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When women have the tools they need to plan their families—information, access to contraceptives, and high-quality health care—they are much more likely to finish their education. That gives them the opportunity to do what they do best: build thriving families, communities, and nations.

MELINDA GATES
CO-CHAIR, BILL & MELINDA GATES FOUNDATION

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EXECUTIVE SUMMARY

Our goal is to expand access to contraceptives to an additional 120 million women and girls in the world's poorest countries by 2020.

At the 2012 London Summit on Family Planning, the leaders of 150 countries, international agencies, civil society organizations, foundations, the research and development community, and the private sector endorsed the goal of expanding access to family planning information, services, and supplies to an additional 120 million women and girls in the world's poorest countries by 2020.

Family Planning 2020 (FP2020) carries forward this momentum. Since its launch, more than 25,000 individuals and organizations have expressed interest in joining FP2020, and the constellation of stakeholders who are vested in improving women's and girls' lives continues to grow.

One-quarter of FP2020 commitment-making countries have launched detailed, costed national family planning plans. One-third of commitment-making countries have increased their national budget allocations for family planning services or supplies. Half of commitment-making countries have held national family planning conferences to emphasize high-level political support and accelerate progress on family planning strategies.

Preliminary data on international donor expenditures indicate an ins on family planning programs. Concrete examples of progress on the local, national, and regional levels are detailed throughout this report.

A rigorous measurement and evaluation agenda has been established as a means of guiding progress in delivering on the promise set forth in London. Over the past year FP2020 initiated a number of activities to establish the systems and infrastructure necessary to monitor the impact of family planning programs and to strengthen accountability for implementing financial, policy, and programming commitments. This undertaking included the selection of core indicators, collating corresponding baseline data, improving the way in which family planning expenditures are tracked, and launching electronic data collection in select countries.

Importantly, FP2020 also laid the groundwork to develop a transformative framework to measure and report on the autonomy, equity, and human rights-based dimensions of family planning programs.

Countries have made progress in addressing supply and demand barriers to accessing family planning.

This report describes significant actions taken in the past year, including price reduction agreements, innovations in contraceptive technology, improvements in service delivery and commodities distribution models, and outreach to vulnerable and marginalized groups in the global effort to continue to expand access and choice for millions of women and girls.

The progress documented in this report demonstrates that we are moving forward—program by program, clinic by clinic, and community by community—towards a future in which all women, no matter what their circumstances, will have the information, services, and supplies they need to decide freely and for themselves whether, when, and how many children they want to have.

Stephanie Freid-Perenchio
photography/SFP STUDIO

FOREWORD

Under the right conditions, bringing together a broad, diverse group can yield results far greater than the participants would achieve on their own.

It may defy the rules of mathematics, but there is truth to the observation that a whole can be greater than the sum of its parts. This insight lies at the heart of the Family Planning 2020 (FP2020) initiative. We believe that, under the right conditions, bringing together a broad, diverse group can yield results far greater than the participants would achieve on their own.

Last year, leaders from governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community converged at the London Summit on Family Planning to agree upon one extraordinary—but absolutely vital—goal: expand access to family planning information, contraceptives, and services to an additional 120 million women and girls in the world's 69 poorest countries by the year 2020. 70 commitments were made, and donors and the private sector pledged US$2.6 billion in new funding.

FP2020 carries forward the momentum of the Summit. It is not a new NGO, nor is it a vertical fund. Instead, it is a different way of working together: a creative network of cooperation that revolves around a hub to promote knowledge-sharing and emergent thinking. Rather than duplicating efforts or pushing organizations into a new hierarchy, FP2020's structure encourages partners to align their agendas, pool their talents, and utilize existing structures in new and complementary ways. One year after the Summit, we have successfully formed new alliances among a broad range of partners from all sectors. We must now hold ourselves accountable.

We believe that the family planning community's greatest resource is the human energy of our diverse leaders, experts, advocates, and implementers. Some of the most exciting progress of the past year came from innovative partnerships that harnessed market incentives to solve formerly intractable problems. Millions of women in the world's poorest countries will now have access to long-acting reversible contraceptive methods thanks to the vision and dedication of colleagues representing governments, NGOs, pharmaceutical companies, donors, and multilateral organizations.

Accurate, timely, accessible information is the lifeblood of this initiative. That's why FP2020 is committed to expanding participation in the practice of measurement, evaluation, and adjustment, which for many countries is in its infancy. For the first time, this report documents the results of our collective effort to establish a measurement framework for the initiative. The indicators, methodologies, and data presented here will serve as the baseline to gauge our progress in future years. This is especially important because, though the world is spending more on family planning, funding is still inadequate. Budgets for international assistance have been cut and programs are under greater pressure than ever before. Through careful analysis we will diminish inefficiencies, leverage economies of scale, and focus on plans that work.

Expanding access to contraceptives for an additional 120 million women and girls will require the equivalent of US$4.3 billion over the next eight years, over and above the US$10 billion necessary to sustain current use. FP2020 will actively seek new funding, policy, and service delivery commitments. We will promote accountability to those commitments by tracking and reporting progress, linking with the UN Secretary General's Global Strategy for Women's and Children's Health, *Every Woman, Every Child.*

Insufficient funding is just one reason family planning programs may fail to reach women and girls. Social and cultural factors such as gender inequality, discrimination, and a lack of appreciation for cultural sensitivities and personal preferences are all formidable barriers. Family planning strategies will not succeed unless they are embedded in a continuum of care, protection of human rights, and promote gender equality. No plan can be said to serve the needs of women and girls if it does not respect their agency.

As we present FP2020's first annual progress report, we look forward to the year ahead. We are inspired by the power and promise of information, the dynamic intelligence and creativity of our colleagues in all sectors, and our shared dedication to achieving our common goal. Reaching 120 million additional women and girls with life-saving contraceptives in just eight short years is an ambitious goal, but together we will succeed.

DR. CHRIS ELIAS
PRESIDENT, GLOBAL DEVELOPMENT
BILL & MELINDA GATES FOUNDATION

DR. BABATUNDE OSOTIMEHIN
EXECUTIVE DIRECTOR
UNITED NATIONS POPULATION FUND

FP2020 PROGRESS

2012-2013

07.12

- London Summit on Family Planning. 70 commitments made towards increasing access to family planning for additional 120 million women and girls including pledges amounting to US $2.6 billion and commitments by more than 20 governments
- Announcement to expand access to *Sayana© Press* injectable contraceptive

10.12

- Kenya launches costed national family planning plan
- Ghana holds national family planning conference, Kumasi

11.12

- Ethiopia holds *National Family Planning Symposium*, Bahir Dar
- India holds *National Review Meeting on Family Planning*, New Delhi
- Nigeria holds *National Family Planning Conference*, Abuja
- Senegal launches *National Strategic Plan for Family Planning Promotion*
- Kenya amends National Family Planning Service Provision Guidelines allowing trained community health workers to offer injectable contraceptives at community level

12.12

- *Responsible Parenthood and Reproductive Health Act* signed, Philippines
- Malawi approves *National Population Policy*
- FP2020 Reference Group meets for the first time, New York

02.13

- Niger launches costed national family planning plan
- FP2020 Stakeholders meet
- Agreement to reduce price of Jadelle© contraceptive implant

03.13

- FP2020 Reference Group meets for the second time, Washington, D.C.

05.13

- FP2020 commitment-makers at *Women Deliver Third Global Conference*, Kuala Lumpur
- PMA 2020 and Track 20 projects launch
- Agreement to reduce price of IMPLANON© and IMPLANON NXT© contraceptive implants
- FP2020 Reference Group meets for the third time, Kuala Lumpur

06.13

- Burkina Faso launches national family planning plan
- Memberships of FP2020 Country Engagement, Performance Monitoring & Accountability, and Rights & Empowerment Working Groups announced

07.13

- Uganda's Parliament approves the *National Population Council Bill*
- One year anniversary of the London Summit on Family Planning
- FP2020 Country Engagement Working Group convenes for first full meeting, Washington, D.C.
- FP2020 Performance Monitoring & Accountability Working Group convenes for first full meeting, Geneva

08.13

- FP2020 Rights & Empowerment Working Group convenes for first full meeting, Washington, D.C.
- Burkina Faso launches Consolidated Action Plan for Family Planning

09.13

- Indonesia holds *National Family Planning Summit*, Jakarta
- Senegal launches nationwide scale-up of Informed Push Model system of distribution for contraceptive commodities
- Zambia launches *Costed Eight-Year Integrated Family Planning Scale-up Plan*
- FP2020 Reference Group Meeting, New York
- Family Planning Association of Pakistan holds seminar *Towards Realizing Family Planning Vision 2020*

10.13

- Tanzania holds national family conference, Dar-es-Salaam
- FP2020 Market Dynamics Working Group membership announced

11.13

- *Third International Conference on Family Planning,* Addis Ababa. New FP2020 commitments announced

12.13

- Uganda to hold national Family Planning Conference

01

SECTION 01

Commitments and Accountability

Family planning programs have had a profound impact in a relatively short period of time. In the developing world, the contraceptive prevalence rate (modern methods) rose from negligible levels in the 1960s to 55% in 2000.[1] Although many groups were under-served, steady progress was manifest.

But the gains stopped, and the contraceptive prevalence rate leveled off. Support for family planning and reproductive health remained high, but the sense of urgency had waned. For far too many decision-makers, funding and implementing these programs were no longer priorities.

Today, this work remains far from finished. There are more than 220 million women in developing countries who don't want to get pregnant but lack access to the family planning information, services, and supplies they need. Nothing short of our full dedication is required to surmount the logistical, financial, geographical, and other barriers they face. It is to these women that FP2020 is ultimately accountable.

1
Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services, Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012, http://www.guttmacher.org/pubs/AIU-2012-estimates.pdf

WOMEN AND GIRLS AT THE HEART OF FP2020

Bridget Anyafulu is the founder and executive director of the International Centre for Women's Empowerment and Child Development (ICWECD). She is based in Delta District, Nigeria. She is a member of the FP2020 Working Group on Rights & Empowerment, with whom she shared this story.

A project that brings fresh running water to a remote, impoverished village—how could it be anything other than a blessing?

The local women didn't see it that way.

In a small village in the Delta District of Nigeria, women would walk up to four kilometers every day to get water from the nearest river. These women had a secret.

Many were desperate to delay getting pregnant. Local people believed husbands should decide how many children to have, and men preferred big families. It was not unusual for women to give birth eight, nine, or ten times. Motherhood started early; one assessment found that approximately 50% of the village's girls already had a child. Tragically, maternal and child deaths were common.

If a woman could get to a hospital, she could get access to contraceptives. But getting there was only part of the problem. By taking contraceptives, a wife was usurping her husband's authority. If she was caught taking a pill, his wrath, and the wrath of his family, could be formidable.

