What are the best practices to promote sexual and reproductive health and rights more effectively, in order to encourage more balanced and sustainable population growth in countries like Niger?

A study of Rutgers' approach

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Executive summary

Global demographic trends and projections display a significant amount of predictable social discords – poverty, famine, suppression of women, and gender based violence. These disharmonies are the outcomes of insufficient sexual and reproductive health and rights (SRHR) services – such as access to modern contraception – mainly in the poorest regions of the world. The inadequacy of SRHR services leads to issues including infant deaths, maternal deaths, infectious diseases, low life quality, short life expectancy, violation of reproductive rights, low growth prospects, high youth unemployment, social unrest, and et cetera. The enormous demand for SRHR education, advocacy, and services is predominant in Less Developed Countries, Sub-Saharan Africa and other African countries that have rapid population growth rates.

UNFPA predicts that the population in Africa will make up more than 40% of the global population by 2100 (UNFPA, 2015). Population issues do not simply consist of numbers or densities, but rather involve full considerations of the impact on qualities of human life, namely prosperity in places of poverty, education in place of illiteracy, and prospects for children (UNPIN, n.d.). Favorable population policies enlarge one's sexuality and reproduction choices, and are means to a better life (UNPIN, n.d.). Reducing natality, providing comprehensive SRHR services, increasing employment opportunities and sustainable economic growth, and improving political stabilities are the key to a more balanced and sustainable development. Thus, population policies are more necessary and relevant than ever, especially for developing regions with more socio-economic challenges. Successfully addressing issues in relation to rapid population growth should be embedded in integrated and interdependent SRHR services and care (Rutgers, 2016d).

The best practice to improve SRHR services is multilevel cooperation of governments, civil societies, NGOs, and donors, through adopting youth-friendly approaches by making SRHR services more approachable to the young; engaging men and boys in SRHR education and services; as well as empowering women in autonomy, defense of reproductive rights, and financial independence. Facilitating measures are needed to ensure the success of SRHR education and services, including progressive legislations that ensure the coherence of SRHR policies; sufficient education and advocacy of SRHR for the younger generation; and most importantly, adequate funding to support SRHR programs worldwide.

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List of Abbreviations

CSE – Comprehensive Sexuality Education
DOH – Department of Health
EIGE – European Institute for Gender Equality
EU – European Union
GBV – Gender Based Violence
GDP – Gross Domestic Product
GIGA – German Institute of Global and Area Studies
HIV/AIDS – Human Immunodeficiency Virus AND Acquired Immune Deficiency Syndrome
ICPD – International Conference on Population and Development
ILO – International Labor Organization
IMF – International Monetary Fund
IOM – International Organization on Migration
LDC – Least Developed Countries
NiDi – Netherlands Interdisciplinary Demographic Institute
NGO – Non Governmental Organization
PRB – Population Reference Bureau
SRHR – Sexual and Reproductive Health and Rights
STI – Sexually Transmitted Infections
UNAIDS – United Nations Programs on HIV and AIDS
UNDESA– United Nations Department of Economics and Social Affairs
UNDESAPD –United Nations Department of Economic and Social Affairs Population Division
UNECA – United Nations Economic Commission for Africa
UNESA – United Nations Economic and Social Affairs
UNESCO – United Nations Educational, Scientific and Cultural Organization
UNFPA – United Nations Fund for Population Activities
UNPD – United Nations Population Division
USCB – United States Census Bureau
SSA – Sub-Saharan Africa
WHO – World Health Organization

Introduction to this final project

Family Planning and population activities have been confronted with many controversies. In 1968, when American biologist Paul Ralph Ehrlich published the book *The Population Bomb*, many of his predictions on the consequences of lack of family planning and rapid population growth, such as severe famines, spread of diseases, and social unrest were ridiculed as being too pessimistic (Manahan, 2011). Nonetheless, current world demographic trends and projections display a significant amount of social discords created by the consequences of lack of reproductive services, mainly in the poorest regions of the globe. The main message of this report is that there is a huge demand for SRHR education, advocacy, and services in the world, predominantly in LDCs, SSA, and countries in Africa. More research is required to explore what approaches of education, advocacy and assistance to services are more effective to tackle the SRHR deficiency.

In the modern context of Ehrlich's prognosis, the primary issues challenged by lack of family planning services are maternal and infant mortality, suppression of women, infectious diseases, lack of reproductive health services, and poor defense of their rights, poverty, famines, low life quality and short life expectancy. In addition, there are secondary questions confronted by high population growth in underdeveloped regions, such as lack of economic opportunities, orphan societies with little growth prospects, high youth unemployment, gender inequality, sexual oppression and so on (Rutgers, 2016b).

To address these collective issues, there is a range of measures which can be applied to tackle the domino effect: reducing natality; increasing sexual reproductive health and rights (SRHR) for men and women, boys and girls; providing access to contraception in underdeveloped regions; offering sexual education to people at an early age; facilitating sexuality empowerment; constructing social and life insurances; making reproductive medical treatments more accessible; reducing teenage pregnancies and child marriages; improving maternal health; encouraging pregnancy spacing; and more.

This research serves the purpose of exploring, analyzing, and advising on the existing and possible approaches for the promotion of sexual and reproductive health and rights (SRHR) in weak states

with high natality and low social securities, such as Niger, with reference to Rutgers' experiences in SRHR projects. The ultimate goal is to find out which courses of actions are the most effective in increasing SRHR and encouraging sustainable population growth for countries like Niger. The central research question of this study is formulated as following:

What are the best practices to promote sexual and reproductive health and rights more effectively, in order to encourage more balanced and sustainable population growth in countries like Niger?

This question will be answered in the subsequent five chapters, which consist of:

1. Overall demographic projections of the world and Africa
2. Implications of rapid population growth
3. A comparative study of family planning & SRHR
4. Success and failure of family planning & SRHR
5. Policy recommendation for better outcomes

Methodology

This project seeks practical approaches to the central research question. Although academic sources must be included to build a logical research foundation, the main emphasis will be on field experiences of various SRHR projects and reports, as well as on selected experts' opinions on the effectiveness of Family Planning methods and SRHR services. Research methods chosen include primary and secondary qualitative research, in conjunction with desk research, interviews with experts, and analyzing case studies.

The sources chosen for this research are based on merits and credibility. The secondary data extracted from data collecting agencies are deemed reliable, as agencies such as UNFPA and USCB are governmentally sponsored agencies with the primary objectives of collecting, categorizing, processing, and analyzing first-hand data in relevant fields. The experts chosen for interviews for this research, namely Mrs. Y. Boggarts, the manager advocacy of Rutgers

Foundation, Mrs. M. van Reeuwijk, senior researcher of Rutgers Foundation, Prf. L. Van Wissen, director of NiDi, are professionals with decades of experiences in both research and practical experiences in relation to population studies, demographic projections, family planning projects and SRHR activities. Due to technical issues (the recording was inaudible) and discretion requests from one particular family planning project that involves financial tracking, only one of the interviews could be published in this research. The interviews were conducted in person, in Den Haag and in Utrecht, The Netherlands.

The purpose of Chapter one and two is to provide an overview of the current demography and the demographic projections of the regions concerned in this research. Chapter one and two are sketches of the current world demographic impression and the impact of current population growth patterns, which requires a large amount of reliable qualitative desk research on collecting data and projections through official reports and reviews by national governments and international organizations with objectives of collecting primary data and monitoring demographic trends, such as the United Nations Fund for Population Activities (UNFPA) – the lead UN agency with the mission to ensure SRHR to all, educating young people with accurate information on SRHR and empowering women by providing SRHR services, knowledge, and expertise (United Nations Fund for Population Activities, [UNFPA], n.d.); Rutgers Foundation, Population Reference Bureau (PRB), the United States Census Bureau (USCB), United Nations Population Division (UNPD), United Nations Departments of Economics and Social Affairs (UNDESA), The Population Council, and et cetera.

Chapter three goes in depth in family planning and SRHR experiences, with a comparative approach of practices and policies on three different levels: national, regional, and international. In this chapter of the research, the primary qualitative source will be interviews with experts on demographic studies in The Netherlands, from both Rutgers — the Dutch center of expertise on sexual and reproductive health and rights (Rutgers, 2016c), and the Netherlands Interdisciplinary Demographic Institute (NiDi) — the national demographic institute of the Netherlands and an institute of the Royal Netherlands Academy of Arts and Sciences, to understand the background of policies and developments in the field of family planning, the stories behind the total demand, unmet needs, and current use and reception of contraceptive methods in different countries in

Africa and South Asia (Bangladesh), in combination with secondary desk research, which includes analysis of official reports from the World Health Organization (WHO), the Guttmacher Institute, and the UNFPA; and the projection of demographic shift and demographic transition of countries that have similar conditions as Niger – one of the Least Developed Countries in the world with severely imbalanced and problematic population growth.

Chapter four discusses a case study of family planning and SRHR that was successful – BRAC's project on SRHR and women's empowerment in Bangladesh. BRAC is the largest non-governmental development organization in the world that is dedicated to empowering people living in poverty, measured by the number of employees and the number of people it has helped (BRAC, 2016). In this chapter, the primary sources of project feedback from Rutgers received through an interview will be analyzed, as well as desk research on relevant reports obtained from Rutgers. Chapter five provides policy and further research recommendations.

Chapter 1. Demographic projections of the world and Africa

To solve problems at any scale, it is important to have a clear picture of the reality. The following chapter provides a sketch of the current global demographic change and trend, with the focus on the demographic transition theory of the continent of Africa, Sub-Saharan Africa (SSA), and the least developed countries (LDC), which include Afghanistan, Bangladesh, Eritrea, Niger, Yemen, and etc. (Appendix 8) (UN Committee for Development Policy, 2016).

1.1 Current global demographic change outlook till 2100

In 10,000 BC, the world population was estimated to be around 10 million (United States Department of Commerce, 2016). It took thousands of years to grow to 1 billion, and then it grew sevenfold in another 200 years (UNFPA, 2015). Today, the global population reached the 7.3 billion mark (UNFPA, 2015), with an average annual increase of 1.18% worldwide and 2.38% in the least developed countries (LDC), and 2.71% in Sub-Saharan Africa (SSA) (United Nations Economic and Social Affairs, 2015). To put these data into perspective and to assess demographic trends and changes in the abovementioned three regions, the subsequent issues will be addressed: general fertility rate, infant mortality, and dependency ratios.

General fertility rate refers to 'the number of live births per 1,000 women age 15-49 in a given year' (Population Reference Bureau, 2016). The general fertility rate on a global scale is slightly decreasing. According to the UN, fertility rate worldwide decreased 0.06% from 2005 to 2015 (United Nations Economic and Social Affairs, 2015).

Location	2005 - 2010	2010 - 2015	2015 - 2020
World	2.56	2.51	2.47
More developed regions [a]	1.67	1.67	1.69
Less developed regions			
Least developed countries [c]	4.62	4.27	3.98
High-income countries [e]	1.76	1.75	1.76
Low-income countries [e]	5.31	4.89	4.52
Sub-Saharan Africa [f]	5.40	5.10	4.75
Africa	4.89	4.71	4.41
Asia	2.29	2.20	2.15
Europe	1.55	1.60	1.62
Latin America and the Caribbean	2.27	2.15	2.05
Northern America [27]	2.02	1.86	1.86
Oceania	2.51	2.42	2.35

Figure 1. General fertility rates projection (United Nations Economic and Social Affairs, 2015).

This figure extracted from the UNESA data base shows the total fertility-children per woman-of all regions in the world. The least developed countries (Appendix 8), Sub-Saharan Africa, and Africa have the highest fertility rate: on average two children more per woman than the overall world fertility rate. It means that four out of ten children worldwide are born in these three groups of less developed regions.

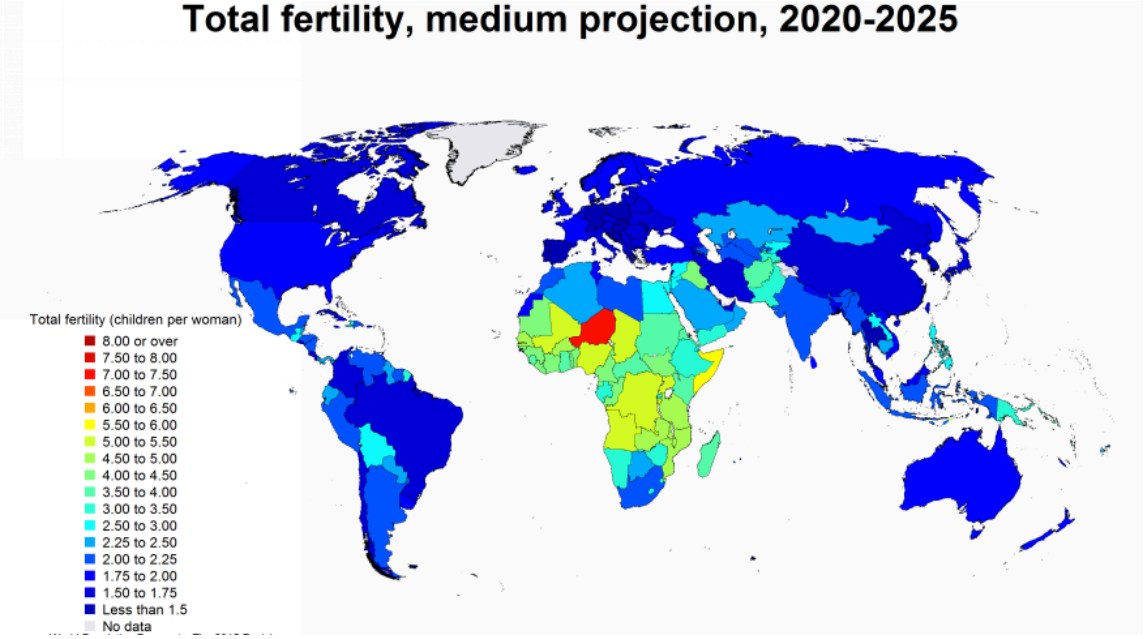

Figure 2. Total fertility projection 2020-2025 (World Population Prospects , 2015).

Infant mortality rate is defined as the number of deaths of infants under the age of 1 per 1,000 live births in a given year (Population Reference Bureau, 2016), and has decreased worldwide. From 2005 to 2010, infant deaths per 1,000 live births all over were 42 (United Nations Economic and Social Affairs, 2015). That number dropped roughly 14% to 32 deaths per 1,000 live births by 2015, and is still in decline (United Nations Economic and Social Affairs, 2015). The infant mortality rate for SSA and Africa is far above the world average — with 75 deaths per 1,000 live births in 2005 and 56 deaths in 2015 (United Nations Economic and Social Affairs, 2015).

Location	Sex	2005 - 2010	2010 - 2015	2015 - 2020
World	Both sexes combined	42	36	32
Less developed regions (b)	Both sexes combined	46	39	35
Least developed countries (c)	Both sexes combined	67	57	50
Sub-Saharan Africa (f)	Both sexes combined	75	64	56
Africa	Both sexes combined	69	59	52

Figure 3. Mortality rates projection 2005-2020 (United Nations Economic and Social Affairs, 2015).

Dependency ratio is the ratio of the economically dependent part of the population to the economically active part, which is arbitrarily defined as the ratio of the elderly (age of 65 and older) plus the young (age of 15 and younger) to the population of working age (age between 15-65) (Population Reference Bureau, 2016). It indicates the potential effects of changes in population age structures for social and economic development, and potential social support requirements of a society (United Nations Department of Economic and Social Affairs, [UN DESA], 2006). A high dependency ratio expresses that the economically active workforce bear greater pressure to produce economic output in order to support the economically non-active, or the dependent population (United Nations Department of Economic and Social Affairs, 2006).

Location	2005	2010	2015	2020
World	54.6	52.3	52.3	53.4
Less developed regions (b)	56.3	53.2	52.5	53.0
Least developed countries (c)	83.7	81.2	77.1	73.0
Sub-Saharan Africa (f)	88.9	87.8	85.6	82.3
Africa	82.6	81.2	80.1	77.9

Figure 4. Dependency ratio projection 2005-2020 (United Nations Economic and Social Affairs, 2015).

As shown in the figure above, SSA, LDC and Africa have the highest dependency ratios in the world: around 80% (see figure 4). It means that almost half of the population of these three regions are economically non-active (based on the dependency ratio formula mentioned above ((aged 0-15) + (aged 65+) / (aged between 15-65)).

Although these data might create the illusion that population issues are no longer threatening to global development both worldwide and in LDCs, SSA, and Africa, overpopulation is being 'solved' as general fertility rate is decreasing, infant mortality rate is decreasing which could mark the improvements of basic maternal care and SRHR services, but the implications of the demographic trends of LCDs, SSA, and other African countries can be disastrous.

1.2 Demographic transition theory

To understand why the demographic data mentioned in the previous section regarding LDCs, SSA, and Africa is concerning to global population issues, the process of demographic transition and the concept of demographic dividend need to be analyzed vis-à-vis the population dynamics in these regions.

Demographic transition theory is a descriptive interpretation of demographic transformations that took place in Europe in the 19th century. It seeks to characterize three different stages of demographic changes (Teitelbaum, 1975) and later on, the forth stage was added by the UNFPA.

Stage one of the transition model can be identified as an equilibrium of population size over the long term achieved by high birth rates and high death rates (Teitelbaum, 1975). The control of high birth rates was considered more manageable for preindustrial countries as opposed to high death rates. Since people desire a healthy and long life, methods of reducing infant deaths were introduced, which resulted in slow decrease of infant mortality rates (Teitelbaum, 1975) and constituted the unstable equilibrium of stage 1. The IMF defines this stage as the beginning of the transition from a largely rural agrarian society to urban industrial society (International Monetary Fund, 2006).

Stage two of the demographic transition is the outcome of the instability of stage 1. It is characterized by 'declining mortality with fertility rates remaining at previous high levels', also known as the 'population explosion', which is the growth of population resulting from a higher birth rate than the death rate (Teitelbaum, 1975).

Stage three starts with the reduction in fertility, which develops towards an equilibrium of low birth rates and low death rates (Teitelbaum, 1975). This equilibrium is theoretically at a much lower level compared to the pre-transition phase/stage one (Rutgers, 2016d). This is the stage in the transition model where a decade-long demographic dividend, also known as a 'window of opportunity', may occur. The UNFPA defines demographic dividend as the result of countries entering a period in which the working-age population has good health, quality education, decent employment and a lower proportion of young dependents because smaller households have the tendency to lead to larger investments per child, more freedom for women to enter into the workforce, and generate more income revenue for old age. In other words, a demographic dividend is created when the national economic payoff can be substantial through this process (UNFPA , 2016). This dividend assumes that there is an increase in employment and income generation.

Recently, the United Nations added the stage four of the transition model and defines it as the stage in which population declines as fertility rates drop below replacement level, with the possible outcome of an aging population (Rutgers, 2016d).

