD's five strategic interventions would seek to address these underlying causes, while the desired outcomes would primarily rest with the MCs. The outcomes, if achieved should lead to an improvement in the current status.

## **RESULTS FRAMEWORK**

In line with the Theory of Change, the results framework setting out Strategic Interventions (Results), Outcome and Output indicators as well as a method of verification has been provided in Annex 1.

In Year 1, PPD will establish a baseline and subsequently carry out independent mid-term and end-term evaluations.

**Figure 1: PPD's 4 Work Streams for South-South Cooperation (SSC)**

**Advocacy & Inter-ministerial Consultation**

- ◆ Sharing and mutual learning
- ◆ Peer reviewing for southern policies and programs
- ◆ Seeking, offering and transferring best solutions and commodities
- ◆ Bilateral negotiations for SS Cooperation

- ◆ Exhibition for RH and commodity solution – showcasing best practices, commodities and technologies
- ◆ Forum of private sector entities and donor agencies
- ◆ SS leaderships forum
- ◆ Global policy dialogue



**Knowledge sharing and technical cooperation**

- ◆ Supporting MCs to strengthen national ability to maximize the opportunities towards achieving national agreed commitments and internationally/regionally agreed agendas
- ◆ Identifying countries that are the source of RH commodity and modern technology as well as development solutions and countries that demand for commodities and technologies

- ◆ Supporting MCs to build their capacity to support other MCs
- ◆ Supporting to identify areas for SSC through mutual learning, sharing knowledge
- ◆ Supporting for replication and scaling up best solutions
- ◆ SS consultation at national level and facilitate the sharing and scaling up of best solutions



**Partnership, Health and Population Diplomacy**

- ◆ Joint collaboration to support country-led health plans through sustainable investment
- ◆ Bringing together leaders from the global health, diplomatic and development communities in order to highlight the global health challenges facing the developing countries and providing solutions to these challenges through SSC

- ◆ Dialoguing with member countries to maintain their commitments towards health and population goals
- ◆ Partnership and policy dialogue with BRICS
- ◆ Partnership and diplomatic leadership in health and population goals of SDGs



**Capacity Building**

- ◆ Strengthening PPD's network of 23 research and training institutions (PIs) to create "centers of excellence" to facilitate access to SS knowledge management, sharing and scaling up of development solutions

- ◆ Increasing contributory scholarships program among MCs
- ◆ Documenting and cataloguing southern development solutions through peer-review processes; creating and maintaining exchange of SS experts