The women devised a plan. They bundled up their contraceptives and hid them in a tree near the river. Every day, on their way to fetch water, they could take their pills out of sight of the men.

Then the pipes came. Now, with running water not 200 meters from their doorsteps, the women had no excuse to visit the tree by the river. They didn't want to get caught by their husbands, but no woman wants to die in childbirth, or lose her newborn.

So they came up with a new plan. The women vandalized the water pipes.

When Bridget saw what had happened, she knew the problem was neither the pipes nor the women. She understood that the root of the trouble was the husbands' attitude toward family planning, and the cultural norms that kept women disempowered. She also knew that if this was a problem in one village, it was likely a problem in other Delta District communities.

Bridget's strategy was to convince husbands that women have the right to live, and to see their children grow and thrive. To do that, women need to space their pregnancies and have fewer children. She went from village to village and home to home, talking with leaders and individual husbands about the benefits of family planning. She persuaded them that having fewer children who are healthy and educated is a better legacy than having many children whose prospects are dim. She helped them understand that when a mother dies in childbirth, the whole family and the community suffer.

It took many years of hard work, but today, attitudes in the Delta District have changed. Family size is smaller and there are fewer maternal and newborn deaths. There is still a long road ahead, but the lessons are clear. Services should never be implemented without a deep understanding of the needs of all members of a community. Building a pipeline is not enough. For change to take root, we must place women's empowerment at the center of the development agenda.

FAMILY PLANNING 2020

The 2012 London Summit on Family Planning was intended to re-energize the global family planning community, but the enthusiasm it unleashed far exceeded expectations. Leaders from 150 donor and developing countries, international agencies, civil society organizations, foundations, and the private sector joined together to endorse the goal of expanding access to contraceptives to an additional 120 million women and girls in the world's poorest countries.

FP2020 carries forward this momentum. Since its launch, more than 25,000 individuals and organizations have expressed interest in joining FP2020, and the constellation of stakeholders continues to grow.

FP2020 has developed a platform that recognizes change must occur on multiple levels, across multiple sectors, by enabling a broad range of allies to participate in their area of expertise. The structure of FP2020 fosters the cross-pollination of ideas and creates a space to reach consensus, especially on crucial matters like indicators to monitor progress.

Equally important are the things FP2020 does not do. It does not create bottlenecks by funneling all participants into one-size-fits-all strategies. In recognition that duplicative reporting structures create significant administrative burdens, FP2020 does not require countries to adhere to a new reporting regime. FP2020 does not divert attention from its constituent stakeholders, but rather magnifies their ability to mobilize resources and deliver life-saving services.

FP2020 STRUCTURE

FP2020 is governed by a Reference Group which sets the overall strategic direction and drives coordination among the partnership's stakeholders. The Reference Group has 18 members representing governments, multi-lateral organizations, civil society, and the private sector.

The current Co-Chairs of the Reference Group are Dr. Babatunde Osotimehin, Executive Director of UNFPA, and Dr. Chris Elias, President of the Global Development Program at the Bill & Melinda Gates Foundation. To date, the Reference Group has met four times: in December, 2012; and in March, June, and September, 2013.

FP2020 has a Task Team responsible for the implementation of day to day activities. It is led by Valerie DeFillipo, reports to the Reference Group, and is hosted by the UN Foundation. The Task Team monitors overall progress for reporting to countries and the Reference Group, coordinates across other entities and external groups, and supports Working Group strategies and implementation.

The imperatives of human rights and public health are not merely compatible; they are indivisible. FP2020 has four Working Groups that mirror the lateral, organic interrelation of the forces that contribute to rights-based family planning programs.

- Countries vary in the type of support they need to develop, implement, and monitor transformational national family planning strategies. The Country Engagement Working Group (CE WG) works with partners to provide support to accelerate the implementation of country plans within the context of their reproductive, maternal, newborn, and children's health strategies. CE WG facilitates access to technical, funding, and other assistance, and coordinates information sharing and peer-to-peer support. CE WG works with the Performance Monitoring & Accountability Working Group to measure the impact of family planning programs, and to strengthen countries' efforts to collect and utilize data on an ongoing basis to inform decision-making.

- Substantial and consistent monitoring and evaluation efforts are central to FP2020's efforts to track advances, identify gaps and challenges, and promote accountability. The Performance Monitoring & Accountability Working Group (PMA WG) strives to improve the quality and availability of information for use at the community, country, and global level and to further explore methodologies to measure service quality, encourage the use of data in program management and policy development, and embed human rights approaches recommended by the Rights & Empowerment Working Group.

- FP2020 envisions a world where the right of women and girls, no matter where they live, to decide whether and when to have children is respected, protected and fulfilled. The Rights & Empowerment Working Group (RE WG) acts as a resource for expertise, guidance, best practices and tools to ensure that a rights-based approach underpins the design, implementation, monitoring and evaluation of family planning programs. RE WG will collaborate with other Working Groups and partners to address the full range of barriers that limit or prevent many women from using family planning information, services and supplies and to prioritize human rights principles such as participation, accountability, non-discrimination, empowerment, transparency, and sustainability in all FP2020 activities.

- FP2020's Market Dynamics Working Group (MD WG) will improve global and national markets to sustainably ensuring choice and equitable access to a broad range of high quality, affordable contraceptive methods. MD WG is driven by the need to ensure that family planning commodities are available for an additional 120 million women and that the market is healthy enough to sustain this demand after 2020. A well-coordinated expert working group focused on addressing tensions and information gaps in the market can unlock new and important opportunities to ensure that access to contraceptive supplies and services is expanded. That is the aim of market shaping, whether it is achieved by making products more affordable, ensuring appropriate product design, securing adequate and sustained supplies, improving product quality, or increasing product availability.

Each Working Group has an affiliated Consultative Network of stakeholders who will be engaged periodically for input on Working Group activities. The Consultative Networks provide additional expertise and are instrumental in identifying critical resources and materials that highlight success stories, high-impact practices, and innovations to share with decision-makers at the country level.

The London Summit on Family Planning last year was a starting point for determined global action on family planning. Public, private and civil society partners from around the world agreed to a goal of giving an additional 120 million girls and women in the world's poorest countries access to voluntary family planning by 2020.

Investing in girls and women in this way is also the smart thing to do. It is about giving women in developing countries the choice over when to get married and how many children to have, control over their lives and their job prospects, and a voice in their communities.

I welcome the progress the FP2020 movement has made so far and the UK will continue play its part. Our goal must be for all girls and women to have the opportunity to shape their own future.

THE RIGHT HONOURABLE JUSTINE GREENING
MP, SECRETARY OF STATE FOR INTERNATIONAL DEVELOPMENT, UNITED KINGDOM

PROGRESS ON COMMITMENTS TO FP2020

The enthusiasm that emerged at the London Summit on Family Planning is yielding tangible results, and it is clear that countries[2] are leading the way. As of July 2013, countries comprised one-third of the 70 commitment-makers to FP2020.

THE FP2020 COMMITMENT-MAKING COUNTRIES ARE:

Bangladesh
Burkina Faso
Côte d'Ivoire
Ethiopia
Ghana
India
Indonesia
Kenya
Liberia
Malawi
Mozambique
Niger
Nigeria
Pakistan
Philippines
Rwanda
Senegal
Sierra Leone
Solomon Islands
South Africa[3]
Tanzania
Uganda
Zambia
Zimbabwe

FP2020 Commitment Makers

- Low Income Countries (23)
- Middle Income Countries (1)
- Donor Countries, Foundations, Private Sector (19)
- Multilaterals and Partnerships (5)
- Civil Society Organizations (22)

2
FP2020's goal is to enable an additional 120 million women in the world's poorest countries (FP2020 focus countries) to use modern contraception by 2020. These countries—69 in total—are defined as those with a Gross National Income (GNI) of $2,500 per year or less (based on the World Bank 2010 classification using the Atlas Method).

3
South Africa's GNI does not qualify as one of the world's poorest countries based on the World Bank 2010 classification using the Atlas Method.

Stephanie Freid-Perenchio
photography/SFP STUDIO

Progress is driven by the governments of these countries, in collaboration with civil society organizations, service providers, advocates, industry leaders, and experts. Multilateral organizations, foundations, and other members of the global family planning community provide support and technical assistance.

One-quarter of FP2020 commitment-making countries have launched detailed, costed national family planning plans. One-third of commitment-making countries have increased their national budget allocations for family planning services or supplies. Half of commitment-making countries have held national family planning conferences to emphasize high-level political support and accelerate progress on family planning strategies. Preliminary data on international donor expenditures indicate an increased level of disbursements on family planning programs. Concrete examples of progress on the local, national, and regional levels are detailed throughout this report.

Snapshot of Country-Led Progress

BURKINA FASO

National family planning plan launched

Introduction plan for Sayana® Press approved

ETHIOPIA

National Family Planning Symposium

National budget for family planning increased

Community Health Extension program expansion continued

GHANA

National Family Planning Conference

INDIA

National Family Planning Review Meeting

INDONESIA

National Family Planning Summit

National budget for family planning increased

Family planning services and supplies available free of charge in national insurance program, commencing January 2014

National resources redirected to smaller islands and areas with greatest unmet need

KENYA

Costed national family planning plan launched

National budget for family planning services and commodities both increased

Guidelines changed to allow community health workers to provide injectables

Increased access to family planning services for the impoverished and youth

MALAWI

National Population Policy approved

NIGER

Costed national family planning plan launched

Introduction plan for Sayana® Press approved

Meeting of 80 traditional chiefs convened by government and UNFPA to discuss family planning

School for Husbands initiative expanded

NIGERIA

National Family Planning Conference organized

National budget for family planning commodities and services increased

Gombe State plan to expand access to family planning launched

Policy change to allow community health workers to provide injectable contraceptives

Cluster model of integrated services implemented by Nigeria Planned Parenthood

President launched Saving One Million Lives initiative

Family planning trainings scaled up

Trainings of community health workers on injectable contraceptives begin

Distribution of contraceptives to the last mile using review-resupply meeting model

BCC and media campaign to increase knowledge and awareness of female condoms

Detailed implementation plan to expand use of modern contraception developed

PAKISTAN

National budget for family planning increased for fiscal year 2012-2013

Provinces currently developing budget frameworks for financing of family planning

SENEGAL

National Strategic Plan for Family Planning Promotion launched

Informed Push Model of distribution scaled up nationwide

Introduction plan for Sayana® Press approved

SIERRA LEONE

National budget for family planning increased

Voucher system for family planning services for the poor implemented

School for Husbands initiative launched

Civil society organizations supported to monitor distribution of reproductive health commodities

SOUTH AFRICA

Revised policy to require public health facilities to offer all contraceptive methods

TANZANIA

National family planning conference

National budget for family planning increased

Framework contract for procurement of contraceptives endorsed by government

Guidelines approved to allow NGOs direct access to Medical Stores Department

UGANDA

Stakeholders meeting to develop FP2020 action plan

National budget for family planning supplies increased

Reproductive health sub-account established to track resource flows

Unified, costed, national family planning plan under development

Policy changes to allow health worker task-sharing and administration of injectables

Introduction plan for Sayana® Press approved

Vouchers for post-partum IUDs

Planning underway for first national family planning conference (December 2013)

Parliament passes bill to establish National Population Council

ZAMBIA

Costed Eight-Year Integrated FP Scale-up Plan 2013-2020 launched

Pilot study on allowing community health workers to provide contraceptive injections

Implementing scale-up of mobile health services

Family planning is not a privilege, but a basic human right. By enabling women, particularly the most disadvantaged and hardest to reach, to make informed choices about the number, timing and spacing of their children, we help them exercise this right.