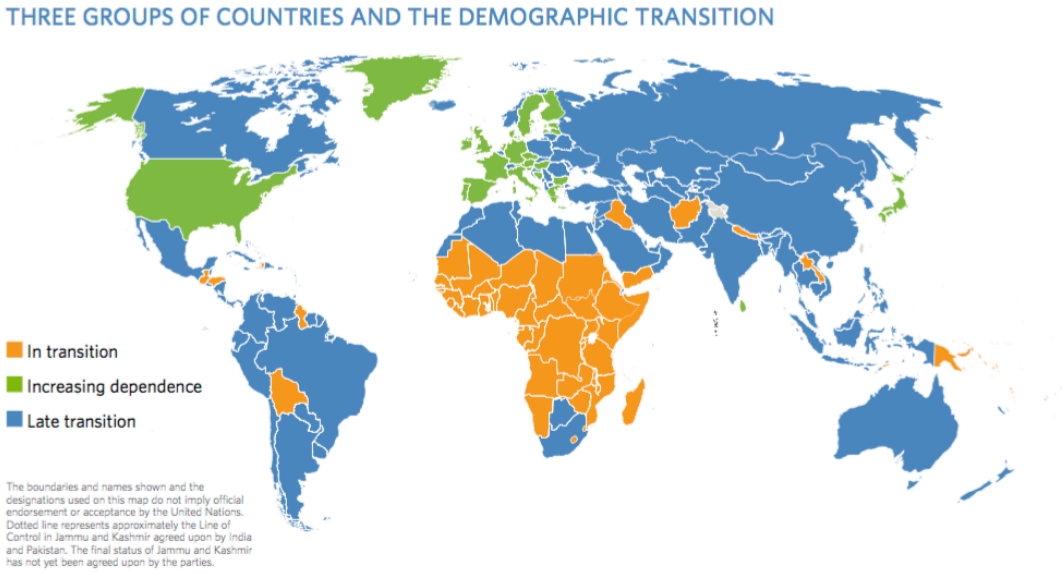

Figure 5. Demographic transition indicator (UNFPA, 2014).

1.3 The sketch of the African continent

More than half of population growth worldwide between now and 2050 is expected to occur in Africa, the continent that has the highest rate of population growth among other regions (United Nations Economic and Social Affairs, 2015). The rapid increase in population is anticipated for Africa regardless of whether the reduction in fertility rates will be substantial (United Nations Economic and Social Affairs, 2015) as it is on average much higher than the rest of the world.

TABLE 1. POPULATION OF THE WORLD AND MAJOR AREAS, 2015, 2030, 2050 AND 2100, ACCORDING TO THE MEDIUM-VARIANT PROJECTION

Major area	*Population (millions)*			
	2015	*2030*	*2050*	*2100*
World	7 349	8 501	9 725	11 213
Africa	1 186	1 679	2 478	4 387
Asia	4 393	4 923	5 267	4 889
Europe	738	734	707	646
Latin America and the Caribbean	634	721	784	721
Northern America	358	396	433	500
Oceania	39	47	57	71

Source: United Nations, Department of Economic and Social Affairs, Population Division (2015). *World Population Prospects: The 2015 Revision*. New York: United Nations.

Figure 6. Total population projection by region (United Nations Department of Economic and Social Affairs Population Division, 2015).

Africa's share of global population is predicted to be 25% in 2050 and 39% by 2100, which will result in a presence of a large number of young people who will reach adulthood in the coming years and start having children of their own, ensuring that Africa will be a main dictating factor in shaping the distribution of global populations (United Nations Economic and Social Affairs, 2015).

The United Nations projects that half of the world's population growth between 2015-2050 is expected to be concentrated in nine countries, in which five countries out of nine are African countries:
-India;
-Nigeria;
-Pakistan;
-Democratic Republic of Congo;
-Ethiopia;
-United Republic of Tanzania;
-United States of America;
-Indonesia;
-Uganda (United Nations Economic and Social Affairs, 2015).

Among these countries, Nigeria's population, currently the seventh largest in the world, is growing the fastest and is projected to surpass the population of the United States of America by 2050 (United Nations Economic and Social Affairs, 2015).

Countries' population profiles: Nigeria and Niger

***Nigeria**:*

The total population of Nigeria as of 2015 is 182,202,000, in which 44% are under the age of 15 and 2.7% are above the age of 65 (United Nations Economic and Social Affairs, 2015). *It means the dependent or economically non-active population of Nigeria makes up 46.7% of the total population. Roughly 55% of the total population are between the age of 15 to 65. Thus, the dependency ratio of Nigeria is 84.9%, higher than the overall dependency ratio of Africa* (United

Nations Economic and Social Affairs, 2015). *The totally fertility (children per woman) is 5.74, and mortality per 1,000 live births is 122* (United Nations Economic and Social Affairs, 2015).

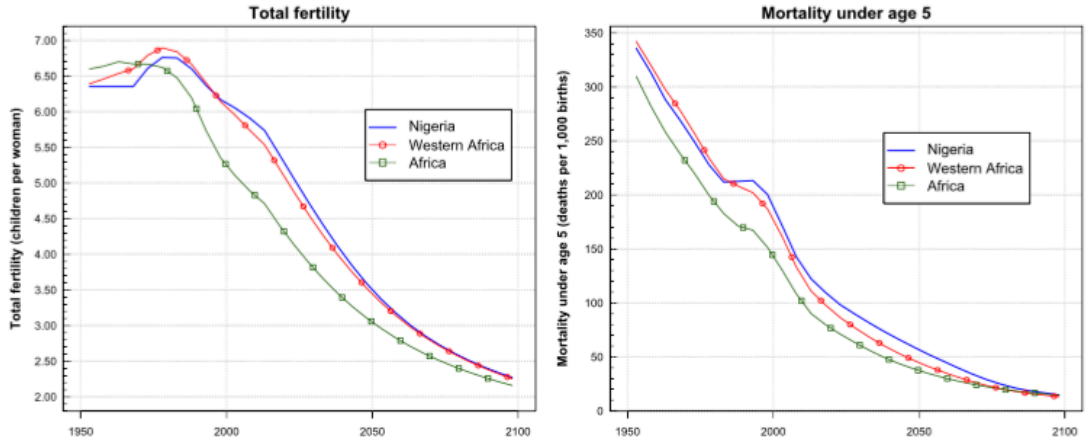

Figure 7. Total fertility and mortality of Nigeria (United Nations Economic and Social Affairs, 2015).

Overall population growth trends of Nigeria till 2100:

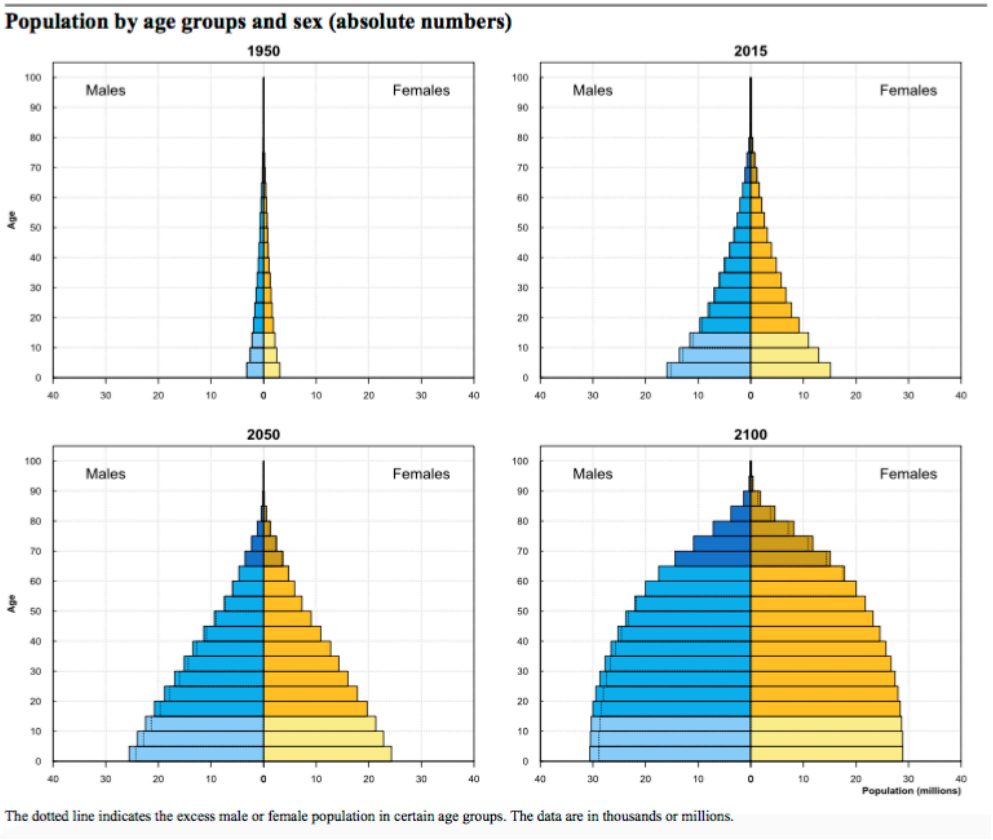

Figure 8. Population projection of Nigeria till 2100 (United Nations Economic and Social Affairs, 2015).

Niger:

Almost 10 times smaller than Nigeria, Niger has a total population of 19,899,000 as of 2015, which 50.5% are under the age of 15 (United Nations Economic and Social Affairs, 2015). *Together with 2.6% of the population being above the age of 65 and 47% of which are between age 15 to 64, the dependency ratio of Niger arrives at 112.97%, which is one of the highest in the world. The social economic burden of people age between 15 to 64 is extremely high. Moreover, out of the 47% economically active persons, 17.9% are under the age of 24* (United Nations Economic and Social Affairs, 2015). *The total fertility rate of Niger (children per woman), is 7.63, also one of the highest in Africa and in the world* (United Nations Economic and Social Affairs, 2015). *Mortality per 1,000 live births is 104* (United Nations Economic and Social Affairs, 2015).

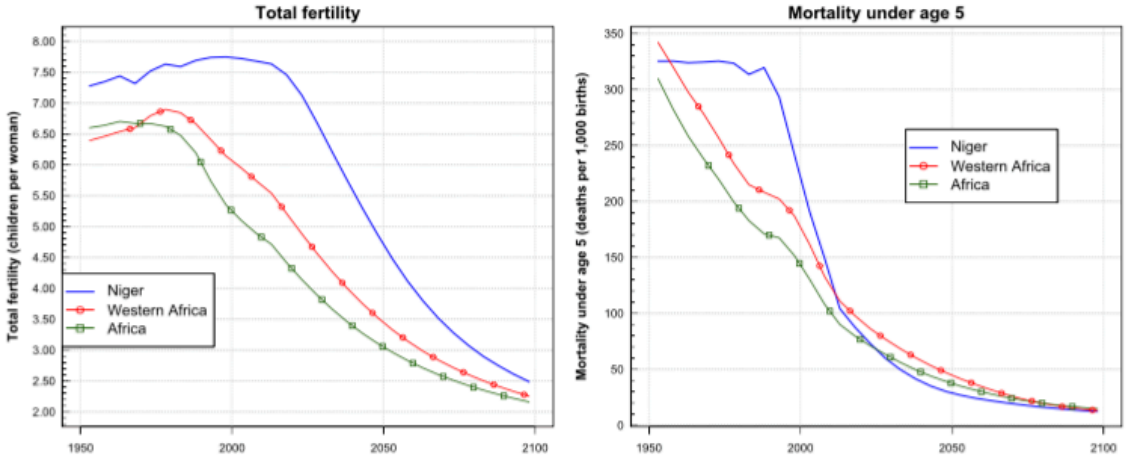

Figure 9. Total fertility and mortality of Niger (United Nations Economic and Social Affairs, 2015).

Overall population growth trends of Niger till 2100:

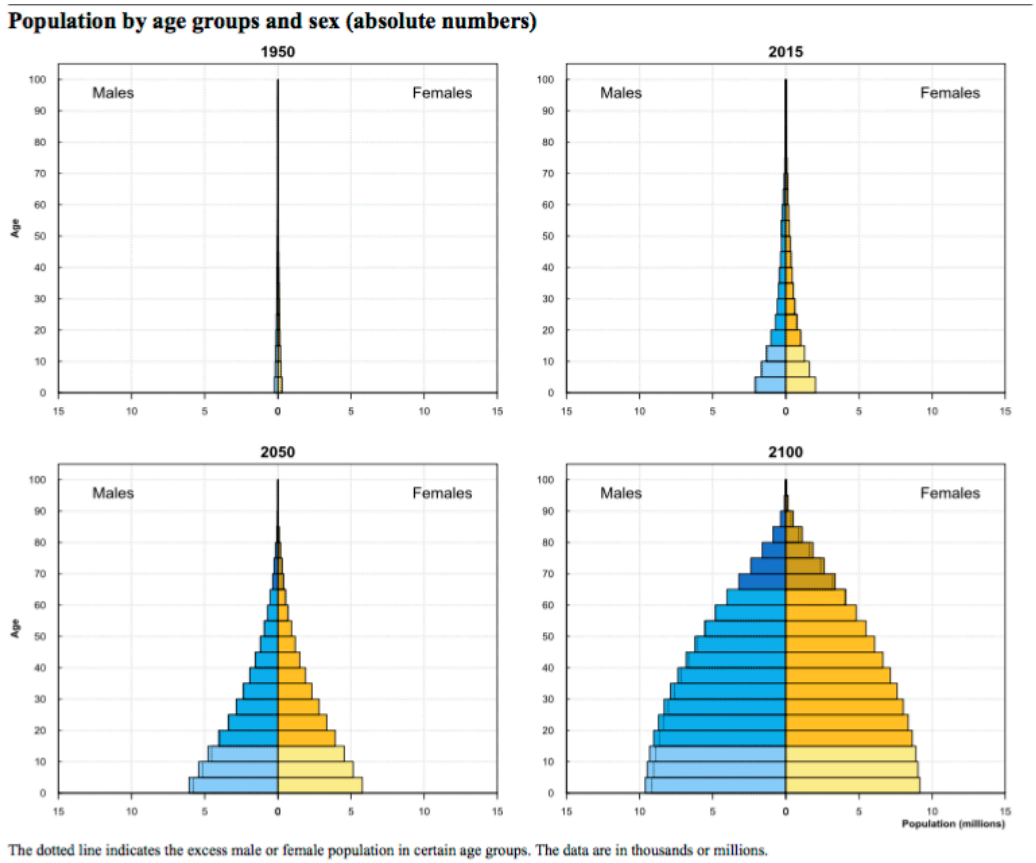

Figure 10. Population projection of Niger till 2100 (United Nations Economic and Social Affairs, 2015).

Chapter 2. Implications of rapid population growth in Africa

2.1 Population dynamics in Africa

Population growth

Population growth is determined by the following equation:

Figure 11. Equation of population growth (Population Reference Bureau, n.d.).

The United Nations Population Fund projected continuous population growth for the African continent till 2100, with a total number of 4,387,000,000 and makes up almost 40% of the world population (United Nations Economic and Social Affairs, 2015). Since 1950, the populations of Niger and Uganda have increased six-fold (UNFPA, 2011). With constant levels of fertility and mortality, by 2100, Niger's population would increase 57 times and Uganda's population 34 times (UNFPA, 2011).

Niger:

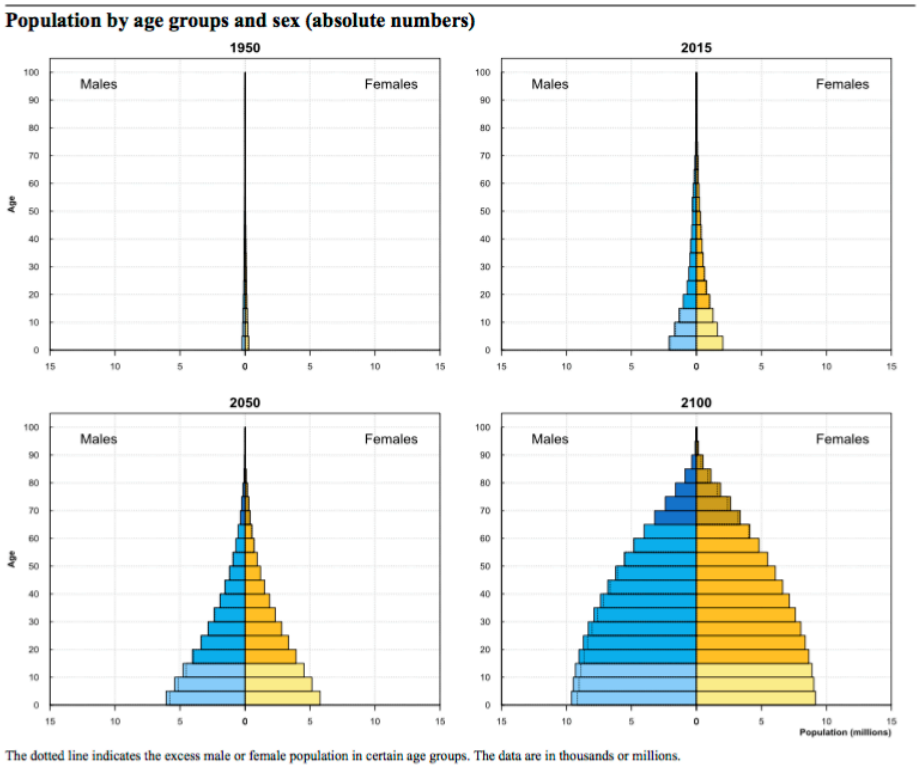

Figure 12. Population projection of Niger till 2100 (United Nations Economic and Social Affairs, 2015).

Uganda:

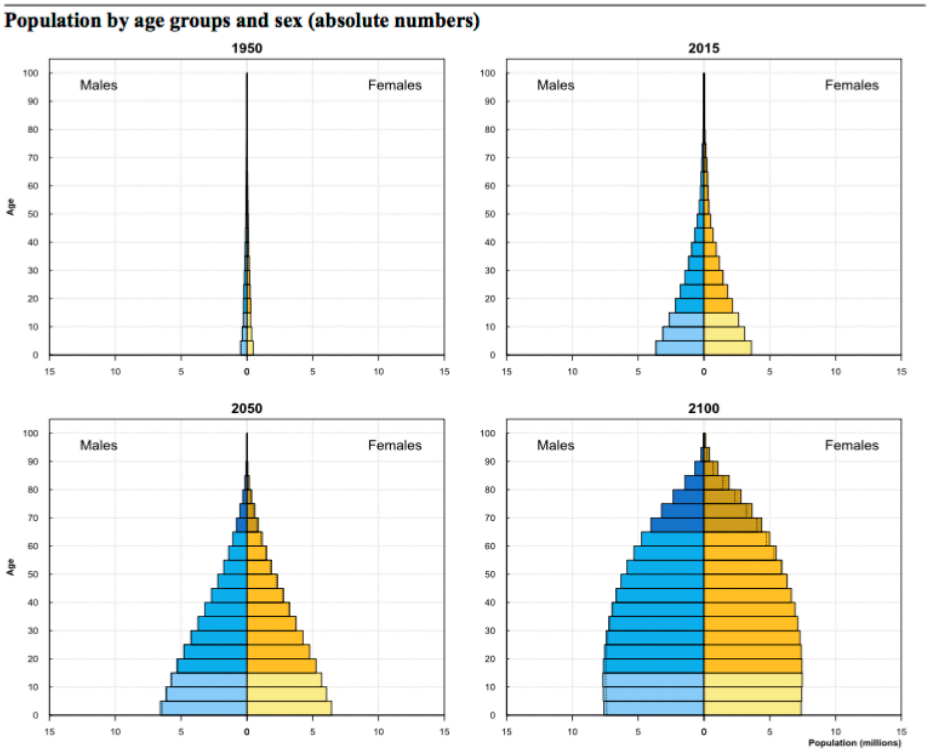

Figure 13. Population projection of Uganda till 2100 (United Nations Economic and Social Affairs, 2015).

