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Renewed effort to boost birth control

There is an increased determination to spread the benefits of contraception, says **Andrew Jack**

As World Population Day approaches on Wednesday, the medium – a UN website – may be glossier than ever, but the message is the same.

There is wide agreement on what is required to provide reproductive health to all, but the reality is falling far short.

Nearly 20 years after governments reached consensus at an international conference in Cairo on family planning in 1994, progress has been limited and, in some cases, the trend has gone into reverse.

About 215m women in developing countries seeking contraception cannot get it. That means 75m unintended pregnancies every year, threatening the health and lives of millions of mothers and their children.

Meanwhile, the world population has exceeded 7bn, placing fresh pressure on economic growth, the environment and the wellbeing of communities.

The realisation of ambitious health-related targets set at international meetings since Cairo has also proved disappointing. The UN Millennium Development Goals agreed at the turn of the century called for significant reductions in infant and maternal mortality by 2015.

In many countries, it is clear these targets will not be met.

Yet there are signs of fresh determination to boost contraceptive assistance. Following meetings in Uganda and Senegal, London is host to a high-level family planning summit on July 11.

The aim is to increase contraceptive access for the poor from 260m women a year today to 380m by 2020.

"Since Cairo, we have had conflicts and economic crises that have hindered progress," says Tewodros Melesse, director-general of the International Planned Parenthood Federation.

"Now is an opportune moment to create political momentum, bring major donors together and mobilise civil society."

Across much of the world in the past, industrialisation, improved nutrition and sanitation pushed down family size with the help of contraception. But while significant advances in immunisation and medical treatment since the second world war have sharply cut infant mortality, that has not always translated so rapidly into falling birth rates.

While some women still want large families, many more do not. Aside from the health risks, there are economic consequences of this "unmet demand". Teenage mothers tend to drop out of school, depriving themselves, their families and societies of a more educated workforce and the prospect of stronger economic growth.

"Family planning has been a huge determinant of long-term development," says Raj Shah, head of USAID, the world's largest donor which gives $625m a year to the field. "We have an obligation and a real need to do a better job."

Andrew Mitchell, the UK's international development minister, adds: "In cost terms, family planning is excellent value for money. The relevant services, including the provision of contraception, cost on average less than £1 per person per year – far less than treating the complications of an unintended pregnancy."

Mobilised by fears that overpopulation would limit development, however, India ran a coercive sterilisation campaign in

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Seeking attention: 215m women who want contraception cannot get it. These Ethiopian women are waiting at a clinic IPPF/Chloe Hall

Inside this issue

Market expected to reach $17bn by 2015

Contraception

Andrew Jack looks at the wide variety of methods used around the world

By their method, you shall know them. Around the world, family planning techniques vary widely, reflecting cultural factors and medical attitudes as well as more practical issues of formulation, price and access.

In Japan, condoms and abortion are common. In China, the coil is widespread and the oral pill has almost no role. In India, sterilisation is the preferred method, while, in Africa, injectables dominate.

"Culture, religion, the social environment and the position women have in society all play a role," says Klaus Brill from Bayer Healthcare, a leader in hormonal contraceptives and the developer of the birth control pill, which by volume remains the most important product it has in the field.

According to a survey by the Guttmacher Institute in 2008, of the 818m sexually active women across the developing world who wanted to avoid becoming pregnant, more than a quarter used no contraceptive at all or a traditional method with limited efficacy, such as withdrawal or periodic abstinence.

That reflects not only high costs and limited availability, but also sometimes misplaced suspicion of side effects and a low perception of risks of pregnancy among those having sex infrequently or still breastfeeding a previous child.

For those using "modern" methods, the pattern also varies widely by geography. In sub-Saharan Africa, for example, injectable contraceptives and implants dominate, accounting for 38 per cent and the pill for another 26 per cent. In south central Asia, sterilisation is the most widely used, making up 64 per cent and the pill just 12 per cent.

Among the world's poorest 69 countries, a study by the Population Reference Bureau showed that sterilisation was most widespread at 17 per cent of women using modern methods, followed by oral contraceptives at 7 per cent, injectables and then intra-uterine devices (IUDs) at just over 5 per cent, with condoms at nearly 4 per cent.

Overall, contraceptives are big business. A recent report by GIA, a market research group, estimates the economic downturn has done nothing to flatten sales, as couples defer or avoid having children to reduce costs. It forecasts demand will rise to $17bn by 2015.

The market for some of the leading products has been dominated by a small number of large western companies, including the pharmaceuticals groups Pfizer, Merck and Bayer.

> Developments include 'dual purpose' products that can also combat HIV

That is beginning to change, through both generic competition and innovative products from new as well as existing producers.

Terrie Curran, general manager for women's healthcare at Merck, says: "In the past five years, there has been a significant increase in investment.

"There was a period when many companies were getting out, but many are now reinvesting, realising there is unmet need and a need for innovation."

Many see IUDs and long-lasting implants as the most promising techniques. While the initial cost is higher than the alternatives, they have the advantages of reversibility, reliability and discretion, important if sexual partners object to contraception.

Merck and Bayer have developed matchstick-sized devices that fit under the skin and release hormones.

The Gates Foundation is studying Sino-Implant (II), a low-cost version made by Shanghai Dahua Pharmaceuticals. While the short-term costs of purchase and insertion are higher, maintenance is then low.

Fresh debate over problems with current contraceptives and the need for more detailed research has been sparked by a study published last year suggesting women taking hormonal injections such as Depo-Provera have twice the rate of HIV of those using alternative methods.

Researchers argue as to what extent the difference is due to the product or other issues such as differences in condom use and sexual frequency.

In the absence of a costly new clinical trial that raises practical and ethical challenges, the World Health Organisation has taken the view that current guidelines should remain, but that women using hormonal injections should also use condoms.

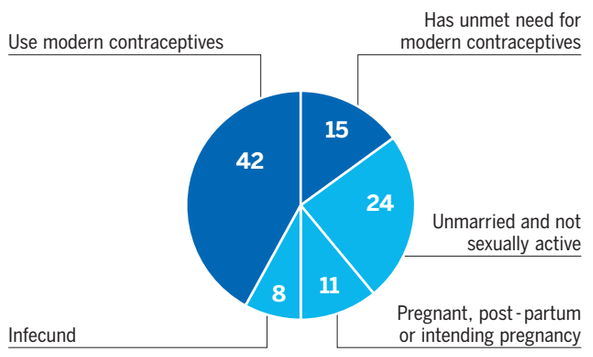
Promising developments include "dual purpose" products that can piggyback off research in related fields.

Zeda Rosenberg, head of the International Partnership for Microbicides, which is co-ordinating clinical trials for the use of a vaginal ring that slowly releases antiretroviral drugs to prevent HIV, sees potential in adding a contraceptive product too.

"Advancing a product that could expand both women's HIV prevention and family planning options could have profound benefits," she says.

Such a device is still some years away at best, however. While not neglecting innovation, greater impetus is required to ensure existing products are used more widely.

Contraceptive needs of women in the developing world
Per cent



Sources: Guttmacher Institute; UNFPA

Bottlenecks that block the chain of supply

Delivery

Price is not the only problem hindering access to products, says **Andrew Jack**

For more than a year, Edward Wilson and his team at John Snow Inc have been struggling with the paperwork to import condoms into Ethiopia, risking supply problems even in one of the countries widely seen to have made big advances in family planning.

"It's taken a long time to understand the regulatory requirements and submit documents that suppliers are not used to," he says. "We've been limited in our ability to ship with only one or two manufacturers registered. If there's a last-minute order, than means it can be difficult to meet."

He highlights problems often neglected in the discussion over access to products. "Unmet demand" for contraceptives is not just about insufficient resources for purchases or the need for newly designed variants, but also innovation in the less sexy "back office" to smooth the delivery of existing stocks.

"Countries have been strengthening their regulatory systems in the past five years," says Mr Wilson, whose company oversees via USAID some of the largest purchases of family planning products in the world. "It's a good thing for them to have more ownership, but registration can be long and complicated."

Terrie Curran, general manager for women's healthcare at Merck, agrees. "The regulatory environment is a critical bottleneck," she says. "Standardised methods of reviewing would help access. Each country has unique requirements. Every dossier has to be different, and the level of work that goes into changing them is significant."

All along the supply chain, obstacles restrict the efficient distribution of relevant commodities. Before donors will even approve the purchase of contraceptives, they often require them to be "pre-qualified" as meeting the standards established by the World Health Organisation.

Dana Hovig, chief executive of Marie Stopes International, says: "The pre-qualification process is broken for family planning and is letting women down. There are hundreds of antiretrovirals approved for HIV, which has brought prices down sharply, but there is a handful of mostly northern [industrialised countries] family planning manufacturers. That's a travesty that keeps prices up."

He and others have been pushing for an accelerated "expert review panel" of international agencies that would scrutinise the quality of family planning products and allow donors to provide funding to purchase them, even while approval is pending.

A UN commission on 13 life-saving commodities for women and children concludes that regulation is proving a barrier by delaying registration or by doing little to prevent low-quality commodities.

The high cost of "bio-equivalence" studies to show that cheap generics are the same quality and efficacy as original versions can deter companies from launching rival products.

That is one contributor to the so-called "market trap": a vicious cycle in which manufacturers anticipate high costs and low returns, so they do not invest and rivals do not enter the field.

It affects manufacturers of contraceptives and other important products for mother and child health.

Many point to high prices limiting access to essential products.

But Klaus Brill from Bayer Healthcare says: "There's often a tendency to argue only about price, but other elements have a bigger impact. Even if manufacturers were to give products away, it would be hard to get them to women."

He says that poor forecasting and erratic orders make it difficult to plan, produce and charge lower prices. "We can't produce within a couple of days. Donors have to give a commitment for longer than 12 months."

John Skibiak, director of the Reproductive Health Supplies Coalition, a non-profit group trying to tackle such problems, says procurers such as the UN population fund place an order only when they have received money from donors, "which is erratic and comes in dribs".

One response has been Pledge Guarantee for Health, providing letters of credit for rapid funding after donors have agreed disbursement but before the cash arrives. That has helped Merck offer significant price cuts on its contraceptive implants. Others are discussing "market shaping" through global pooled procurement with volume guarantees.