DR. BABATUNDE OSOTIMEHIN
EXECUTIVE DIRECTOR, UNFPA

A CLOSER LOOK: GHANA

GHANA'S COMMITMENT TO FP2020

Ghana is committed to making family planning free in the public sector, and supporting the private sector to provide services. Services will be available for young people through youth promoters and adolescent friendly services. Improved counseling and customer care will be prioritized. Contraceptive choices are being expanded to include a wider range of longer acting and permanent methods along with including task shifting options and improvement of postpartum and post-abortion family planning services. The government has put in place a comprehensive multi-sector program to increase demand for family planning as a priority intervention in the MDG 5 Acceleration Framework, including advocacy and communications to improve male involvement, such as the "Real Man" campaign.

Ghana has a diverse and inspiring range of family planning and maternal health programs. The city of Tamale, for example, has a brand new Marie Stopes clinic situated in the middle of an enormous open air market. Fully stocked with a range of family planning information and modern contraceptive options, it makes access easy for the women who work in the crowded midday market.

Worlds away from the bustle of the city, there are clinics like the one Planned Parenthood of Ghana built in an isolated village north of Bolgatanga. It offers an integrated mix of family planning and other health education and services. The local people are proud of their clinic. It is their only source of medical care.

Not long ago, UNFPA Ghana welcomed a delegation of leaders at the isolated clinic. To get there, they rode by bus from the nearest city for three hours on unpaved roads.

The delegation was greeted with enthusiasm and excitement. About 200 people—village elders, mothers and fathers, grandmothers and grandfathers, children—had come out to show support for their clinic. They talked about the difference the clinic was making in their lives.

As the delegation toured the facility, they happened to notice one person who wasn't taking part in the excitement. Her name was Afia, pictured here, and she sat very quietly, in a corner, on a hard wooden bench. A midwife was by her side.

Afia's face was etched in pain, but her cries were muted. With quiet dignity, and few of the trappings that attend births in wealthier countries, they found out she was in labor to deliver her first child. She had reason to be scared.

In Ghana, for every 100,000 women who go into labor, 350 die giving birth or because of pregnancy-related complications.

The following day, the delegation learned that Afia had a lovely baby girl, and both mother and child were happy and, most importantly, healthy.

In the coming months and years, the Planned Parenthood of Ghana clinic will help Afia keep herself and her baby healthy, and will give her the information and contraceptives she needs to plan her family and her future.

The Planned Parenthood of Ghana clinic will help Afia keep herself and her baby healthy

Stephanie Freid-Perenchio photography/SFP STUDIO

The London Summit on Family Planning was a defining event for Indonesia's family planning program. Our commitment there crystallized actions we were considering for revitalizing our program. FP2020 continues to be a catalyst, as was evident during Indonesia's Summit on Family Planning.

DR. JULIANTO WITJAKSONO
DEPUTY OF FAMILY PLANNING AND REPRODUCTIVE HEALTH OF INDONESIA'S NATIONAL POPULATION AND FAMILY PLANNING BOARD (BKKBN)

A CLOSER LOOK: INDONESIA

INDONESIA'S COMMITMENT TO FP2020

Starting January 1st 2014, family planning services and supplies will be available free of charge through Indonesia's universal health coverage system, and efforts are underway to improve 23,500 clinics and strengthen human resources in order to meet increased demand. Resources are being reallocated to focus on the most densely populated areas, and efforts will be concentrated on reaching populations in rural areas and the smaller islands. The government is committed to working with national and international partners to provide the technical support needed to provide gender-sensitive, high quality family planning information and services to all people, including unmarried women, youth, and the poor.

Indonesia's Family Planning Summit and Commemoration of World Contraception Day, held on September 26, 2013, in Jakarta, was a resounding success. More than 1,700 participants were in attendance. The Vice President of Indonesia, Dr. Boediono, opened the meeting by reiterating the government's strong commitment to family planning and personally pledging his full support. Five government Ministers presided over the opening and high level panel discussions.

Dr. Julianto Witjaksono, Deputy of Family Planning and Reproductive Health of Indonesia's National Population and Family Planning Board (BKKBN) serves on the FP2020 Reference Group. BKKBN's Dr. Siti Fathonah serves on FP2020's CE WG, and Dr. Roy Tjiong of the Indonesian Planned Parenthood Association serves on PMA WG. All three played an active role in designing and executing the Indonesia Summit.

Historically, Indonesia had one of the world's most successful family planning programs. However, progress has decelerated over the last decade, and the contraceptive choices available for women have diminished. Today, fewer women are using IUDs and implants than 15 years ago. Responding to this stagnation, Indonesia committed to improving the quality of its family planning program at the London Summit on Family Planning.

Responding to this commitment, BKKBN convened four FP2020 country meetings. The meetings, which were co-chaired by USAID and UNFPA, had a catalytic impact on the reproductive community and reframed and reinforced the government's revitalization efforts.

BKKBN's new chair, Dr. Fasli Jalal, told the Indonesia Family Planning Summit attendees that family planning must be prioritized as a long-term, multi-sector development issue. To do so, it is essential to build support in the local governments of more than 500 districts. Some significant actions discussed during the Summit include increasing access to long-acting methods of contraception, improving and increasing midwifery services; and mounting a communication campaign to raise awareness of family planning choices.

One highlight of the Summit was a panel of young people who discussed the needs of youth in Indonesia, and challenged the government to increase the legal age for marriage from 16 to 18 years old. They asked for more attention and resources for sexuality education, and greater support for young people, especially the poor and most vulnerable. The Minister of Health, Dr. Nafsiah Mboi, spoke of the critical importance of family planning in reducing maternal and infant mortality, and underlined the need to collaborate across government programs to support the needs of women and girls. Attendees applauded midwives for their heroic efforts to improve maternal health and for the pivotal role they play in improving access to family planning and expanding contraceptive options.

Another high point was the announcement that BKKBN and the Population Commission of the Philippines had signed a memorandum of understanding to support south-to-south collaboration with a focus on Mindanao Island, a conflict area in the Philippines with a large majority Muslim population. Areas of collaboration include strengthening the role of faith-based organizations, sharing lessons on decentralization and local advocacy, and sharing best practices.

A CLOSER LOOK: UGANDA

UGANDA'S COMMITMENT TO FP2020

At the London Summit on Family Planning, Uganda committed to reduce unmet need for family planning from 40% to 10% by 2022. Uganda will increase the annual government allocation for family planning supplies from USD$3.3 million to USD$5 million for the next five years and improve accountability for procurement and distribution. The government will develop and implement a campaign for integration of family planning into other services. This will include partnerships with the private sector and scaling up of innovative approaches, such as community-based distribution, social marketing, social franchising, and youth friendly service provision. Uganda will strengthen the institutional capacity of public and community-based service delivery points to increase choice and quality of care at all levels.

In September 2012, the Ugandan Ministry of Health brought stakeholders together to begin an intensive, collaborative effort to capitalize on President Yoweri Museveni's commitment to FP2020. Partners in Population and Development Africa Regional Office (PPDARO) convened members of parliament to share the President's commitment and devise an action plan to hold the government accountable. The Uganda Family Planning Consortium (UFPC), comprised of all major private providers of contraceptive services and supplies in the country, strategized to use a total market approach to coordinate service delivery and increase access to a full range of contraceptive methods for all. Donors, government, and others assessed the realities of speeding delivery of services and supplies to ensure universal access to quality, voluntary family planning services.

Within a year, the three main pillars of the commitment—increased national government investment in family planning, more donor support, and systems strengthening—had been accomplished. Specifically, the allocation for family planning supplies increased from USD$3.3 million to USD$5 million in the current budget. UNFPA, USAID and DFID exceeded the additional $5 million called for from donors. Finally, a reproductive health sub-account was established to track reproductive health resource flows and improve the National Medical Stores' ability to distribute reproductive health supplies and commodities.