**Figure 2: Theory of Change**

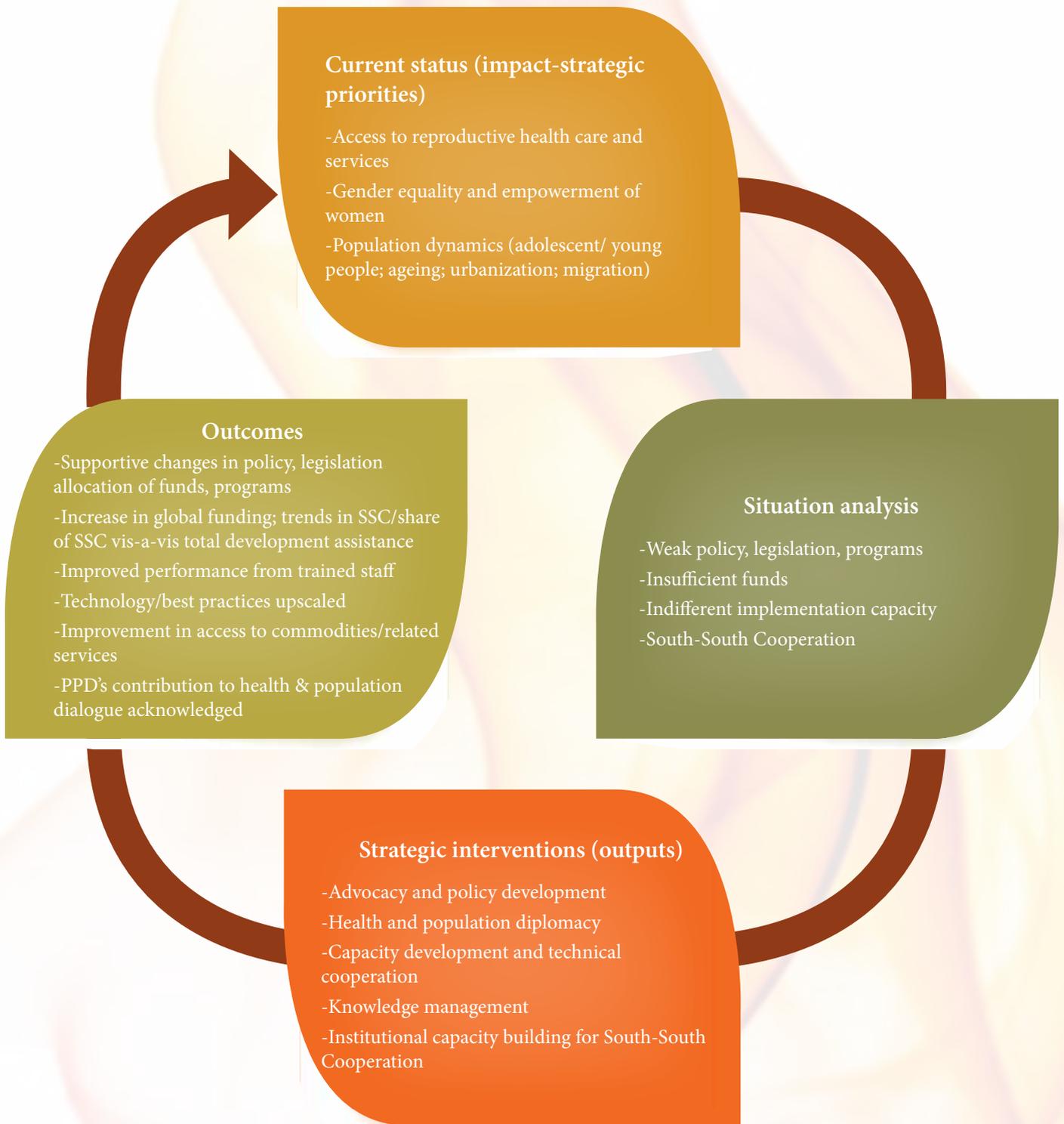
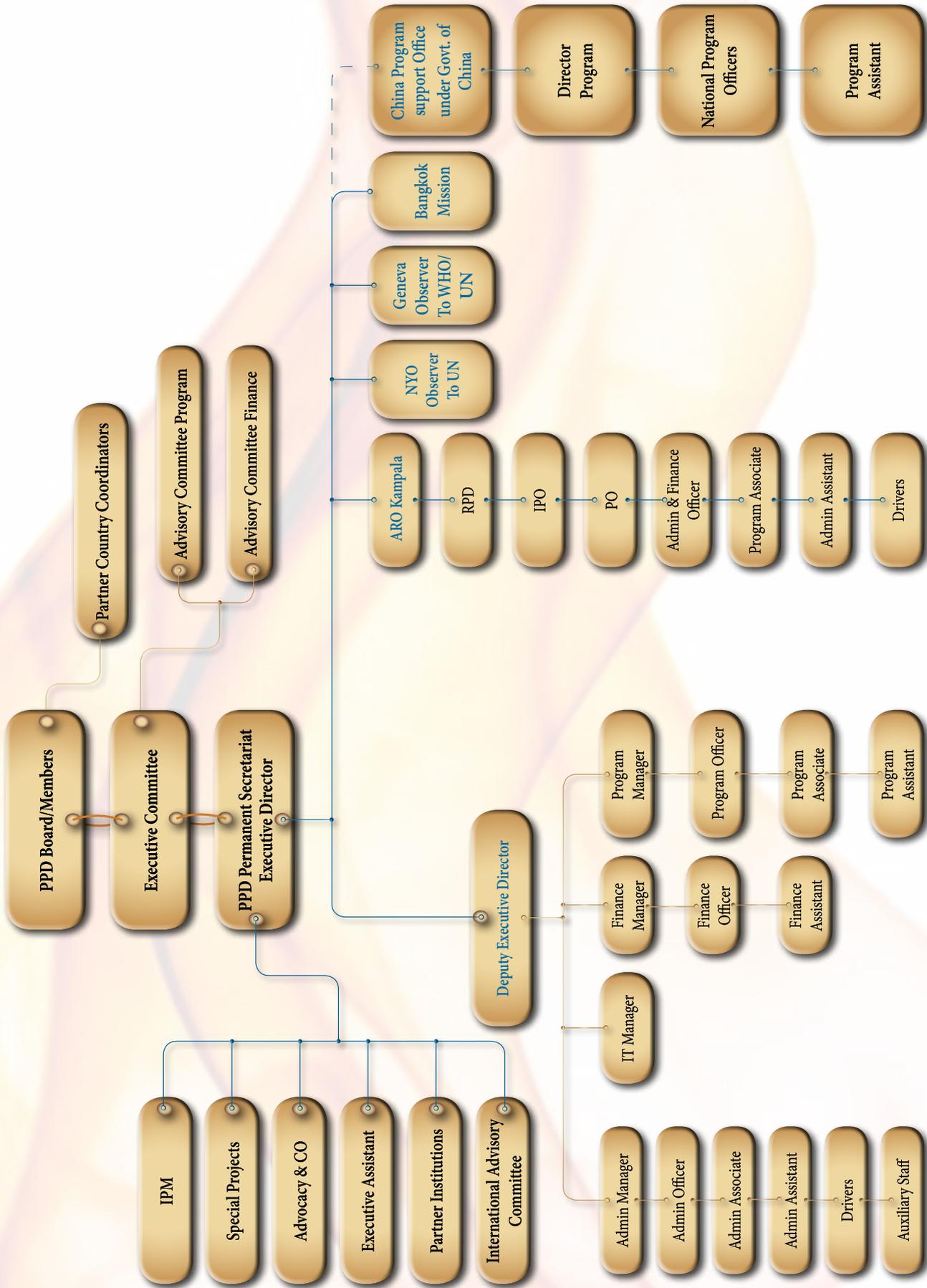


Figure 3: PPD Organizational Structure



Note: IPM – International Program Manager for Resource Mobilization; ARO – Africa Regional Office; RPD – Regional Program Director; PO – Program Officer; NYO – New York Office; UN – United Nations; Advocacy & CO – Advocacy and Communication Officer

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## 6. MANAGING FOR CHANGE AND SUCCESS

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### OVERVIEW OF EXISTING GOVERNANCE SYSTEM

PPD's current governance system, institutional arrangements and organisation structure are shown in Fig. 3. The Bye-Laws signed by each member state regulate the governance and functioning of PPD. A brief description of roles and responsibilities is provided in the paragraphs that follow:

#### The PPD Board

The PPD Board consists mainly of Ministers of Health, Population and Social Development from all 26-member countries and ensures the highest policy level commitments. Board members are envisaged to:

- \* Advocate for widening south-south collaborative exchanges;
- \* Support resource mobilization in both developed and developing countries;
- \* Guide and provide political and financial support to PPD;
- \* Nominate a Partner Country Coordinator;
- \* The Board meets once a year. Annual meetings of the GB culminate in a “declaration” reflecting a consensus amongst members. Recent declarations include: Beijing 2000; Kochi 2001; Jakarta 2003; Yangtze 2004; Agra 2005; Rabat 2007; Kampala 2008; Yogyakarta 2010; Pretoria 2011; Dhaka 2012; Beijing 2013 and New Delhi 2014.