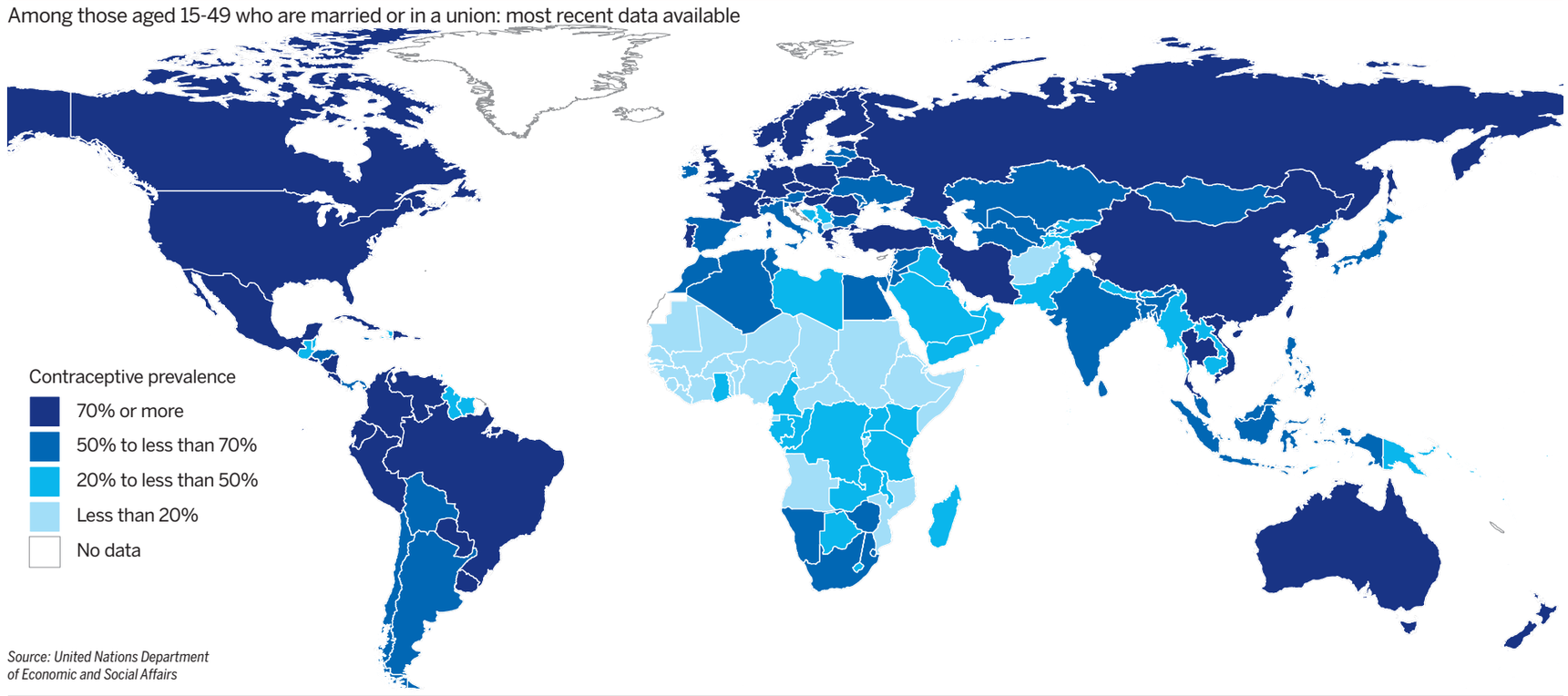
But even if products are funded, authorised, ordered and given national regulatory approval, there is still no guarantee they will consistently reach women seeking them.

"Stock-outs" are frequent, reflecting poor procurement and supply-chain management, triggering experiments such as the "informed push model" in Senegal to provide better co-ordination and information from regions to the distribution centre.

"For a long time, people have thought it's just something that happens in the back office," says Mr Wilson.

"We need to persuade stakeholders that, while they need to be able to control the supply chain, they don't need to do all the work: it could be private, public or through NGOs."

Percentage of women using some method of contraception
Among those aged 15-49 who are married or in a union: most recent data available



Source: United Nations Department of Economic and Social Affairs

Renewed effort to boost birth control

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the 1970s. China still operates a one-child family policy, highlighted last month by a widely publicised case of a compulsory abortion.

Apart from the human rights abuses that such policies represent, evidence from other countries such as Bangladesh has shown that significant progress can be achieved voluntarily, as long as there is the political will.

But if the Cairo conference condemned coercion and reached a clear consensus on how to help women meet their own desire to limit family size, momentum to provide them with the necessary support has slowed.

Some argued at the time that birth rates were already falling and greater action was no longer required. Donors began to switch to different causes. Ideology and religion also played a role, with US policy requiring recipients of aid to condemn prostitution and not undertake abortions; and the hierarchy of the Roman Catholic church critical of contraception.

Gary Darmstadt, director of family planning at the Gates Foundation, which has upped its own contribution, says: "There was pretty broad support for family planning in the 1970s and 1980s across people of various political backgrounds and ideologies, but then the issue became more polarised. Abortion was linked to contraception and it began to create a divide that persists today."

For him and others focused on this week's conference, a first priority is renewed political commitment linked to fresh funding. It will cost $10bn between now and 2020 for the world's poorest 69 countries to maintain current levels of contraceptive support for 260m women. A further $4.5bn will be required to help 120m more, including $2.3bn from donors.

Efforts are focused on a combination of new money and better use of existing resources, with countries putting forward plans tailored to their own needs.

Participants will also seek greater accountability and co-ordination, pushing for better scrutiny of governments and charities to increase efficiency.

But many also argue for a bigger role for both the private sector – where many women turn for contraceptives – and faith-based organisations.

"Many people think that religious leaders are against family planning," says Ray Martin, head of Christian Connections for International Health. "Of course, some are, but many, probably most, are not."

A second issue at the London summit is "market shaping" to remove regulatory hurdles, ease procurement, improve forecasting and strengthen distribution. That should help reduce uncertainty, boost volumes and push down prices for contraceptives.

A third tack will be to foster improved technologies, whether by using mobile phones to track supply shortages better or new longer-lasting contraceptive implants that are discreet, reversible, reliable and minimise the inconvenience.

> 'Family planning is not just about commodities. It is about health, education and empowerment'

Given tough economic times and the longstanding reluctance of donors to co-operate and pool resources, finding money will be one challenge for richer and poorer countries alike in meeting the latest objectives. Another will be fear that a renewed "vertical" focus on family planning risks diverting thinly stretched medical workers and undermining a more holistic "horizontal" approach to the provision of healthcare, including other still more neglected infections such as syphilis or schistosomiasis, which can in turn boost susceptibility to HIV.

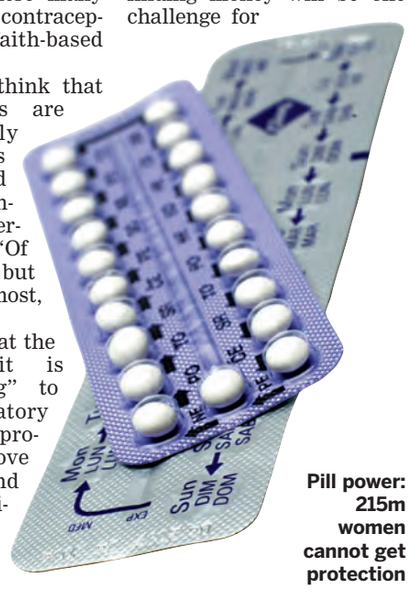
A final issue is the broader question of women's power. Pam Barnes, head of EngenderHealth, a New York charity, says: "Family planning is not just about commodities. It's about health, education and empowerment. I've lived in places where women can't even walk to the health post without permission. Male involvement is vital."

Ironically, while many organisations working in family planning are heavily staffed by women, they are often run by men.

British officials have dropped the phrase the "golden moment" to describe the London summit's efforts to remobilise global support for family planning. But, in the build-up to the Olympic Games, participants are hoping at least for a bronze medal in effort and funding.

If they succeed, the legacy could be far longer lasting than the sporting event that follows.

If they fail, human suffering and economic stagnation will certainly be greater.



Pill power: 215m women cannot get protection

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Safe sex needs to be taught beyond the schoolroom

Education

Childhood and classes often end at an early stage in the developing world, says **Chris Cook**

At root, all sexual health problems are education problems. There is little that anyone can do to mitigate the risks of sexually transmitted disease or unwanted pregnancy if they do not first understand the dangers associated with sex or the technologies available to render it safer.

Sadly, according to Demographic and Health Surveys in the developing world, agencies and governments are failing to spread this life-saving information. Ignorance about sexual health and HIV prevalence too often go hand-in-hand.

There are areas where knowledge is relatively good: 82 per cent of young women in Gabon in 2000 knew there were effective ways to prevent the spread of HIV. However, some areas are appalling: a similar survey taken a year later found only 54 per cent of their contemporaries in Mali had such knowledge.

Moreover, this understanding is often theoretical or vague. While 35 per cent of female respondents in Mali knew that condoms were an effective means of preventing the spread of HIV, only 8 per cent were sexually active and knew where to get one. Sex education appears, too often, to be an abstract discipline.

There is also a problem with knowledge about HIV, in particular. In Niger, only 19 per cent of teenage girls and 36 per cent of young men knew that the disease could be carried by a healthy-looking person. Only 23 per cent of women in that survey knew that the virus could be transmitted from a mother to her child.

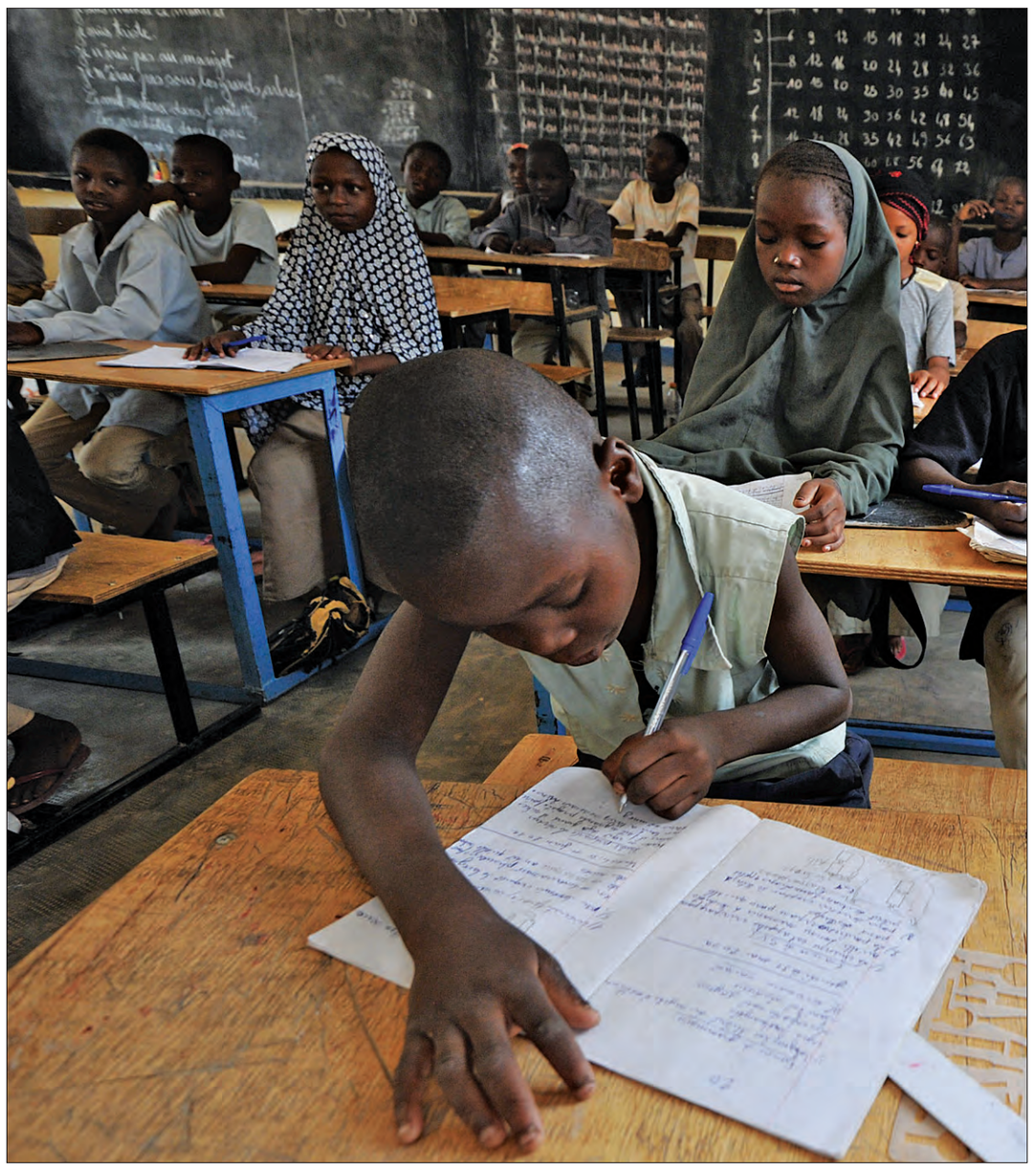
Part of the problem for Africa is the relatively narrow window for formal sex education across much of the continent. Childhood and schooling end more rapidly in the developing world than in the developed. This means that the opportunity for agencies wishing to impart sex education in good time is limited.

Susheela Singh, vice-president of the Guttmacher Institute, which specialises in reproductive health, writes of "the need for sex education to begin at a minimum before age 15, and, to be most effective, significantly before this age... Sexual coercion is probably quite widespread and that it occurs at quite young ages..."