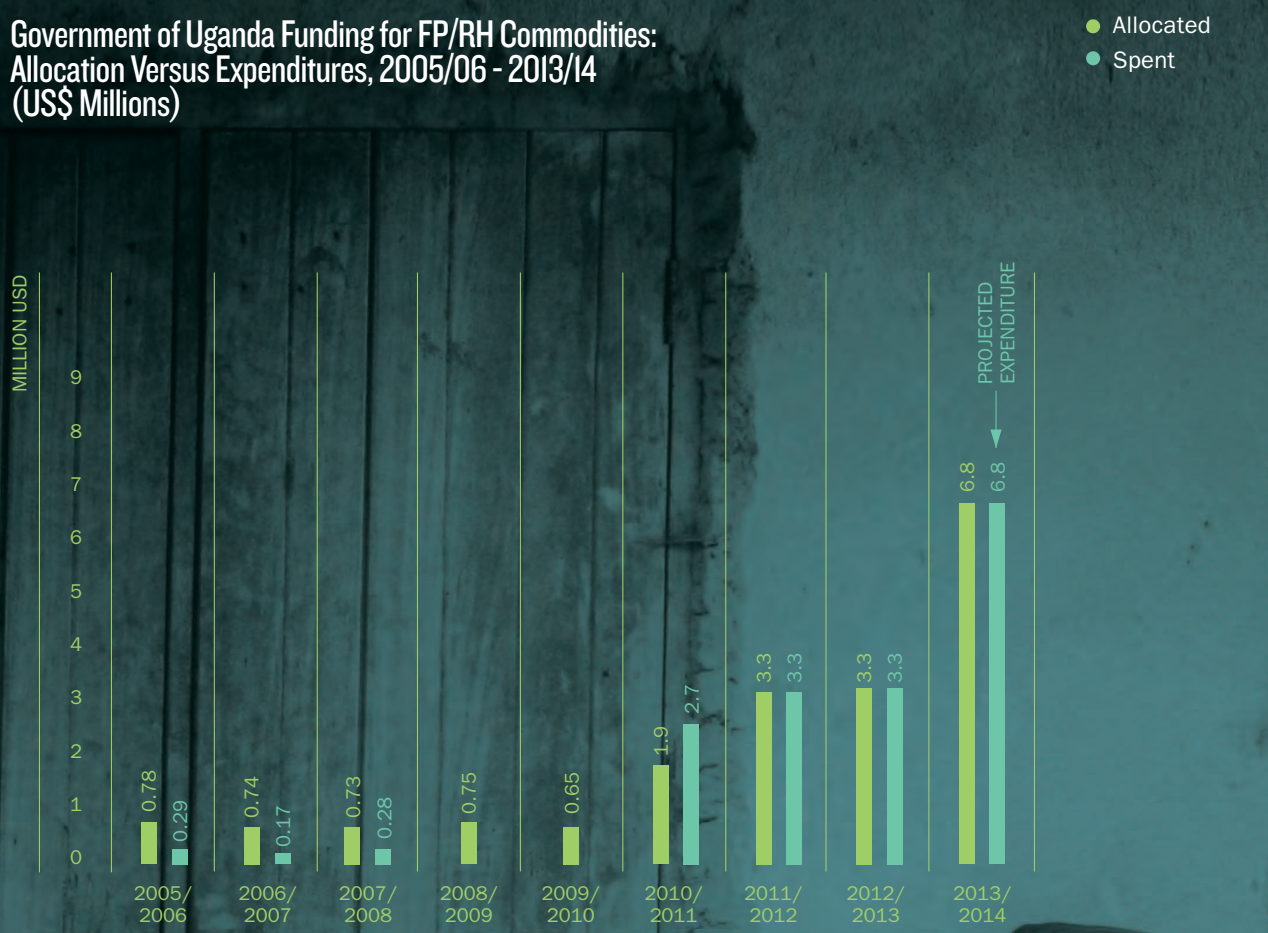
The government and its partners are now working to create a unified and costed national plan for family planning using the FP2020 commitment as a guide and to firmly ground the plan in Uganda's development priorities. The plan is expected to be completed with implementation underway by the end of 2013.

The UFPC and Advance Family Planning have already begun expanding access to family planning through innovation supported by government policy. These innovations include task sharing for contraceptive procedures and provision of contraceptive injectables by village health teams, and post-partum availability of IUDs through voucher programs. PPDARO will lead efforts to track the continued fulfillment of the commitment. The first-ever Ugandan family planning conference will take place in December 2013, coordinated by the Ministry of Health, the UFPC, and others, with support from UNFPA.

Though Uganda's family planning needs are acute, there is renewed optimism that progress is possible and health and development prospects will be significantly improved. With gains made toward fulfillment of the FP2020 commitment, universal access to family planning is in reach.

SOURCE
Advance Family Planning, September 2013.

Government of Uganda Funding for FP/RH Commodities: Allocation Versus Expenditures, 2005/06 - 2013/14 (US$ Millions)



SOURCE
Reproductive Health Financing for Uganda: Commitment to Action. Partners in Population and Development Africa Regional Office, June 2013.

Uganda's FP2020 commitment presents a great opportunity to move forward on family planning. We have already met the main first-year components of the commitment and now we must work together to see them bear fruit.

DR. COLLINS TUSINGWIRE
ASSISTANT COMMISSIONER FOR
REPRODUCTIVE HEALTH,
UGANDA MINISTRY OF HEALTH

HIGHLIGHT

UNFPA DISBURSEMENTS

At the London Summit on Family Planning on Family Planning, UNFPA committed to increasing the proportion of its resources focused on family planning from 25% to 40% based on funding levels at that time. It calculates this will bring new funding for family planning of at least USD$174 million per year from 2013 to 2019. In 2012, UNFPA spent approximately 40% of its total resources on family planning (~USD$272 million) and approximately 70% on sexual and reproductive health (~USD$470 million).[4]

ACCOUNTABILITY: FROM COMMITMENTS TO PROGRESS

Accountability is an aspect of justice: it invokes the expectation that institutions will understand and respect the needs of all the people who are affected by their actions, and will operate in a way that promotes equity and inclusion.

FP2020 will promote accountability by tracking progress on existing and new commitments. There has been a surge of investment as a result of FP2020 to establish mechanisms to monitor the implementation of commitments and elevate civil society voices in policy debates to shape country-level policies and programs.

While it did not have the infrastructure in place to do so this year, FP2020 does intend to track financial, policy, and service delivery commitments going forward. FP2020's methodology will be informed by feedback from countries, lessons learned from the Partnership for Maternal, Newborn and Child Health's monitoring of commitments to the Global Strategy, and expertise from the Commission on Information and Accountability and the independent Expert Review Group.

This report includes preliminary data on donor expenditures. Early results demonstrate that many donor governments have already budgeted increased levels of funding for family planning in 2013, and indicate progress towards fulfilling financial commitments made at the London Summit on Family Planning. These figures (See chart on page 33.) are provisional and for indicative purposes only. The FP2020 tracking methodology will be improved to include, as far as possible, a standard definition of family planning expenditures, consistent data sources and common reporting periods. (See page 92.)

TRACKING DONOR EXPENDITURES

Tracking donor expenditures is critical to accountability, yet current financial tracking mechanisms are limited in their ability to provide real-time information specific to family planning assistance and do not fully account for all resource flows.

Beginning in 2014, the Kaiser Family Foundation (KFF) will report annually on global family planning disbursements from all public and private sources. KFF will adapt the comprehensive methodology it uses to monitor global spending on HIV/AIDS to measure family planning financing. This year, KFF began to track donor government disbursements for family planning in an effort to establish the baselines necessary to monitor progress towards meeting FP2020 financial commitments.

While support from all sectors is critical to meeting our goal, donor governments provide a significant share of global funding for family planning services. Preliminary data from KFF's research indicates donor government disbursements for family planning increased in 2013.

4 Internal UNFPA analysis from interim FP expense tracking. SRH overall estimates from UNFPA Country Programme Documents approved by UNFPA Executive Board

Donor Government Family Planning Disbursements, 2012

COUNTRY	SUMMIT COMMITMENTS	BILATERAL (US$ MILLIONS)	MUTILATERAL - UNFPA CORE CONTRIBUTIONS (US$ MILLIONS) *	TOTAL (US$ MILLIONS)	NOTES
AUSTRALIA	Plans to spend an additional AUD$58 Million over 5 years on family planning, doubling annual contributions to AUD$53 million by 2016. This commitment will form a part of Australia's broader investments in maternal, reproductive and child health (at least AUD 1.6 billion over five years to 2015).	$42.7	$14.9	$57.5	Australia identified USD$44.6 in FY11/12 using the FP2020-agreed methodology, which includes a percentage of a donors core contribution to UNFPA. Australian bilateral funding was determined by adjusting its total funding level to take into account its UNFPA contribution.
CANADA		$41.5	$17.4	$58.9	Bilateral funding is for family planning and reproductive health activities (including life skills education) in FY12.
DENMARK	An additional USD$13 million over eight years.	$13.0	$44.0	$57.0	Bilateral funding is family planning specific in FY 11, the most recent year available, and includes a specific contribution (in addition to its core contribution) to UNFPA;s "Reproductive Health Commodities Fund."
FRANCE	An additional €100 million on Family Planning within the context of reproductive health through to 2015, in nine countries in francophone Africa.	$49.6	$0.5	$50.1	Bilateral funding is for a mix of family planning, reproductive health and maternal/child health activities in FY12.
GERMANY	€400 million ... to Reproductive Health and Family Planning over 4 years, of which 25% (€100 million...) are likely to be dedicated directly to Family Planning, depending on partner countries priorities.	$47.6	$20.7	$68.3	Bilateral funding is family planning specific in FY11, the most recent year available.
NETHERLANDS	€370 million in 2012 for sexual and reproductive health and rights, including HIV and health, and [plans] to extend this amount from €381 million in 2013 to €413 million in 2015.	$65.5	$49.0	$114.5	The Netherlands provided a total of USD$484.8 million in FY12 for "Sexual and Reproductive Health & Rights, including HIV/AIDS" of which an estimated USD$65.5 million was for family planning specific activities. In FY 13, the Netherlands increased funding for "Sexual and Reproductive Health & Rights, including HIV/AIDS" to USD$504.1 million.
NORWAY	Doubling its investment from USD$25 million to USD$50 million over eight years.	$3.3	$59.4	$62.7	Bilateral funding is family planning specific in FY12. For FY13, the Norwegian budget provides an estimated USD$25 million in "new" (additional) family planning funding as well as a slight increase in its UNFPA contributions.
SWEDEN	Increasing spending on contraceptives from its 2010 level of USD$32 million per year to US$40 million per year, totaling an additional US$40 million between 2011 and 2015.	$41.2	$66.3	$107.5	Bilateral funding is for family planning and reproductive health in FY12.
U.K.	Committing £516 million (US $800 million) over eight years.	$99.4	$31.8	$131.2	Bilateral funding is family planning specific in FY12/13. Family planning specific funding is estimated to increase in FY13/14.
U.S.		$485.0	$30.2	$515.2	USAID stipulates that specified bilateral subtotal is family planning specific in FY12.
OTHER DAC COUNTRIES **		$11.0	$98.0	$109.1	Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Credit Reporting System (CRS) database and represents funding provided in 2011, the most recent year available.
TOTAL		$899.8	$432.3	$1,332.1	

KAISER FAMILY FOUNDATION PRELIMINARY ANALYSIS: DONOR GOVERNMENT ASSISTANCE FOR FAMILY PLANNING

This analysis establishes a baseline level of disbursements[5] in 2012 that can be used to track total international assistance funding levels for family planning[6] over time as well as specific donor government progress in meeting London Summit on Family Planning commitments.

It includes an analysis of funding provided by the 24 governments who were members of the Organisation for Economic Co-operation and Development (OECD) and Development Assistance Committee (DAC) in 2012.[7]

Of these, eleven made specific commitments at the Summit to increase funding for family planning including: Australia, Denmark, the European Commission, France, Germany, Japan, Korea, the Netherlands, Norway, Sweden, and the United Kingdom. In addition, there are several other donor governments, particularly the United States and Canada, which, while not making specific commitments at the Summit, also provide funding for family planning activities.