#### Executive Committee (EXCO)

The Executive Committee currently consists of four<sup>4</sup> elected Board Members (Chairman, Vice-Chairman, Secretary and Treasurer), one from each of the four main regions (sub-Saharan Africa, Asia; North Africa and the Middle East; and Latin America and the Caribbean). EXCOM members serve two consecutive terms of 3 years each, with the exception of Bangladesh that has a permanent membership, by virtue of hosting the PPD Secretariat in Dhaka. Further, the country hosting the EXCOM meetings is an ad hoc non-voting member. The EXCOM meets at least once a year between Board Meetings. Its role is to review/recommend annual plans and budget, monitor progress and provide guidance to the Executive Director of the Secretariat. Two Advisory Committees support the EXCOM for Program, Planning and Development and Finance and Risk Management respectively; these committees meet once in a year and provide guidance on implementation of the annual plans.

#### Partner Country Coordinators (PCCs)

The Partner Country Coordinator (PCC), a senior government official, designated by each Board Member is expected to develop the country's annual south-south work-plan; initiate and support PPD's activities in each country; co-coordinate with the Secretariat and in-country donors; and document and disseminate information about projects, organizations, and individuals engaged in south-south initiatives. PCCs meet annually for consultative discussions and suggestions on how to strengthen south-south cooperation activities among PPD's countries.

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<sup>4</sup> However, the Pretoria 2011 Board meeting approved increasing EXCOM membership to 6 to increase regional representation

## Secretariat, Dhaka

The permanent Secretariat located in Dhaka is headed by a full time Executive Director, supported by a Deputy Executive Director and about 15 staff members. The role of the PPD Secretariat is to assist member countries and other developing countries to expand and improve SSC in the field of reproductive health, population and development. The Secretariat:

- \* Facilitates policy dialogue;
- \* Serves as a focal point for networking and clearing house of information;
- \* Facilitates south-south exchange including identification of new opportunities and sources of funding;
- \* Advocates, markets and builds a positive corporate image for south-south exchanges.

## Africa Regional Office (ARO)

The Maputo Plan of Action, September 2006 highlighted SSC as one of the key routes for the attainment of its objectives. In response, PPD opened the ARO in Kampala, Uganda in Feb 2007 to support the SRH program in Africa while fostering SSC. Apart from organizing forums and meetings on SRH, the ARO conducts high level policy dialogue with African leaders and other stakeholders to facilitate effective transfer of knowledge, information and technologies and commodity security through SSC.

A Regional Program Director, supported by about 5 staff members, heads the ARO.

## China Programme office

The China Program Office was set up in 2006 primarily to take the lead in building staff capacities for the promotion of SSC in reproductive health, population and development. In addition, the Office also facilitates the transfer of RH Commodities and Technologies between developing countries. The China Program Office is headed by a full time Program Director and is fully supported by the Government of China.

## Other PPD offices

PPD was conferred with Permanent Observer Status at the UN General Assembly in November 2002. According to the requirement of the UN Observers, PPD maintains a liaison office to the UN in New York. The role of the office is to:

- \* Provide high-level representation for PPD at meetings of the General Assembly, Economic and Social Council, UNDP/UNFPA Executive Board and other UN agencies;
- \* Maintain regular liaison with the Permanent Missions of PPD member countries and other UN members, and senior officials of UN Organizations;
- \* Undertake other external relations activities, as appropriate and develop or participate in projects, relevant to the work of the PPD.

In addition, PPD has representation in Geneva and Bangkok.

## Partner Institutions

PPD has established partnerships with 22 national and regional training and research institutions in Asia, Africa, Middle East and Latin America. These PIs have necessary professional staff and infrastructure to conduct research, document best practices, develop training programmes and conduct training/ manage scholarship programmes.

## International Program Advisory Committee

The International Program Advisory Committee (IPAC) consists of outstanding professionals and provides guidance to PPD in the design, development and implementation of South-South programmes in the field of reproductive health, population and development.

## KEY CHALLENGES

While the above institutional arrangements have served PPD well, its full potential is yet to be realised. There are several challenges including: (1) the need for greater focus on results, i.e., outcomes and impact; (2) mainstreaming and institutionalizing PPD's work at the country level; (3) engaging PIs more effectively around PPD's strategic priorities; (4) strengthening the joint identity, coordination and relationships between various PPD entities (Dhaka Secretariat, Africa Regional Office, China Country Office, global representatives); (5) PPD's advocacy in global fora to represent a more united voice, advancing member states' interests; and (6) more effectively communicating PPD's progress and achievements to garner a greater degree of public support.