In a survey taken in Niger in 1998, only 7 per cent of 15- to 19-year-old women attended a school, and only 7 per cent of respondents already had seven years of education behind them. But 60 per cent of those young women were cohabiting or married, whether formally or by common law tradition.

The same was not quite true for young men: surveys find negligible numbers of teenaged men settled down – but large numbers were sexually active, and many with multiple partners. In Malawi in 2000, only 4 per cent of young men were in a union, but 61 per cent reported in surveys that they had already had sex.

Heather Boonstra, a senior associate at the Guttmacher Institute, says: "In a country such as Burkina Faso, many adolescents never make it beyond primary school – especially girls. So, although schools are a good place to focus our efforts, it's important that sex education starts early, in an age-appropriate fashion."



Early learning: the opportunity is limited in Africa for agencies to impart sex education in good time Getty

This education is likely to require a broad curriculum, Ms Boonstra says: "Evidence built up over the past 15 years shows that abstinence-only-until-marriage programmes do not help teenagers to delay sex. By contrast, there is a strong body of evidence on the effectiveness of more comprehensive approaches."

A Unesco study of abstinence-only programmes found that "two of the 11 studies reported that the evaluated programmes delayed sexual initiation, while nine revealed no impact".

Meanwhile, programmes that only stressed that not having sexual intercourse as the safest option but also discussed contraceptive use were more likely to delay sex, reduce intercourse, and cut the number of partners

These programmes tend to be much broader-based than many of their critics would imagine, Ms Boonstra says.

She adds: "Comprehensive sex education is not just about delaying sex and teaching contraception, but also about teaching adolescents how to communicate, have healthy relationships, and reduce the risk of violence."

Difficulty spreading education is not confined to Africa: Latin America has a significant number of weak school systems. But it is particularly pronounced in Africa. This makes sex education something that needs to go beyond school.

This creates other problems: the rise of the mobile phone and the spread of the radio continues apace. But there are still areas where young people – especially women – lack access to newspapers, radio or television. As recently as 2000, 81 per cent of teenage women in Ethiopia were reporting that they had no access to these media.

The existing infrastructure needs to be deployed effectively. Ms Boonstra says: "Adolescents say they want information about sex-related matters to be reliable and to come from trusted sources – such as clinics and hospitals.

"In fact, some health clinics are trying to reach young people in their communities and create safe and supportive environments."

Education needs to go well beyond schools.

A toxic mix of tradition and religion

Egypt

Abeer Allam considers prospects for ending female genital mutilation

In the run-up to the Egyptian presidential election, Mohamed Morsi, the Muslim Brotherhood candidate who became president last month, was asked on television to comment on the state-imposed ban on female genital mutilation. He said it was a private issue between mothers and daughters, adding that families, not the state, should decide.

His response caused uproar, particularly among children's and women's rights advocates who have been working for years to change the perception of the procedure in the society.

Human rights groups are increasingly concerned that Islamist parties are seeking to roll back women's rights and reverse laws passed under the former regimes to appease their ultraconservative base.

While this is true, Mr Morsi's views are commonly held across the country. A law banning female genital mutilation, or FGM, was passed five years ago after several girls who bled to death after the cutting of their clitoris, but FGM is still rampant among rural and lower socioeconomic classes.

The practice is passed down from one female generation to the next. Mothers who were forced by their mothers and grandmothers to undergo the cutting before they reached puberty do the same to their daughters.

For them, tradition and custom overrides the law, even religion. They believe FGM curbs sexual desire and "purifies" the girl and prepares her to be a chaste wife, a "treasure" much sought after by eligible grooms.

Although support for FGM is still widespread there has been considerable change since the mid-1990s. In 1995, 82 per cent of women aged (15-49) believed FGM should continue. This dropped to 75 per cent in 2000 and to 62.5 per cent in 2008, according to Unicef.

Meanwhile, those who try to challenge the practice, eventually succumb to societal pressure. "I didn't want to circumcise my younger daughter because I felt it was an outdated custom from my mother's time, not hers. "But her father insisted," says Iman Attar, 38, a housekeeper who lives in a working class Cairo neighbourhood. "Everybody told me it was unfair to leave her like this."

The practice is often performed without girls' consent. But female relatives portray FGM as rite of passage to womanhood and marriage.

About 90 per cent of all women of child-bearing age in Egypt have undergone female genital mutilation, according to the 2008 Egypt Demographic and Health Survey.

Years of campaigns in which religious scholars pr eached against the practice (the Grand Mufti issued a fatwa in 2009) have resulted in a drop from 77 per cent to 74 per cent in the number of girls who underwent FGM between 2005 and 2008. The survey suggests that the FGM will eventually decline to 60 per cent among girls currently under three.

"It's difficult to end, because it's rooted in a toxic mix of culture and religion," says Mona Eltahawy, a feminist writer. "As much as many Muslims deny it has anything to do with Islam, you'll find many clerics advocating it. When parliament criminalised it in 2007, some of the fiercest opponents of the law were from the Muslim Brotherhood."

In May, the Brotherhood's Freedom and Justice Party (FJP) was accused of launching a medical campaign for FGM in the southern governorate of Minya. The party denied the report, but human rights groups filed a complaint to the attorney-general and governor of Minya to stop the campaign.

President Mohamed Morsi's attitude to FGM caused uproar

Doctors, however, complain that most people ignore the ban and perform the procedure anyway.

One public hospital doctor says: "It is impossible to change tradition overnight. At least they should allow only doctors to perform it to control the damage and avoid death. Sometimes parents ask me to circumcise their daughters and I know when I say 'no', they will go straight to any untrained paramedic to do it for them anyway."

It is usually performed on girls between the ages of nine and 12. In the past, it involved removing the clitoris, together with labia minora. The operation was frequently performed using knives or razors. In recent years, however, more than 60 per cent of circumcisions have been performed by physicians and nurses, Unicef says.

Besides the psychological scars, the practice leads to difficulties with menstruation, intercourse and childbirth. Activists are worried by lukewarm attitudes to the law among newly-elected officials.

Azza el-Garf, one of the few Brotherhood's Freedom and Justice female parliamentarians, described the procedure as "plastic surgery or a form of "beautification" that women are entitled to do if they opt to, attracting harsh criticism.

Women should be given the power of choice

Guest Column

MELINDA GATES

What would happen if, at the stroke of midnight tonight, every woman in Europe lost access to contraceptives?

How many girls would drop out of school? How many women would quit their jobs? Could parents provide for their children? What new phrase would we have to coin to express the catastrophe that would befall economies that are already in "crisis"?

More than 200m women and girls in poor countries, mostly in Africa and south Asia, do not have access to contraceptives. That is more than all the women of reproductive age in Europe.

I have made family planning my priority, because the women I meet when I travel consistently tell me that having the power to decide when to have a child is central to achieving their goals in life. They want to be able to feed their children, take them to the doctor when they are ill, and send them to school so they can fulfil their potential.

This week, our foundation is joining the UK's Department for International Development in sponsoring the London Summit on Family Planning, which brings together thousands of partners around a single ambition: to provide 120m additional women with access to contraceptives by 2020.

The summit builds on a long history of success in extending access to contraceptives to poor women. Family planning programmes have been around for more than 50 years, and they have helped transform most of Asia, Latin America and the Middle East.

But progress has slowed in recent years. Among many donors, especially in Europe, the idea of access to contraceptives is so uncontroversial that it hardly seems worth investing in. Conversely, in countries such as the US, the issue has become a proxy for the fight over abortion, so it is too controversial to invest in.

Meanwhile, hundreds of millions of women are unable to make basic decisions about their future. Our objective is to remind everyone that there should be no controversy – but a strong sense of urgency – around giving women the power to make a better life for themselves and their children.

Over the years, we have learnt countless lessons about how to do this work better. There are three big themes running through the summit.

First, and most important, we are putting women and girls at the centre. In the past, some programmes put too much emphasis on trying to manage population growth. Some of these set specific population targets, and some even resorted to coercion to reach them. Participants in the summit agree that empowering women and girls to make their own decisions is the best and only way to encourage large-scale economic and social improvements.

Second, the work is being led by stakeholders in the countries where it is happening. More than 20 countries have been reviewing data and pinpointing weaknesses in their family planning programmes. They are announcing plans to address these gaps at the summit. None of the investments we are discussing is being imposed; we are relying on the commitment and expertise of those in the countries where women who do not have access live.

Third, there is a diverse group working more collaboratively to break through the barriers blocking progress. In particular, the private sector is playing a much bigger role. In Senegal, for example, our foundation is working on a pilot project that provides incentives to small businesses to make sure contraceptives are always in stock at the health clinics, which has been a serious problem.

Drug companies are working with countries to supply high-quality products at affordable prices. UN agencies are working with countries to streamline the regulatory approval processes, so that more companies can enter the market.

Companies are also working with universities and non-profit groups on research and development to create products that meet more of women's needs. For example, injectable contraceptives that could be administered by women in their homes would be more practical for women who live far away from health clinics..

What if 120m women such as these had access to contraceptives by 2020? How many more girls could go to school? How many more women could work? How many more parents could provide for their children? What new phrase would we have to coin for the economic progress in some of the poorest parts of the world?

Melinda Gates is co-chair of the Bill & Melinda Gates Foundation

FT Health: Sexual & Reproductive Health

India and Bangladesh Uneven quality of care

Faiza keeps up a stream of chatter as she takes off her burka for a physical examination at a clinic in central Mumbai run by an NGO. She is in the first month of her fifth pregnancy and has come in to schedule an abortion, which the clinic can perform legally and safely at a subsidised rate of Rs500 (about $9).

"I have two children already. My husband and I don't want any more, because otherwise we would have to work more than we already do to earn enough money," says Faiza (not her real name), having miscarried and aborted two previous pregnancies.

She confesses to limited knowledge of contraception, but listens carefully to the doctor's description of everything from sterilisation to intra-uterine devices and injectables. It does not take much thought before she considers getting an IUD.

Variations of Faiza's story abound, especially among low-income families. Over the past 40 years, rigorous campaigning for family planning and, more recently, an emphasis on sexual and reproductive health has, drastically reduced rates of fertility, and maternal and infant mortality.

But vast gaps persist in the supply of quality services, and the country, with a population of 1.2bn, is set to overtake China as the world's most populous by 2025.

Having come down from nearly six children per woman in 1960, India's average fertility rate has stood at 2.6 for the past five years. Though this is an achievement in itself, experts say much work remains to be done to achieve the replacement rate of 2.1.

"We don't yet see the desired level of achievement, in the country's total fertility rate," says Vishwanath Koliwad, secretary-general of the Family Planning Association of India (FPAI). "The biggest challenges are in educating the people. Nearly 60 per cent of women are married before the age of 18 and, in many parts, there's a preference for male children. There's often opposition to family planning from religious leaders. All that kind of culture is difficult to change."

Some regions fare better than others, depending on female literacy, better awareness of birth-spacing methods and contraceptives, and low infant mortality. For instance, according to government data, the southern state of Kerala is close to achieving the UN's millennium development goals: its fertility rate is 1.7, maternal mortality ratio 95 per 100,000 live births, and infant mortality 12 of 1,000 births.

By contrast, Bihar in the north has 3.9 children per woman and maternal and infant mortality rates of 312 and 56 – all well above the national average.

With the spectre of forced sterilisations looming large in its recent history, India adopted a rights-based approach to stabilising the size of its population – a strategy espoused by most countries after a UN conference in Cairo in 1994 emphasised sexual and reproductive health over targets-oriented population control.

In Bangladesh, the rights-based approach ended up shifting focus away from a highly successful family planning programme. For the next 10 years, the country's fertility rate would plateau at 3.0 after decades of a continuous fall brought about through door-to-door campaigning, a combination of domestic and foreign funding and political commitment "at the highest levels", according to experts.

Arthur Erken of the UN Population Fund in Bangladesh, says: "The broadened concept of a human rights-based approach is good in theory, but it created challenges, such as diverting resources and the need to integrate education and contraceptive promotion programmes."