FINDINGS

- In 2012, donor governments provided US$900 million for bilateral family planning programs and an additional USD$432 million in core contributions to the UNFPA.
- The U.S. was the largest bilateral donor providing USD$485 million and accounting for more than half (54%) of total bilateral funding in 2012. The U.K. (USD$99 million, 11%) was the second largest bilateral donor followed by the Netherlands (USD$65.5 million, 7%), France (USD$49.6 million, 6%), and Germany (USD$47.6 million, 5%).
- Sweden (US$66.3 million) was the largest donor to UNFPA followed by Norway (USD$59.4 million), the Netherlands (USD$49.0 million), and Denmark (USD$44.0).
- While complete funding data for 2013 is not yet available, two donor governments (Norway and the U.K.) have already budgeted increased levels of funding for family planning in 2013.
- In addition, while family-planning-specific funding is not yet available, the Netherlands increased funding in 2013 for "Sexual and Reproductive Health & Rights, including HIV/AIDS" to USD$504.1 million, fulfilling its Summit commitments.

* All UNFPA core contributions are for FY2012.

** Austria, Belgium, European Union, Finland, Greece, Ireland, Italy, Japan, Korea, Luxembourg, New Zealand, Portugal, Spain and Switzerland. Czech Republic, Iceland and Slovak Republic became DAC members in 2013 and therefore not included in analysis.

5 A disbursement is the actual release of funds to, or the purchase of goods or services for, a recipient. Disbursements in any given year may include disbursements of funds committed in prior years and in some cases, not all funds committed during a government fiscal year are disbursed in that year.

6 Family planning services including counselling; information, education and communication (IEC) activities; delivery of contraceptives; capacity building and training.

7 Since 2012, three other governments have become DAC Members: The Czech Republic, Iceland, and the Slovak Republic.

Donor Government Disbursements for Family Planning in 2013 (Totals in USD Millions)

01
$11
Other DAC Countries

02
$ 43
Australia

03
$42
Canada

04
$13
Denmark

05
$50
France

06
$48
Germany

07
$65.5
Netherlands

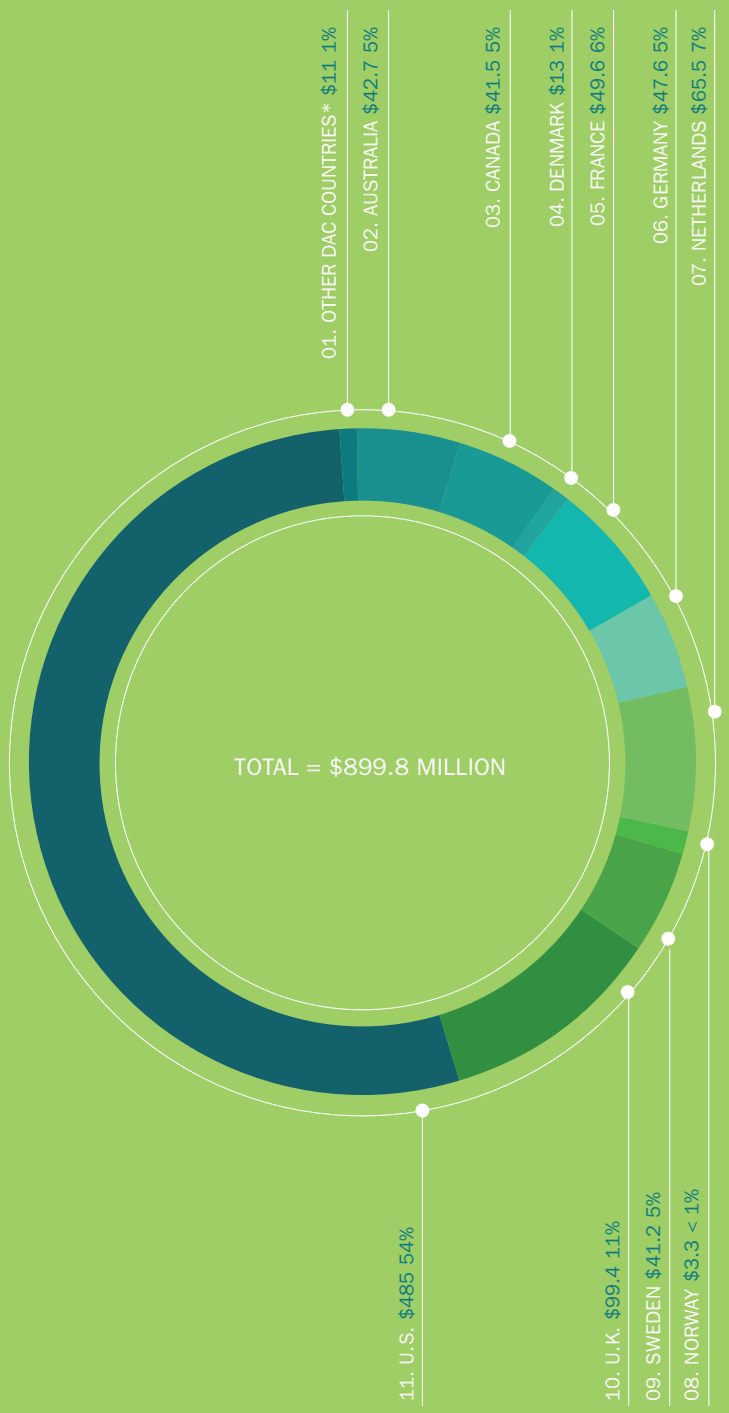
08
$3
Norway

09
$41
Sweden

10
$99
U.K.

11
$485
U.S.

*Includes the other 14 donor members of the OECD Development Assistance Committee in 2012



METHODOLOGICAL NOTE

The financial data presented in this analysis represent disbursements, and are a significant step forward, in terms both of currency and substance. However, in the wake of the London Summit on Family Planning, tracking financing for family planning in the developing world should be considered a work in progress. The data presented was obtained through direct communication with donor governments, analysis of raw primary data, and from the OECD Creditor Reporting System (CRS). UNFPA core contributions were obtained from United Nations Executive Board documents; however, we were unable to determine what share of these core contributions are attributable to family planning specifically (since such funding is also used to support broader reproductive health and related efforts).

Similarly, it is also difficult in some cases to disaggregate bilateral family planning funding from broader reproductive and maternal health totals, and the two are sometimes represented as integrated totals. In addition, family-planning-related activities funded in the context of other official development assistance sectors (e.g. education, civil society) have remained largely unidentified. For purposes of this analysis, we worked closely with the largest donors to family planning to identify such family-planning-specific funding where possible (see Table notes). Going forward, it will be important to efforts to track donor government support for family planning if such funding was more systematically identified within other activity categories by primary financial systems.

ADDITIONAL NOTE

In advance of the London Summit on Family Planning, a number of donors including the United Kingdom agreed to use an adapted version of the G8 Muskoka methodology[8] for tracking donor support to maternal, newborn and children's health, which does take into account the fact that reproductive health often includes significant spend on family planning as an integrated service, as well as a small percentage of other health codes. The total family planning disbursements reported by donors using this methodology will likely be higher than the figures given here, which are mainly for funds coded to family planning alone. Please see reference on page 30.

8
Official G8 Health Working Group Methodology for Calculating Baselines and Commitments: G8 Member Spending on Maternal, Newborn and Child Health

Bloomberg Philanthropies is pleased to have recently rolled out our first grant from our FP2020 commitment. This grant builds on a maternal health program we have supported in Tanzania since 2006 and will allow for the integration of comprehensive family planning services in some of the country's most remote health facilities.

Establishing health services that promote women's choices and the delivery of high-quality care means fewer maternal complications, fewer maternal deaths and ultimately, healthier households and communities.

DR. KELLY HENNING
DIRECTOR PUBLIC HEALTH PROGRAMS,
BLOOMBERG PHILANTHROPIES

ALIGNMENT WITH EVERY WOMAN EVERY CHILD

Launched by UN Secretary-General Ban Ki-moon during the Millennium Development Goals Summit in September 2010, *Every Woman Every Child* aims to save the lives of 16 million women and children by 2015. It is an unprecedented global movement of more than 250 partners that mobilizes and intensifies international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children around the world. The effort puts into action the Global Strategy for Women's and Children's Health (Global Strategy), which presents a roadmap on how to save these lives through the achievement of MDG 4 (Reduce Child Poverty) and MDG 5 (Improve Maternal Health).

FP2020 is proud to be included in this global effort. In the past two years, family planning has gone from being identified as a previously neglected intervention to receiving the largest number of commitments to the Global Strategy. The London Summit on Family Planning was a major driver of recent increases. Analysis shows that both disbursements of new and additional funds have increased substantially over the past year and many stakeholders have made significant progress in implementing their commitments. Further, data is emerging that demonstrates that FP2020 is bolstering progress towards the Global Strategy's goals of preventing 33 million unintended pregnancies and reaching 43 million new users in 49 countries in 2015.

FP2020's monitoring and accountability efforts will complement and contribute to *Every Woman Every Child* accountability efforts, through the Commission on Information & Accountability framework for global reporting, oversight and accountability on women's and children's health and the independent Expert Review Group. Collaboration with *Every Woman, Every Child,* the Partnership for Maternal, Newborn and Child Health (PMNCH) and alignment with relevant UN mechanisms is fundamental to the success of FP2020.