## PPD'S ORGANISATIONAL STRATEGY: TRANSFORMATIVE CHANGES

In order to address the above challenges and take forward the Strategic Plan, a number of transformative changes are envisaged:

### *Unity of purpose*

- \* This Strategic Plan will guide the functioning of all PPD offices. The PPD Secretariat, ARO, China Office and other offices would prepare annual plans in line with the Strategic Plan. The Secretariat will then consolidate the annual plans and report on progress to the Executive Committee. Necessary changes in the planning and reporting system will be made.

### *Increased emphasis on accountability*

- \* All PPD offices will work in accordance with the results framework provided in Annexure 1.
- \* All MOU/agreements between PPD Secretariat and different offices would be updated/ revised to reflect reporting relationships and indicators of performance. PPD Secretariat has an oversight and monitoring role over the ARO office.
- \* PPD's overall governance, policies and procedures documented in the form of manuals would be applicable to the Secretariat, ARO and other offices, with the exception of the China program office that is fully funded by the Govt. of China.

### *Larger role for Member Countries/ Partners Country Coordinators (PCCs)*

- \* The implementation of the Strategic Plan would be a joint effort of PPD and Member Countries. MCs are envisaged to promote the mainstreaming of SSC within the international cooperation components of the national RH, population and development plans, budgets and coordination mechanisms. This includes establishing SSC components within RH and population and development work-plans and line items within national budgets, establishing or supporting the functioning of cross-sectoral coordination mechanisms (including National SSC Task Forces), and the strengthening of the human and institutional capacities within lead Ministries to act as focal point, facilitate and report on SSC work related to RH, population and development.
- \* There would be at least two meetings of PCCs each year. PCC meetings will be used to report progress, identify best practice examples and explore potentials for peer support. Recognizing that many countries have experienced high turnover of staff responsible for SSC, priority will also be given to improving the orientation and mentoring of new staff, particularly the PCCs. Briefing packs (including Terms of Reference) for PCC would be updated, and “twinning” and mentoring arrangements linking less with more experienced PCCs would be encouraged.

### *Improved communications*

- \* PPD will develop a communication strategy and plan, clearly articulating target segments including MCs, communication objectives, and indicators for tracking progress. The communication Interventions shown in Annexure 2 would be a sub-set of the above communication strategy and plan. Progress against the communication plan will be tracked and reported to the EXCOM.

### *Strengthening of PPD capacities*

- \* The organisation structure and staffing of the Secretariat/other offices would be reviewed to ensure that it is fit for the purpose and efficient. The resource mobilisation, communication and monitoring and evaluation functions will be strengthened.

# 7. BUDGET AND RESOURCE MOBILISATION

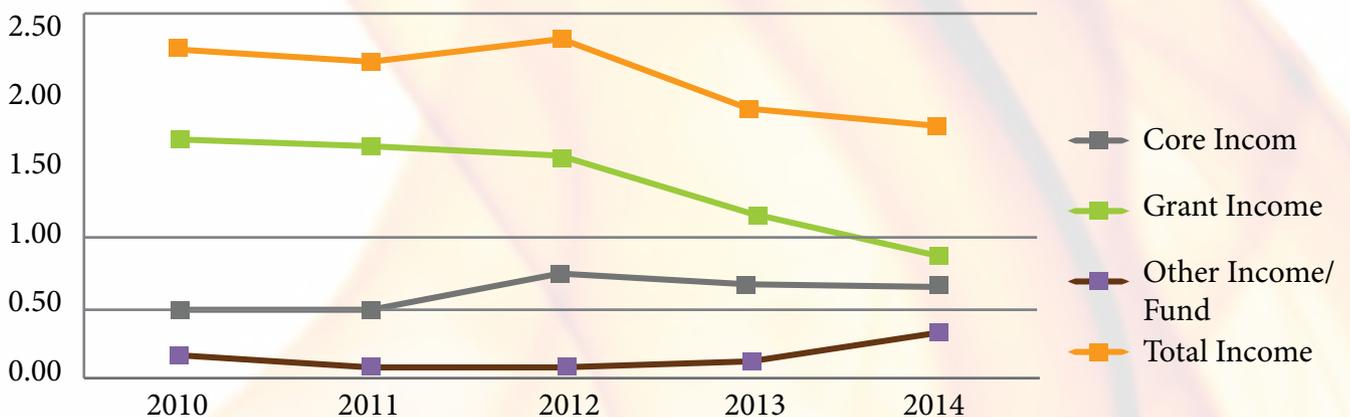
## FINANCIAL TRENDS, 2010–14

### Income

During the 5-year period, 2010–14, PPD including Kampala office had a total income of 10.3 million USD; membership fees (core income) from MCs and grants from donors accounted for 28% and 66% respectively. This does not include: (1) direct contributions from MCs by way of support to scholarships, full or partial coverage of office expenses, technical assistance, commodities, hosting various meetings, land for PPD building in Dhaka; (2) Contributions to construction of PPD building.