The overall projection of population growth in Africa:

Africa

	1950	1970	1990	2000	2005	2010	2015	2020	2030	2050	2075	2100
Total Population												
Total population (thousands)	228 902	365 626	631 614	814 063	920 239	1 044 107	1 186 178	1 340 103	1 679 301	2 477 536	3 524 628	4 386 591
Population density (persons per square km)	8	12	21	27	31	35	40	45	57	84	119	148
Median age (years)	19.3	17.9	17.6	18.3	18.8	19.1	19.4	19.8	21.2	24.8	29.8	34.9
Dependency ratios (per 100)												
Total dependency ratio (a)	80.4	89.8	91.6	85.3	82.6	81.2	80.1	77.9	70.8	61.5	55.6	56.5
Child dependency ratio (b)	74.6	83.9	85.4	79.1	76.4	74.9	73.8	71.5	63.7	52.0	40.9	34.1
Old-age dependency ratio (c)	5.8	5.9	6.1	6.2	6.2	6.3	6.3	6.5	7.0	9.5	14.7	22.4

Figure 14. Overall population projection in Africa till 2100 (United Nations Economic and Social Affairs, 2015).

Increasingly young population

In LDCs and Sub-Saharan Africa, countries have a proportionally large youth cohort compare to the rest of the world—in 15 countries of SSA, half the population is under the age of 18 (UNFPA, 2014).

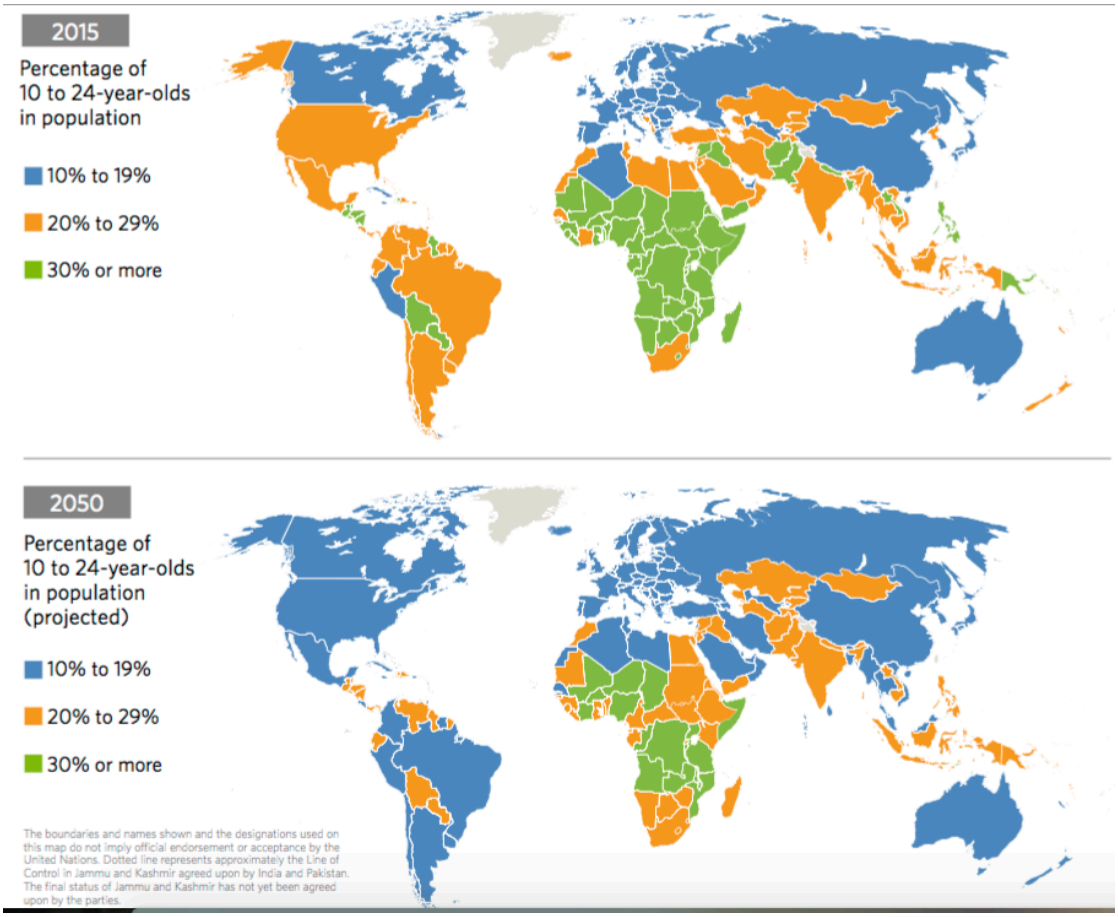

Figure 15. Percentage of 10 – 24-year-olds in the world (UNFPA, 2014).

World Bank data shows that children have higher poverty rates than adults in the poorest countries of SSA and LDCs, with more than half of all children living in conditions of extreme poverty (UNFPA, 2014). Social infrastructural support to young people stays poor in SSA and LDCs, which fails to provide quality education, decent economic opportunities, human rights protection, access to sexual and reproductive health information and services (UNFPA, 2014). In 2011, UNESCO reported that out of the 69 million eligible adolescents in the world that did not attend secondary school, 22 million lived in Sub-Saharan Africa (UNFPA, 2014). A good education gives young people, especially girls, the skills and knowledge that will enable them to mitigate

reproductive health risks and exercise their rights, and 35.89% of adolescent girls from SSA did not complete secondary schools (UNFPA, 2014).

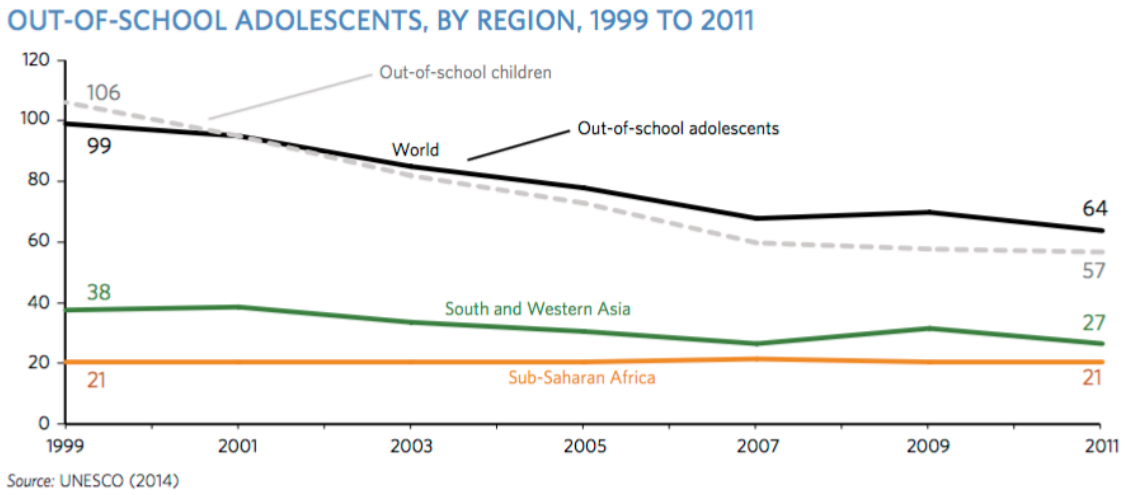

Figure 16. Percentage of adolescents out of school in the world and SSA, SWA (UNFPA, 2014).

Life expectancy

Life expectancy at birth reflects the overall mortality level of a population (World Health Organization , 2016). Global life expectancy at birth in 2015 was 71.4 years (World Health Organization , 2016), while African region's life expectancy average is at 60 years (World Health Organization , 2016).

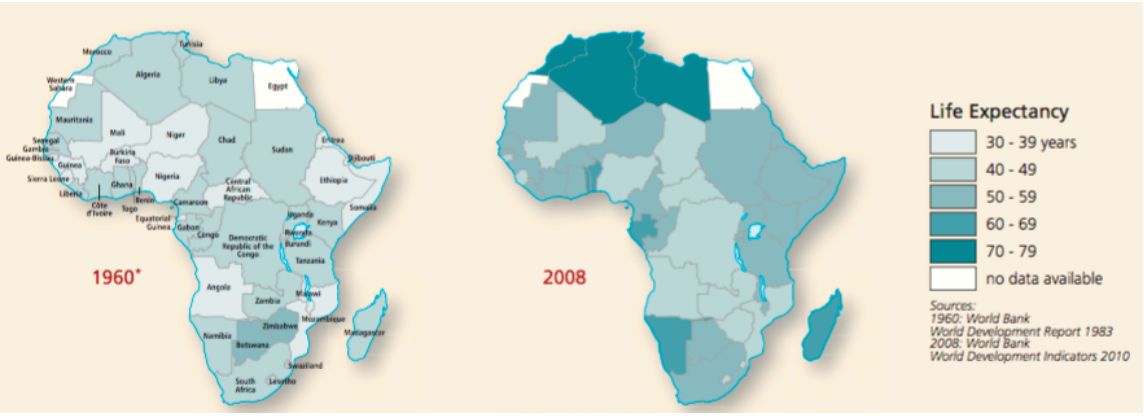

Figure 17. Life expectancy in Africa (Akinyoade, 2009).

Family planning & SRHR

Countries in SSA still have challenges related to gender equality, female empowerment, and reproductive rights to overcome (UNFPA, 2014). The UNFPA reported in the study from the National Violence Against Children Survey that, 38% of women aged between 18 to 24 in Swaziland, 27% in Tanzania, and 32% in Zimbabwe had experienced sexual violence before the age of 18 (UNFPA, 2014); 3 million girls are at risk for female genital mutilation each year in Africa (UNFPA, 2014); and at least 50% of sexually active women between the ages of 15 to 24 in East and Southern Africa and West and Central Africa would use contraceptives if they had access to them, regardless of marital status (UNFPA, 2014). Due to the percentage of young people who did not complete secondary education and sexual reproductive education is high, comprehensive knowledge about HIV or AIDS remains low amongst them (UNFPA, 2014). The United Nations estimated that only 28% girls and 39% boys between the ages of 15 to 24 living in Sub-Saharan Africa have knowledge about HIV and other STIs (UNFPA, 2014). Consequently, contraceptives use for prevention of STIs and pregnancies are low.

2.2 Issues related to fast population growth

The problem of rapid population growth is not simply a problem of numbers, but rather the problem of human welfare and development (United Nations Population Information Network, n.d.). Unsustainable population growth can have serious consequences for the well-being of humanity worldwide (United Nations Population Information Network, n.d.). The costs of rapid population growth are cumulative: more births today make the task of slowing down population growth in the future difficult, as today's children become tomorrow's parents (United Nations Population Information Network, n.d.). Development entails the improvement and quality in life, which can be measured by income, health, education and general well-being of the population and, to the second level, it includes self-esteem, dignity to life, and freedom of choice (United Nations Population Information Network, n.d.). Subsequently, the following issues need to be addressed in order to assess how rapid population growth influences development:

1. Improvement in standards of living: will African countries be capable of improving the standards of living for their people with the current and anticipated levels of population growth (United Nations Population Information Network, n.d.)?
2. Advancement in social infrastructure: to what extent does rapid population growth make it more challenging to provide social services, such as housing, sanitation, medical care, social insurance, transport, security, and etc. (United Nations Population Information Network, n.d.)?
3. Problem of unemployment: how will African countries cope with the vast increase in demand of job opportunities for the increasing youth population (United Nations Population Information Network, n.d.)?
4. De-alleviation of poverty: what are the implications of higher population growth rates among the world's poor for their chances of overcoming the misery of absolute poverty (United Nations Population Information Network, n.d.)?
5. Healthcare and education: will African countries be able to provide adequate education and healthcare for all, with the anticipated population growth rate (United Nations Population Information Network, n.d.)?
6. Freedom of choice: is there a relationship between poverty and family size (United Nations Population Information Network, n.d.)? And to which extent will low living standards influence parents' choice of a desired family size (United Nations Population Information Network, n.d.)?

2.2.1 Healthcare

Adequate health and welfare services might be affected by fast population growth (United Nations Population Information Network, n.d.). In individual families, death and illness might be increased by high fertility, absence of SRHR services which lead to easy and frequent pregnancies, and the necessity of caring for excessive numbers of children with scarce resources (United Nations Population Information Network, n.d.). Furthermore, the physical and mental developments of children in large families are often neglected because of malnutrition, lack of prevention of infectious diseases, and insufficient adult contact (United Nations Population Information Network, n.d.).

2.2.2 Poverty

The links between rapid population growth and the absolute poverty are proved to be factual by Nancy Birdsall, the president of the Center for Global Development in Washington, DC, who defines absolute poverty as having less than the income necessary to ensure a daily diet of 2150 calories per person (Birdsall, 1980). Poverty is influenced by — and influences — population dynamics, including population growth, age structure, and rural-urban distribution (UNFPA, 2014). All of this has a critical impact on a country's development possibilities and prospects for raising living standards for the poor (UNFPA, 2014).

Population growth stretches both national and family budgets thin with the increasing number of children to be fed and educated and workers to be provided with jobs (Birdsall, 1980). Many characteristics of poverty can cause high fertility, high infant mortality, lack of education for in particular for women, too little family income to invest in children, inequitable shares in national income, and the inaccessibility of family planning (Birdsall, 1980).

2.2.3 High youth unemployment

Rapid population growth means that there will be an increase in the dependency ratio (United Nations Population Information Network, n.d.). This means the economic output will decrease, as economically non-active persons will make up a large proportion of the population mix (United Nations Department of Economic and Social Affairs, 2006). Consequently, the labor market will shrink as the economic growth is insufficient, which will result in an even higher rate of youth unemployment and serious implications for the provision of productive employment (United Nations Population Information Network, n.d.).

According to the International labor Organization, labor market in Northern Africa and Sub-Saharan Africa remain pervasive, particularly among women and youth (International Labor Organization, 2016), with the highest unemployment rate in the world — at 12.1% in 2015 (International Labor Organization, 2016). Additionally, rapid population growth is

normally accompanied by a proportionate increase in the supply of the labor force (United Nations Population Information Network, n.d.). In Africa, the rate of labor force supply has outstripped that of job creation, implying that the rates of unemployment have been increasing rapidly (United Nations Population Information Network, n.d.). In other words, the number of people seeking employment will grow more rapidly than the number of available jobs, which poses a menacing problem for society (United Nations Population Information Network, n.d.).

2.2.4 Unstable Societies

Unsustainable population growth can also lead to political and social conflicts among different ethnic, religions, linguistic and social groups (United Nations Population Information Network, n.d.). As population grows rapidly, there will be increasing demands for governmental and social services in health, education, welfare, and other functions, which could contribute to or even be the cause for violent aggression (United Nations Population Information Network, n.d.). The large proportions of young people, particularly those unemployed or have little prospects for a satisfactory future, might form or join disruptive and potentially explosive political forces (United Nations Population Information Network, n.d.).

To sum up, population issues are not simply consist of numbers or densities, but rather involve full considerations of the qualities of human life: prosperity in places of poverty; education in place of illiteracy; opportunities for the next generations of children (United Nations Population Information Network, n.d.). Favorable population policies should open up one's options and enlarge one's choices, thus, population policies are means to a better life (United Nations Population Information Network, n.d.).

2.3 Urbanization, Migration and Social Unrest

Population growth has an inevitable effect on mobility, which include urbanization and migration (Rutgers, 2016d). Despite low fertility rates in urban areas, strong urbanization is largely caused by migration of rural populations to urban areas: in 1950, 30% of the world's population was living

in urban areas, currently 54% reside there and by 2050, the number will raise to 66%, with Africa and Asia showing the strongest urbanization rates (Rutgers, 2016d).

The benefits of urbanization, in a historical setting, were seen as major drivers for reduction of poverty and social transformation, as it expanded access to public services such as education, housing, electricity, water and sanitation (Rutgers, 2016d). In the context of modern day Africa, urbanization might become a threat to sustainable development, as investments in infrastructure and services do not meet the urbanization rate and policies to ensure equitable sharing of social benefits (Rutgers, 2016d).

Migration of Africa is a reflection of its socio-economic dynamics over time (Kohnert, 2007). Based on the 'push-pull' theory, apart from push factors like violent conflicts, human rights violations, population pressure, degradation of natural resources, and poverty, the major part of current migration is due to pull factors, such as threats of unemployment and lack of perspectives in their home country, especially for young people (Kohnert, 2007).

The Push-pull theory points at poverty as the main cause of mass migration from Africa. Yet, evidence shows that migrants are usually among the relatively well-off, including many students who migrate for educational purposes (Rutgers, 2016d). Even though the largest share of African migrants migrate within the African continent (Rutgers, 2016d), Europe, especially Western Europe, remains the most popular migration destination (Kohnert, 2007). According to the estimation of 2005 by the International Organization on Migration (IOM), There are about 4.6 million recorded Africans living in the EU, compared to 890,000 in the USA (Kohnert, 2007).

2.3.1 Migration pressure for Southern Europe

According to the estimation of the Migration Policy Institute, there are 7-8 million irregular African immigrants living in the EU, mostly in its Southern parts (Kohnert, 2007). West Africans constitute by far the largest share of Sub-Saharan African migrants in Europe (Kohnert, 2007). Because of more rigid migration controls of EU member states, the sealing off of its Southern borders and of the costal line between Morocco and Mauritania against the increasing influx of irregular migrants, migration routes shifted increasingly to

sea-bond alternatives (Kohnert, 2007), creating migration pressure for southern European countries bordering the Mediterranean Sea (Choe, 2007).

In 2006, the Spanish Canary Islands registered over 31,000 African refugees, with an additional 5,000 who were intercepted by the islands' coastguards, as estimated by Spanish border authorities in Tenerife (Kohnert, 2007). In December 2015, the IOM confirmed that over 1 million irregular migrants and refugees arrived in Southern European from Syria, Africa and South Asia, namely in Greece, Bulgaria, Spain, Italy, Malta and Cyprus (International Organziation on Migration , 2015).

Although poverty might not be linked directly to migration, it is however, directly related to social unrest (Rutgers, 2016d). As discussed previously, youth employment is a crucial driver for the economy. If young people do not have the opportunities to participate in economic activities, together with lack of perspectives, this can lead to frustration among young men specifically (Rutgers, 2016d).

Large numbers of unemployed, frustrated young people can fuel up the socio-economic tension, which can lead to higher crime rates, violence, drug and alcohol abuse, political instability and participation in conflicts (Rutgers, 2016d). These consequences of poverty creates social unrest, which is detrimental to sustainable development in many African countries (Rutgers, 2016d).