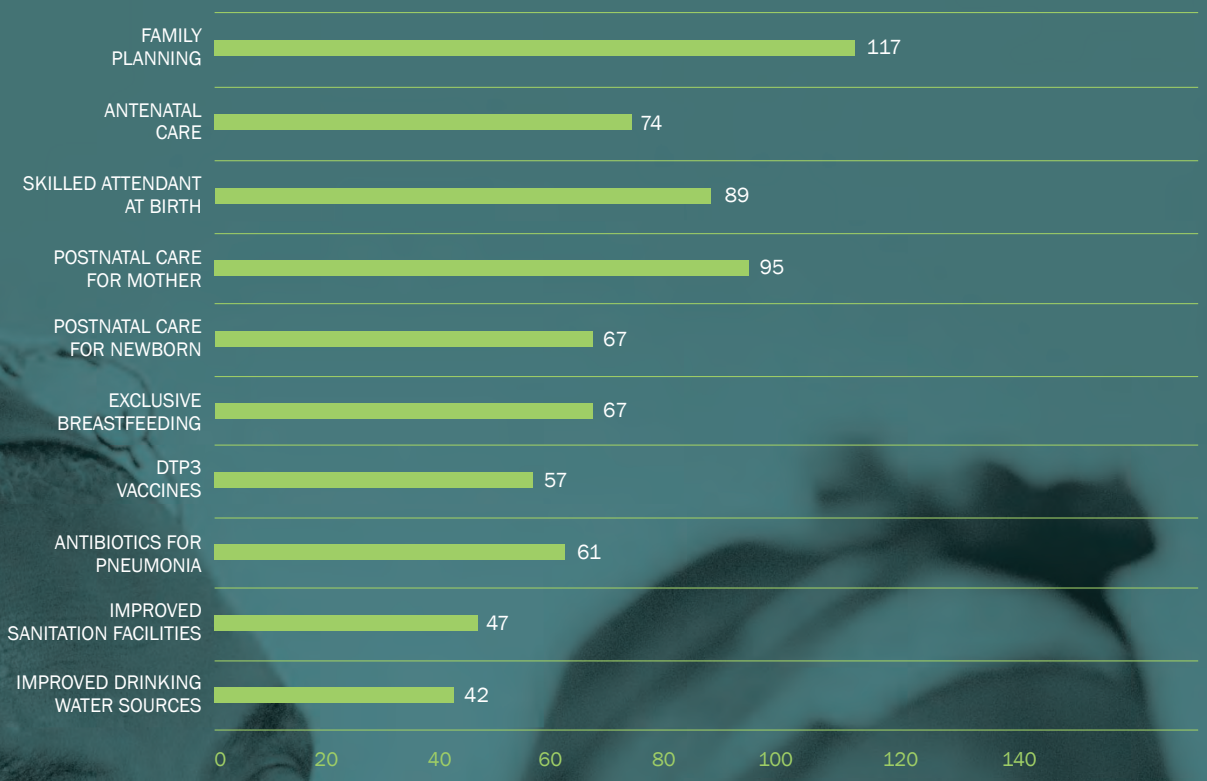
PROMOTING ACCOUNTABILITY

All political leaders have multiple urgent responsibilities. Despite their best intentions, and regardless of the merits of an issue, if stakeholders do not persistently, visibly, and persuasively hold leaders accountable, the promises they make may never be fulfilled. Commitments serve to inspire; accountability brings results.

Pending ministerial approval, DFID will support an NGO consortium to serve as an accountability secretariat for country-led efforts to hold leaders accountable for their FP2020 commitments. The consortium will coordinate with FP2020's PMA WG and complement existing accountability efforts such as Advance Family Planning.

With support from the Bill & Melinda Gates Foundation, a consortium of European NGOs will advocate funding for family planning as a key element of Official Development Assistance for health. Working in at least eight European countries and at the EU level, they will focus on sustaining and increasing support for family planning over and above 2012-2013 levels, and honoring FP2020 commitments.

Number of Commitments to the Global Strategy for Women's and Children's Health



SOURCE
PMNCH

Stephanie Freid-Perenchio photography/SFP STUDIO

02

SECTION 02

Innovation and Partnership

How do we expand access to contraceptives and services for an additional 120 million women and girls in the world's poorest countries? Many live in the least accessible, least developed regions, or they have been displaced by conflict or natural disaster. Some belong to groups who face discrimination or exclusion, and have little, if any, financial or other resources of their own. Too often, these women and girls have been the last to benefit from infrastructure improvements and other development initiatives.

Some barriers have less to do with access to services than with dislike or fear of particular contraceptive methods. Women may experience side effects, or worry that their health or ability to breastfeed may be adversely impacted. When women are unhappy with the contraceptive method available to them they are less likely to use it consistently, or at all.[9]

Using interventions that work elsewhere may not reach these underserved groups. As recommended by the Population Council in its publication *FP2020: A Research Roadmap*, "a clear, accurate accounting of the particular barriers that still prevent the most disadvantaged women and girls from using family planning services is needed, so that effective interventions can be developed to overcome them."[10] One woman's circumstances and preferences may differ not only from another's, but will mostly likely change over time. Meeting the needs of all women and girls requires us to adapt and innovate family planning products and service delivery strategies.

FP2020 is predicated on the belief that collaboration is integral to successful innovation. Over the past year, collaborative efforts have produced innovations and price reductions in long-acting reversible contraceptive (LARC) and other methods. Improvements in distribution and service delivery models will make contraceptives available to more women than ever before. New technology will support the timely and successful collection and reporting of high quality data. New and renewed partnerships among long-established organizations will facilitate outreach to some of the most vulnerable and under-served populations.

9
Darroch JE, Sedgh G and Ball H, Contraceptive Technologies: Responding to Women's Needs, New York: Guttmacher Institute, 2011.

10
Population Council, FP2020: A Research Roadmap, New York, 2013. www.popcouncil.org

EXPANDING CONTRACEPTIVE METHOD OPTIONS

Contraceptive implants and injectables are among the most reliable and effective methods for preventing pregnancies. Because they require fewer return visits and do not require users to store supplies, they are more discrete, cost-effective, and convenient than other reversible methods. This is especially true for women who would otherwise have to travel long distances to their nearest health facility or drug dispensary refills of shorter-acting methods.

Millions of women around the world do not have access to implants or injectables because health facilities either do not offer them, or because they are not offered consistently. Some women cannot get to a clinic to begin use of one of these methods, while others start but are unable to continue because they cannot return for follow up visits. Some places have laws that limit which health workers can administer injections or implants; this becomes a barrier when there are staff shortages, particularly in rural areas. Studies have shown that a far greater number of women would choose a long-acting reversible method such as an implant if it were consistently available and supported by counseling and clinical services.

CONTRACEPTIVE INJECTIONS

Sayana® Press offers the potential to improve contraceptive access for women worldwide.[11] It uses the Uniject™ injection system, a small, pre-filled, single-use device to deliver a new lower-dose formulation of Depo-Provera® via subcutaneous, rather than intramuscular, injection. Like the currently available Depo-Provera intramuscular contraceptive, a single dose of Sayana Press is effective for three months. Its safety and ease of use mean community health workers (CHWs) may be better able to administer injections outside of health facilities. And while Sayana Press currently is not labeled for home or self-injection, in the future this delivery mode may offer women a convenient private option for contraception.

At the London Summit on Family Planning, public and private partners announced plans to reach women in sub-Saharan Africa and South Asia with up to 12 million doses of Sayana Press between 2013 and 2016 and conduct rigorous evaluations of the product's impact on contraceptive use. The Sayana Press pilot introduction and evaluation partnership includes the Bill & Melinda Gates Foundation, USAID, DFID, UNFPA, Pfizer Inc., and PATH.

The ultimate success of Sayana Press hinges on it being affordable and acceptable to family planning clients, providers, and decision makers. With support from the USAID PROGRESS project and PATH, FHI 360 worked with the Ugandan and Senegalese Ministries of Health and local partners to assess acceptability of Sayana Press and offer recommendations for method introduction. The studies, which concluded in 2013, found that most clinic-based providers, CHWs, and clients preferred Sayana Press over the intramuscular formulation. The studies also found that trained CHWs can safely administer Sayana Press. The findings suggest that provider recommendations on service delivery, client counseling, and community sensitization should be considered during implementation planning, and that community-based distribution of either injectable formulation is anticipated to meet more women's family planning needs.

Pilot introduction of Sayana Press is scheduled to begin in Bangladesh, Burkina Faso, Niger, Senegal, and Uganda in the first quarter of 2014. Over the past year, each country has developed an introduction plan for Sayana Press. The pilot introduction will evaluate to what extent Sayana Press expands access to injectables for new users, improves contraceptive continuation rates, and is cost-effective in various delivery settings including community-based distribution and social marketing. Evidence generated will enable countries to make informed decisions regarding inclusion of Sayana Press in the family planning method mix and programs. Whether or not countries continue to provide Sayana Press after the pilot introduction, the partners will ensure that systems are in place to give women access to other contraceptive methods for continuity of service.

CONTRACEPTIVE IMPLANTS

Contraceptive implants last longer than injections, making them an important option for women who have the greatest difficulty accessing health services or supplies. Unfortunately, access to contraceptive implants in low-resource settings has been relatively limited. Prior to this year, price reduction agreements covered only certain forms of short-acting contraceptive methods.

On January 1, 2013, it was announced that Bayer HealthCare AG would cut the price of its contra-

ceptive implant Jadelle® from US $18 to $8.50 per unit. Through the new Jadelle® Access Initiative, the product is available at this price in more than 50 countries, including those deemed least likely by the UN Secretary-General to meet the targets of MDGs 4 and 5 by 2015. The initiative is expected to reach approximately 27 million women. In May, 2013, Merck/MSD announced it would reduce by half the price of its contraceptive implants IMPLANON® and IMPLANON NXT® in 69 focus countries identified at the London Summit on Family Planning. Both agreements were developed and supported through partnerships between Bayer HealthCare AG and Merck/MSD, the Bill & Melinda Gates Foundation, the Clinton Health Access Initiative (CHAI), the Governments of Norway, the United Kingdom, the United States and Sweden, the Children's Investment Fund Foundation, and UNFPA.

The Sino-implant (II)® initiative has been at the forefront of helping to reduce the cost of implants in resource-constrained settings. As a result of price ceiling agreements established with distribution partners, Sino-implant (II), manufactured by Shanghai Dahua Pharmaceutical Co., Ltd., is currently available in the public and NGO sectors for approximately US $8 per unit.

The Sino-implant initiative, which is led by FHI 360 with support from the Bill & Melinda Gates Foundation and USAID, provides technical assistance to facilitate the global introduction of Sino-implant (II). It works in close coordination with a number of organizations, including government officials, distributors and service delivery groups, to facilitate introductions at the country level. This includes conducting independent quality testing, negotiating public-sector price-ceiling agreements, supporting the WHO prequalification application process, and working with distributors to secure national regulatory approvals.[12] Unlike many other contraceptive methods, when an implant reaches the end of its effectiveness period, or a woman wants to discontinue its use, she must seek help from a medical professional to have it removed. The need for a removal procedure precludes use of an implant for women who either cannot afford or cannot get to a medical appointment. With funding from USAID, FHI 360 is working with innovators in the field of novel drug delivery systems to develop a safe, effective, acceptable and affordable biodegradable contraceptive implant that would not require removal. Proof-of-concept testing conducted by these investigators will be initiated by the end of 2013.

CONTRACEPTIVE VAGINAL RING

Many women assume they do not need to use contraceptives if they are lactating, but research suggests the risk of unintended pregnancy is substantial. Women who are breastfeeding may fear that contraceptives will negatively affect their breast milk or newborn.[13] For these women, a safe and effective contraceptive method suited to their needs is essential. The Population Council is currently evaluating trial introductions of the Progesterone Vaginal Ring, which is a user-controlled contraceptive method for lactating women. Already proven safe and effective in clinical trials, each progesterone vaginal ring lasts for up to three months, and a woman can use the method for one year. It does not affect breast milk, and contraceptive effectiveness is ensured as long as the woman continues to breastfeed at least four times per day.

To expand contraceptive options for women in low-resource settings, the Population Council is developing a new contraceptive vaginal ring that will provide protection for 13 menstrual cycles and does not require refrigeration.