There has been a declining trend in total income, while contribution from MCs has shown significant increase:

Figure 4: Trend of income(in USD Millions), 2010-14



### Expenditure

The total expenditure over the last 5 years is 10.7 million USD; salaries and consultancies, conference and meetings and travel accounted for 42%; 32% and 13% respectively:

Figure 5: Expenditure of PPD including kampala and New York Offices (in USD Millions and %)



## KEY PRINCIPLES

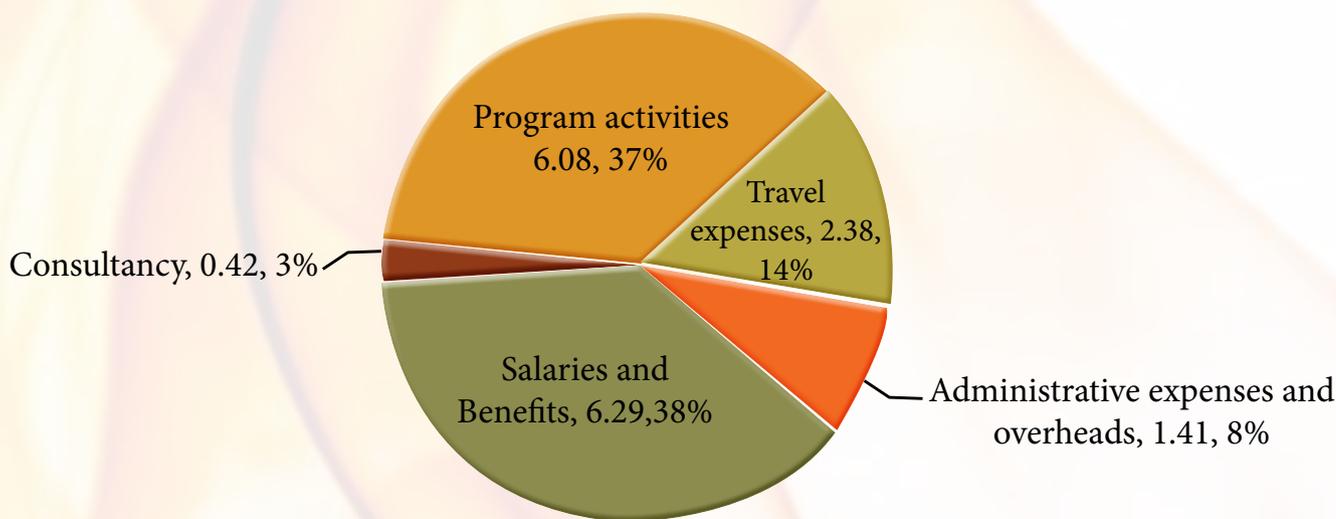
Over the next 5 years, PPD will move towards:

- \* Covering core expenses, i.e., salaries, office expenses, costs of essential activities through own income, i.e., MC fees, interest from corpus (UNFPA trust fund);
- \* Greater sustainability/decreasing dependence on donors by exploring alternative options for raising funds, e.g., charging a fee for services rendered in south-south collaboration. Rental income (see below) should primarily be used for programmes.
- \* Improved efficiency through, e.g., managing personnel related expenditure to show better value for money
- \* Establishing common systems across offices for capture and reporting of all sources of income and items of expenditure

## BUDGET REQUIREMENTS, 2015–19

In order to implement the strategic plan, the Secretariat including Kampala and New York Offices would need US\$16.58 million over the five year period 2015–19, i.e. about 55% more than the expenditure of US\$10.70 million incurred in the preceding 5-year period (for details refer to Fig.6)

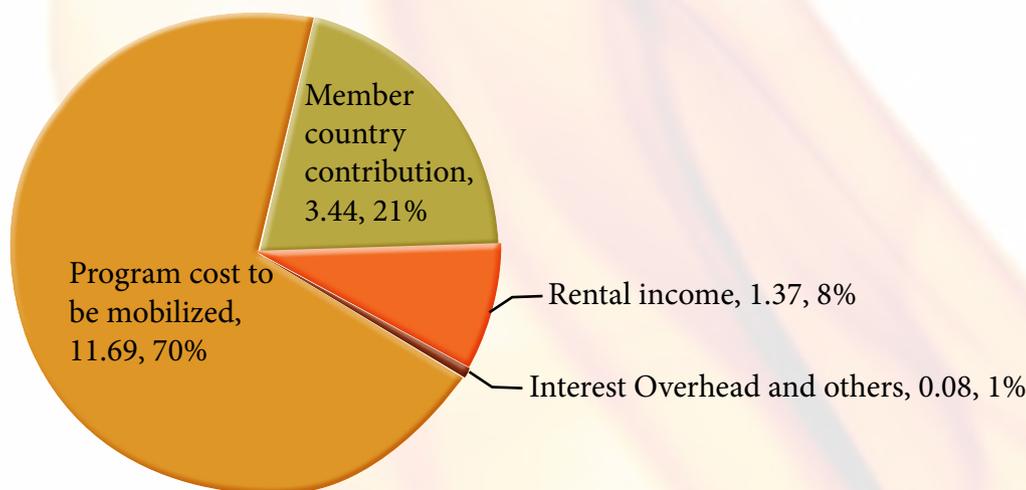
Figure 6: Expenditure Budget, 2015-19( in USD Millions and %)



## RESOURCE MOBILISATION, 2015–19

PPD expects to mobilise US\$16.58 million over the next 5 years primarily through funding for programs (70%), MC contribution (21%) and rental income (8%).

Figure 7: Resource mobilisation 2015-19(in USD Millions and %)



### Rental income

The Government of Bangladesh has donated 27,872.5 sq.ft. land in a premium locality in Dhaka valued at US\$8 million. PPD intends to construct office space both for its own use and for earning rental income. PPD Member Countries have already contributed an amount of US\$450,000 to construct the building. PPD received contribution from the Government of China valued at US\$200,000, Government of India US\$100,000, Government of South Africa US\$100,000 and Government of Bangladesh US\$50,000.