2.4 Conclusion

To tackle the abovementioned issues caused by rapid population growth, reducing natality, providing sufficient SRHR services and healthcare, increasing employment opportunities, ensuring sustainable economic growth and development, and improving political stabilities are the key to a more balanced and sustainable development for Sub-Saharan Africa and other African countries facing difficulties in relation to population issues.

Chapter 3. A comparative study of Family Planning and SRHR

At the macroeconomic level, reduced fertility has helped creating preferable conditions for socioeconomic development in some countries (DaVanzo, 1998). An example to prove this connection has been the 'Asian Economic Miracle' (DaVanzo, 1998). From 1960 to 1990, the five fastest-growing economies in the world were South Korea, Singapore, Hong Kong, Taiwan, and Japan (DaVanzo, 1998). During this 30-year span, women in these East Asian countries reduced their fertility rates from an average of six children or more to two or fewer in a single generation per woman (DaVanzo, 1998). These reductions in fertility in the past decades relieved not only dependency burdens but also dependence on foreign capitals by contributing to higher financial saving rates. A lower ratio of children to adults can create a 'demographic bonus/dividend': with fewer children, families have more disposable income to save or invest (DaVanzo, 1998). Furthermore, a smaller proportion of children means that a greater percentage of the population is in the working age group, which reduces the dependency ratio of the population (DaVanzo, 1998). If the economic market can provide an adequate amount of job opportunities for the population within working ages, the economy will grow (DaVanzo, 1998).

3.1 Modern methods of contraception and family planning

Family planning and SRHR measures in this section primarily focuses on modern methods of contraceptives. Princeton University Office of Population Research suggests that modern contraceptive methods were invented, so couples could act on natural impulses and desires with diminished risks of pregnancy (Hubacher, D., Trussell, J., 2015). These methods are technologically advance designed to overcome biology, in which they must enable couples to have sexual intercourse at any mutually-desired time (Hubacher, D., Trussell, J., 2015). The term modern contraceptive is rarely defined, however, organizations and individuals who use the term simply name contraceptives and approaches that fit into their perception of that label (Hubacher, D., Trussell, J., 2015). The definition of contraception chosen for this report is: a product or medical procedure that interferes with reproduction from acts of sexual intercourse (Hubacher, D., Trussell, J., 2015). These modern products and procedures namely include:

1. Barrier methods:
    a. Contraceptive sponge;

   b. Diaphragm, cervical cap, and cervical shield;
   c. Female condom;
   d. Male condom;
2. Hormonal methods:
   a. Oral contraceptives – combined pill ('the pill');
   b. Oral contraceptives – progestin-only pill ('mini-pill');
   c. The patch;
   d. Shot/injection;
   e. Vaginal ring;
3. Implantable devices:
   a. Implantable rods;
   b. Intrauterine devices;
4. Permanent birth control methods:
   a. Sterilization implant;
   b. Surgical sterilization;
5. Emergency contraception (United States Department of Health and Human Services Office of Women's Health, n.d.).

3.2 Measures to reduce natality: Family Planning & SRHR unmet need

Reducing natality through family planning and sexual and reproductive services is the key to preventing many population-related issues. It provides multilateral and multilevel benefits to mothers, children, fathers, and families (The Philippines Department of Health , n.d), by allowing people to 'attain their desired number of children and determine the spacing of pregnancies' (World Health Organization, 2016). Promotion of family planning is crucial to ensuring the well-being and autonomy of women, as well as backing the health and development of families and communities (World Health Organization, 2016). There are seven universally recognized benefits of family planning and use of modern contraception:

1. It prevents pregnancy-related health risks for women (World Health Organization, 2016). Contraceptives are proven to be effective in preventing unintended pregnancies, reduce the number of abortions, and lower the incidence of deaths of childbirth and disability related complications (UNFPA, 2016). Envisaging that all women with an unmet need for

contraceptives were able to use present-day methods, then prediction of its effect is that 24 million abortions (14 million of which would be unsafe), six million miscarriages, 70,000 maternal deaths and half a million infant deaths would be prevented (UNFPA, 2016).

2. It reduces infant mortality (World Health Organization, 2016). Most deaths among newborn are caused by maternal health related factors, such as close spacing, ill-times pregnancies and births, that subsidizes some of the world's highest infant mortality rates, as well as maternal death rates (World Health Organization, 2016). Family planning can prevent these maternal health threats that lead to high mortality, for the infants and the mothers.
3. It helps to prevent HIV/AIDS and other sexually transmitted infections (World Health Organization, 2016). When male and female condoms are used correctly and consistently, the risk of getting sexually transmitted infections (STI), including HIV, can be adequately reduced (UNFPA, 2016). Furthermore, family planning also lowers the risk of unintended pregnancies among women living with HIV, resulting in fewer infected babies and orphans (World Health Organization, 2016).
4. It empowers people and enhances education (World Health Organization, 2016). Access to contraception and contraceptive information is an important step in achieving gender equality (UNFPA, 2016). When women and couples are able to plan whether and when to have children and how many children they would have, it enables women to achieve their potentials better—such as completing education; generating income for the household and gaining financial autonomy (UNFPA, 2016). This does not only strengthen women's economic security and well-being but also that of their children and families and, cumulatively, these benefits contribute to reducing poverty and social economic development (UNFPA, 2016).
5. It helps to reduce adolescent pregnancies (World Health Organization, 2016). With premarital sex increasing, the risks of unintended pregnancies increase as well (Rutgers, 2016d). For SSA, the number of adolescent pregnancies between age 15-19 is 35% and, almost 39% (74 million annually) of all pregnancies in developing countries are unintended (Rutgers, 2016d). Pregnant adolescents are more likely to have pre-mature or low birth-weight babies, which result in higher rates of neonatal mortality (World Health Organization, 2016). A considerable amount of adolescent mothers is unable to complete

secondary education, which contributes to many long-term disadvantages to themselves, their children, the economy, and the society (World Health Organization, 2016). From an economic point of view, the lifetime opportunity cost related to adolescent pregnancies ranges from 1% of annual GDP in a large country—such as China—to 30% of annual GDP in a small economy—such as Uganda (UNFPA, 2016).

6. It slows unsustainable population growth (World Health Organization, 2016). Unsustainable population growth can lead to negative impacts on economy, environment, and national, regional and international development efforts (World Health Organization, 2016). Implementation of family planning is fundamental to slowing unsustainable population expansion (World Health Organization, 2016).
7. It brings economic benefits (UNFPA, 2016). The UNFPA calculated that for every dollar invested in contraception, there will be a $1.47 reduction in the cost of pregnancy-related care (UNFPA, 2016). If adolescent girls in Brazil and India were able to wait to have children until they are in their early twenties of age, the estimated increased economic productivity would equal more than $3.5 billion and $7.7 billion, respectively (UNFPA, 2016). For the three regions at hand, SSA, LDCs, and Africa, meeting unmet needs for contraception and family planning would initiate great health and welfare gains through demographic dividend—which can be realized through the demographic transition, facilitated by family planning (UNFPA, 2016).

A deficit in family planning and SRHR services is present to many developing countries, in particular the three regions this research focuses on: LDCs, SSA, and Africa. A study from Guttmacher Institute suggests that currently, among the 125 million women in developing countries who give birth every year:

1. 54 million do not receive adequate antenatal care;
2. 43 million do not deliver in a health facility;
3. 21 million women and 33 million newborns do not receive care for medical complications;
4. 550,000 pregnant women living with HIV do not receive treatment to prevent mother-to-child transmission of HIV (Guttmacher Institute , 2014).

The World Health Organization claimed an estimation of 225 million women in developing countries, who would like to delay or stop childbearing but are not using any method of contraception (World Health Organization, 2016). These women have unmet need for family planning. The notion of unmet need in the family planning context can be defined as 'women who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child (World Health Organization, 2015). Essentially, the concept of unmet need represents the gap between women's reproductive intentions and their contraceptive behavior (World Health Organization, 2015).

Reasons for unmet need of contraception in general can be concluded as follow:

1. lack of access to information & services, particularly among young people, poorer segments of populations, or unmarried people;
2. limited choice of methods;
3. lack of support from their partners and communities;
4. fear or experience of side-effects;
5. cultural or religious opposition;
6. poor quality of available services;
7. users and providers bias;
8. gender-based barriers (World Health Organization, 2016).

A wide range of measures is available in closing the gap that unmet need represents. The following discussions include three measures that could have long-term positive effects on meeting the unmet need of family planning and SRHR services: male education on family planning, social insurances, and sustainable SRHR services.

3.2.1 Male involvement in Family Planning

Male engagement in SRHR and gender equality benefits both men and women (Rutgers, 2016d). Historically, most family planning programs focused on the fertility behavior of women (Rutgers, 2016d). Placing this burden on women and given inadequate attention to men's SRHR needs has resulted in women bearing most of the responsibilities of their own and their children's, and did nothing to challenge the mentality that men are not responsible for their own, or their partners' SRHR (Rutgers, 2016d).

SRHR is not a women's issue. Engaging and educating men regarding their own sexual and reproductive health is imperative in preventing STIs (including HIV), unwanted pregnancies, gender based violence (Rutgers, 2016d). In addition, it is also important that men are seen as individuals with male-specific sexual and reproductive health needs (Rutgers, 2016d).

3.2.2 Social insurance measures

Social insurances add up to the general stability of a nation. Two of the most important social insurances are economy development and education, which contribute endlessly to SRHR and family planning.

3.2.2.1 Increase economic opportunities

To complete the demographic transition and realize the goals of Family Planning and SRHR services, investments and policies are needed in developing national economies (Rutgers, 2016d). Lack of economic development and opportunities in LDCs and SSA aggravate the deficit of SRHR services and Family Planning efforts. LDCs and SSA have high dependency ratios,

Location	2005	2010	2015	2020
World	54.6	52.3	52.3	53.4
Less developed regions (b)	56.3	53.2	52.5	53.0
Least developed countries (c)	83.7	81.2	77.1	73.0
Sub-Saharan Africa (f)	88.9	87.8	85.6	82.3
Africa	82.6	81.2	80.1	77.9

Figure 18. Dependency ratio (United Nations Economic and Social Affairs, 2015),

which means these countries have large dependent population and have higher overall consumption than production (Rutgers, 2016d). Even though the fertility rates in many LDCs and SSA countries are declining, economic growth does not follow automatically (Rutgers, 2016d). According to the International Labor Organization (ILO), In 2015, up to 20% of young people in developing countries are unemployed and another 2/3 of young workers are in vulnerable employments, such as unpaid family work (International Labor Organization, 2015).

For SSA, the IMF estimated that up until 2035, 18 million jobs will need to be created annually in order to meet the demand of the growing labor force (Rutgers, 2016d). The consequence of insufficient economic growth is the risk of falling into the demographic trap, which refers to the situation where a country remains in stage 2 of the demographic transition, as poor living conditions reinforce high fertility levels, which in turn reinforces poverty (Rutgers, 2016d).

In order to avoid a demographic trap, it is vital that investments are made to create employment and to meet the demands for public services (Rutgers, 2016d).

3.2.2.2 Complete educational systems

Empowerment is strongly related to education (Rutgers, 2016d). Educated people are generally more empowered and more likely to invest in the education of their children (Rutgers, 2016d). The relationship between the fertility transition and human development works in both directions by creating a virtuous cycle that can accelerate fertility decline, social development, and economic growth (Canning, 2015).

Education, especially education for young girls, is one of the highly interactive accelerators that drives low desire of high fertility and the transition from high to low fertility (Canning, 2015). Complete educational systems can enable girls' education better, which declines fertility rates and in turn, has a strong effect on education by allowing for fewer, healthier, better nourished, and better educated population (Canning, 2015). Among others, education contributes largely to increased knowledge on health, more economic opportunities, and less poverty (Rutgers, 2016d).

3.2.3 Sustainable SRHR services

Providing sustainable and continuous SRHR services to young people is essential in achieving goals of family planning. As proposed by Rutgers' experts on SRHR programs in Uganda, these sustainable family planning and SRHR services should include:

1. The accessibility to SRHR education and knowledge: providing a package of comprehensive sexuality education and knowledge, which is the first step to promoting SRHR, that includes information regarding family planning, maternity care, safe abortion, prevention and treatment of STIs and HIV, and so on (Rutgers, 2016d).

2. Continuous and shame-free supplies of contraception methods: among all of the social, educational and economical barriers of using contraception for young people, sometimes the greatest difficulty is the possibility of getting these products. Access to these modern contraceptive methods can be disrupted for many reasons: short of supply from local medical facilities; absence of qualified medical personnel; discontinuation of funds; cultural shaming of contraceptive use among local communities; absence of autonomy and independence of women; misconception of modern methods; and et cetera. (Bogaarts, personal interview, November 16, 2016).

3. Cooperation and support from local communities: as local communities play an important role in shaping norms and values in many African countries, it is important that communities members are aware of the sexual and reproductive health and rights of their own, and of each other. Thus, community cooperation and support are key factors in the success of the promotion and implementation of SRHR services (Bogaarts, personal interview, November 16, 2016).

4. Normalization of use of contraceptive methods: contraceptive use has increased in many parts of the world, especially in Asia and Latin America, but continuously to be low in Sub-Saharan Africa (World Health Organization, 2016). Globally, the use of condoms increased to 57.4% in 2015 compare to 54% in 1990 (World Health Organization, 2016). In Asia it has risen to 61.8% condom use and 66.7% in Latin America and the Caribbean (World Health Organization, 2016). In Africa as a whole, the percentage of condom use is 28.5% as of 2015 (World Health Organization, 2016).

   One of the main reasons for the low usage of condoms in Africa, as suggested by Rutgers, is the idea of a diminished manhood as a result of using condoms in sexual activities

(Bogaarts, personal interview, November 16, 2016). This was caused partially by the way condoms were promoted in the past, which predominantly focused on disease control and prevention of pregnancy (Bogaarts, personal interview, November 16, 2016). Male and female condoms are the only devices that both reduce the transmission of HIV and other sexually transmitted infections (STIs) and prevent unintended pregnancy (United Nations Program on HIV/AIDS, 2015). To increase the percentage of condom uptake, new approaches and strategies in social marketing on both male and female condoms can be an effective way of promoting the use of condoms (Bogaarts, personal interview, November 16, 2016).

4.1 *Perceptions of male & female condoms*

One of the main factors of low condoms uptake in Africa is acceptability (Beksinska, M., Smit, J., Mantell, J., 2012). For instance, studies undertaken in the last two decades investigating male condom acceptability in South Africa reported that male condoms were disliked because they reduced sexual pleasure, called into question partners' fidelity, and challenged notions of masculinity (Beksinska, M., Smit, J., Mantell, J., 2012).

Negative perceptions regarding public sector male condoms are regarded to be inferior in quality in comparison to the commercially available and socially marketed condoms (Beksinska, M., Smit, J., Mantell, J., 2012). Concerns in relations to comfort and breakage and unpleasant smell were cited as reasons for not wanting to use free condoms provided by government or NGOs (Beksinska, M., Smit, J., Mantell, J., 2012).

Anthropologist Dr. Maheshvari Naidu from University of KwaZulu-Natal, South Africa, conducted a research on the perceptions of second generation female condoms focusing on women's experiences. She concluded that a staggeringly high number of African women who are potentially the beneficiaries that stand the most to gain from a female initiated contraception, have very little exposure and knowledge of the female condom (Naidu, 2013). Out of 1,220 elicited usable responses, only 111 respondents could specifically comment on the knowledge and perception of female condoms (Naidu, 2013).

Among the 111 respondents, there was a small percentage of women who had positive experiences with female condoms, and thus considered these a desirable alternative to male condoms (Naidu, 2013), however, the lack of knowledge of this female initiated contraception contributes to the lack of control over women's sexuality in Africa as a whole (Naidu, 2013).

3.3 Obstacles for family planning & SRHR

Poorer men and women and those living in rural areas often have less access to family planning services (UNFPA, 2016). Certain groups, such as adolescents, unmarried people, sex workers and people living with HIV, are confronted with a wide range of barriers to family planning and contraception (UNFPA, 2016). Social barriers of family planning and contraceptives include opposition by partners, families or communities, and sometimes, the greatest difficulty could be that travelling to a health facility to obtain methods is just impossible (UNFPA, 2016). These barriers can lead to higher rates of unintended pregnancy, increased risk of HIV and other STIs, limited choice of contraceptive methods, and higher levels of unmet need for family planning, and other sexual and reproductive health services (UNFPA, 2016).

3.3.1 Funding for contraception

Spending $25 per woman each year would dramatically reduce maternal and newborn deaths – Ann Starrs (Guttmacher Institute, 2014).

The Guttmacher Institute concluded through their universal access to sexual and reproductive health services study that it would cost on average $25 per women, aged between 15 to 49, to provide a package of essential sexual and reproductive health services to all women in developing regions each year (Guttmacher Institute , 2014). The package includes contraceptive services, pregnancy and antenatal care, special care and service to mothers and their children living with HIV, and treatment for 4 other STIs (Guttmacher Institute , 2014). The impact of such a package can be sensational. If all women wanting to avoid pregnancy used a modern contraceptive method, the number of unintended

pregnancies would drop by 70% and unsafe abortions by 74% (Guttmacher Institute , 2014).

The cost of such a SRHR service package varies broadly by region, particularly between the less developed regions and the least developed ones. According to the study, the average annual cost of providing a woman with such a care package in Asia is $14, and in Latin America and the Caribbean is $31 (Guttmacher Institute , 2014). But in Sub-Saharan Africa, the cost is significantly higher—$76 per woman, due to less advanced healthcare infrastructural support (Guttmacher Institute , 2014).

On a global scale, fully meeting the need for modern contraceptive services for all sexually active women would cost $9.4 billion (Rutgers, 2016d); providing the recommended levels of maternal and new-born healthcare for women who have a live birth would cost $21.7 billion (Rutgers, 2016d); providing the recommended care for women whose pregnancies end in miscarriage, stillbirth and abortion would cost $2 billion (Rutgers, 2016d); meeting the need for HIV testing and counselling for all pregnant women and antiretroviral treatment for those living with HIV during pregnancy and up to six weeks after delivery would cost $3 billion (Rutgers, 2016d); meeting the needs of newborns for testing and treatment related to HIV in the first six weeks of their lives would cost $1.3 billion (Rutgers, 2016d); treating the major curable STIs of all women of reproductive age would cost $1.7 billion (Rutgers, 2016d). If these investments were made together they would bring the total cost for SRHR services to $39.2 billion annually (Rutgers, 2016d).

Currently, the annual costs for SRHR services are lower than $19 billion (Rutgers, 2016d). Nonetheless, should $39.2 billion is invested in SRHR care annually, it would only amount to $25 per woman of reproductive age or $7 per person in the developing world (Rutgers, 2016d).

3.3.2 Suppression of women & gender based violence

Gender and gender based violence (GBV) is a major challenge for family planning and SRHR promotion (Beksinska, M., Smit, J., Mantell, J., 2012). GBV or 'violence against women' are terms used interchangeably as most gender-based violence is inflicted by men on women and girls (European Institute for Gender Equality, n.d.).

violence against women is an expression of power inequalities between women and men (European Institute for Gender Equality, n.d.). 'The effects of gender based violence (GBV) on women's ability to engage in condom-protected sexual intercourse are manifest in gender relations, and are reinforced by the broader context of socioeconomic inequalities that make women dependent on men' (Beksinska, M., Smit, J., Mantell, J., 2012).