According to the last demographic survey in Bangladesh, the desired fertility rate expressed by the public is already at 1.9, while the actual rate stands at 2.3.

"This means people already understand the importance of having two children, but more resources need to be invested in getting the services to those who need it," says Mr Erken.

A similar loss of policy focus in India has limited the development of services and their distribution, especially in neglected urban areas and remote rural areas.

"The government of India is now working to enhance access to contraceptives and adopting [birth] spacing methods," says Mr Koliwad. "But even there, the lack of infrastructure and medical expertise makes service delivery a problem."

Some women, such as Faiza, manage to find legitimate healthcare. But many Indian women still end up in poorly-equipped government hospitals or worse still, in shifty "facilities" run by quacks.

"I know some women in my neighbourhood who have been in my situation," Faiza says as she tucks her hair into her headscarf at the end of the consultation. "Honestly, if more people knew about clinics like this, they would be full."

Kanupriya Kapoor

Health care: fewer than 10 per cent of married Nigerian women between the ages of 15 and 49 use a modern method of contraception Reuters

Stymied by culture and faith

Nigeria

Xan Rice considers the reasons behind the country's baby boom

It was only mid-morning but the reception area of the small hospital in the Nigerian city of Port Harcourt was already packed. Those waiting for the doctor were all women; some in their teens, some who looked closer to 40. all but a few of them had a baby on their laps.

Decades of high population growth have made Nigeria easily Africa's most populous country, with more than 160m people. In 1982, the fertility rate was 6.4; 30 years on and it has dipped only slightly to 5.7.

According to a forecast by the Population Reference Bureau, Nigeria will be the world's third most populous country by 2050, with 433m people, behind India and China. The consequences of the continued baby boom are profound, given that more than six in 10 of Nigeria's people already live in poverty and steady economic growth appears to be doing little to change that.

The government is aware of the difficulties the swelling population presents. On June 27, President Goodluck Jonathan said Nigerians should have smaller families, and backed birth control measures. But he also acknowledged it will be not be easy to change people's attitudes because of religious and cultural beliefs.

Indeed, the continued preference for large families rather than unmet demand for contraception is the main obstacle to reducing fertility rates.

Figures bear this out. Fewer than 10 per cent of married women between the ages of 15 and 49 use a modern method of contraception, according to the latest Nigeria Demographic and Health Survey, conducted in 2008. The average across sub-Saharan Africa is 17 per cent.

About half the women surveyed who were not using family planning services said they had no intention to do so in future. A further 27 per cent were unsure about further use. Only 24 per cent said they wanted to use contraception at a later date.

Religion plays a strong role in this. The country is roughly equally split between Christianity and Islam, and influential leaders of both faiths have historically been opposed to family planning.

Although views are changing, it is happening slowly, as President Jonathan acknowledged when he said that most Nigerians still see children as gifts from God and "it is not expected to reject God's gifts".

As elsewhere in the world, urban women typically have fewer children than their rural counterparts, while the fertility rate drops as education levels rise.

But there are also huge differences based on where in Nigeria the women live. In the mostly Muslim north, for example, the average mother has seven or eight children. In Jigawa state, in the far north, fewer than one in 300 women uses modern contraception.

Richard Boustred, country director for Marie Stopes International, says efforts by his and other organisations to promote family planning were sometimes hampered by perceptions that they were part of a conspiracy by western countries to stop Nigeria achieving its potential.

> 'The government needs to educate the public in the advantages of having fewer children'

The dominant social position of men, especially in the north, was another difficulty. "We encourage women to involve their husbands in family planning decisions and some say 'there's no way I can tell my husband'. So they prefer invisible methods of contraception, such as injections," Mr Boustred says.

In the mostly Christian and more prosperous south, the fertility rate is 4.6, with women more inclined to make decisions independently of the church. "We are seeing changes. People are now saying 'four children is enough, three is enough'," says Mr Boustred. They are doing more planning."

Besides religion and culture, lack of knowledge about birth control methods, and myths about them – especially a belief that they can damage a woman's health – were among the main reasons given in the survey for not using contraception.

Fewer than 1 per cent of respondents cited cost as a factor, suggesting that the government's announcement last year of free family planning services may not have much effect, even if primary healthcare clinics are properly stocked with contraceptives.

Overall, the total unmet demand for family planning services is only about 20 per cent, and most of that relates to a desire to space births rather than limit them.

The natural demographic growth is already straining resources in the country, with education and health systems unable to keep up. The majority of the millions of young people entering the Nigerian job market each year have no chance of finding formal employment. In the north, increasing poverty and lack of prospects for young people is one reason that the leaders of an Islamist insurgency have found it easy to attract recruits.

"The government needs to educate the general public in the advantages of having fewer children," says Akin Bankole, at the Guttmacher Institute, a US-based research group.

Links with family planning bring benefits

HIV-Aids

Sarah Murray considers efforts to provide more integrated services

Potential: combination policy costs little IPPF/Chloe Hall

Ethiopian policy makers, faced with a rapidly expanding population and rising numbers of HIV-Aids infections, decided to tackle both problems together.

They introduced family planning into the counselling and testing programmes that are a core part of HIV-Aids prevention and treatment.

When counselling women on reproductive health or child immunisation, family planning clinics can also discuss HIV testing and prevention, particularly condom use, as well as introducing pregnant women to mother-to-child HIV transmission prevention services.

HIV prevention and treatment service providers could talk to HIV-positive couples about how to have more children safely or how to prevent unwanted pregnancies.

"There's plenty of room for synergy," says Christopher Purdy, executive vice-president at DKT International, which uses social media to improve access to reproductive health products and services in Latin America, Africa and Asia.

"If a young woman wants to come in for a cycle of pills, that's a great time to talk about HIV-Aids – and promote a barrier method if she has multiple partners," he says. "Or if a young man has multiple partners, that's a good time to talk about family planning."

International donors acknowledge the need for more integrated services.

Guidelines recently issued by Pepfar, the US programme to tackle HIV-Aids abroad, endorse provision by family planning centres of counselling and testing, referrals for prevention of mother-to-child transmission and HIV care and treatment services.

The Pepfar guidelines also endorse provision of family planning counselling and referrals for contraceptives for women in HIV programmes.

However, experts say policy rhetoric on integration is not always matched by practices on the ground. Use of funding for contraceptives is prohibited even in the Pepfar guidelines, says Heather Boonstra, senior public policy associate at the Guttmacher Institute,

> Targets cannot be met without more co-ordination between different programmes

a US-based policy group, in a research paper.* She also says it is easier for family planning professionals to add HIV-related services than the other way around.

"One direction of the equation, which is HIV testing in family planning clinics, is politically feasible and may be happening more," says Ms Boonstra. "What has not been as prevalent is counselling within HIV programmes around reproductive health and family planning."

In the US, part of this can be ascribed to political sensitivities and conservative resistance to expanding family planning services.

However, logistical factors also come into play. HIV counsellors may not be trained to have conversations with women or couples on family planning or may not have strong referral networks.

Social and cultural preconceptions can also hamper integration of family planning and HIV prevention and treatment services.

"Ironically, these two fields have had a hard time seeing eye to eye," says Mr Purdy. "A lot of this centres around the fact that transmission routes for HIV – drugs, extra-martial sex, commercial sex, young people having sex – are loaded with behaviours that are deemed socially difficult."

Another barrier is the stigma attached to diseases.

Funding priorities can also limit what organisations can do on the ground.

"Sometimes funds come with certain labels," says Ade Fakoya, HIV-Aids specialist at the Global Fund to Fight Aids, Tuberculosis and Malaria, a multilateral donor organisation. "So if the funding comes with an HIV label, you can't provide an integrated service for maternal and child health."

However, all agree that these barriers need to be overcome, not least because of the mounting cost of delivering healthcare services globally. In this respect, the Ethiopian example demonstrates great potential, since only modest incremental investment was required to integrate family planning into HIV-Aids programmes.

According to the World Health Organisation, the one-off cost for Ethiopia's family planning training was $325 per trainee and the only substantial recurring costs were regular monitoring visits by Pathfinder International, a non-governmental organisation that was involved in the programme – and these amounted to only $1,562 a year per facility.

Looking beyond costs, however, broader policy targets – such as the Millennium Development Goals to reduce child mortality, improve maternal health, and combat HIV-Aids, malaria and other diseases – cannot be met without greater co-ordination between family planning and disease prevention programmes.

"Everyone accepts that we won't reach Millennium Development Goals 4, 5 and 6, unless we have better integration," says Dr Fakoya.

**Linkages Between HIV and Family Planning Services Under PEPFAR: Room for Improvement, Heather Boonstra, Guttmacher Policy Review, Fall 2011*

One-child policy is a threat to growth

China

Skewed population ratios are leading to problems, writes **Patti Waldmeir**

On the face of it, China's one-child system looks like one of the most successful social policies of all time.

Not only does the government credit it with reducing the number of births by 400m over the past 30 years – about 100m more than the current population of the US – but it has so thoroughly penetrated the national psyche that millions of Chinese who are permitted to bear a second child, choose not to have one.

Inspired or diabolical – depending on your point of view – few can dispute the effect the policy has had on China's population.

Like all social experiments, it has had unforeseen consequences: the drop in the birth rates has created an imbalance between young and old, producing an ageing crisis so serious that it could imperil economic growth.

Birth limits, coupled with a traditional preference for sons, have also led to a sharply skewed gender ratio and a shortage of brides.

The impact of the policy has been intensified by rising wealth, since growing prosperity always depresses birth rates. In many big cities, for example, young people who were themselves only children are allowed to bear two offspring – but they do not even want one child, let alone two.

Shanghai, for example, is said by demographers to have the lowest birth rate in the world. Most of those who do not want children cite the high cost of child rearing – but many candidly admit that, having grown up pampered, they simply do not want to make the sacrifice to be parents.

Some are delaying childbearing so long that China now has 50m infertile couples.

The one-child policy is something of a misnomer because of the many exceptions: if both spouses are only children, they can have two offspring; rural families can have a second if the first is a girl or handicapped; and ethnic minorities can have more than one.

Whatever the number, population control has had an impact well beyond the size of the population: the slowdown in births has led to a big rise in the ratio of pensioners to the young workers needed to support them. According to the 2010 census, the number of people over 60 has risen to 13.3 per cent of the population compared with just over a 10 per cent a decade ago; children under 14 comprise less than one-sixth of the population, down from almost a quarter 10 years ago. In big cities the situation is far more unbalanced: a fifth of Shanghai's population is already over 60, and that figure is forecast to rise to 29 per cent by 2030.

The 2010 census also showed 34m more men than women – also the indirect result of the policy.

> The policy is either inspired or diabolical – depending on your point of view

Families forced to limit their family to only one child – especially those in more traditional rural areas – often prefer their single offspring to be a boy.

Girls are sometimes aborted before birth, skewing the sex ratio and raising the risk of social instability caused by men who cannot find wives.

The gender imbalance may not be as bad as it seems. Cai Yong, a demographer at the University of North Carolina, says many girls' births were simply never registered. "School enrolment data suggest that the number of school-aged boys is not as high as the number of male births registered, suggesting that a considerable number of girls are 'hidden' in the population," he says.

But no one would dispute that the shortage of wives is serious even so: it has fuelled considerable cross-border trafficking of brides from south-east Asian countries such as Vietnam.

The impact of the policy on society is so broad and profound it has even affected seemingly unrelated areas such as sport. China's soccer industry suffers from a shortage of players who engage in soccer throughout their schooling – because Chinese parents do not want to see their only child make a career in sports.

Beijing has been considering relaxing the policy for years – although there are still isolated cases of brutal forced late-term abortions such as one that recently went viral on the internet. But the irony is that, even if Beijing decided today to abolish the policy, there is little chance that the Chinese would resume having many more children – partly because they have simply become accustomed to smaller households.

China has been internationally reviled for the policy for the past 30 years. But it still has plenty of supporters within government circles, especially at local level. It seems safe to say that they will not be declaring it a failure in the near future.