11
Sayana Press and Depo-Provera are registered trademarks of Pfizer, Inc. Uniject is a registered trademark of BD. Country-level regulatory approvals are in place in three of the five pilot introduction countries, with all five expected to be approved in the first quarter of 2014.

12
http://www.fhi360.org/projects/sino-implant-ii

13
Darroch JE, Sedgh G and Ball H, Contraceptive Technologies: Responding to Women's Needs, New York: Guttmacher Institute, 2011

NEW MODELS FOR SUPPLIES AND SERVICES

Product improvements and price reductions can create unprecedented levels of consumer demand. This has profound implications for the procurement, movement, and delivery of family planning commodities. A broad group of stakeholders within the reproductive health community is working to ensure all individuals can obtain and use affordable, quality reproductive health supplies of their choice whenever they need them. Improvements in distribution methods and service delivery are overcoming some of the most persistent barriers to access.

MINIMIZING STOCK-OUTS WITH THE INFORMED PUSH MODEL

Many women have no dependable source of family planning supplies. Unexpected stock-outs of a woman's preferred contraceptive—or all forms of contraceptives—may last for indefinite periods of time, and may occur in both public and private health facilities, in rural and urban settings, putting women at risk of unintended pregnancy. They can happen for a number of reasons including poor forecasting and lack of inventory control. Stock-outs can be minimized only by addressing the root causes of breakdowns in family planning supply chain management and by establishing systems that respond quickly to short-term disruptions.

The Informed Push Model of distribution uses timely and good quality information to inform resupply decisions. It was inspired by the commercial sector, and looks much like a typical system used for vending machines. A driver with a truck full of supplies visits each point of sale on a regular schedule, topping up the stock and recording quantities of products sold. The data collected by the driver is used to ensure sufficient stock at the warehouse and at each site, figure out which products and sites are the most popular, and prepare the manufacturers to keep pace with demand. On the systemic level, the information is used by regional and national decision-makers to determine the quantity and types of contraceptives requested and dispensed. This is instrumental to optimizing the performance of the health system to provide women with high quality family planning services and a dependable supply of contraceptives.

INCREASING ACCESS WITH THE CLUSTER MODEL

The "cluster model" is a public-private partnership strategy designed to improve access to family planning and strengthen the continuum of care through integration with other health services. Pioneered by Planned Parenthood Federation of Nigeria, it works by creating a cluster of five health facilities located within a short distance of each other for easy referral. The sites specialize in different aspects of health and range in size from small health post to hospital. One of the five provides integrated reproductive health and family planning services. The clusters include government and private sector providers, community-based distributors, faith-based organizations, and Planned Parenthood Federation of Nigeria. Traditional, religious and social institutions play a role in generating demand for services in their communities. The cluster model holds great promise for reaching under-served populations. Evaluations of the impact of the cluster model show an increase in the utilization of family planning and related services.

HIGHLIGHT

THE GLOBAL PROGRAMME TO ENHANCE REPRODUCTIVE HEALTH COMMODITY SECURITY

UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) works with countries to develop sustained approaches for securing essential reproductive health supplies. GPRHCS develops countries' capacity to strengthen national health systems, and assists in procuring reproductive health commodities. Over five years, this flagship thematic fund mobilized USD$565 million in donor support and helped governments procure contraceptives in 46 priority countries. As a result, GPRHCS has contributed to higher contraceptive prevalence rates, more service delivery points, fewer stock outs, more choices of contraceptives in more health centers, and a greater prioritization of family planning in country governments.

SENEGAL

The unmet need for family planning in Senegal is one of the highest in the world. At the London Summit on Family Planning, Senegal committed to improving the family planning supply chain and reducing contraceptive stock-outs. A six-month collaborative effort led by the Reproductive Health Department of the Ministry of Health tested the Informed Push Model of distribution in select sites. The results were impressive, and it has now been launched nationwide.

Stephanie Freid-Perenchio photography/SFP STUDIO

In Senegal, we are bringing women greater contraceptive choices through the innovative Informed Push Model of product distribution. Now more women can trust that the contraceptive method that best meets her needs will be available every time she needs it.

DR. AWA MARIE COLL-SECK
MINISTER OF HEALTH, SENEGAL

MEETING THE NEEDS OF UNDER-SERVED COMMUNITIES IN SIERRA LEONE

The 25,000 residents of the fishing communities of the Sherbro Islands live just a short distance off the coast of Freetown, Sierra Leone, but until recently they were isolated from basic social services like health care.

The 40 Sherbro Islands are located in a wide estuary, and are only accessible through turbulent waterways, creeks and mangrove swamps. Despite a distance of only 145 kilometers, the journey from the mainland to the largest and most accessible of the islands, Bonthe, could take anywhere from nine hours in the dry season to two days in the wet season.

That changed when Marie Stopes Sierra Leone launched its own speedboat for the purpose of bringing family planning and maternal health services to these remote communities. The speedboat was acquired with assistance from DFID and the European Commission.

The speedboat took to the water in December 2012. In the first three months of the boat's use, the health care workers provided services to more than 3,000 women and men – nearly 10% of the entire population of the island chain.

MARIE AND BAINDU TAKE CONTROL

Two of the women who have been able to access family planning for the first time are Marie (30) and Baindu (34). They both live on Benducha Island with their husbands and children (Marie has eight children and Baindu has six), none of whom have been able to attend secondary school.

Neither of them wanted such big families. With the arrival of the Marie Stopes speedboat and the vital services that its outreach team provides, both women are now able to decide if and when to have more children.

They received counseling with their husbands on different methods of contraception. Both women opted for a contraceptive implant. It will provide three years protection against pregnancy and will mean that they can focus on caring for the children that they already have.

STILL MORE TO DO

Despite the early successes of the Marie Stopes Sierra Leone speedboat, there are still challenges inherent to providing services in such remote communities, and there is always more to be done.

The physical demands on the outreach team are enormous: they travel by boat under the blazing sun, and then trek along dirt tracks to reach the furthest communities. When bad weather strikes, as it frequently does in this coastal region, the journey to the most remote islands becomes even more treacherous.

But like all of Marie Stopes International's 8,500 team members across the globe, the speedboat outreach team remains dedicated to overcoming these and other challenges in order to bring family planning services where they are needed most.

SOURCE
Marie Stopes International. March, 2013. Author: Shumon Sengupta, Country Director, MSI Sierra Leone http://www.mariestopes.org/news/launching-family-planninng-sierra-leone%E2%80%99s-fishing-communities

HIGHLIGHT

PARTNERSHIP ACCELERATES PROGRESS IN ZAMBIA

"Zambia's national family planning strategy is very ambitious, but it is also achievable. We are on track to better serve the needs of the hardest to reach communities. The women and girls of Zambia will benefit from the renewed commitment to expand family planning services," commented Dr. Caroline Phiri, Director of Mother Child Health

Zambia has one of the highest maternal mortality ratios in the world: 591 per 100,000 live births. The loss of life and the impact on families and communities is devastating. At the London Summit on Family Planning, Zambia took an important step towards improving maternal health when it pledged to increase the contraceptive prevalence rate for modern methods from 33% in 2007 to 58% by 2020.

With support from partners including DFID, FHI360, MSI, Planned Parenthood Association of Zambia, UNFPA Zambia, and the USAID-funded Health Policy Project, the Zambian Ministry of Community Development, Mother and Child Health, developed and launched the Costed Eight-Year Integrated Family Planning Scale-up Plan 2013-2020.

It is projected that the implementation of Zambia's plan will avert 3.5 million unintended pregnancies, more than 100,000 child deaths, and nearly 10,000 maternal deaths. It is expected that the plan will save Zambia 1,492 million ZMW.

As the world's largest bilateral donor of family planning, USAID is proud to be a core partner in Family Planning 2020 and work alongside country governments and other donors to increase access to voluntary family planning information, products, and services.

Family Planning 2020 has brought together the comparative advantages of multiple stakeholders and united the global community under a clear and shared vision. This is crucial as we know that family planning is essential for promoting health, economic growth, and development across the globe.

DR. ARIEL PABLOS-MÉNDEZ
ASSISTANT ADMINISTRATOR FOR
GLOBAL HEALTH AT USAID

IMPROVING DATA COLLECTION AND USE

PMA2020

PMA2020 promotes the use of accurate, timely, accessible information to facilitate annual progress reporting in ten FP2020 countries across Africa and Asia by harnessing innovations in and widespread expansion of technology. The project, led by the Bill & Melinda Gates Institute of Population and Reproduction at the Johns Hopkins Bloomberg School of Public Health, leverages a mobile Assisted Data and Dissemination System (mADDS) to produce new analyses that are automatically and rapidly generated to better inform family planning programs and policy.

PMA2020 will deliver data from nationally-representative household and facility surveys in real-time using mobile phone technologies and fielded through a cadre of resident enumerators who are recruited, trained, and deployed on a regular basis to conduct successive survey rounds. In addition to replicating questions included in the Demographic and Health Survey (DHS) and Multiple Indicator Cluster Survey (MICS), PMA2020 introduces new questions that address access, equity, quality, and choice. These questions generate a broader set of family planning data allowing for more in-depth monitoring and analysis across a subset of countries, and are critical to tracking whether rights are respected, protected and fulfilled. At the time of preparing this report, data is being collected in Ghana and surveys are about to begin in Democratic Republic of Congo, Ethiopia, Kenya, and Uganda. Data collected from these surveys will feed into FP2020 core indicators and be presented in future FP2020 Annual Reports.

PMA2020 has trained more than 100 female resident enumerators in Ghana. Each is recruited from her community, where data is collected. Together, they create a sentinel network that is activated to conduct repeated rounds of the survey, interviewing approximately 40 households and three service delivery points each time. Each is equipped with a smart phone, supported by a regional supervisor, and compensated for her work. Through training, equipping, and supporting this network of sentinel resident enumerators, PMA2020 builds local skills for generating meaningful and timely data for program improvement. Enumerators commented on what they liked best about the training: “it gave us the opportunity to build self-confidence,” “the belief that we can do it,” and “the training has brought improvement to my life.” In addition, the project strengthens the capacity of local university partners to manage all aspects of survey implementation.

Courtesy PMA2020

ENSURING RIGHTS AND EQUITY IN FAMILY PLANNING PROGRAMS

Family planning services are a means through which women and girls exercise self-determination. Therefore, the ultimate metric through which a family planning program must be judged is the degree to which it contributes to empowering women and girls. On an operational level, family planning programs that do not respect and reflect the agency of women and girls are inherently flawed and destined to fail.

The New Framework for Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights[14] was drafted by Futures Group, EngenderHealth, and the Bill & Melinda Gates Foundation as a tool to elucidate what a rights-based family planning program should include and how it should be implemented. The Framework was reviewed by more than 150 people from 25+ countries through a series of in-person and web-based consultations and the WHO consultation on rights-based family planning held in April 2013.