Partner violence and GBV decrease women's ability and autonomy to control their own sexual encounters and therefore, because of gender power inequities, generally, condom use remains in favor of male dominance in Africa (Beksinska, M., Smit, J., Mantell, J., 2012).

3.4 Necessary facilitating measures

To break the spell of 'more children equals more income' belief and to facilitate family planning programs in LDCs, SSA and Africa, there are several necessary measures that need to run parallel to SRHR services.

These measures consist of social insurance plans, which provides a comprehensive insurance system on healthcare, pension, life insurance, and other forms of social insurances in order to ensure the correct and sustainable implementation of family planning programs and SRHR services in LDCs, SSA, and Africa. In-depth research on these measures is required to determine their pre-conditions, effectiveness, and feasibility.

Chapter 4. Analysis of success and failures: Family Planning & SRHR

The International Conference on Population and Development (ICPD) defines sexual and reproductive health and rights (SRHR) to be the right for all people, regardless of age and gender, to make choices regarding their own sexuality and reproduction, provided that they respect the rights of others (Rutgers, 2016d).

The ICPD Program of Action and Member States recognized that reproductive rights embrace existing human rights and that sexual and reproductive health and rights are central to health, well-being and to development (International Conference on Population and Development, 2014). Aggregating gains in SRHR over the past 20 years mark the consensus of that recognition (International Conference on Population and Development, 2014). However, while many countries exhibiting progress among families in the upper wealth quintiles, progress remains flat or marginal among poor households (International Conference on Population and Development, 2014).

This phenomenon highlights the inequalities in several development models that leave many less-privileged behind, resulting in the near impossibility of realizing health for all and universal access to SRHR (International Conference on Population and Development, 2014).

The following sections aim to demonstrate and analyze the pros and cons of SRHR programs and family planning services in the past, in combination with a success case study of family planning in Bangladesh, to provide evidential basis for potential policy recommendations that answer the question of best approach to promote SRHR in countries like Niger.

4.1 What failed SRHR initiatives in the past?

According to Rutgers Foundation, the reasons why family planning and SRHR activities failed in the past can be summarized as misconception of SRHR and family planning, and incorrect or divisive approaches to the implementation.

By the early 1970s, international efforts to reduce rapid population growth in the developing regions were well advanced, as the World Bank loaned a substantial amount to population projects;

the UNFPA was established; the United States of America, together with other Western countries provided significant amounts of foreign assistance funds for population programs (Rutgers, 2016d). Consequently, developing countries were under pressure of these top-down population policies and programs, that were driven by global targets to adopt population policies and family planning programs (Rutgers, 2016d). Not surprisingly, disappointing results of these early family planning programs divided the movement: demographers increasingly came to believe that deeply embedded cultural traits, as well as the economic and emotional values of children to poor households, were the primary causes of program failure, while public health professionals ascribed these to programmatic design flaws (Rutgers, 2016d). This lead to the inefficient implementation of family planning programs and the failure of early SRHR promotions and services.

The perception of SRHR and family planning had been negative in the past. The 1974 World Population Conference in Bucharest put emphasis on how the SRHR programs should be framed, as it was felt that 'Western countries were pressing too hard for population control through global demographic goals and targets, while neglecting other areas of economic interventions (Rutgers, 2016d), and subsequently, public action to lower birth-rates sometimes led to the introduction of strong coercive elements (Rutgers, 2016d). These elements include permanent castration for both male and female, unsafe abortions, and penal mechanisms.

The design and implementation of SRHR programs in the past by autocratic governments contributed to their failure. Women's rights activists argued that women in particular paid a high price in earlier population programs, as they were viewed as passive targets who needed to become acceptors of contraception (Rutgers, 2016d). These concerns were acknowledged by the 1994 ICDP in Cairo, which established that population objectives would be reached faster if couples' and individuals' needs were taken into account instead of imposing macro-demographic goals (Rutgers, 2016d). Additionally, women were recognized as key agents in the process of reproduction and should be empowered through education, information and access to health services, to have control over their own bodies (Rutgers, 2016d). This realization plays an important role in later and modern day family planning programs. Empowerment of women is the fundamental principle and key to the success of any SRHR services and family planning programs.

In addition, the way SRHR programs were conducted problematized sex by seeing it as 'something that needs to be controlled in order to avoid negative health outcomes such as HIV, STIs, and unwanted pregnancies' (Rutgers, 2016d). The positive aspects of sex and sexuality, such as pleasure and fulfillment, were ignored by many programs (Rutgers, 2016d). This caused the developments of negative sentiments against SRHR services and family planning programs in SSA, LDCs and Africa, as it is counter-productive to the efforts of normalizing sexual conducts with a clinical approach and making sexuality education and information more accessible. Furthermore, SRHR programs focused primarily on married adults and gave too little attention to young people in the past. This gives little room of drastic improvements in SRHR for the populations in general, as it neglects one of the most relevant proportions of the population. Moreover, young people make up a large part of economically non-active persons in a market. If young people do not receive adequate attention in SRHR services and family planning programs, the risk of falling into a demographic trap instead of a demographic dividend (as referred to in Stage 3 of the demographic transition theory) increases. Sustainable development is to the benefit of younger people and the next generations and it will only happen with the full involvement and support of young people (Rutgers, 2016d).

4.2 What is proven to be working well?

Voluntary family planning with a focus of social development and broader SRHR policies and programs embedded with political and social issues did make great progress in reducing natality and raising awareness of SRHR.

The consensus document – the World Population Plan of Action – created by the 1974 World Population Conference in Bucharest, recognized social development has an important role in reducing fertility (Rutgers, 2016d). It called for a mix of family planning and other development investments that would help reduce the demand for children (Rutgers, 2016d). These policies and programs gave couples access to information and family planning services and resulted in a worldwide reproductive revolution (with the exception of SSA), where fertility rates declined by 50%, while contraceptive prevalence among women increased from less than 10% to nearly 60% (Rutgers, 2016d).

By the mid-1990s, the focus of population policies had moved from narrow family planning to include the broader sexual and reproductive health and rights. Population policies and programs came to include a series of new issues, including women's empowerment, the fight against poverty and the protection of the environment (Rutgers, 2016d). These policies and programs benefited from transformations in the economy and the role of women, as well as changes in traditional attitudes towards sexuality and reproduction, a process facilitated by the fast transmission of new ideas through new means of communication.

To conclude, women's empowerment, male's involvement in SRHR, and increasing market's economic capacity are the main drivers of success in family planning and SRHR programs. These elements provide concrete basis for the implementation of the voluntary family planning programs and broader SRHR policies with a focus of social and economic developments.

4.3 Case study: 'Gender Justice and Diversity' of BRAC in Bangladesh

The SRHR project developed by BRAC in Bangladesh is a positive example of how to promote gender equality among adolescent girls and boys, men and women; reduce natality in LDCs; increase SRHR awareness among the people; decrease violence against women; and etc. (BRAC, 2016). It resulted in the increase of acceptance of contraception in adolescent girls and boys, more pregnancies spacing for women and decreased maternal mortality in Bangladesh (BRAC, 2016).

This initiative is a SRHR program within the 'Gender Justice and Diversity' project created in 2012 with the consortium of 6 partners, Oxfam Novib, Bangladesh Nari Progati Sangha (BNPS) – an activist women's organization, Campaign for Popular Education (CAMPE), Family Planning Association of Bangladesh (FPAB), HIV/AIDS and STD Alliance of Bangladesh (HASAB), and BRAC, which aims to contribute to the significant reduction of the number of adolescent girls suffering from avoidable maternal deaths and the prevention of other major sexual and reproductive health hazards in both adolescent girls and boys (BRAC, 2016).

BRAC's vision for project 'Gender Justice and Diversity' is to free the world from all forms of exploitation and discrimination where everyone has the opportunity to realize their potential (BRAC, 2016). The project goal is to promote gender equality, empowerment of women and

inclusiveness within BRAC as well as within the broader community that BRAC operates in (BRAC, 2016), and is achieved through five objectives:

1. To promote a culture and environment, inclusiveness within all programs, that respect gender equality;
2. To build capacity of staff to achieve BRAC's goal of gender equality;
3. To create a platform for community mobilization against gender-based discrimination and domestic violence, sexual harassment at the workplace and public place;
4. To promote SRHR within the society;
5. To include policy advocacy for women's rights, both nationally and internationally (BRAC, 2016).

The project focused on gender equality and empowerment of women at the local, national and international levels, where women and men have access to equal rights and opportunities, as well as the realization of one's own choices and potentials in economic, social and cultural spheres in Bangladesh (BRAC, 2016).

It helped to build a gender-friendly working environment and community platform, where each individual within BRAC and in the local community works as agents of change to establish a just society for women, men and children (BRAC, 2016).

It also acts as a catalyst to promote sensitivity on issues such as sexual and reproductive rights, people with different sexual orientation, and people with different abilities and cultural background (BRAC, 2016).

Moreover, the project was actively involved in the national level policy advocacy through different human rights organizations, networks and alliances of government, non-government, and civil society organizations. And lastly, the future objective of the project is to seek cooperation with various government departments to implant gender sensitivity and equality in future national policies (BRAC, 2016).

The BRAC approach:

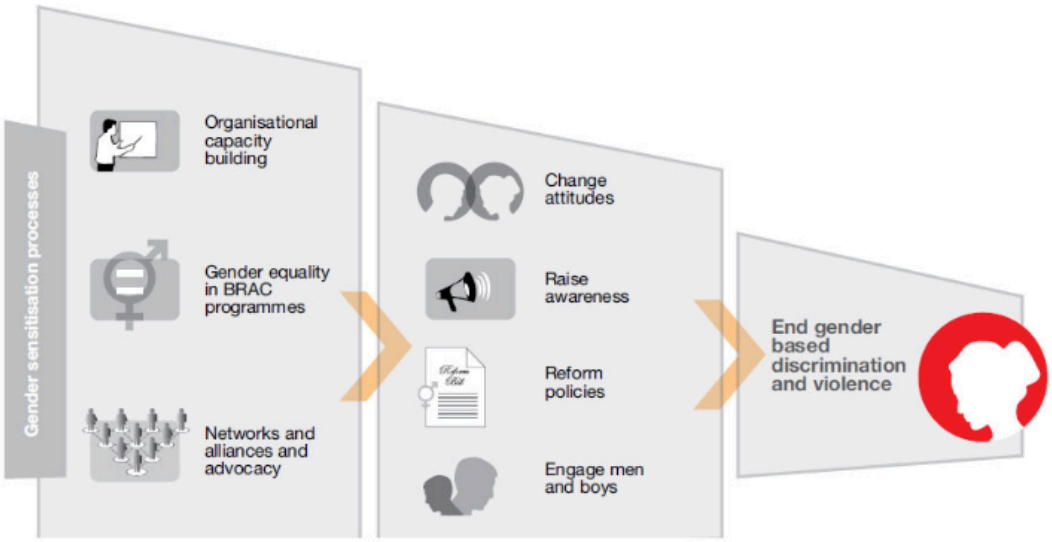

Figure 19. The BRAC's approach (BRAC, 2016).

This multilevel-cooperation approach of the BRAC's SRHR project contributed to its success. The project largely involved young people and adolescents, the local communities, civil societies and NGOs, and advocating on SRHR to national government. It combines organizational capacity building to increase the abilities of SRHR advocacy agents, creating gender equality programs and networking with civil society stakeholders to build alliance and advocacy capabilities. The approach aims to achieve attitude change among men and women in Bangladesh, to raise awareness of SRHR to the general public, to reform existing policies and engage men and boys in ensuring SRHR for all and eventually, it achieves the goal of ending gender based discrimination and violence against women and men with different sexual orientations in Bangladesh (BRAC, 2016).

Chapter 5. Policy Recommendations

It is safe to conclude that population policies are more necessary and relevant than ever for LDCs, SSA, African countries, and other developing regions in the world. Successfully addressing these fertility challenges should be embedded in the integrated and interdependent set of sexual and reproductive health and rights services and care (Rutgers, 2016d).

5.1 Best practices to improve Family Planning and SRHR

Youth-friendly Approaches

SRHR and family planning policies should focus on the empowerment of younger people, which requires adequate investment in their health, together with sexual and reproductive health and education and comprehensive sexuality education (Rutgers, 2016d). Attitudes and values related to gender equality, sexuality, and health behaviors are established in adolescent period and have important implications for health and social well-being in later life (Rutgers, 2016d). 'Promoting mutually respectful attitudes between and among adolescent boys and girls in connection with sexuality as well as other healthy behaviors will form the foundation for the good health of population, as adolescents become adults, and for social and economic development more broadly' (Rutgers, 2016d).

Based on Rutgers experiences in providing and promoting SRHR services, emerging evidence suggests that Comprehensive Sexuality Education (CSE) programs that include content on gender equality, human rights, and use of participatory methods are more likely to show positive SRHR outcomes for adolescents (Rutgers, 2016d). Successful youth-friendly SRHR programs usually combine training and support of health workers, improving youth friendliness of the facility, building community support for health service provision to adolescents, and generating adolescent demand (Rutgers, 2016d).

Promising approaches in preventing intimate partner violence and sexual violence among adolescents include: school-based dating violence interventions; community-based interventions to promote gender-equitable attitudes among boys and girls; and educating parents to prevent child maltreatment (Rutgers, 2016d).

Engaging men & boys in SRHR

According to Rutgers, a lack of adequate knowledge and communication around SRHR may further reflect and exacerbate such gender inequalities, particularly when their knowledge is mainly based on male dominant and pornographic information (Rutgers, 2016a). Sexual consent may be a particularly troubling area, in which inequitable attitudes lead to sexual violence (Rutgers, 2016a). Women's ability to negotiate contraception is often very limited, and their attempts to do so may be perceived as disrespectful and could provoke further violence (Rutgers, 2016a). A significant proportion of men who use violence against women did so for the first time as adolescents (Heilman, 2014). Boys who experience violence or witness violence against their mothers are up to three times more likely to use violence against their female partners in their adult life (Rutgers, 2016d). Engaging men and boys in SRHR and gender equality education is urgent, and must include sexuality education for boys and girls, with a strong focus on gender and opportunities for changing rigid norms and patterns (Rutgers, 2016a). By engaging men and boys in the agenda for gender equality, they can be active supporters and allies in promoting necessary social change, supporting SRHR of women and in preventing gender based violence (GBV), ultimately to the benefit of women, girls and boys and the men themselves (Rutgers, 2016a).

Women's empowerment

Better educated and healthier women — with more market, social, and decision-making power in their families — are more likely to have fewer children (World Bank, 2012). Women who have less children, as a result of delayed age of marriage, delayed first sexual contact, or more space between births, are much more likely to enter the paid labor market and become economically active, to have higher revenues, and to be more empowered in the society they live in (Canning, 2015). There are three domains in which women's empowerment can be realized as categorized by Rutgers Foundation on top of education:

1. Economic empowerment: women's economic contribution to economic activities is far below its potential, because women take less part in formal employment than men, and are over represented in unpaid and informal jobs (Rutgers, 2016d). If women were given better opportunities to participate in the labor force and have greater earnings, it will not only benefit the economy, but will also result in higher expenditure on children's schooling, potentially triggering a virtuous circle (Rutgers, 2016d).

2. Increased intra-household decision-making and bargaining power: it refers to equal power between couples and other household members, which affects all kinds of decisions, including decisions on age and terms of marriage, family size, contraceptive use, healthcare uptake, child care, children's education, division of household tasks or tasks in general, freedom of movement, and economic engagement (Rutgers, 2016d).

3. Having control over and autonomy of one's own body. This includes being able to secure oneself against gender based violence and other forms of violence, and having opportunities for sexual satisfaction (Rutgers, 2016d). Globally, between the age of 15 and 65, 71% of women experienced physical or sexual violence by an intimate partner (Heilman, 2014).

   In many countries, women especially are unable to exercise their right to make choices regarding their sexuality, this includes inability to refuse sex, or in a lack of power in condom negotiation (Rutgers, 2016d). Power is complex, rendering the image of heterosexual men as always powerful and women (and men with a different sexual orientation) as powerless invalids. Women are likely to be in a submissive position, with a low level of political and economic power (Rutgers, 2016d).

5.2 What needs to be done:

To ensure the best outcomes of these recommended approaches to promote SRHR, a multilevel/multi-component cooperation, including national governments, NGOs, civil societies and donors, is required.

5.2.1 By national governments

Governments at national level in LDCs, SSA, and Africa need to put in place progressive laws, policies and programs and address the weak implementation of existing gender inequality and SRHR policies and programs, and ensure policy and policy implementation coherence at all levels (Arrow, 2016). Moreover, national governments need to address the unmet need for all SRHR information and services including contraception for women and girls (Arrow, 2016).

5.2.2 By NGOs like Rutgers Foundation

International Organizations such as Rutgers Foundation can help strengthening community-based and youth-friendly reproductive health services, advocating for policies in support of family planning, and providing global leadership in SRHR promotion by convening partners including national governments to develop evidence and policies, and offering programmatic, technical and financial assistance in SRHR services to LDCs, SSA, and African countries (UNFPA, 2016).

5.2.3 By civil society

'Governments cannot neglect information and suggestions received from hundreds of civil society organizations. Organizations working closely together like we [Rutgers] did, disseminating the same messages and materials, symbolize a strong front' (Gilleberg, 2012). Civil society plays an important role in advocating sexual and reproductive health and rights, raising awareness of gender equality and family planning, lobbying for empowerment and material services, and monitoring the implementation of SRHR programs and care.

5.2.4 By donors

The most important facilitating measures of SRHR services is funding. It is an understatement to say that SRHR activities and services are insufficiently funded worldwide, especially in LDCs, SSA, and African countries.

Here are some facts and figures of SRHR's ideal funding situation:

1. It would cost $9.4 billion annually to meet all women's needs for modern contraception in the developing regions (Guttmacher Institute, 2014), which is equivalent to 0.01% of the global GDP in 2015 –$73.9 trillion (World Bank, 2015) to avoid 52 million unintended pregnancies and 14.9 million unsafe abortions (Guttmacher Institute, 2014).

2. It would cost $28 billion annually for pregnancy-related care for all women and their newborns, if all needs for modern contraception were met (Guttmacher Institute, 2014), which is a rather modest investment in comparison to the $2.58 trillion global defense

expenditures in 2012 (United States Department of State, 2016). This $28 billion would help to avoid 194,000 maternal deaths and 2.24 million newborn deaths every year (Guttmacher Institute, 2014).

3. It would cost $1.7 billion annually to treat all women of reproductive age for the major curable STIs –chlamydia, gonorrhea, syphilis, and trichomoniasis (Guttmacher Institute, 2014), which is less than 10% of what The Netherlands spent on national defense in 2012—$9.8 billion (Global Security, 2013).