Additional reporting by Shirley Chen

Funds for services held back by dogma

The US

Sarah Murray outlines the repercussions of entrenched moral positions

Like chaos theory's butterfly – flapping its wings in one place to cause a hurricane in another – political shifts in one country can shape people's lives elsewhere.

As moral positions on abortion harden in the US, the prospect of renewed restrictions on federal support for international family planning assistance is casting uncertainty over many overseas development programmes.

Opposition to abortion also has an impact at home and, among some socially conservative politicians, is being extended into resistance to contraception services. In February 2011, the House of Representatives voted in favour of cutting funding for Planned Parenthood, a large women's healthcare provider, and disqualifying its affiliates from participating in any federally subsidised family planning programmes.

"Those policies were rebuffed by the Senate and the president, so none has taken effect," says Susan Cohen, director of government affairs at the Guttmacher Institute, a policy group focusing on health and reproductive rights. "But [social conservatives] have made it clear they're waging a war on family planning."

Meanwhile, US states are introducing restrictions of their own.

The number of reproductive-age American women living in a state hostile to abortion rights rose from 31 per cent in 2000 to 55 per cent last year, the institute says.

Terminations are not the only services being affected. Five states have introduced legislation creating or expanding exemptions to contraceptive cover, it says. These include provisions exempting employers who cite religious objections from having to provide contraception cover as part of an employee healthcare package.

Much of the opposition to Planned Parenthood has arisen because it offers abortion services, although the organisation says this accounts for just 3 per cent of its offerings.

But, Ms Cohen says: "A lot of conservative-dominated state legislatures and states run by conservative governors are enacting restrictions because they have adopted a view that Planned Parenthood is only about abortion and they don't want anything to do with it."

While most Americans are in favour of banning use of federal funds for abortion, political resistance to contraception services does not appear to reflect broader public opinion.

In a poll conducted in June for the National Women's Law Centre and Planned Parenthood, almost 73 per cent of voters agreed that all women should have access to affordable birth control.

Political views are also having an impact abroad. Debates centre on the so-called "global gag rule", which restricts federal funding for non-governmental organisations (NGOs) overseas that promote or provide abortions, and on US funding for the UN Population Fund (UNFPA).

The global gag rule has become something of a political football. Introduced in 1984 by Ronald Reagan, the restrictions were lifted when Bill Clinton took office in 1993, but then put back in place by George W. Bush in 2001. In 2009, President Barack Obama signed an executive order once again repealing the restriction rules.

Politics: a protest against Mitt Romney, Republican candidate, who has promised to cut federal funding Getty

However, given statements this year by Mitt Romney, the Republican presidential candidate, promising to cut federal funding to Planned Parenthood, many believe that if he becomes president, the global gag rule could once again be reinstated.

For NGOs and donors the uncertainty creates difficulties, since the processes needed to establish a programme – including negotiating with health ministries and finding local organisations to deliver services – eat up a great deal of time.

It takes about two years to get a programme up and running once Congress has appropriated the funding, says Latanya Mapp Frett, head of Planned Parenthood's global programmes.

"And if there's possibility that, after investing those two years in what you hope will be a sustainable programme, you're faced with a policy that changes your direction, that can be a significant challenge," she says.

Despite the uncertainty, the US remains a generous provider of funding for international family planning assistance and reproductive health programmes, with $610m appropriated for the financial year 2012.

This, says the Guttmacher Institute, will make it possible to provide more than 31m women and couples with contraceptive services and supplies to prevent 9.4m unintended pregnancies and 4m induced abortions (of which 3m are unsafe). The institute says this could avert 22,000 maternal deaths, preventing 96,000 fewer children from losing their mothers.

With 222m women lacking modern family planning services, according to the UNFPA, the development community is dependent on the generosity of donor countries such as the US.

For this reason, those working in women's health and reproductive rights can only hope for a more stable political approach to funding.

"The challenges are maintaining the resources and understanding that development happens over decades," says Ms Mapp Frett. "You have to be there for the long haul and [US policy changes] make that difficult."

Maternal mortality rates are in sharp decline

Care

The number of women dying in childbirth has halved, writes **Charis Gresser**

Concerted action to reduce deaths from childbirth is making a difference, according to a recent report by Countdown to 2015, an initiative that tracks progress towards the UN Millennium Development Goals on deaths of mothers and children under five.

The number of women dying because of complications from pregnancy or birth has nearly halved since 1990 to 287,000 a year.

While the rate of progress is still not good enough to meet the Millennium pledge, some countries, such as Nepal, Vietnam and Equatorial Guinea, have shown big reductions maternal mortality rates.

The reasons behind the trend are twofold, says Joy Lawn, director of global evidence and policy at Save the Children, a UK charity, and a co-author of the report. "The world has really changed in the past few years. Maternal mortality is falling by 4.2 per cent a year. This change is being driven by improvements in Latin America and south Asia and there are two big factors behind this: the first is falling fertility and access to family planning – in Bangladesh and Nepal for instance," she says. "The second is care at birth, with some countries, such as Malawi and Rwanda, really upping the proportion of births attended by midwives."

But for many countries, meaningful progress towards cutting maternal mortality is proving elusive, despite cheap and effective therapies for complications during childbirth.

Mickey Chopra, chief health officer at the UN Children's Fund (Unicef) and co-chair of the initiative, says: "There are three major causes of maternal mortality in developing countries: bleeding after childbirth; infections [such as malaria or sepsis during birth]; and complications of childbirth [where the baby gets stuck and you need a caesarean section]." He adds: "There are interventions that are not expensive and can be delivered in low-resource settings for these: antimalarials and iron tablets, for instance." There are straightforward treatments, too, for haemorrhages.

Experts argue that the same holds true for the care of newborn babies. "For neonatal care," says Dr Chopra, "there are interventions that don't require hospitals. There are effective ways of preventing hypothermia, and cleaning the cord, which can have a big impact on reducing deaths from infection.

"There are cheap and simple drugs that are not being used: for instance steroids for pre-term babies. We don't need large budgets to have a big impact. We need to use the resources in a smarter way and target the interventions at the women who are not receiving them."

A bottleneck in improving the safety of childbirth is getting enough trained midwives, medical assistants and health workers to keep pace with birth rates.

Trained professionals can mean the difference between life and death. Caesarean sections, for instance, can be performed by trained clinicians who are not necessarily doctors.

Prompt care for newborns, who die in far greater numbers than mothers [nearly 2m a year either during labour or shortly thereafter] means frontline healthcare workers need to be trained in resuscitation and care of pre-term babies.

What is preventing greater use of interventions that experts say are both cheap and effective?

Funding plays a part, especially if there are "out-of-pocket" payments that women have to make for treatment. Another is the way health services are delivered.

Immunisations and vitamin supplementation can achieve broad coverage, partly because they can be delivered via big campaigns aimed at all children in a community.

But maternal and newborn care is different. It is more unpredictable, requires follow-up and may also need access to specialised equipment, if surgery or blood transfusions are needed.

Cesar Victora, professor of epidemiology at the Federal University of Pelotas in Brazil and another co-author, believes in the importance of local care. "A hot topic in global health is whether to save child lives you can move interventions out of hospitals and health facilities and into communities via community-based management."

There are many complex factors that complicate pregnancy for women in low-income countries. These include the relatively poor health state of many pregnant women, perhaps because of poor nutrition, micronutrient deficiencies, or because they are too young.

Save the Children says that girls under the age of 15 are five times more likely to die in pregnancy than women in their 20s and that pregnancy and childbirth are the leading cause of death for teenage girls between 15 and 19.

In addition, the shortage of health workers, the status of women and their access to family planning services, government investments in health and education, all play their part in the struggle of millions of women and their babies to survive childbirth.

Charis Gresser is head of research at Meteos, a non-profit think-tank working on pharmaceutical and public health policy.

The Civil Society Declaration to the London Summit on Family Planning was signed by these civil society organizations from 177 countries:

Africa

Association Algérienne pour la Planification Familiale, Associação Angolana para o Bem Estar da Familia, Association Beninoise pour la Promotion de la Famille, Botswana Family Welfare Association, Association Burkinabé pour le Bien-Être Familial, Association pour la Promotion de la Santé de la Reproduction, Institut Africain de la Santé de la Reproduction, Women Environmental Programme Burkina, ActionAid Burundi, Association Burundaise Pour Le Bien-Être Familial, Association pour la Promotion du Bien, Alternatives Durables pour le Développement, Cameroon Agenda for Sustainable Development, Cameroon National Association for Family Welfare, Collectif des Femmes pour la Protection de l'Environnement et de l'Enfant, Health Development Consultancy Services, No Limit For Women Project, Organization of African Youth, Platform of Actors for the Fight Against Hiv/Aids in Cameroon, Rural Women Centre for Education and Development, Self Employed Women Association - Kumbo, Servitas, Associação Caboverdiana de Protecção da Família, Association Centrafricaine pour le Bien-Être Familial, Fondation Les Enfants D'Abord, Association Tchadienne pour le Bien-Être Familial, Network of Women with Disabilities in Chad, Association Comorienne pour le Bien-Être Famille, Association Congolaise pour le Bien Être Familial , Association Nationale des Sourds et Deficients Auditifs du Congo, Association Ivoirienne Pour Le Bien-Être Familial, UNFPA Côte d'Ivoire, ABEF, Action Pour Le Developpement Integral De La Femme, Association des Femmes pour la Promotion et le Développement Endogène of DR CONGO, Association Pour Le Bien-Être Familial Naissances Desirables, Complementaire Medecine Alternative Theurapie Education Sante, Groupe de Volontaires pour la Promotion de la Maternite sans Risques, Association Djiboutienne pour l'Equilibre et la Promotion de la Famille, Alliance for Arab Women, Cairo University, Egyptian Family Planning Association, Association for Women's Sanctuary and Development, EngenderHealth Ethiopia, Family Guidance Association of Ethiopia, Federal Ministry of Health, Ipas, Kulich Youth Reproductive Health and Development Organization, Medico Socio Development Assistance, Nia Foundation, Oromia Development Association, Orphans and Girls Assistance Association, PHE Ethiopia Consortium, Save Your Generation Ethiopia, Young Women's Christian Association in Ethiopia, Mouvement Gabonais pour le Bien-Être Familial, BOFWA, The Association of Non-Governmental Organisatons, AFFRAM-ASAPH Foundation, Alliance for Reproductive Health Rights, Care Net Ghana, Centre for the Development of People in Kumasi, Community and Family Aid Foundation, Dafoko Concepts, Denis Dekugman Yar, at Department of Community Health, School of Medical Sciences, Kwame Nkrumah University of Science and Technology, Global Media Foundation, Hope For Future Generations, Kabor Foundation, Light For Children, Muslim Family Counselling Services, Women and Youth Development Association, Partners in Development, People's Action To Win Life All-Round, Planned Parenthood Association of Ghana, Rural-Urban Women And Children Development Agency, Sibling Women Development Group, Association Guinéenne pour le Bien-Être Familial, Associação Guineense para o Bem Estar Familiar, African Women Leaders Network for Reproductive Health and Family Planning, Centre for Legal Rights Education, Advocacy and Development, Division of Reproductive Health, Ministry of Public Health & Sanitation, Global Outreach Foundation, Institute of Primate Research, Ipas Africa Alliance Office, Kenya Community Health Network, School of Medicine, University of Nairobi, Total Healthcare Group, Tumaini Women Group & Mary Youth Support Group, Young Women Entrepreneurs Kenya, Lesotho Planned Parenthood Association, ActionAid Liberia, Network for Empowerment & Progressive Initiatives, New Narratives - Africans Reporting Africa, Planned Parenthood Association of Liberia, Solidarity Incorporated, Youth Focus Center (Youfocent), FIANAKAVIANA SAMBATRA - Association Malgache pour le Bien-Être Familial, Centre for Youth and Children Affairs, Family Planning Association of Malawi, Malawi Health Equity Network, Youth Impact, 3A, A. DOKE, A. SOS E.VI, AADR/Yiriwa, ACD, ACD/SAHEL, ACEF, Action Mopti, Action Nord Sud H.I., ADAC, ADAF GALLE, ADDA, ADEMIR, ADERA, ADES, ADEV, ADIC, ADICO, ADIES MALI, ADPIB, ADPM, ADPS, ADRA/Mali, ADS Diamnati, AEC, AES, AFAD, AFASO Mali, AFESM, AGF, AID/Mali, AID/SAN, Aide a L'Enfance, Aide au Sahel, AIDEMET, AIF DONKANSIGI, AJDM, AJPM, AJPS/MST/SIDA, AJSAD, ALCPM, ALHER, ALUTAS, AMAC, AMACO, AMADE PELCODE, AMADECOM, AMAPEC, AMAPRODE, AMAPROS, AMAS, AMAS BIF, AMD, AME, AMEN, AMEP, AMIFA, AMLUD, AMPDR , AMPE, AMPES, AMPJ, AMPJF, AMPPEAS, AMPPF, AMPRODE/SAHEL, AMPSAF, AMPSEF , AMS ONG , APCM, APEF, APFEF, APFM, APGR, APPF/KITA, APROFEM, APROMORS, APSM, ARCAD/SIDA, ARCC, ARDIL, ARECDEV, ASADES, ASAME, ASCOV, ASDAP, ASEEM, ASEEM, ASG, ASS FASO YEELEN, ASS. BAARA YIRIWA, ASS. LADOO, ASS. SODIA pour le DVPT, ASS. DEMBA GNOUMA, ASSA DDEC, ASSAF, ASSOC. DANAYA TON, Association de Southien au Développement des Activités de Population, Association des Sages–Femmes du Mali, Association Ecole Pour Tous les Enfants du Mali, Association Malienne pour la Protection et la Promotion de la Famille, Association Pour la Promotion de L'Artisanat au Mali, ATPFEM, AUTRE MONDE, AY BAAKOY, BAARA NYUMAN, CADEV, CADICBA, CAEB, CARD, CARE MALI, CDIFME, CEDPA, CEDPIE, CEFODAP, CERDEPE, CFORES, COFFESFA, COMUSO, Conseil National de la Jeunesse do Mali, Coordination des Associations et O.N.G. Féminines du Mali, CRADE, CROIX ROUGE, DHA, DII SI WILLO, DIVAROF, DJEKAFO, DMD, DONKO, EADS, EDS, EFFAD, ENDA TIERS MONDE, ERAD, FAMILY CARE INTERNAT , FASO DJIGUI, FDS, Fondation Merieux Mali, Forum des Organisations de la Société Civile au Mali, GAAS MALI, GAD, GADB, GADIC, GADS, GAFA/MOPTI, GAIE FEMME, GAPROC, GARDEM, GED.SES, GERAD/MALI, GIAD, GOLE SIRE, GRAAP, GRAFE, GRAPES, GRAT, GRDR, GREFFA, GROUPE EUREKA, HANDIC MALI, IADS, IAMANEH, IARA, IBFAN-MALI, IRED MALI, IRUK, ISIFA, JEKATANIE, JEUNESSE & DEVELOPPEMENT, JIGI, JIGI YIRI MALI, K.Y.T, KARED/NIORO, KENEDOUGOU SOLIDARITE, KENEYA BLOWN, KILABO, KMESE, KOUKIA, LAKANA SO, MALI ENJEU, MANENE, Medecine for Mali, MEDI VISION, Merveilles Karité, MISSION SAHEL, MUSOW JIGI, Nouveau Horizons, ODI SAHEL, OMADECOS, OMADIS, OMAFES, ONG ATN, ONG MAYA TON, ONG NYETA SAABATI, ONG SIGINYONGONJE, PADI, PCB, POLICY/FUTURES GROUPE, RAC, RADEC MALI, RAID, RAN FORD 2000, Reproductive Health Sector Reform Training Network, Réseau National de la Jeunesse du Mali, RISAQ, SAD, SADEB, SADEVE, SADEVI, SAHEL SOLIDARITE, SANTE SUD, SINI SANUNA, SOCIETE MALIENNE DE PHYTOTHERAPIE, SODAC, SODEP MALI, SOLIDARITE SIDA, SOLTHIS, SOS PALUDISME, SOUTOURA, SPM, STOP SIDA, TANGRAM MALI, TKH, VISION POUR 1 DVPT, WALE ACTION, WOIYO KONDEYE, YEREDEME, ZAMONGON, Association Mauritanienne pour la Promotion de la Famille, Association pour le Developpement et de la Promotion des Droits Humains, Santé Sans Frontière, Health and Safety Promotion Network, Mauritius Family Planning & Welfare Association, United Nations Association, Association « Avec Elles », Association « L'heure Joyeuse », Association « Le Jour » des Personnes Vivant avec le VIH, Association Afak, Association Al Amal, Association Al Fawz, Association Al Manar, Association Bayti, Association Bouregreg, Association de l'Avenir, Association de Lutte contre le Sida (ALCS), Association de Rabat-Salé d'Aide Médico-sociale aux Tuberculeux, Association de Solidarité Féminine, Association Démocratique des Femmes du Maroc, Association des Femmes Sans Frontières, Association des Handicapés de Yacoub El Mansour, Association Droits des Personnes, Association El Amal des Jeunes de Salé, Association Ennajda – FAMA, Association Ennour, Association ESPOD, Association Fès Saiss, Association INSAF, Association IPDF, Association Lalla Salma pour la Lutte Contre le Cancer, Association le Féminin Pluriel, Association Marocaine d'Aide aux Enfants en Situation Précaire, Association Marocaine de Lutte contre l'Avortement Clandestin, Association Marocaine de Planification Familiale, Association Marocaine de Solidarité et de Développement, Association Marocaine des Droits de l'Homme, Association Marocaine des Jeunes Contre le Sida, Association Ribat El Fath, Association S.O.S. Diabète, Association S.O.S. Tuberculose, Association Soleil pour le Soutien des Enfants Affectés et Iinféctés par le VIH/SIDA au Maroc, Association Solidarité Féminine, Association TAMESNA., Association Thaqafat, Centre d'écoute Nejma, Croissant Rouge Marocain, Espoir Trait d'Union, Fondation JAMAI, Fondation Mohammed V pour la Solidarité, FONDATION ORIENT OCCIDENT, Fondation pour le Développement de l'Education Socio-Sanitaire et l'Environnement, Harakat Badail Mouwatina, Ligue Marocaine Contre les Maladies Sexuellement Transmissibles, Organisation Marocaine Des Droits De L'homme, Organisation Panafricaine de Lutte Contre le SIDA, Union de l'Action Féminine, Union Nationale des Femmes du Maroc, Associação Moçambicana para Desenvolvimento da Família, Namibia Planned Parenthood Association, Association Nigerienne Pour Le Bien-Être Familial, Santé et Développement SADEV, Action Group on Adolescent Health, ActionAid Nigeria, Advanced Fertility Clinic, Advocacy Nigeria, African Centre for MDGs Advocacy, African Council for Sustainable Health Development, Alliance Cornerstone Positive Outreach Concepts, Alliance of Southern Civil Society in Global Health , Association for Child Health, Association for Reproductive and Family Health, Association Internationalité des Etudiants en Sciences Economiques et Commerciales (AIESEC), Association of Demography and Social Statistics Students, Born Extraordinarily Excellent International, Center for Integrated Health Programs, Centre for Health Sciences, Training, Research and Development, Centre for Nonviolence and Gender Advocacy in Nigeria, Centre for Research in Reproductive Health, Olabisi Onabanjo University,, Champion Newspapers Limited, College of Medicine, University College Hospital, College of Medicine, University of Lagos, Dorcas Oke Hope Alive Initiative, Dreams Come True Production, Educare Trust, Environmental Health and Safety Network, Family Health and Population Action Committee, Family Planning Action Group, Federation of African Medical Students' Association Standing Committee on Population Activity (FAMSA-SCOPA), Federation of African Medical Students' Associations, Federation of Muslim Women Association of Nigeria, Garga Foundation, Gede Foundation, Gender and Development Action, Grassroots Development and Empowerment Foundation, HASHFEM Group Concepts, Health Alive Foundation, Health Reform Foundation of Nigeria, International Centre for Women Empowerment and Child Development, Ipas, Nigeria, Jhpiego Corporation, Kebetkache Women Development & Resource Centre, Kids & Teens Resource Centre Nigeria, LiveWell Initiative LWI, Niger Delta Women for Justice, Niger Delta Women's Movement for Peace and Development, Nigerian Urban Reproductive Health Initiative, Noble Missions for Change Initiative, Partnership for Transforming Health Systems 2, Planned Parenthood Federation of Nigeria, Population Studies Unit, Geography Department, University of Lagos, Rural Health and Women Development, Save Visions Africa (SVA), Society for Development & Community Empowerment, Society for Family Health, Society of Gynaecology and Obstetrics of Nigeria, Students In Free Enterprise (SIFE), University Of Ibadan, Tomorrow's Women Development Organization, Vision Spring Initiatives, Women & Community Livelihood Foundation, Women in Technology in Nigeria, Women's Health & Action Research Centre, Women's Rights Advancement and Protection Alternative, Association Rwandaise pour le Bien-Être Familial, Associação para o Planeamento da Família, Associação Santomense para Promoção Familiar, Association Sénégalaise pour le Bien-Être Familial, People Initiative & Impact in Society, SSF: Santé Sans Frontière, Alliance of Solidarity for the Family, Planned Parenthood Association of Sierra Leone, Sierra Leone Environmental Journalists Association, Young Peace Builders, Youth Partnership for Peace and Development, Somaliland Family Health Association, Al Amal Society for Women and Children, Effective Care Unit, University of Witwatersrand & University of Fort Hare, Maternal, Adolescent and Child Health Durban, Qhamasande Projects, Reproductive Health Research Unit, University of Stellenbosch, Commitato Collaborazione Medica, ARC-Sudan Program, Nyala Darfur, Network for Adolescents and Youth of Africa, Sudan Family Planning Association, Sudan Peace and Education Development Program, White Ribbon Alliance - Sudan, Family Life Association of Swaziland, ActionAid, Association of Private Health Facilities in Tanzania, Bugando Health Movement, Christian Spiritual Youth Ministry, East Central Southern Africa (ECSA) Health Community, Tanzania, Human Development Trust, Mtaji Microfinance, Orphans Relief Services (ORES Tanzania), Population Service International, Social Economic and Governance Promotion Centre, Southern Corridor Development Association, UMATI, Uzazi na Malezi Bora Tanzania, Alliance pour la Recherche et le Renforcement des Capacités, Association Togolaise pour le Bien-Être Familial, ATBEF, CILSIDA, Association Tunisienne de la Santé de la Reproduction, Access For Action Uganda (ACFA), Action For Fundamental Change and Development-AFFCAD, Action Group For Health, Human Rights and HIV/AIDS, ADUA Organisation, Aids Information Center, Allied Youth Initiative, College of Health Sciences, Makerere University, Dr. Ssebadduka, at The National Referral Hospital, Eagles Youth Development Group, Excel Hort Consult Ltd, Family Support Uganda, Federation of Uganda Medical Students' Associations, HWC-U, Integrated Rural Youth Development Initiatives, Kigezi Health Care Foundation, Mama Alive Initiatives, Mityana District, local government, Naguru Teenage Information and Health Centre, National Care Centre, Nnabagereka Development Foundation, Pan African Development Education & Advocacy Programme, PAORINHER, Partners in Population and Development, Regional Center for Quality in Healthcare, Regional Center For Quality of Healthcare, Reproductive Health Uganda, Rwenzori Foundation for Community Development, SAMASHA Medical, Sorak Development Agency, Text To Change, Uganda Health Marketing Group, Volunteers for Development Association in Uganda, Afya Mzuri, Angel of Mercy: Community Child Health Project, Malcolm Watson Mine Hospital, Mufulira, Planned Parenthood Association of Zambia, ReproNet-Africa, University Teaching Hospital, University of Zambia, Youth Vision Zambia, Zambia Forum for Health Research, University of Zimbabwe-University of California San Francisco Collaborative Research Programme, Zimbabwe National Family Planning Council.