The total estimated construction cost is valued at US\$5.05 million, broken down as follows:

	US\$ million
Phase 1: Part 1, 2014-15: completion of 2 storey building with 6 storey foundation	: 0.75
Phase 1: Part 2, 2015-16: completion of 6 storey building	: 1.3
Phase 2: Completion of another new building (12 storey)	: 3.00
-----	
Total	: 5.05

Rental income is estimated to be valued at US\$195,600 in 2016 and 2017 from the 6-storey building; and US\$782,500 from 2019 onwards. Four MCs have contributed US\$450,000 towards the cost of construction and the balance, i.e., US\$4.6 million would need to be mobilized.

### Strategy to mobilize resources

The above figures are indicative. A comprehensive resource mobilization strategy identifying specific target segments, expected volumes/share and likely trends over the next five years would be finalized along with an action plan.

# Annexure 1

## RESULTS FRAMEWORK: ILLUSTRATIVE PPD OUTCOME AND OUTPUT INDICATORS

**Strategic Priority (Result 1)<sup>5</sup>** : Ensure universal access to reproductive health care and services.

**Strategic Priority (Result 2):** Integrate population dynamics in development planning at national, regional and international levels.

**Strategic Priority (Result 3):** Advance gender equality and the empowerment of women.

Strategic Intervention	Outcome and /Output Indicators	Method of verification
1. Advocacy and policy development	<p><i>Outcome</i></p> <p>1.1 Supportive changes in policy, legislation, allocation of funds in MCs in PPD's three strategic priority areas<sup>6</sup></p>	Report from Member Country (MC), with appropriate evidence e.g. government order, guideline, etc.
	<p><i>Output</i></p> <p>1.1.1 Peer review of policy, legislation, allocation of funds; success stories, etc. across MCs during annual Inter-Ministerial Conference/regional events/ other platforms</p> <p>1.1.2 Need driven support to specific MCs in bringing about supportive changes</p>	<p>Reports of Annual Inter-ministerial conference/other events.</p> <p>MC Advocacy Plan with expected role for PPD; Report on support provided by PPD.</p>
	<p><i>Outcome</i></p> <p>1.2 Increasing trend in SSC/ sharing of SSC vis-a-vis total development assistance</p>	Report from MC.
	<p><i>Output</i></p> <p>1.2.1 Communication strategy highlighting role of PPD developed and implemented</p>	Communication strategy document; progress report on implementation

Strategic Intervention	Outcome and/Output Indicators	Method of verification
<p>2. Health and population diplomacy</p>	<p><i>Outcome</i></p> <p>2.1 ICPD post 2014 priorities (as proposed in the Framework document) are embedded in the post 2015 sustainable development agenda; increase in funding for (1) addressing post ICPD and MDG agenda in general and PPD strategic priorities in particular and (2) South-South co-operation</p> <p><i>Output</i></p> <p>2.1.1 Advocacy plan including objectives, strategy, outputs, activities, costs and monitoring &amp; evaluation framework; progress against plan</p>	<p>Relevant global documents (e.g. Post 2015 sustainable development framework document)</p> <p>Advocacy Plan document; progress reports</p>
	<p><i>Outcome</i></p> <p>2.2 PPD's contribution to health and population dialogue, role in evolving better global decisions and supporting national policies and programs acknowledged.</p> <p><i>Output</i></p> <p>2.2.1 Work plans including objectives, strategy, outputs, activities, costs and M&amp;E framework; progress against plan</p>	<p>Statements from key stakeholders</p> <p>Work Plan; progress reports</p>

Strategic Intervention	Outcome and/Output Indicators	Method of verification
	<p>increase in funding for (1) addressing post ICPD and MDG agenda in general and PPD strategic priorities in particular and (2) South-South co-operation</p> <p><i>Output</i></p> <p>2.1.1 Advocacy plan including objectives, strategy, outputs, activities, costs and monitoring &amp; evaluation framework; progress against plan</p>	
<p><b>3. Capacity development and technical co-operation</b></p>	<p><i>Outcome</i></p> <p>3.1 Participants in scholarship programme continue to work in the three PPD strategic priority areas/evidence of improved on job performance</p> <p><i>Output</i></p> <p>3.1.1 XXX (number) need based courses developed/modified to cover PPD's 3 strategic priorities</p> <p>3.1.2 XXX number of staff from MCs avail of the scholarship programme</p> <p>3.1.3 Improvement in on job-performance by scholars/ contribution to PPD's 3 strategic priority areas</p>	<p>MC report with appropriate evidence</p> <p>Report from PIs</p> <p>Report from PIs MC report</p>

Strategic Intervention	Outcome and/Output Indicators	Method of verification
	<p><b>Outcome</b></p> <p>3.2 Parliamentarians, senior government officials and key influencing agents actively promote advocacy objectives in terms of international commitments and national priorities</p> <p><b>Output</b></p> <p>3.2.1 Training/sensitisation plan proposal setting out objectives, approach, and M&amp;E framework prepared.</p> <p>3.2.2 XXX number of parliamentarians and senior government officials trained/ sensitised in line with the training plan proposal</p>	<p>MC report, with evidence e.g. questions raised in Parliament/ appropriate for government official information reports; media coverage, etc.</p> <p>Training plan document</p> <p>Report from PI</p>
	<p><b>Outcome</b></p> <p>3.3 Improvement (availability/ price/quality) in access to SRH commodities/related services</p> <p><b>Output</b></p> <p>3.3.1 Proposal(s) including criteria/ method of assessment of impact prepared</p> <p>3.3.2 Signed MOU</p> <p>3.3.3 MOU implemented</p>	<p>Report on assessment of impact of commodity related MOU.</p> <p>Copy of proposal</p> <p>Copy of MOU</p> <p>Progress report from MCs</p>