4. All in all, a total of $39.2 billion is needed annually to fully meet the need for modern contraception, maternal and newborn health care, antiretroviral care for pregnant women living with HIV and their newborns, and treatment for four major curable STIs (Guttmacher Institute, 2014).

   It is less than what American shoppers spent in 2 days after Thanksgiving in 2015 –a total of $50.9 billion over the Black Friday weekend (Amadeo, K, 2016). Moreover, it would result in greater overall financial gain. Meeting the needs for maternal and newborn care would cost $35.8 billion annually at current levels of contraceptive use, however, fully satisfying the needs for modern contraception would lower this cost to $28 billion because with fewer unintended pregnancies, fewer women and newborns would require care (Guttmacher Institute, 2014).

5. In fact, these numbers boil down to an average cost of $25 per woman per year to provide a universal package of all essential sexual and reproductive health care to all women in the developing regions (Guttmacher Institute, 2014), which incidentally, is the cost of a movie ticket and a box of popcorn in New York City (Gilmore, K, 2015).

Comprehensive sexual and reproductive health services and modern contraception are not only integral to recognizing the right to good health for all people, accomplishing sustainable development, and essential for achieving gender equality, they are also a smart financial investment (Rutgers, 2016d). Research shows that every $1 spent on modern contraceptive

methods would yield $120 in overall benefits, including the reduced pressure on public spending and the environment (Rutgers, 2016d). According to the UN, investment in contraception and SRHR services have been shown to save $4 for every $1 invested in Zambia, $31 for every $1 invested in Egypt across other public sectors, including education, food, health, housing, and sanitation (Boldosser-Boesch, 2015).

More investments in SRHR are necessary and urgent, as sexual and reproductive health and rights related problems are largely preventable (Rutgers, 2016d). With a focus on prevention, investments in SRHR are not only critical to people's wellbeing and the prosperity, but are also proven to be cost-effective and cost-saving, freeing resources for investments in other development priorities (Rutgers, 2016d), and bringing more social and economic benefits to less developed countries, Sub-Saharan Africa, and other countries in Africa that will encounter imminent implications due to rapid population growth in the next decades.

5.3 Research Recommendations

There are several limitations to this research report, due to resource and time restraints. More research is needed on several fronts:

1. Determining the effectiveness of social insurances as facilitating measures to promote sexual and reproductive health and rights in Sub-Saharan Africa, Less Developed Countries, and countries in Africa.
2. Research on funding gaps of SRHR programs in LDCs, SSA, and Africa, understanding the casual link between lack of fund in SRHR and achieving sustainable development goals.
3. In-depth research on Niger's country profile with regards to its population dynamics.
4. More research needed on successful SRHR case studies, such as BRAC-Bangladesh 'Gender Justice and Diversity' and Rutgers Foundation's Uganda project.

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Appendix

Interview transcript 1: Interview with Rutgers

Interview: Rutgers; 16th Nov. 2016 09h30; Utrecht, NL.

Participants: Y. Bogaarts, M. van Reeuwijk, J. Voorhoeve, L. Guo

Topic: Rutgers' experiences in SRHR related proejects

LG: May I start with getting to know the projects the Rutgers are conducting for family planning in Africa?

YB: Yeah that would be my first remark, we don't specifically work in Niger. We work in a number of countries in Africa, including Uganda, in high fertility regions. So we work in Uganda, in Kenya, in Malawi, we will start working in Zimbabwe and Senegal, we are working in Ethiopia, we have two small projects in Nigeria and Cameron, that's' it. We used to work in Tanzania, Rwanda and Burundi.

JV: So perhaps it's useful to generalize it from Niger to your experience in Africa.

YB: Yeah, ok. So what is the question?

LG: For instance, how do these projects get started? Does it start from grass-root initiatives between communities? How do you insert these projects into these African countries?

YB: How do we start? I think that's a combination of things. Our experiences in certain countries with certain partners, you know the needs we see, and then based on that I think we usually start by really bringing partners together, and well, what I would say is the fashion right now is to start developing a theory of change. What do we see as the biggest problems and how do we address those, and…?

MR: Yeah I would say most of our programs start with, we have long term partnerships, so we have organizations that we work with in those countries. And of course it depends on where the money is coming from, and what the frame is for the program, then we start to look for which partners are most suitable for what. And most of the funding comes from the Dutch ministry of foreign affairs for us, and one of the requirements is that we work in alliance. That we alien our programs also with the growing evidence for having multicomponent interventions. So rather only working with an organization that provides sexuality education, with those alliance programs we try to link them to service providing organizations and organizations that do advocacy,

organizations that are grass-root level organizations, that work in the communities, that create an enabling environment. So we are trying to combine those as much as possible to have the most effective strategies on the ground.

YB: and develop those jointly, I think that's what I tried to explain in working together with all these partners, you know as a real start, and then based on that, develop actually annual plans. I mean also to make them practical and workable to what we are going to do.

LG: So when you are promoting, for instance, reproductive rights and services, what do you mean exactly by rights and services? Do you also provide access to information? To local communities for instance having a, because how exactly do you promote this message among the people?

MR: Depends, depends on which partners. So the Rutgers direct partner, IPPF member associations. And IPPF organization typically have clinics, and for instance provide outreach services, so they bring the service providers into the rural villages, to provide services there. Traditionally, this was family planning, so focusing on women, and trying to space birth. But now for instance in Uganda, it's very essential that we reach adolescents and young people, so the messages change but also the strategies to create demands amongst young people, to create support from the communities that we interact with young people and provide them with contraception and family planning services and etc. integrated services, there's a lot around that. So we work a lot with young people, who are the drivers of those interventions, we use the social networks of young people, to mobilize young people, we work between young people to provide information to other young people, and then to mobilize them to come to these outreach services. That is one of the most effective strategies we have to rural, hard-to-reach young people.

YB: That is one of the programs, I think there are others, the ones coming from the advocacy department, in which we really, how do we say that, we got a huge grant from the ministry of foreign affairs, to really work on advocacy, which enabled us to select the best advocacy partners in countries. So previously we had to work with, say the implementing partners, which at times are very good advocates, but at times also are not. With this strategic partnership we had the abilities to really move in a process, develop a process to select the best partners, to do actually what we wanted to do, really with workshops and value clarifications, what do we mean when we talk about all these issues, are we on the same page, and who really wants to work with us. And that program is called right here right now, and is dealing with adolescent sexual reproductive

health and rights, and specifically the sensitive issues, including abortion, including LGBTQ, including comprehensive sexuality education, access to services for young people.

JV: What is the abbreviation which ended on the Q?

YB: Lesbian gay bisexual transgender queer. And, the way we try to work is really we had a whole, during the whole 2016, there were workshops in 10 countries in the region we work in, to get to those common understandings, and once invited for that, for these workshops, were based on a mapping exercise, prior to that to really determine who would be the best suited partners for this initiative, and we envision building a strong national platform, strengthening existing platforms, depending per country, to have a combination of interesting and strong advocates, but also combining that with people with more human rights work, health work, women's empowerment, also some service provision in there, to get that working together, that's the plan, and then have hat collectively developed proposal, and that proposal, well the idea is that they do advocacy towards their governments, and parliaments of course, for better policies, for sufficient budgets, for implementation of policies. Depending on what the situation in a certain country is, and to also advocate towards that government, to what they bring to the regional and international level. And also follow the processes on the regional and international level. Both those in New York, more on the development side, as well as those in Geneva, the human rights side. So for instance, let me give an example, Uganda was up for the Universal Periodical Review, in Geneva, so we, with partners in country, wrote a submission, we followed up with all the countries who could question Uganda in Geneva, and you know, doing that both in Uganda as well as in Geneva, and now they just had their UPR session, but then, try to bring that back and fit that into a country, so they can use it again in their …, so that government cannot just go somewhere and do something which no one knows in the country and they can get away with saying things which are very different than what they do at home. Trying to bridge that gap, make it a kind of a loop. Bridge the gap between what's happening on an international level and a national level, as well as say between, more the development side and the human rights side, bridging that gap.

LG: And what are the successful or reasonable policies that, for instance, government of Uganda had legislated to benefit family planning purposes? Are there any good examples?

MR: what I know is that, the recent developments in Uganda in terms of the government banning sexuality education in schools, which has enormous backlashes on our programs. And much of the advocacy efforts of the societal groups that we work with focusing on that (family planning), and

trying to work with the local champions to counter-act that voice, what you see happening in Uganda is that Uganda is the place where it is very much American influenced, church influenced, which is fueling the debate and it has been picked up by the ministry of education and health…

JV: it's American NGOs and American governments that follows the natality lines?

MR: it's actually the churches, I think. I wouldn't say the US government,

YB: The angelical, particularly right-wing Christian conservative American organizations. And the president's wife in Uganda is a new-born Christian, and that's also how that influenced.

LG: So generally religion also has a very important role, in preventing family planning programs.

YB: Yeah I would say yeah.

LG: Are there similar cases in other African countries?

YB: I would say everywhere yeah.

JV: Depending on the religion of course.

LG: So then why Bangladesh is a success? Because Bangladesh is also a religious country.

MR: Yeah that is a good question, and I think you can find evidence and data on that. And I don't know exactly but my guess would be that it has a lot to do with the fact that in Bangladesh, the big difference between Niger, if you compare those two countries. In Bangladesh, you will find that because of the norm or the demand of girls not to have sex before marriage, and to stay virgin, is incredibly high. So pre-marital sex is not something that happens a lot in Bangladesh. But what you do see is early forced marriages, you also see that in Niger, and then early pregnancies, and then lots of children. I think family planning programs in Bangladesh has been focusing a lot on spacing, and there has been the gain in terms of reduction of numbers of children being born. So religion is still a very much influence there, because religion also controls female bodies, and family planning has been focusing on the women there, girls were married even when they were 14, can access family planning, because they are allowed to be sexually active. If you are 14 years old and you are sexually active and you are not married, then you have a problem. So that will have an influence over the success of a family planning program.

JV: So you mentioned spacing of new pregnancies, what is the reasoning given to women and men there, that makes possible? Is it simply the mother's health? And the health of the children? Or what are the other reasoning that was given there to help convince people that spacing, and as a result, lower number of new born, is a good idea?

MR: The key word is health. You also see that with reasoning for postponing forced marriages for instance.

YB: And that is also something that a religion cannot object.

MR: So that is the key angle. And that is also quite convincing for people. Another argument that is been given is to go through economics of it, making the investment case. So reasoning about, well, do you need 7 children, or do you prefer to have 4 and then invest in them so that you can actually send them to school. And education is often something that parents want for their children, so, but you will also see that that is more successful in urban areas compare to rural areas. Because in rural areas there are economic benefits of having many children, but also child mortality is higher, so the need for more children is higher there. And then this reasoning will be less convincing for people who have to run a farm, or have to depend on their children for when they are older.

LG: So do the same reasoning apply to the African countries? Economic developments and health?

MR; Yes, I think so, yeah but you will see that it only makes sense to people if they see that education is good, that there is a chance for their children to finish education and that it will lead to employment. And then that is the problem, because there's no jobs.

JV: So in general, the first line to convince people is health of the girl and the mother. What is a good second reason to change people's attitude? Social insurance? Health insurance? Pension funds?

LG: Economic developments?

MR: Yeah, household economics.

JV: So the question is can you afford. But that is not a strong argument particularly rurally, when the man wants 10 kids to help on the farm, and to make sure he is taken care of when he is old.

MR: And then comes long-term working injectable for instance, because for women, they often make different choices than men. They need permission from their men, but what we find, for instance at these outreaches, often we find women there, who do not want to get pregnant soon or again, even though their husbands want them to become pregnant. And because of the injectable, they prefer using those, because nobody will see that they have that.

JV: And does that explain why injectable is more successful than for instance new physical contraception like female condom?

YB: I think there are more sides to it, but this is one.

MR: This is something that women can somehow control. If they can access it, so if they have reliable outreaches where they can go to without people seeing them and telling their husbands, at least in Africa, I don't know so much about Asia, probably the same, so that they prefer injectable.
YB: But there is another side to it too, because I think it is also very much pushed by donors. Because long acting methods, bring value for money. And with the condoms you never know what happens. You can distribute them but you will never know whether they will actually be used.
JV: Whether the men accepts it.
YB: And I think that there are even agreements to, for instance the FP2020, a Gates funded movements, making deals with the pharmaceutical companies who manufacture these injectable, you know they buy a huge number for a somewhat lower price, and I think the companies are very happy because they can have their profits for years. And a number of women will have to start to use it. It's just in my view, not realistic. And if we are not careful, it will lead to issues of pressure or coercion. So the method makes an offer to people in countries is often very small, and I think there is not a single method which women can use throughout their lifetime, preferences and situations change.
LG: I don't the exact data of women who meet the requirements of contraception who are sexually active, but do you know roughly how popular is injectable for women between 14-49 who are sexually active?
MR: Yeah that very much depends on your target group, the group that you look at. So, for unmarried women, they would not like to use injectable, also because of the believe that it might cause infertility. So if you haven't had a child yet, you will not likely to use injectable.
YB: And you will probably not get it from your provider, I mean there is a provider bias here.
MR: So for the majority of our program focuses on the young people, and many unmarried, and also oral contraception is not the preferred method. So condoms and female condoms are what we promote mostly. But that is very much a challenge, especially with male condoms, as a girl if you bring a condom then you are branded as a slut, a whore, or somebody who has too much knowledge about being sexually active. And boys typically don't like to use it, or to bring them, unless you provide them with a lot of dialogue and information. That's why it is so important to combine the provisional services of contraception, with correct information. Especially in countries where 70% of the population are young people, we need to focus on them. And then also includes those boys and men into taking responsibility. Also talk about sexually pleasure, because if you don't do that,

people won't use condoms. And that's what I think that they are doing really well with promoting female condom, is looking at how it can enhance the sexual experience. And that's quite groundbreaking. And of course you can't take about it publicly, but where you see there is interaction with young people that's how they accept to use it.

YB: One way to assess is to see where it is available. Young people always have to go to a clinic, that's kind of scary and can be stigmatizing, why are they going there? For instance, you can have condoms, male and female, and can have numerous outlets where they can go.

JV: Where does it work? With this spreading of female condom use? There is a gap in my knowledge because, when I left the World Population Fund, we had the first project advocating female condoms in a number of countries that involved soccer players, pop singers and so on and so forth, what is the experience?

YB: I think what we see in the regions we work is only a half percent optic of contraception use.

JV: Oh really, so it hasn't been

YB: Not big.

MR: But it has more to do with supply than with demands, I think.

YB: It has to do with, well, people can't voice the demand if you don't know it exists. So it's not like a new brand of toothpaste, everyone knows what to do with toothpaste, but female condom is something really different, people haven't seen, can't buy, so it's really a new and different project. And I think it is not something which can be done in just a couple of years. If you look at tampons, which are used now widely, it took at least 20 years. But what we do know now, of the FP2020, they have set the target of 120 million new users for contraceptives in 2020. They are legging behind. Because for all kinds of reasons, people don't want to use certain methods because they have health concerns, they wouldn't become pregnant, they have infrequent sex and feel there is no need, they are breastfeeding and they think it is, all kinds of, you know, different groups and there is not, and that's what I'm trying to bring across in my messages that if you only focus on the long term reversible contraceptives, then you will reach a certain number. But there are a lot of people whom you never reach and in the end, it's about this method mix and people knowing what is in there to be able to make their choices. And that's problematic. Especially in countries where governments are saying that our young people don't have sex, or shouldn't have sex, and they don't want to interfere into this and don't want to give sexuality education, because that would also lead to young people having more sex which we know isn't true but still that's what they

believe, so at times you are in that sense a bit stuck I would say, between you know, governments not willing to act and donors focusing on these long term acting over reversible methods.
LG: So this is one of the biggest obstacles for promoting contraception, the concern for health and the various layers of resistance.
YB: And that is not in line with people's wishes, according to that specific time in their life.
LG: So what could be a possible solution to that?
YB: That's what we are trying to say, to make sure to bring a method mix. Make it accessible.
JV: If I may use your question, to change it a little bit. If I would be Bill Gates, and I would tell Rutgers here is a hundred million dollars, tell me how you are going to use it? How would you divide that money because that would define your priorities? Based on your experience what do you think is the most effective?
YB: I think then it's our, the idea of combining the three angles,
MR: Yeah, of course the Gates have their own strategies, so they will steer us into a specific direction.
JV: Ok let's forget Gates, I have a private secret fund and I tell here right and now here you have it, 100 million dollars, tell me what are you going to do with it?
MR: if it would be up to me, I would definitely invest it into outreach services. Because there is an immediate need and you want to serve that need, you want to increase access and uptake of contraception amongst young people. And the way to do that, and that's why it is not so popular with donors because it needs continuously flow of money, it's not very sustainable until the health system can take over meeting that demand, and in many countries they can't. this is the way to do it, this is the way to provide young people with contraception. And through outreach, that's what our partners do, they offer that mix method. Including female condoms, that often works because young people are just curious about it not because it is partially their routine. So definitely that's where investments just need to go to. Also, we work with the health system and we work with training service providers, making sure they have supplies, making sure they are user friendly, mentoring them, working with social accountability, making sure the community is involving so they can demand from their local outlets for good quality services. So that you are helping the existing health system, to meet that demands. An important strategy is peer provision, so having young people living in the communities that are service points for other young people, to provide free condoms and basic SRHR services. So they are community health workers but they are not

older people who young people don't dare to approach. Those are working strategies to meet the demands. But at the same time, what's crucial is sexuality education, and you see there is also, now you mentioned Gates, tend to focus on 10-14 years olds and influencing gender norms there. Because there is a lot to gain if you change gender norms for 10-14 years olds that would have a huge win later on in their lives. Both for their personal lives and for changing society. So the more you can do it there, and the more structural you can do it there, there is a lot to win.

YB: And I would combine it with an enabling environment. Working on the services, on the sexuality education, and the enabling environment.

MR: Yeah of course if you want to have stable changes, there will need to be a continuous change.

LG: So could you be a bit more specific on what are the activities involved in the outreach communities? If you have 100 million Euros for these purposes, how would you use it? What kind of establishment would be there?

YB: We always work with locals.

MR: We would work with the partners who have professional service providers, and that can bring the service providers into the communities. To provide the services, especially the medical services. Around that you have to organize your providers, your peer educators, you have to work with the community health workers the way they are, there are service providers of the government, you need to work with the local health facilities, and you need to work hand in hand with the district officials. And that is actually what enables us to still work in Uganda, despite the bad or anything that has to do with sexual education for unmarried young people, is that because of decentralization, more power lies in the district level. We see that the demand for our programs and support for that in a district and community level is high. Even despite national governments saying we don't want it. So that enables us to still do, outside of a school setting, through the outreach we can provide sexuality information and education, and serve the demand that that creates immediately.

LG: Ok so this outreach comes in forms like seminars, or group meetings, or?

MR: I can show you a picture to give you an idea.

YB: Because you have to work on the issues, the three issues, I would say in combination. Because if you provide sexuality education in and out of school, and there is no way young people can get the services they need, then it only leads to frustration. So you have to work on those service side as well, but then again there is this environment around you, parents, teachers, providers.