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Asia & Oceania

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ODISAH, Asha Foundation, Asha Kiran, Asha Niketan, Asha Nivas, Ashirbad, Association for Promoting Social Action, AYZH Health and Livelihood Pvt Ltd, Baba Shri Nath Shiksha Sansthan, Bal Shayog, Bangalore Medical Services Trust, Bapu Bal Vikas Mahila Kalyan Society, Basava Teertha Vidya Peetha., Beladingalu Network Bidar, Bhairavi Club, Bharat Gyan Vigyan Samiti, Bharat Integrated Social Welfare Agency, Bharat Scouts & Guides District Association, Bhartiya Gramin Mahila Sangh, Bhoruka Charitable Trust, BIRDS-Bijapur Integrated Rural Development Society, BISHWASS, Bisma Social Welfare Society, BMST, BOSCO Yuvodaya, Buds of Christ, Calcutta Rescue , Calcutta Samaritans , CARD Ganjam, CARE, CCOORR, Center for Feminist Legal Research , Center for Women Development Studies, Centre DIRECT, Centre for Child Women Development, Centre for Health and Social Justice, Centre for Health Education, Training and Nutrition Awareness, Centre for Human Resource and Rural Developmental Programmes, Centre for Public Health and Equity, Centre for Urban Research & Alternative Medicines, Centre For Youth & Social Development , Centre for Youth Development & Activities, Chetna, Child In Need Institute, Children of the World, Chozha Kalalayam, CINI Bandhan, Committed Communities Development Trust, Community Development Centre, Creating Resources for Empowerment Action, D.D Nagar Seva Samiti, Dalit Sangh, Dedicated Society Of Teachers, Deen Dayal Research Insitiure, SATNA, Deepgriha, Delhi Network of Positve People, DHAN Foundation, Dindigul District HIV Positive Society, Doud Memorial Christian Grameen Vikas, Dr Sancheetee, at SCIR---NGO/CBO, Dr. Anju Aggarwal, Dr.Reddy's Foundation, EDUCATR, EK Lakshya Foundation, EKTA, empowering children | enabling wellbeing, Esscorts Organisation, Family Planning Association of India, Family Welfare Society, Federation of Obstetrics and Gynaecologists Society of India, FELLOWSHIP, FOGSI, Freedom Foundation, FXB India Suraksha, Gandhigram Institute of Rural Health and Family Welfare Trust, Gautam Buddha Jagriti Society, Gram Bharati Samiti, Grameen Punarnirman Sansthan, Azamgarh, Grameen Vikas Sanstha, Gramin Evam Nagar Vikas Parishad, Gramin Vikas Sewa Samiti, Basti, Gramin Vikas Vigyan Kendra, Gramodaya Samajik Sansthan, HACS, HelpmateIndia Charitable Trust, Hindustan Latex Family Planning Promotion Trust, Hosa Jeevanna, Human Touch, Humana People to People India, Impact Theter Art Samiti, India Female Foeticide, India Social Institute, Indian Red Cross Society, Indian Red Cross Society, Inner Wheel Club of Bangalore Orchards, INSA India, Institute for Reproductive Health, Institute for Social Development, Institute of Health Systems, Institute of Social Studies Trust, Ipas, India, IRD, Jabalpur Network of Positive People, JAGABANDHU JARASHRAM, Jan Kalian Maha Samiti KMS, Jan Shikshan Sansthan, Janhitay Mandal, Chandrapur, Janodaya Public Trust, Jayamatha Women Empowerment and Child Health, Kadamba Trust, Karnataka Cancer Society, Karnataka Network for people living with HIV, Karwar Diocesan Development Council, Kayakalpa, KIDS - Karnataka Integrated Rural Development Services, KISAN SEVA SANSTHAN, BASTI U.P, Kotagiri Women's Welfare Trust, Krishi Gram Vikas Kendra, Kshitij Premnagar Madan Mmahal, LEPRA India, Life Line Service Society, Lok Kala Parishad, Maa Foundation, Madhya Shibpur Human Care Rural Development Society, Madhyapradesh Network of People Living with HIV, Maglir Sakthi, Mahesh Foundation, Mahila Chetna Manch, Mahila Dakshata Samiti, Mahila Kalyan Sammittee, Mahila Samakhya, Mahila Samiti Chhatarpur, MAHIMAS, Mamta Health Institute for Mother and Child, Manavya, MEDVAN, Medak District Voluntary Agencies Network), Meera Foundation, Micronutrient Initiative India, MILANA, Mother Care Clinic, Mother Land Women Welfare Society, MPSACS, Muktangan, Mutual Education for Empowerment and Rural Action - MEERA FOUNDATION, MY Heart, Myrada Bidar, Narayani Seva Sansthan, NARI, National Centre of Human Settlement & Environment, National Insitute of Applied Human Research development, Navachar Sansthan, Naya Prayas, Nehru Yova Kendra, Network of Positive People, NIDAN, Nikhila Utkal Harijan Adivasi Sab Sangha, National Institute of Rural Affars Samiti, Native Medicare Charitable Trust-NMCT, NMP Plus, Open Learning System, Orbit, Orissa Institute for Medical Research & Health Service, Orissa Patita Udhar Samiti, Orissa Volunatry Health Association, Pandit G. B. Pant Institute of Studies in Rural Development, Pandit Govind Ballabh Pant Institute of Studies in Rural Development, Paraspara Trust, Paribar Seva Sanstha, Parivar Seva Sanstha, PATCHE Trust, Pawansut Servangin Vikas Kendra, Peoples Trust, Peoples Welfare Forum , PFI, Global Fund – RCC, PGSS, PGVS, Plan India, Population Foundation of India, Population Services International, Prayas, Prayatan, Pregna International Ltd, Premwati College of Nursing, Poor Urban and Rural Women's Association, Coordination Centre, Palmyrah Workers Development Society, Radha Govind Public Welfare Society, Rawal Mahila Kalyan Samiti, Rehabilitative Assistance for People in Distress, RAPID Dharwad, Red Cross, Regional Centre for Development & Cooperation, Resource Institute of Social Education, Rotary Club of Venugram, Belgaum, Ruchika Social Service Organisation, Rudra Dheeraj Prakshian Samiti, Rural India Self Development Trust, RUSS Foundation, Sadhane, SAHARA, Saharda Bidar, SAHAYOG, Sahayoga, Saheli, Sakaar Samajik Sanstha, SAKAV, Samabhavana Society, Samaj Welfare Organisation , Samapathik Trust, Samara, Samaritan Help Mission, Samarthan-Centre for Development Support, Sambavana Trust, Sambhav Social Service Organisation, Samrat Ashok Technologies Inst., Samridhi, SAMT , Samuha Suraksha, Samvada, Sangama, Sanket, Sansthan, SANTANA, Sarathi Development Foundation, SARD SAMPARK, Sard Sampark, SCODWES, Scouts & Guides, Serva Seva Sangh, Sevadham Trust, Sewa Bharti, Shakti Organization, Shelter Trust - Namakkal , Shohrat Garh Environmental Society, Shri Ram Krishan Charitable Trust, Shri Shalvhan Shiksha Saamiti, Shuruaat, SIRD, SLADS, Smile Foundation, Sneha Kunja, Social Awareness Institution, SOCIAL EDUCATIONAL AND ECONOMIC DEVELOPMENT SOCIETY, Social Welfare Inst. VARANASI, Society for Improvement in Backward Areas for Rural Development, Society for Promotion of Youth and Masses, Society of Developmental Action , Society of Social Networking for Education, Health & Agriculture, SOCO Trust, SOSVA, Soudamini, SPAD - Society for People's Action for Development, Spandana Network of Positive People, Sparsh Comunity Care Center, Spread, State Institute for Rural Development, Sumangali Seva Ashrama, Swasti, Swati Mahila Sangha, Sweekar- Organization, Synergy Sansthan, Tagore Scciety for Rural Development, Tarun Sanskar, Jabalpur, Tarun Sanskar, Ranjhi, Tata Steel Family Initiative Foundation, Tata Steel Rural Development Society, TEDDY Trust, The Hunger Project, Universal Service Organisation, Usha Kiran Shiksha Samiti, Uthkarsha, Vanchit Vikas, Vasavya Mahila Mandali, Vigyan Foundation, VIKASH, Vimochana, Vimuktha Federation, Vishwa Gram Vikas foundation, VJSS, Voluntary Health Service, World Vision, Youth for Seva, YWCA of Delhi, Zabarwan Welfare Child Development Organisation, Advance Family Planning, Cipta Cara Padu Foundation, Indonesian Planned Parenthood Association, RSPAD Gatot Soebroto Ditkesad (Gatot Soebroto Army Center Hospital), Samsara, Seruan Mahasiswa Peduli Kesehatan UMJ, Family Planning Association of the Islamic Republic of Iran, Iraqi Reproductive Health & Family Planning Association, Jssor Youth Organization, Voice of Independent Women, Israel Family Planning Association, International Committee on MCH Handbook, Japan Family Planning Association, Japan Organization for International Cooperation in Family Planning, Ugoku/Ugokasu (Global Call to Action against Poverty Japan), Ahl Al-Jabal, Mafraq, Kazakhstan Association on Sexual and Reproductive Health, Kiribati Family Health Association, Korean Family Planning & Maternal Child Health Association of DPRK, Planned Population Federation of Korea, Reproductive Health Alliance of Kyrgyzstan, Association Libanaise pour une Famille Moderne, Federation of Reproductive Health Associations, Society for Health Education, Ministry of Health, Mongolian Family Welfare Association, Kachin Development Group, Aamaa Milan Kendra, ActionAid, BPKIHS Department of Maternal Health Nursing, Britain Nepal Medical Trust, Family Planning Association of Nepal, Women Development Society, Youth Action Nepal, Abortion Law Reform Association of New Zealand, New Zealand Family Planning Association, Time Plus Talents, Aware Girls, Community Support Concern, CRY- Coalition on Rights & Responsibilities of Youth, David and Lucile Packard Foundation, Greenstar Social Marketing Pakistan (Guarantee) Limited, Human Resources Organization, Rahnuma-Family Planning Association of Pakistan, Rashid Latif Medical College, Rural Community Relief Organization, Rutgers WPF Pakistan, The Resource Enhancement for Empowerment Welfare Organization, Youth Action for Pakistan, Abna Al Quds Club, Abu Dies Club, ActionAid, Al Aisawia Community Center, Al Beit Al Falstine, Al Daheria municipality, Al Jahleen Bedouin local council, Al Kbiba local council, Al Maqased Society, Al Marfa Counseling Center, Al Muntda Forum / BEDO, Al Mutran School, Al Nahda Society, Al Nazmiah School, Al Sadeq Al Tayeb , Al S'ahra local council, Al Saria Society, Al Tanmia Al Rifia, Biet An'an local council, Bisan Research Center, BNI Na'am Municipality, Bounat Al Mousaqbel, Burg Al Laqlaq Society, Caritas, The Old City Counseling Center, Childhood Programs Society, Children Village SOS, Community Service Center, Dar Camdien, Defense for Children International, Der Al As'al local council, DOURA youth club, Family Protection Society, Frere School, Haloul Women's Center, Health Work Committees, Jerusalem Advocacy Network, Jerusalem Youth Parliament, Juzoor Foundation, Kharas Women's Center, MIFTAH Organization, Palestinian Counseling Center, Palestinian Family Planning & Protection Association, Palestinian Medical Relief Society, Palestinian Red Crescent Society, Rural Women Center, SAWA Center, Sharek Forum, Sheifq Saad Society, Shufat Camp Community Center, SOURIF youth club, Spafford Children's Center, The East Jerusalem YMCA, The Social Affairs, Abu Dies, The Women Counseling Center, The Women Studies Center, The Women Worker Center, The Women's Center, Abu Dies, The Women's Center, Beit Oula, The Women's Center, Shouk, The Women's Center, Shufat Camp, Treatment and Rehabilitation of Victims of Torture, UNWRA, Women Affairs Technical, Women Center for Legal Aid and Counseling, Worker Women Association, Yatta municipality, Papua New Guinea Society of Obstetrics and Gynecology, Alliance of Young Nurse Leaders & Advocates International Inc., Democratic Socialist Women of the Philippines, Family Planning Organization of the Philippines, Inc., Forum for Family Planning and Development, Inc., Isis International, Men's Responsibilities in Gender and Development, Mindanao State University, Philippine Center for Population and Development, Philippine NGO Support Program, Inc., Philippine Rural Reconstruction Movement, Population Services Pilipinas Incorporated, Waray-Waray Youth Advocates, WomanHealth Philippines, Women's Global Network for Reproductive Rights, Samoa Family Health Association, Singapore Planned Parenthood Association, Solomon Islands Planned Parenthood Association, Family Planning Association of Sri Lanka, Syrian Family Planning Association, Tajik Family Planning Alliance, Asia Pacific Alliance for Sexual and Reproductive Health and Rights, Asian Forum of Parliamentarians on Population and Development, Planned Parenthood Association of Thailand, Tonga Family Health Association, Family Health Association, Uzbek Association on Reproductive Health, Vanuatu Family Health Association, Center for Health Consultation and Community Development, Institute for Reproductive and Family Health - RaFH, Vietnam Family Planning Association, Yemeni Association for Reproductive Health.