Strategic Intervention	Outcome and/Output Indicators	Method of verification
	<p><i>Outcome</i></p> <p>3.4 Need based technology transfer/ technical assistance arrangements (SSC/ triangular) designed, approved, implemented and impact assessed.</p> <p><i>Output</i></p> <p>3.4.1 Proposal(s) including criteria/ method of assessment of impact prepared</p> <p>3.4.2 Signed MOU</p> <p>3.4.3 MOU implemented</p>	<p>Copy of MOU and impact assessment report</p> <p>Copy of proposal</p> <p>Copy of MOU</p> <p>Progress reports from MCs</p>
4. Knowledge management	<p><i>Outcome</i></p> <p>4.1 Best practices transferred (between MCs) and upscaled</p> <p><i>Output</i></p> <p>4.1.1 XX (number) of best practices identified</p> <p>4.1.2 MOU/plan for transfer of knowledge/ upscaling including criteria/ method of assessment of impact</p> <p>4.1.3 MOU implemented</p>	<p>Copy of MOU for transfer of best practice; progress and impact assessment reports of upscaling</p> <p>Report/ details of best practices</p> <p>Copy of MOU</p> <p>Progress report from MC</p>
	<p><i>Outcome</i></p> <p>4.2 PPD established as a knowledge centre</p> <p><i>Output</i></p> <p>4.2.1 Detailed proposal for development of a well functioning Knowledge Centre/ MOU</p> <p>4.2.2 Implementation in line with MOU</p>	<p>Trend in queries/requests for assistance from MCs/other stakeholders</p> <p>Copy of Proposal /MOU</p> <p>Progress report by PPD</p>

Strategic Intervention	Outcome and/Output Indicators	Method of verification
5. Institutional capacity building for south – south co-operation	<p><b>Outcome</b></p> <p>5.1 Well functioning (1) Parliamentary committees for SRHR , population and development (2) National SSC Task Forces (3) Partner Country Coordinators</p> <p><b>Output</b></p> <p>5.1.1 Peer Review at Inter-Ministerial Conference; Meetings of PCCs</p> <p>5.1.2 Need based training/sensitization programmes</p>	<p>Minutes of meetings of Parliamentary Committees/ National SSC Task Forces; SSC components within SRHR and population and development work plans and line items within national budgets established.</p> <p>Meeting reports</p> <p>Copy of proposal and report on training/ sensitization</p>

<sup>5</sup> Indicators for the three Strategic Priorities are provided in Table 2, Chapter 4.

<sup>6</sup> The ICPD Beyond 2014 Monitoring Framework provides a number of indicators e.g.

Ensure universal access to sexual and reproductive health care services and rights	Advance gender equality and the empowerment of women	Integrate population dynamics in development planning at national, regional and international levels
<ul style="list-style-type: none"> <li>* Share of health expenditure in total government expenditure</li> <li>* New and/or increased resources are committed to SRH services</li> <li>* Government share of spending on SRH services;</li> <li>* Dedicated budget line for family planning/ contraceptive commodity procurement</li> <li>* Grounds on which abortion is permitted;</li> <li>* Legal barriers towards SRH services for adolescents and youth</li> <li>* Comprehensive sexuality education and on sexual and reproductive health , gender equality and human rights among adolescents in or out of school</li> </ul>	<ul style="list-style-type: none"> <li>* Existing property and inheritance laws do not discriminate against women and girls/ legislation guaranteeing equal inheritance;</li> <li>* Existing laws against child marriage including legislation stating a minimum age of marriage as 18 years</li> <li>* Gender quota in elections</li> <li>* Duration of maternity, paternity and parental leave</li> </ul>	<ul style="list-style-type: none"> <li>* Dedicated budget line for strengthening national statistical capacity</li> <li>* Existence of non-restrictive internal migration policy</li> <li>* Data on urbanisation trends are produced and used in public policies including urban planning</li> <li>* Percentage of budget allocated to excluded / vulnerable groups</li> <li>* National policy on vocational education and skill upgrading</li> <li>* Existence of laws that ensure equal access to health services for international migrants</li> </ul>

## Annexure 2

### PPD's COMMUNICATION TOOLS

Items	Frequency	Indicators	Outcomes	Target Audience
Facebook	Whenever new information are available	<ul style="list-style-type: none"> <li>◆ New news are shared</li> <li>◆ Pictures are shared</li> <li>◆ Videos are shared</li> <li>◆ Page like increased</li> <li>◆ User interaction increased</li> </ul>	<p>A facebook page created-  <a href="https://www.facebook.com/ppdSecretariat">https://www.facebook.com/ppdSecretariat</a></p> <p>PPD information disseminated</p>	BM, PCCs, Stakeholder and Regular browsers
Twitter	Whenever new information are available	<ul style="list-style-type: none"> <li>◆ News and related information are tweeted</li> <li>◆ Follower increased</li> </ul>	<p>A Twitter site created-  <a href="https://twitter.com/ppdsec/">https://twitter.com/ppdsec/</a></p> <p>Information disseminated</p>	BM, PCCs, Stakeholder and Regular browsers
Instagram	PPD is not availing this service at the moment. PPD is using Picasa web album instead.			
Blog	Minimum once a month	<ul style="list-style-type: none"> <li>◆ Write-ups uploaded</li> <li>◆ User feedbacks received</li> </ul>	<p>A blog page created-  <a href="http://ppdsec.wordpress.com">http://ppdsec.wordpress.com</a></p> <p>Idea, thoughts, future planning shared with regular readers.</p>	BM, PCCs, Stakeholder and General browsers