MR: This is what an outreach looks like. It's interesting that there is a female condom in there. So you see that these are service providers, they bring a tent for confidentiality. This is the lab, so the only service you can provide here are those that can be done by the lab. So if you want STI testing you need to, hmm, these specific laboratory testing you need to refer to a facility. Typically integrated, so HIV voluntary testing and counseling, and family planning. But what you see is young people are running this (facility), they are organizing it. They attract other young people and motivate them to come, they organize games, sports activities, all sorts of things to make it attractive to young people, also send the message: this is for young people, not only for adults. Then there is a lot of efforts to provide good quality information, that fits with the realities and the needs and the experience of the young people. Here you mainly create the demand and what you see there is then they go for testing, for exercising contraception. So this is typically what it more or less look like.

LG: And for instance these activities that outreach sponsors are financially supported by Rutgers or by the ministry of foreign affairs?

MR: So we get money through the Ministry of foreign affairs, and we support programs that we know that are effective, and we try to technically support partners to carry the projects out in the way that we know is the most effective, but of course they might also get money from Japan, and from Irish aid, Scandinavia, and for core funding they depends on IPPF. So for instance this project (in Uganda), is paid by a private family in The Netherlands. But it could have been the ministry of foreign affairs, it could have been any kind of donor.

LG: And for example, after the outreach, when the young people want to order condoms or injectable, how would they continue?

MR: They continue through their peer educators, we link their peer educators to existing health facilities, which often has not more than one room with a nurse who has to support all the health problems of all the people in the village around. So her priority goes to malaria, to diarrhea, to all sorts of emergency infectious diseases, not to SRHR, especially not to young people who are not married. So we support her by linking her to trained community health workers and peer educators who handle these cases in communities. So if there is a demand for preventive care, they can do that themselves, whether is the provision of the pill, or injectable, the community health worker can do that, they don't need to come to the facility. But if it is about reproductive health, safe pregnancy, these kind of services, then they need to come to the facilities.

LG: May I be a bit more specific, so once the young people had shown their intention to obtain condoms for example, do they need to purchase them from the community outreach? Do they need to go through their health insurance? How does it work in Uganda?
MR: We distribute them freely, and so they can get them for free through the peer educators.
YB: But not always everywhere. But I would say, overall, contraceptives in Africa are very much donor funded. And again sometimes in social marketing programs, you know there are groups that had to pay something, also to make it sustainable for the long run.
LG: So the projects do not purchase condoms themselves, they get sponsorship for outside.
MR: Sometimes we do, and sometimes we don't. that's what I wanted to say. The core funding from IPPF insures that at least the services that are provided by our partners, that they have the right equipment, the right stock, so they have plenty of condoms. But for the health facilities, they are depending on the system that is there. And if the system if not good, then you find, and that is one of the reasons young people don't like to go there, is out of stock. So that again, is addressing our alliance programs through supply chain management skills. And training the service providers to demand, or to predict how medication is being used, and to make sure that they order it in time and to make sure they can lobby with the ministry that they can demand, also to say can you promise us this amount, but there is no money so where does the money go?
YB: But I mean it's different, I would say there is different systems. There is public government system that contribute to this picture, but if you talk about RHU and this, this is the NGOs which should provide services, and then I would say there is the private market. So we can't say for sure where people get their contraceptives.
LG: But I assume that if condoms cost money then people are less willing to make a purchase, right?
MR: Yeah, especially the young people.
YB: True, at the same time, if it can be done secretly (to purchase them), at times it is also something preferred.
MR: But I wouldn't say (money) is the barrier number one to use condoms. I think the most important thing is gender inequality. The key concern is unintended pregnancy. HIV also but especially pregnancies problem.
YB: Pregnancy is the key concern.

MR: But, as boys say there is transitional sex. So girls get something back from having sex with the boy, in a relationship but also casual sex. So the boy gives something to the girl by accepting their presents or the money, or mobile phone recharge vouchers, those kind of things, so then she accepts to his terms, basically. And because of those rules and also the gender inequality, the boys sometimes say well, you said yes, if you become pregnant then it is your problem. The boys also say well the deal is that I get pleasure, so I don't see the need of using a condom here.

LG: You mentioned previously that the female condoms sort of achieved the goal of giving pleasure for the sexual experience, is that correct?

MR: That is how we promote them, yeah.

LG: But is that the fact? Have you got feedback from?

MR: That it can enhance pleasure. What I appreciate it about (female condoms) and what I have seen about promoting female condoms, is that there is more attention to how it can enhance pleasure for both partners. And the normal condoms, they always promoted it as you should use it to prevent HIV. And if that is the only message you bring, young people won't use it.

YB: Because they don't feel at risk.

MR: Also they don't feel whether it is their true experience of, or whether this is just the norm, the belief that using condoms reduces pleasure or reduces your manhood or reduce whatever. And unless we talk about that, and typically we can't talk about that.

YB: And you know they find it difficult to talk, they don't have the skills to discuss it and to actually demand it, so there is a whole problem of…

JV: So is there a successful way of framing it? Enhance pleasure, one of the new ways to develop new condoms is (to make believe) that it enhances the boys' pleasure.

MR: People do that, manufactures do that. If you look at how DKT, is a big manufacture social marketing organization, they promote their condoms through the commercials, fiesta, music festivals, they brand it as this is cool to use, you are a star if you use it, you are a real man,

JV: So it is more effective than (the message of) prevention of diseases.

LK: And has shown that is more effective in Uganda, for instance? This type of branding?

MR: Yes, Uganda typically has been very focused on ABC, because of the American influence, abstinent, abstinent, be faithful, and if you can't do those two, then ok you can use condoms. Kind of rationale. So many messaging has been within the HIV programing, that has been the main message for the last thirty years.

YB: No not that long, I think Uganda was doing very well actually, and then someday we had this change in the way, this influence from this US Christian organization then they turned it into ABC and then figures went worse again. But they were doing quite well on issues like teenage pregnancy, on lesser HIV infections, then they turned it around. And now it is getting worse again.
LG: I have another question about the supply of the condoms. So the supply is depending on the donors. And there is usually disruption on the supply or is that the case?
MR: Not only, so you have the health system that is there, the governmental system. But it is weak. So what you see is that civil society steps in to cover a need. For instance, in Uganda you have a specific organization that focuses on insuring governmental accountability for having a good supply chain and for having good management of that. So that no money is disappearing. So it is a very important rule for civil society there to check on how the government is doing this.
YB: So that's what I already said, there is these three systems that are problems, that is the public, I would say the NGOs, social marketing, and the private sector. And they each have different ways of getting their supplies. And if you look at systems of certain countries it's like things which you have in computers, so there are all kinds of different and difficult lines so you think oh my god can this ever work. There is a lot of donor funding but in the end, it's people who fund out of pocket.
JV: How about if I may, using the business case, of young people wanting to earn something, and getting contraceptives rather cheap from elsewhere, perhaps encouraged by NGOs or companies, and selling them for a very maneuvered price, in their villages, in poor urban neighborhoods, so they themselves for business reasons, advocates on contraceptive use?
MR: Is that the case for female condoms? I know it; snot the case in our programs, this is not how it works because…
JV: Has it been tried?
MR: I think there are drugstores that sell condoms amongst other things, and there is can work. But for peer educators, they will not earn enough.
YB: There is quite a reluctance to selling these things over the counter. And I think there is even reluctance sometimes to have peer educators handing out contraceptive pills to others. Because providers want to do these things themselves, and feel better for keeping in check and everything. Not to loose control.
JV: And with injectable, the nurses are in control. Now you said one of the reasons that that is successful is that the women can decide on her own, when she goes to a clinic for something else,

ask for an injectable, and not inform the men. Now this is simply a medical question, are these injectable run out? After some time? Or do they have to be taken out?

MR: They run out. But you also have these implant, and they need to be taken out.

YB: Implants really need to be inserted and removed.

JV: And what times do the injectable work?

MR: Three months. And for an implant, you need a medical professional to do that.

YB: What we see now a new development which has been introduced at the reproductive health coalition meeting in Seattle, is the self-injectable, that women can administer themselves.

JV: That is interesting, then of course, it may lead to terrible fights between the man and the woman, the man not wanting it, the woman wanting it, she does it in secret he punishing her. It certainly would not be a reason for anyone not to do this, I am just looking at the practicality, an injectable that only has the effect of three months, is a limited gain, because it uses a little bit of the lifetime of the woman, the succession of different pregnancies, and reduces somewhat her risks.

MR: And you need to make sure every three months she goes back to that access.

JV: And of course even if it is kept in secret, the story spreads, the men not wanting spacing, may very much object to this.

YB: But it is too simple to say that that is true for every woman in Africa, I mean there are very progressive women and there are ones who can never ever use anything because they get beaten, or whatever, you know. There is so much variation in between. If you only have that women in mind, then you can't work on any strategies except convincing the men. Which is what we are trying to do, to educate boys and men in relation to SRHR.

LG: And how is that going?

MR: I think that goes well, it depends on the realization of how we enforce on it. We have and used to have programs targeting men, but what we are doing now is mainstreaming that in all our programs. So insuring in everything that we do, we engage men and boys. And not only to support their girlfriends in taking decisions, also to address their own SRHR issues. So with Rutgers we capture the gender transformative approach, so whether it is sexuality education, or it is service provision, we ensure there is focus on promoting gender equality.

YB: At times, it also means that we first have to bridge the gap, because women are so much lacking behind, you have to address that gap first before you can start talking about gender equality

and other preventive measures. And I would say that is also, looking more into policy level, what people say that are women so much behind if there is illiteracy, if all these indicators are that bad, you cannot focus too much on men, because that is the impression you give if you say you want to work with men and boys. There has to be some, a bit more equality to enable discussion. Otherwise it will be again all the money going into men.

JV: How successful is the approach of working with role models? Male role models? People who are on television, who are on radios, and explain that?

MR: If that is the only thing you do, then it is unsuccessful. If you combine this with other interventions, and face-to-face interventions, then it is successful. And that is what we try to achieve. But ultimately, if you really want to have a successful family planning program in a country, you would need combination of these kinds of interventions, this one is very much addressing norms and attitudes, but you need of course individual, making it relevant for individuals, face-to-face information and advice, and you need access to your services, good quality care, and you need promoting laws and policy environment. But also, maybe it is a way to introduce what we have here, if you want to have a successful family planning program you need to focus on development and economic development in general. Because by promoting female participation in the workforce for instance, this will more or less automatically lead to having fewer children. And having access to money, enables people to better access and services, and for a health system to become stronger. And I think that is more and more the realization of how these domains interconnect. And how if you really want to make progressive steps, you need to link it to debates around economic developments, the environments, population growth, conflicts, migration, and that is becoming more of a realization of how SRHR becomes fundamental discussion of addressing these issues.

JV: And related to basic health insurance, basic pension programs, so the incentives change for individual people. Do you have a good analysis of what explains the success of Bangladesh?

MR: You mentioned BRAC, and that has been a very important element in this success. So you have the government, and then you have civil society and BRAC is like a shadow government almost. So they are so big, that they can really make a change. They are not fragmented like much of the civil society organizations are in other countries. So they are basically providing…

JV: The BRAC started small. And when it was a very small organization, Oxfam NOVIB picked it up and started supporting it. It grew tremendously. And it now works in 8 other countries,

including community development in Afghanistan of all places. So there is something in its formula that made it possible to organize itself notwithstanding the very poor conditions not withstanding the corrupt government, the Islamic influences, the poverty of people, so it was basically a message of an approach of involving local, uneducated women. And having a package of credit agricultural information, marketing, informal basic education, everything the government should have done. And it grew into a shadow government, some people think that is to be criticized. Of course it is not because it shows how well the formula works. And now, what is this original formula? What is the growth idea? The seed of BRAC?

MR: Community participation I think.

JV: But why was it successful in Bangladesh and not in other countries? Leadership?

YB: I think I would say a political will is always important.

MR: But also, they acknowledge the problem. Bangladesh has been quite densely populated, so I think as a country and as a people they have been very much aware that this would have caused problems for their environment and for themselves as a country. So I think the support for family planning has been big from the start.

JV: But I understand that BRAC started basically as a people to people help organization to reintegrate refugees after the war. The war between the east and west Pakistan, millions of Bangladeshi were dislocated. Having fled to India, or other areas. People themselves in villages taking the initiative to help. So it started simply with their humanitarian drive to help migrants. And if I understand well, then the BRAC people thought well, now we have to make sure that they have some kind of income and jobs. So they started with agriculture, rice growing, how to manage their water, the kids don't go to school because the schools are not there, so let's organize some informal education. And then they added family planning service.

MR: But BRAC is also not completely donor-dependent, they had their own banking system, they have their own economy,

JV: And all was created out of nothing. They had people who thought we should do this ourselves. It's self-reliance with very little means. But they still accept money from abroad. Because they say well it helps and we don't need your help, they told Oxfam, but it's nice that we have to report to you. So they applied the Dutch saying 'other eyes force us to be transparent'. The question which attracts me is why did it work in Bangladesh where there are so many countries with similar conditions where it doesn't happen?

MR: But if you would compare it to Niger, and I think there is something to do with the infrastructure and the fact that in Niger, it would be very difficult to reach people who are in the dessert or rural areas, while Bangladesh is of course very urbanized as well. So it is easier to reach a large amount of people there.

JV: BRAC worked particularly in area for agriculture. But there is also something in people's own attitudes, that is important to figure out and how to encourage that.

MR: But if you look at solutions, which you are, would you say that maybe we should replicate the BRAC formula? Or would you say that maybe we should do it with the existing government system?

JV: But there are so many countries where the government's system is wrong and corrupted and ineffective. And the advantage of the BRAC example is the government is wrong ineffective and corruptive, and BRAC worked anyway.

MR: But you can have the risk that a shadow system becomes corrupt and ineffective as well.

JV: Somehow BRAC idea grew tremendously.

MR: It also comes with risk, because I do hear sounds that there is tension, because of the power BRAC has, tension with the government.

JV: Yes, because the government is bad. Like in many other countries.

MR: But also because BRAC can do things and there is political power within BRAC, which is of course a threat to especially those who are in power and want to stay there. There is also a risk for conflict, of a system collapse.

JV: Yeah certainly. The best solution would be that the government adopts BRAC policy.

LG: So, for instance, assuming that there is 100 million Euros, and within the different stages that you just discussed, which part do you think requires the most money?

YB: The service is always more expensive compare to education compare to enabling environment, the advocacy part.

MR: At the same time, it is now more important than ever to focus on what we can achieve there.

YB: So I wouldn't measure the importance with the budget.

JV: I think everything starts with attitudes. Both wrong and positive. Let's take the Trump problem, the basic problem is attitudes of middle aged white people. And the anger they have. That makes them to look for a politician who shares their anger and has no solution whatsoever for their

problems. If you have lost your mortgage because of the financial crisis in 2007, Trump cannot fix it. Same applies to Wilders' policies in The Netherlands. The fact that people do not look for a solution, that might work for them, but follow their emotions, also negative emotions, and don't think practical.

YB: But I also think that a lot of people are actually, how to say that, are served by the system. So they think, for them Hilary is perpetuation of that system. And that's what they definitely don't want. It doesn't say that they really like Trump. That's something different. But they feel that the system fails them. And which I think in a way it's true, I mean look at divide in income and I think that's the same in The Netherlands. You know if you look at what a teacher at a primary school earns, I think the salary hasn't gone up for the last how many years. I mean that's ridiculous I think.

JV: I agree, but then, still,

YB: I don't say that Wilders is the solution, or Trump,

JV: I understand your point, but the key is changing people's thoughts and attitudes, once they are really interested in spacing children,

YB: But I think the way the political debate is, if you only hear words like you are a lair, …. I'm sorry I cannot say this in English, then what impression do you get? You know if you look at bankers, and the money they earn, the idea people have and their salary increases year after year after year

JV: You use the verb earn, I would use the verb rob, much of it is fraudulent, but again, it is people's thoughts that make the changes. For good or for worse. It's their attitudes that is what can change things around quite rapidly for the worse. For changes that would be favorable for family planning, and for people's health and for women's rights, strengthening the position of girls. You emphasize that too.

MR: But you need two different things. Because you can influence opinions and attitudes through for instance campaigns, but what you ultimately want is an empowered community, people who can critically think. For that we need a very well functional educational system. And that means that you need to revolutionize the way that,

JV: Well, you talked about the educational system, one of the developmental projects that I once visited for Oxfam, was an extremely low cost program in India. Indian students going into the worst areas in the large cities, asking the women where are the kids, the kids are there playing in the dirt. Why are they not in school? Yeah that's not for us, we are the lowest cast, the kids are

refused at school. No madam, did you know that in the Indian legislation, every kid has the right to go to primary school. So we come back tomorrow, have your kids ready, we go to school. We rattle at the gate and we ask for a talk with the headmaster, and say these kids they belong in this school, whether you like them or not, you have to take not. If they refuse, we take them to the local journalists the next time. And in two weeks we return, and ask why are there no separate toilets for girls and boys? Where are the school books? Where is the teacher? The teacher is also a taxi driver. So what changes then, in this simple approach, is the thinking of the mothers and fathers. Hey, we have the rights to education for our kids. And that change leads to meetings with these people, discussing their experiences, I was in such meetings, and it's marvelous the energy comes out of these Dallas, the lowest of the cast, we have rights, and it's just that idea, we have human rights, one of them is education for our kids. And if that works with students from Indian high schools, and it costs almost nothing, you have to organize these students, and that's all Oxfam does, so I'm looking for such solutions that

MR: But you need one step more, you need to show these people the democratic channels to then bring about change. Because then they send their kids to school, but the teacher is not there because he is also a taxi driver, they will say there is no use, you see. Unless they can then, hold accountable those who are responsible for the well functioning of that educational system, of that school and of their education, this will not work. Because that's what we have also seen that people they claim for their rights, the right to contraception, the right to services. If it's not there, then they become even more dispersed. Like you see, this is not for us. What we see works, especially amongst young people, is that if you link them to civil society organizations, that gives them the channels and the platforms to those who hold the power, then there you can create change.

JV: It's meetings with people in similar situations who exchange their experiences, also share anger about this situation, and most of all, share solutions. Someone stepping out and say yeah this happened to me too. So it's basically a community development, and changing people's attitudes. Because that can increase the demand for contraceptives and for birth spacing. It starts, and that's in a way also the beauty of it, it starts with something that cost nothing: a better idea. And in this day and age, better ideas can spread in a friction of a second through telephone and internet.

MR: But it then again can become a risk, because you see that youth movement and young people who use social media to mobilize each other to these kinds of discussions, that is there is not a quick resolve, then it can also create a lot of unrest. So how to go about for these challenges,

because that is for us also sometimes the ethical dilemma, by making people more aware of their rights, and by enhancing their way of critical thinking, and ask them questions to those who are in power, you also fire up people's anger.

JV: So called Arab spring which had worsen the situation except for one successful case, Tunisia, still, I mean social change often cause a lot of violence. But it is in a way a necessary part in long term social developments. It's a very bad ingredient of course and the best is peaceful adjustment to the needs of the future. But, many people experience the collective tensions which turned violent. I will stop.