Europe

Qêndra për Popullsinë dhe Zhvillimin, Österreichische Gesellschaft für Familienplanung, European NGOs for Sexual and Reproductive Health and Rights, Population and Development, European Parliamentary Forum on Population and Development, Fédération Laïque de Centres de Planning Familial, International Centre for Reproductive Health, Mama's aan de Evenaar, VZW, Millennia2025 "Women and Innovation" Foundation, Public Utility Foundation, Prof. and MP Mrs. Marleen Temmerman, Sensoa, Association for Sexual and Reproductive Health XY, Bulgarian Family Planning and Sexual Health Association, Gender Alternatives Foundation, Cyprus Family Planning Association , Spolecnost pro planovani rodiny a sexualni vychovu, Danish Family Planning Association, Eesti Seksuaaltervise Liit / Estonian Sexual Health Association, The Finnish NGDO Platform to the EU Kehys, Väestöliitto – Family Federation of Finland, Association Genre en Action, ENDA Europe, Forum des Organisations de Solidarité Internationale issues des Migrations, French Family Planning Movement, Médecins du Monde France, Mouvement Français pour le Planning Familial, Plan International France, PRO FAMILIA Bundesverband, Family Planning Association of Greece, BOCS Foundation, Frædslusamtök um kynlíf og barneignir, ActionAid, AIDOS, Avvocato Michela Cocchi - Studio Legale, Latvian Association of Obstetricians and Gynecologists, Latvijas Gimenes Planošanas un Seksualas Veselibas Asociacija, Šeimos Planavimo ir Seksualinés Sveikatos Asociacija, Health Education and Research Association, Societatea de Planificare a Familiei din Moldova, Terra-1530, CHOICE for Youth and Sexuality, dance4life foundation, i+solutions pharmaceutical management support, Plan Nederland, Rutgers WPF, Simavi, Belfast Feminist Network, Sex og Politikk, ASTRA Central and Eastern European Network for Sexual and Reproductive Rights and Health, Federation for Women and Family Planning, Towarzystwo Rozwoju Rodziny, ADDHU-Associação para a Defesa dos Direitos Humanos, ONGD, AMPLOS, ANUP - Associação das Nações Unidas - Portugal, ASPF, Associação Santomense para Promoção Familiar, Associação Para o Planeamento da Família, Bue Fixe- Associação de Jovens, Mulher Migrante - Associação de Estudo, Cooperação e Solidariedade, Saúde em Português - Associação de Profissionais de Cuidados de Saúde dos Países de Língua Portuguesa, Societatea de Educatie Contraceptiva si Sexuala, Russian Association for Population and Development, Serbian Association for Sexual and Reproductive Health and Rights, Slovenská spolocnost pre plánované rodicovstvo a výchovu k rodi., Africa Viva Fundación, Barcelona Institute for Global Health / Instituto de Salud Global de Barcelona, Federación De Planificación Familiar Estatal, Instituto de Cooperación Social INTEGRARE, Population Matters Sweden, RFSU, Santé Sexuelle Suisse, Türkiye Aile Planlamasi Dernegi, ActionAid, Asha Projects, AVA, Bond, Cara International Consulting, Evidence for Action Consortium, Family Planning Association, Gender and Development Network, Imkaan, Irish Family Planning Association, Kensington Midwives, Margaret Pyke Trust, Marie Stopes International, Newham Action Against Domestic Violence, Professor Peter Piot, at the London School of Hygiene and Tropical Medicine, RCOG: Faculty of Sexual and Reproductive Healthcare of the RCOG, Respect, Roshni, Rotarian Action Group For Population And Development And The Rotary Club Of London, Royal College of Obstetricians and Gynaecologists, Sarah Hyde Consultancy, The Pleasure Project, Women's Networking Hub, Women's Resource Centre, NGO Women Health and Family Planning, Virtus.

Global

If Everyone Cares, 34 Million Friends of UNFPA, Abt Associates, ActionAid International, Advance Family Planning, Advocates For Youth, American Refugee Committee International, Bayer Healthcare Pharmaceuticals, Care International, Center For Environment And Population, Center for Health and Gender Equity, Center For Women Policy Studies, Centre for Development and Population Activities, Commonwealth Medical Trust, Concept Foundation, Deutsche Stiftung Weltbevoelkerung, Development Media International, EngenderHealth, Equilibres & Populations, Family Care International, FHI 360, Friends of UNFPA, Futures Group, Futures Institute, Gillespie Foundation, Global Health Strategies Initiatives, Global Health Workforce Alliance, WHO, Global Network of Sex Work Projects, Global Tech Women, Guttmacher Institute, Hands to Hearts International, Health Poverty Action, Interact Worldwide, International Center for Research on Women, International Consortium for Emergency Contraception @ Family Care International, International Federation of Gynaecology and Obstetrics, International HIV/AIDS Alliance, International Medical Corps, International Network of People who Use Drugs, International Partnership for Microbicides, International Planned Parenthood Federation, International Rescue Committee, IntraHealth International, Ipas, John Snow, Inc, Management Sciences for Health, Maternity Worldwide, Medical Women's Federation, Medical Women's International Association, Medicines360, Merlin, PATH, Pathfinder International, Planet 21, Population Action International, Population and Sustainability Network, Population Connection, Population Council, Population Matters, Population Media Center, Population Services International, Reproductive Health Supplies Coalition, Save the Children International, Stop Aids Now, UCL Institute for Global Health, Umeå Centre for Global Health Research, United Nations Foundation, USAID/Private Health Sector Program, Venture Strategies Innovations, VSO, WestWind Foundation, White Ribbon Alliance for Safe Motherhood, Women and Children First, Women Deliver, Women Donors Network, WomenCare Global, World Association for Sexual Health, World YWCA, Y Care International, Youth Coalition for Sexual and Reproductive Rights International.

Latin America & Caribbean

Anguilla Family Planning Association-The Primary Health Care, Antigua Planned Parenthood Association, Caribbean Family Planning Affiliation Ltd, Fundación para la Salud del Adolescente, Hospital Municipal "Dr. Bernardo Houssay", Foundation for the Promotion of Responsible Parenthood (Aruba), Bahamas Family Planning Association, Barbados Family Planning Association, National Organisation of Women, Belize Family Life Association, Teen Services, Centro de Investigación, Educación y Servicios, Bem Estar Familiar no Brasil, Grupo Gay Da Bahia, Movimento D´ELLAS, Reprolatina- Soluções Inovadoras em Saúde Sexual e Reprodutiva, Canadian Federation for Sexual Health, Asociación Chilena de Protección de la Familia, Asociación Pro-Bienestar de la Familia Colombiana, Fundación Esar, Fundación Oriéntame, Profamilia Colombia, Asociación Centro de Investigación y Promoción para América Central de Derechos Humanos - CIPAC, Asociación Demográfica Costarricense, Sociedad Cientifica Cubana Para el Desarrollo de la Familia, Foundation for the Promotion of Responsible Parenthood, Fundashon Familia Plania, Dominica Planned Parenthood Association, Asociación Dominicana Pro-Bienestar de la Familia, Centro Ecuatoriano para la Promoción y Acción de la Mujer de Guayaquil, Ecuador, Silueta X Association, Asociación Demográfica Salvadoreña, Grenada Planned Parenthood Association, Association Guadeloupéenne pour le Planning Familial, Asociación Pro Bienestar de la Familia de Guatemala, Women's International Network for Guatemalan Solutions, Guyana Responsible Parenthood Association, Association pour la Promotion de la Famille Haïtienne, Diaspora Community Services, Asociación Hondureña de Planificación de Familia, Jamaica Family Planning Association, Latin American Federation of Ob & Gyn Societies, Association Martiniquaise pour I'Information et l'Orientation Familiales, Centro de Desarrollo e Investigación sobre Juventud, A.C. , Equidad de Género: Ciudadanía, Trabajo y Familia, Espacio Amigable Kanantaba, Espolea, A.C., Fundación Mexicana ara La Planeación Familiar, AC., Investigación en Salud y Demografía S.C., Red Juvenil en Respuesta al VIH, Universidad Autonoma Metropolitana, Graduate Program on Population and Health, Nevis Family Planning Association, Asociación Pro-Bienestar de la Familia Nicaragüense, Asociación Panameña para el Planeamiento de la Familia, Genos Global, Inter-American Parliamentary Group on Population and Development, El Centro Paraguayo de Estudios de Población, Apoyo a Programas de Población - APROPO, Instituto Peruano de Paternidad Responsable, Red Nacional de Promoción de la Mujer, Asociación Puertorriqueña Pro-Bienestar de la Familia, Saint Lucia Planned Parenthood Association, St. Vincent Planned Parenthood Association, Stichting Lobi, Advocates for Safe Parenthood: Improving Reproductive Equity, Art's Insight, Family Planning Association of Trinidad and Tobago, Asociación Civil de Planificación Familiar.

North America

Action Canada for Population and Development, Centre for Health Policy and Innovation, All Our Lives, bon lèspwi DESIGNS CO, Coalition Advancing Multipurpose Innovations, Evidence to Action (E2A) Project, Feminist Task Force of the Global Call to Action against Poverty, Goddesses Blessing Goddesses Org., Grounds For Health, Institute for Reproductive Health at Georgetown University, Just In Case, Inc, Kaicombey Foundation, Life For Mothers, MamaDrama, Mapp Biopharmaceutical, Inc, National Women and AIDS Collective, Planned Parenthood Federation of America, Pro Mujer, Public Health Institute, Re: Generation Consulting, LLC, Religious Institute, Rotarian Action Group for Population & Development, United Methodist General Board of Church & Society, University ResearchCo., LLC, Women Explore Lecture and Discussion Forum, Women's Refugee Commission.

IPPF International Planned Parenthood Federation

Through a process of global consultations including an online survey, this declaration of support represents the combined views of more than 220 respondents from 57 countries This letter was written through a consultative process involving over 220 Civil Society Organizations and an International Steering Committee from: **Association Malienne pour la Protection et la Promotion de la Famille, Bem Estar Familiar no Brasil, Centro de Investigacion, Educacion y Servicios, Countdown 2015 Europe, Marie Stopes Ethiopia, Marie Stopes Ghana, Rahnuma the Family Planning Association of Pakistan, The Family Planning Action Group – Nigeria, The Family Planning Association of India, The International Planned Parenthood Federation, The Reproductive Health Supplies Coalition, The UN Foundation.**

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