LinkedIn	Whenever new information are available	<ul style="list-style-type: none"> <li>◆ PPD updated information are uploaded</li> <li>◆ Professional network with PPD LinkedIn site increased</li> </ul>	<p>A LinkedIn Site created-  <a href="https://www.linkedin.com/company/partners-in-population-and-development-ppd-">https://www.linkedin.com/company/partners-in-population-and-development-ppd-</a></p> <p>Network of professionals in the field of RH, Population and Development.</p>	BM, PCCs, Stakeholder and Professional Networks
PPD Website	Whenever new information is available	<ul style="list-style-type: none"> <li>◆ Website is uploaded with latest news, articles, pictures, videos, reports, etc.</li> <li>◆ User visits increased</li> <li>◆ User interaction increased</li> <li>◆ PPD web page sharing increased</li> <li>◆ Pages are shared through the social media sites</li> </ul>	<p>PPD website is functional at the following address-  <a href="http://www.partners-popdev.org">http://www.partners-popdev.org</a></p> <p>PPD information disseminated</p> <p>PPD visibility increased</p> <p>PPD's strength portrayed</p>	BM, PCCs, Stakeholder and Regular browsers
Youtube	Whenever new videos are available	<ul style="list-style-type: none"> <li>◆ Videos related to PPD events and activities uploaded</li> <li>◆ Videos are shared through other social media sites</li> </ul>	<p>PPD Youtube channel created-  <a href="https://www.youtube.com/user/ppdsectube">https://www.youtube.com/user/ppdsectube</a></p> <p>Dissemination of PPD information through video</p>	BM, PCCs, Stakeholder and General browsers

Wikipedia	Whenever PPD information is changing	<ul style="list-style-type: none"> <li>◆ Wikipedia site is updated with latest PPD information</li> </ul>	<p>PPD Wikipedia site is available at the following address-</p> <p><a href="http://en.wikipedia.org/wiki/Partners_in_Population_and_Development">http://en.wikipedia.org/wiki/Partners_in_Population_and_Development</a></p> <p>PPD information is available through wikipedia</p>	General browsers
Newsletter	Minimum once in a month	<ul style="list-style-type: none"> <li>◆ At least one newsletter published in a month</li> <li>◆ Newsletter disseminated through the mailing list</li> </ul>	<p>Newsletters are available through PPD website</p> <p>Latest news and updates are shared with regular readers</p>	BM, PCCs, Stakeholder and Regular readers
Picasa Web Album	Whenever there is any event held	<ul style="list-style-type: none"> <li>◆ Pictures related to PPD events and activities are uploaded</li> <li>◆ Pictures are shared through PPD web</li> <li>◆ Pictures are shared through PPD social media sites</li> </ul>	<p>Picture albums are available through PPD website</p> <p>PPD activities are visible through pictures.</p>	BM, PCCs, Stakeholder and Regular browsers
Media Fire	When large file size need to be shared or downloads need to be tracked.	<ul style="list-style-type: none"> <li>◆ Large files are uploaded and links are shared to download</li> </ul>	<p>Large volume of files are transferred</p> <p>Downloading of documents are tracked</p>	Relevant person working with PPD
Google Calendar	Every day	<ul style="list-style-type: none"> <li>◆ Google Calendar is updated with PPD events</li> <li>◆ Calendar is synchronized regularly</li> </ul>	PPD Events are visible	PPD Staff and general browsers

Mail Chimps	Whenever newsletters and other information need to be shared in the mailing list	<ul style="list-style-type: none"> <li>◆ Newsletter, news, press release, announcement or other related information are shared.</li> <li>◆ Mailing list subscription increased</li> </ul>	PPD activities are visible through the mailing list	Mailing list subscribers
Annual Report	Once a year	<ul style="list-style-type: none"> <li>◆ One Annual report developed</li> <li>◆ Annual reported printed and disseminated</li> <li>◆ Annual reported uploaded on the PPD web and social media sites.</li> </ul>	PPD activities are accumulated and shared	BM, PCCs, Donors, Stakeholders
Publications	Whenever required	<ul style="list-style-type: none"> <li>◆ PPD Advocacy materials printed (depends on the availability of the budget)</li> </ul>	PPD activity documented and disseminated through publications	BM, PCCs, Donors, Stakeholders

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## References

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- <sup>i</sup> *The Millennium Development Goals Report, 2014, United Nations*
- <sup>ii</sup> *“Framework of Actions, ICPD Beyond 2014”, Report of the Secretary General, United Nations*
- <sup>iii</sup> *ibid*
- <sup>iv</sup> *ibid*
- <sup>v</sup> *ibid*
- <sup>vi</sup> *WHO position paper, Beyond 2014*
- <sup>vii</sup> *WHO, A-6*
- <sup>viii</sup> *ibid*
- <sup>ix</sup> *“Framework of Actions, ICPD Beyond 2014”, Report of the Secretary General, United Nations, p.28*
- <sup>x</sup> *AA1 p.38*
- <sup>xi</sup> *Consolidating the Gains, Closing the Gaps, PPD, August 2014*
- <sup>xii</sup> *ibid*
- <sup>xiii</sup> *<http://databank.worldbank.org>*
- <sup>xiv</sup> *ibid*
- <sup>xv</sup> *ibid*

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