MR: For us, this is one of the solutions we seek. We empower young people to be advocates to talk with the local leaders. We see in local leaders a lot of change in attitudes, can already start there. And you see this especially effective if it's about early child marriage, female genital mutilation, things that are part of a traditional system, and if you have enough people, sometimes it's be pushed by young people who want the change, who say we don't want this any longer, and for these and that reasons, then you see that things are changing in terms of fire walls that are being adjusted, and from there it can go from bottom up. Ideally you want to do top down things, and bottom up things and bring them together.

JV: Bottom up can be encouraged by mobile telephones and internet, which spread very fast, also in the poorest countries, social media.

MR: And that is what we have seen in Uganda, our partners, who provide sexuality education so for whom is this debate the dialogue, very hot debate also in the media where they are being slammed, targeted, including their own names, of promoting homosexuality, which has nothing to do with, but very frustrating. They mobilize their constituency, young people, to come to a inter-gender dialogue in universities, where they have invited the opposition, religious leaders, including the ambassador of the Dutch embassy. And the media was there and they had a dialogue. And I think that is now an increasing power way of having debates about it. This was in Uganda.

JV: And the Dutch ambassador participated? Against the government line?

MR: He spoke as a father, which was interesting, but also of course from his position, yes he spoke for pro sexuality education and the question was whose responsibility is this? And the governmental staff was like no, biology is enough. The civil society organizations and the young people said no, we have the right to know and we need to know and somebody has to address this

and you cannot and should not stop us. And the ambassador was supporting our partners which was fantastic.

YB: youth participation into our activities is our basic principle.

JV: I am looking for reasons that people cannot deny that are valid. Also in their value system. Like what e discussed in the beginning, the health of the girl of the lady, you remember the Pakistani doctor who was on our board, of the World Population Fund, Nafi Sadiq, she was a local physician in a local village. What I am telling now is her origin and later on her fame and her role as head of the development UN institution. She saw the suppression of women, and she as a local female physician coming from a wealthy family, where the father was a general and encouraged that his daughter would go to university. And she called all the men in the village she worked or in the city where she worked, which are mostly Pakistani military officers. And she said I am very concerned about the health of and how your sons are doing. I see a lot of unnecessary illnesses, I see psychological problems, and I think you all can create a much better condition for the future for your sons if you approach their mothers in a different way. And that of course they couldn't deny that it was a very effective way and approach. And started her fame. So the question is the right way of entering into the minds of the people concerned.

LG: So what are the effective messages to penetrate the resistance of contraception in Uganda?

MR: I think it's not anti-contraception, I think not on a policy level. In the community yes, I mean there is the norm for showing fertility and raising social status if you have many children. So there is an attitude to address there. But I think in general, and that is everywhere, things that have to do with sexuality are very much loaded with how people view sexuality.

YB: It's about morality, how people should behave,

MR: And that influences so much on what rules are passed and what policies are being developed. And for Uganda, we built progress progress progress, then comes the new leadership, bang. You have to go back. And you have to go build it again and again and again. So for us it seems that always one step forward two steps back, one step forward, two steps back. It's the same with Trump, we go back now, and hopefully in 4 years of time, or earlier,

YB: Hopefully earlier,

JV: He will run into trouble,

MR: And hopefully there will be more space for more progressive leaders there. I think now in this world you are better to say that it seems to be, the divide, the polarization in the world is bigger

than ever. And what you see is when Trump was elected, emails from big organizations that say we need to stand together now more than ever. We need to form allies and have our strategies to be there to be able to cope with this.

YB: It's not always rational. Sometimes you can prove things but people wont believe you. And that is frustrating.

MR: Everything is evidence based, we build our evidence, and then people will just ignore it.

LG: People you mean people in Uganda or?

MR: In general, People in power who have strong opinions. They will only believe the evidence when it is in their interests.

YB: its also a lot to do with emotion. Because of the new media, something happens somewhere and within seconds people worldwide know about it already, even if it is wrong.

JV: the social media has a lot of issues with false messages.

YB: in a way we are living in the safest times of history, but everyone feels very unsafe and insecure because we are more aware (of the internet safety).

JV: Social media is a very important mean for Rutgers, I think. And for likeminded organizations. You will have to reach people much better because you also have to cover the false information that is spread by the same media channels.

MR: What might help you is this report. You might like this paper, it's a bit of analysis, and also where and how family planning programs were developed in the past, where resistance and pro family planning programs come from, and where it is now. And as Rutgers what we see and how we think it should be moved forward.

JV: I see here that some of the strongest decrease is in east and central European countries, where we see indeed in the population projections of the UN, that those countries shrink. While other European countries remain more or less stable or also shrink. And even though in some of these countries the church is still very powerful and old fashioned ethics prevail,

YB: But people do use contraception.

JV: I remember just a funny anecdote, when Romania opened after the democratic revolution, there was an order of condoms from The Netherlands. And the counter question was how are you going to pay, we can't pay was the response, we can only butler trade. And I have a truckload full of broomstick for you.

LG: I am adding that to my thesis.

Data sheet 1: UNFPA World Population Projection 2100 (United Nations Economic and Social Affairs, 2015)

Total Population by sex (thousands)		
Location	**Note**	**2100**
World		11 213 317
More developed regions	a	1 277 379
Less developed regions	b	9 935 938
Least developed countries	c	3 167 116
Less developed regions, excluding least developed countries	d	6 768 822
Less developed regions, excluding China		8 910 082
High-income countries	e	1 512 091
Middle-income countries	e	7 224 894
Lower-middle-income countries	e	4 916 720
Upper-middle-income countries	e	2 308 174
Low-income countries	e	2 471 875
Sub-Saharan Africa	f	3 934 828
Africa		4 386 591
Eastern Africa		1 576 955
Burundi		62 662
Comoros		2 307
Djibouti		1 126
Eritrea		15 616
Ethiopia		242 644
Kenya		156 856
Madagascar		105 499
Malawi		87 056
Mauritius	1	952
Mayotte		752
Mozambique		127 648
Réunion		870
Rwanda		25 692
Seychelles		81
Somalia		58 311
South Sudan		41 752
Uganda		202 868
United Republic of Tanzania	2	299 133
Zambia		104 869
Zimbabwe		40 263
Middle Africa		721 296
Angola		138 738
Cameroon		82 382
Central African Republic		12 515
Chad		68 927
Congo		22 015
Democratic Republic of the Congo		388 733
Equatorial Guinea		2 984
Gabon		4 466
Sao Tome and Principe		538
Northern Africa		451 763
Algeria		61 060
Egypt		200 802
Libya		8 144
Morocco		40 888
Sudan		127 328
Tunisia		12 494
Western Sahara		1 047
Southern Africa		80 737
Botswana		3 681
Lesotho		3 548
Namibia		5 730
South Africa		65 696
Swaziland		2 082
Western Africa	3	1 555 840
Benin		35 544
Burkina Faso		80 990
Cabo Verde		680
Côte d'Ivoire		101 154
Gambia		8 896
Ghana		73 033
Guinea		49 049

Guinea-Bissau		5 489
Liberia		15 977
Mali		92 981
Mauritania		13 059
Niger		209 334
Nigeria		752 247
Saint Helena		3
Senegal		75 042
Sierra Leone		14 489
Togo		27 873
Asia		4 888 653
Eastern Asia		1 176 865
China	4	1 004 392
China, Hong Kong SAR	5	7 924
China, Macao SAR	6	1 023
Dem. People's Republic of Korea		24 842
Japan		83 175
Mongolia		4 487
Republic of Korea		38 504
Other non-specified areas		12 518
South-Central Asia	7	2 456 649
Central Asia		90 000
Kazakhstan		24 712
Kyrgyzstan		9 046
Tajikistan		18 559
Turkmenistan		5 606
Uzbekistan		32 077
Southern Asia		2 366 649
Afghanistan		57 638
Bangladesh		169 541
Bhutan		793
India		1 659 786
Iran (Islamic Republic of)		69 637
Maldives		438
Nepal		29 677
Pakistan		364 283
Sri Lanka		14 857
South-Eastern Asia		769 404
Brunei Darussalam		489
Cambodia		23 928
Indonesia		313 648
Lao People's Democratic Republic		10 411
Malaysia	8	40 778
Myanmar		56 026
Philippines		168 618
Singapore		5 593
Thailand		41 604
Timor-Leste		3 234
Viet Nam		105 076
Western Asia		485 736
Armenia		1 793
Azerbaijan	9	9 636
Bahrain		1 602
Cyprus	10	1 386
Georgia	11	2 438
Iraq		163 905
Israel		17 285
Jordan		14 147
Kuwait		6 484
Lebanon		4 741
Oman		5 751
Qatar		3 170
Saudi Arabia		47 586
State of Palestine	12	15 516
Syrian Arab Republic		38 098
Turkey		87 983
United Arab Emirates		13 389
Yemen		50 826

Europe		645 577
Eastern Europe		208 024
Belarus		6 916
Bulgaria		3 406
Czech Republic		8 774
Hungary		6 506
Poland		22 289
Republic of Moldova	13	1 856
Romania		10 700
Russian Federation		117 445
Slovakia		3 732
Ukraine	14	26 400
Northern Europe	15	128 679
Channel Islands	16	182
Denmark		6 838
Estonia		904
Faroe Islands		52
Finland	17	5 857
Iceland		384
Ireland		6 372
Isle of Man		114
Latvia		1 278
Lithuania		2 013
Norway	18	7 845
Sweden		14 470
United Kingdom		82 370
Southern Europe	19	118 491
Albania		1 755
Andorra		60
Bosnia and Herzegovina		1 919
Croatia		2 615
Gibraltar		28
Greece		7 393
Holy See		1
Italy		49 647
Malta		348
Montenegro		437
Portugal		7 407
San Marino		30
Serbia	20	5 334
Slovenia		1 693
Spain	21	38 337
TFYR Macedonia	22	1 487
Western Europe	23	190 384
Austria		8 335
Belgium		13 210
France		75 998
Germany		63 244
Liechtenstein		47
Luxembourg		1 030
Monaco		55
Netherlands		17 220
Switzerland		11 245
Latin America and the Caribbean		721 224
Caribbean	24	40 262
Anguilla		11
Antigua and Barbuda		114
Aruba		84
Bahamas		498
Barbados		259
British Virgin Islands		36
Caribbean Netherlands		32
Cayman Islands		99
Cuba		7 103
Curaçao		208
Dominica		52
Dominican Republic		12 027
Grenada		72

Guadeloupe	25	437
Haiti		13 544
Jamaica		1 704
Martinique		289
Montserrat		5
Puerto Rico		2 212
Saint Kitts and Nevis		63
Saint Lucia		168
Saint Vincent and the Grenadines		77
Sint Maarten (Dutch part)		63
Trinidad and Tobago		984
Turks and Caicos Islands		52
United States Virgin Islands		69
Central America		216 959
Belize		677
Costa Rica		4 993
El Salvador		4 420
Guatemala		34 812
Honduras		10 646
Mexico		148 404
Nicaragua		6 996
Panama		6 012
South America	26	464 003
Argentina		58 572
Bolivia (Plurinational State of)		18 118
Brazil		200 305
Chile		19 744
Colombia		45 321
Ecuador		24 499
Falkland Islands (Malvinas)		3
French Guiana		891
Guyana		595
Paraguay		8 665
Peru		41 557
Suriname		548
Uruguay		3 258
Venezuela (Bolivarian Republic of)		41 927
Northern America	27	500 143
Bermuda		42
Canada		49 668
Greenland		41
Saint Pierre and Miquelon		7
United States of America		450 385
Oceania		71 129
Australia/New Zealand		48 483
Australia	28	42 389
New Zealand		6 094
Melanesia		21 096
Fiji		696
New Caledonia		419
Papua New Guinea		17 951
Solomon Islands		1 354
Vanuatu		677
Micronesia	29	744
Guam		242
Kiribati		244
Marshall Islands		75
Micronesia (Fed. States of)		116
Nauru		9
Northern Mariana Islands		29
Palau		29
Polynesia	30	805
American Samoa		40
Cook Islands		21
French Polynesia		297
Niue		2
Samoa		262
Tokelau		2

(United Nations Economic and Social Affairs, 2015)

Data sheet 2: UNFPA World Population Projection 2100 Africa

Total Population by sex (thousands)		
Location	**Note**	**2100**
World		
Sub-Saharan Africa	f	3 934 828
Africa		4 386 591
Eastern Africa		1 576 955
Burundi		62 662
Comoros		2 307
Djibouti		1 126
Eritrea		15 616
Ethiopia		242 644
Kenya		156 856
Madagascar		105 499
Malawi		87 056
Mauritius	1	952
Mayotte		752
Mozambique		127 648
Réunion		870
Rwanda		25 692
Seychelles		81
Somalia		58 311
South Sudan		41 752
Uganda		202 868
United Republic of Tanzania	2	299 133
Zambia		104 869
Zimbabwe		40 263
Middle Africa		721 296
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Cameroon		82 382
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Congo		22 015
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Egypt		200 802
Libya		8 144
Morocco		40 888
Sudan		127 328
Tunisia		12 494
Western Sahara		1 047
Southern Africa		80 737
Botswana		3 681
Lesotho		3 548
Namibia		5 730
South Africa		65 696
Swaziland		2 082
Western Africa	3	1 555 840
Benin		35 544
Burkina Faso		80 990
Cabo Verde		680
Côte d'Ivoire		101 154
Gambia		8 896
Ghana		73 033
Guinea		49 049
Guinea-Bissau		5 489
Liberia		15 977
Mali		92 981
Mauritania		13 059
Niger		209 334
Nigeria		752 247
Saint Helena		3
Senegal		75 042
Sierra Leone		14 489
Togo		27 873

(United Nations Economic and Social Affairs, 2015)

Data sheet 3: UNFPA World Population Projection 2100 Europe

Total Population by sex (thousands)		
Location	**Note**	**2100**
World		
Europe		645 577
Eastern Europe		208 024
Belarus		6 916
Bulgaria		3 406
Czech Republic		8 774
Hungary		6 506
Poland		22 289
Republic of Moldova	13	1 856
Romania		10 700
Russian Federation		117 445
Slovakia		3 732
Ukraine	14	26 400
Northern Europe	15	128 679
Channel Islands	16	182
Denmark		6 838
Estonia		904
Faroe Islands		52
Finland	17	5 857
Iceland		384
Ireland		6 372
Isle of Man		114
Latvia		1 278
Lithuania		2 013
Norway	18	7 845
Sweden		14 470
United Kingdom		82 370
Southern Europe	19	118 491
Albania		1 755
Andorra		60
Bosnia and Herzegovina		1 919
Croatia		2 615
Gibraltar		28
Greece		7 393
Holy See		1
Italy		49 647
Malta		348
Montenegro		437
Portugal		7 407
San Marino		30
Serbia	20	5 334
Slovenia		1 693
Spain	21	38 337
TFYR Macedonia	22	1 487
Western Europe	23	190 384
Austria		8 335
Belgium		13 210
France		75 998
Germany		63 244
Liechtenstein		47
Luxembourg		1 030
Monaco		55
Netherlands		17 220
Switzerland		11 245

(United Nations Economic and Social Affairs, 2015)

Data sheet 4: UNFPA World Population Projection 2100 men in Africa

Total Population by sex (thousands)		
Location	**Note**	**2100**
World		
Sub-Saharan Africa	f	1 962 759
Africa		2 190 403
Eastern Africa		783 069
Burundi		30 999
Comoros		1 152
Djibouti		551
Eritrea		7 847
Ethiopia		119 822
Kenya		77 509
Madagascar		52 878
Malawi		43 464
Mauritius	1	474
Mayotte		373
Mozambique		63 314
Réunion		425
Rwanda		12 554
Seychelles		39
Somalia		28 873
South Sudan		20 807
Uganda		100 679
United Republic of Tanzania	2	149 498
Zambia		51 991
Zimbabwe		19 818
Middle Africa		357 316
Angola		68 705
Cameroon		40 733
Central African Republic		6 108
Chad		34 141
Congo		10 955
Democratic Republic of the Congo		192 712
Equatorial Guinea		1 480
Gabon		2 218
Sao Tome and Principe		264
Northern Africa		227 644
Algeria		30 931
Egypt		102 035
Libya		4 139
Morocco		20 555
Sudan		63 082
Tunisia		6 369
Western Sahara		532
Southern Africa		39 585
Botswana		1 824
Lesotho		1 752
Namibia		2 832
South Africa		32 164
Swaziland		1 013
Western Africa	3	782 789
Benin		17 604
Burkina Faso		40 321
Cabo Verde		342
Côte d'Ivoire		50 384
Gambia		4 382
Ghana		36 310
Guinea		24 509
Guinea-Bissau		2 693
Liberia		8 032
Mali		47 189
Mauritania		6 484
Niger		105 678
Nigeria		380 150
Senegal		37 782
Sierra Leone		7 137
Togo		13 790

(United Nations Economic and Social Affairs, 2015)

List of Least Developed Countries

United Nations
Committee for Development Policy
Development Policy and Analysis Division
Department of Economic and Social Affairs

List of Least Developed Countries (as of May 2016)*, **

Afghanistan (1971)	Madagascar (1991)
Angola[1] (1994)	Malawi (1971)
Bangladesh (1975)	Mali (1971)
Benin (1971)	Mauritania (1986)
Bhutan (1971)	Mozambique (1988)
Burkina Faso (1971)	Myanmar (1987)
Burundi (1971)	Nepal (1971)
Cambodia (1991)	Niger (1971)
Central African Republic (1975)	Rwanda (1971)
Chad (1971)	Sao Tome And Principe (1982)
Comoros (1977)	Senegal (2000)
Dem. Rep Of The Congo (1991)	Sierra Leone (1982)
Djibouti (1982)	Solomon Islands (1991)
Equatorial Guinea[2] (1982)	Somalia (1971)
Eritrea (1994)	South Sudan (2012)
Ethiopia (1971)	Sudan (1971)
Gambia (1975)	Timor-Leste (2003)
Guinea (1971)	Togo (1982)
Guinea-Bissau (1981)	Tuvalu (1986)
Haiti (1971)	Uganda (1971)
Kiribati (1986)	United Rep. Of Tanzania (1971)
Lao People's Dem. Republic (1971)	Vanuatu[3] (1985)
Lesotho (1971)	Yemen (1971)
Liberia (1990)	Zambia (1991)

** The list will be updated when new decisions become available.*

*** Year of inclusion on the list in brackets.*

[1] General Assembly resolution A/RES/70/253 adopted on 12 February 2016, decided that Angola will graduate five years after the adoption of the resolution, i.e. on 12 February 2021.

[2] General Assembly resolution A/RES/68/18 adopted on 4 December 2013, decided that Equatorial Guinea will graduate three and a half years after the adoption of the resolution, i.e. on 4 June 2017.

[3] General Assembly resolution A/RES/68/18 adopted on 4 December 2013, decided that Vanuatu will graduate four years after the adoption of the resolution on 4 December 2017. General Assembly resolution A/RES/70/78 adopted on 9 December 2015, decided to extend the preparatory period before graduation for Vanuatu by three years, until 4 December 2020, due to the unique disruption caused to the economic and social progress of Vanuatu by Cyclone Pam.

(United Nations Committe for Development Policy, 2016).