The Framework describes four domains in which the rights implications of family planning programs should be considered:

- Policy level: the conditions of governance (especially political commitment) and accountability (especially to the community) support family planning programs that respect, protect, and fulfill rights (especially in the areas of information, supplies, and services).

- Service level: the elements of quality of care (quality, accessibility, availability, and acceptability) guide programming to adhere to the highest standard of care and thus protect inherent human rights principles (especially in the areas of method mix, technical competence, and service integration).

- Community level: the political, financial, and social environments are supported by the effective participation of diverse community groups (especially youth) in all aspects of family planning policy and program development, implementation, and monitoring (especially in the areas of policy making, funding, and societal norms and equity).

- Individual level: the various contexts in which an individual lives allow the person to exercise his or her rights (especially in the areas of behavior, knowledge, access to information and services, and empowerment).

14 Hardee, K., K. Newman, L. Bakamjian, J. Kumar, S. Harris, M. Rodriguez, and K. Willson. 2013. Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework. Washington, DC: Futures Group.

EDUCATING AND ENGAGING YOUNG PEOPLE

Pregnancy and childbirth can have a devastating impact on a young girl's health. New initiatives are encouraging young people to wait until they are 18 before marrying and giving birth, to allow two years between pregnancies, and to utilize reproductive health services.

The government of Burkina Faso and Pathfinder International have introduced youth friendly services in health facilities in Diapaga and Ouga, and initiated a peer education program to support the use of these services complemented by ongoing involvement of religious leaders. This effort is part of a West Africa initiative launched by Pathfinder to work with local partners to build their capacity to implement an evidence-based, scalable program to serve young married women and their partners.

In Sierra Leone, a youth-led organization called YES Salone is leading a multi-sector program that includes five government ministries, UNFPA and other UN agencies, and NGOs. The acronym YES stands for "Young, Empowered and Safe." The program will scale up demand for family planning and health services for young people. Activities this year included the development of minimum standards for services; a mobile minibus outreach effort including music, drama, debate, and discussion; and a peer to peer education program in 13 districts.

The "It Takes Two" campaign was founded by the Global Poverty Project and Women Deliver with the goal of promoting gender equality, especially in health and education. Using an online platform and mobile application, it makes advocacy both fun and relevant to young people's social lives by tracking activities and awarding points that translate into entertainment events. "It Takes Two" demonstrates that the nexus of digital entertainment, grassroots organizing, and social media opens up tremendous opportunities for young people to gain vital information and participate in civil society.

Currently in its first phase of implementation, the campaign is aimed at youth living in urban centers in five African countries, starting with Uganda, but has already generated 60,000 actions from people in 27 countries. To engage young people and raise awareness, they offer activities that include customizing condom wrappers online to voicing support for family planning programs.

NEW AND RENEWED PARTNERSHIPS

Four of the world's largest organizations devoted to improving the health of women and girls are core partners in FP2020:

DEPARTMENT FOR INTERNATIONAL DEVELOPMENT (DFID)

DFID is the ministerial department that leads the UK's work to end extreme poverty. Their responsibilities include honoring the UK's international commitments and taking action to achieve the MDGs, and improving the lives of girls and women through better education and a greater choice on family planning.

THE BILL & MELINDA GATES FOUNDATION

Guided by the belief that every life has equal value, the Bill & Melinda Gates Foundation works to help all people lead healthy, productive lives. In developing countries, it focuses on improving people's health and giving them the chance to lift themselves out of hunger and extreme poverty.

UNITED NATIONS POPULATION FUND (UNFPA)

UNFPA delivers a world where every pregnancy is wanted, every birth is safe, every young person's potential is fulfilled. UNFPA is the longest-serving multi-lateral agency leading in the field of family planning, and currently supports family planning progress in more than 150 countries. UNFPA promotes family planning as part of a comprehensive approach to sexual and reproductive health and reproductive rights. This includes not only essential supplies but also training midwives, eliminating barriers to access, making family planning available to adolescents and unmarried people, empowering women and girls, engaging men and boys, responding in humanitarian emergencies, and mobilizing national and global commitment.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT (USAID)

USAID is the United States federal government agency primarily responsible for administering civilian foreign aid. USAID seeks to extend a helping hand to those people overseas struggling to make a better life, recover from a disaster or striving to live in a free and democratic country. USAID has been the leading donor in international family planning for more than 40 years—both in terms of financial resources (in most years making up 40–50% of all donor funds) and technical leadership (advancing new technologies and supporting program innovation, implementation, and evaluation).

THE NEEDS OF WOMEN AND GIRLS WHO LIVE IN OR MUST FLEE FROM CONFLICT ZONES, OR WHO ARE DISPLACED BY NATURAL DISASTERS, ARE ESPECIALLY ACUTE.

Providing family planning services in an environment where basic infrastructure is severely compromised, overloaded, or nonexistent is extraordinarily difficult. A new level of partnership between seven International Planned Parenthood Federation (IPPF) Member Associations and UNFPA will focus on providing services to vulnerable groups, including refugees and migrants, as well as youth and unmarried people. The new approach will vary according to the context and needs. The collaboration between IPPF and UNFPA builds upon the institutions' long-standing history of cooperation on family planning and reproductive health.

In 2013, USAID and UNFPA renewed their commitment to collaboration on global initiatives including FP2020, Committing to Child Survival: A Promise Renewed, *Every Woman Every Child*, and the UN Commission on Life-Saving Commodities for Women and Children. Their priorities include coordinating supply planning, filling critical funding and technical assistance gaps, and improving program monitoring and evaluation.

Together with DFID, AusAID, and the Bill & Melinda Gates Foundation, USAID is a member of the Alliance for Reproductive, Maternal, and Newborn Health. The Alliance promotes the cost-effective use of resources, leverages resources to fill funding gaps, reduces duplication, and encourages the sharing of best practices among partners to accelerate progress in achieving MDGs 4 and 5. Alliance partners work together at headquarters' level and in ten high-need countries in sub-Saharan Africa and Asia. To promote alignment and leverage existing relationships, the Alliance is represented on the FP2020 Country Engagement Working Group.

In support of FP2020, the Alliance and WHO hosted the first Family Planning Implementation Research Donor Meeting in December, 2012. The meeting brought together more than 40 representatives from 21 funding agencies that identified research gaps that could be addressed through collective action, and outlined the initial strategies for doing so.

OUGADOUGOU PARTNERSHIP AND FP2020

Launched in February 2011, the Ougadougou Partnership is dedicated to improving access to family planning in nine countries in French speaking West Africa. It is led by the governments of Benin, Burkina Faso, Côte d'Ivoire, Guinea, Mali, Mauritania, Niger, Senegal and Togo. At the London Summit on Family Planning, members of the Ougadougou Partnership pledged to accelerate progress towards their goal.

In 2012, the Ougadougou Partnership established a Coordination Unit to provide support to countries and facilitate relationships among donors, governments, and other stakeholders. Agence Française de Développement, the Bill & Melinda Gates Foundation, the William and Flora Hewlett Foundation, the French Ministry of Foreign Affairs, and USAID provide core support to the Ougadougou Partnership. UNFPA, WHO, and WAHO also provide important assistance on the global and country levels.

The development and implementation of national, broad-based Costed Implementation Plans for Family Planning (FP CIPs) as part of countries' reproductive, maternal, newborn, and child health efforts are crucial to their success. FP CIPs serve to clarify a country's strategies by articulating its priorities for family planning. They describe activities, and include an implementation roadmap and detailed budget. They estimate the demographic, health, and economic impacts of the program, and prescribe a monitoring strategy to accurately measure and evaluate those impacts going forward. Crucially, FIP CIPs are needed to identify funding gaps, secure donor commitments, increase political support, and promote accountability. In collaboration with USAID and other partners, the Health Policy Project is assisting the countries of the Ougadougou Partnership to develop and augment their FP CIPs.

The Ouagadougou Partnership and FP2020 work together to support the Ougadougou Partnership countries' efforts to develop and fully implement their family planning plans. To facilitate the seamless sharing of information, the director of the Ougadougou Partnership's Coordination Unit is a member of FP2020's Country Engagement Working Group. To minimize administrative burdens on countries, FP2020 and the Ougadougou Partnership have agreed to accept and share the same country action plans (countries are not asked to submit a different plan to each entity). FP2020 and the Ougadougou Partnership will work together to seek funding for countries' plans and share information and best practices with the global family planning community.

Collaboration multiplies our power to change the world. Working together, we will accelerate progress globally, creating a brighter future for women, families, and communities everywhere.

KATHY CALVIN
PRESIDENT AND CHIEF EXECUTIVE OFFICER,
UNITED NATIONS FOUNDATION

Progress is the result of dedication combined with knowledge. The stakeholders in FP2020 are dedicated to a common goal; now, with the foundation of a strong platform for measurement and evaluation, we'll have the knowledge we need to guide us towards success.

VALERIE DEFILLIPO
DIRECTOR, FP2020

Stephanie Freid-Perenchio
photography/SFP STUDIO

03

SECTION 03

Measuring Progress

Approximately 260 million women in the world's 69 poorest countries currently use a modern method of contraception. Sustaining this level of use between 2012 and 2020 will cost roughly USD$10 billion through resources principally provided by country governments' health budgets, supported by individuals' out-of-pocket expenditures and external donor contributions. At the London Summit on Family Planning, the global community took a significant step to expand the availability of voluntary family planning information, services and supplies to enable a total of 380 million women and girls to choose and use contraception by 2020 through the commitment of resources equivalent to USD$4.3 billion in funds above and beyond the level of funding provided for family planning in 2010.[15]

This unprecedented declaration of support marks a significant step towards realizing the FP2020 vision that women and girls should have the same access to lifesaving contraceptives and services no matter where they live. With such an ambitious goal, it is clear that FP2020 must have an equally ambitious performance monitoring and accountability system devoted to improving the quality and availability of information that can be utilized for annual reporting, planning, evaluation, decision-making, and advocacy at the community, country and global levels.

FP2020 is predicated on the belief that measurement and results are necessary to drive change. In the first year, FP2020 initiated a number of activities to establish the systems and infrastructure necessary to monitor progress towards the FP2020 goal, to ensure that girls' and women's rights to voluntary contraception are respected and promoted, and to strengthen accountability for implementing financial, policy and programming commitments made by country governments, donors, the UN, civil society, and others. Building accountability is at the heart of FP2020; we are all accountable to women and girls.

These activities, detailed throughout this report, included selecting core indicators and collating corresponding baseline data, improving the way in which family planning expenditures are tracked and launching electronic collection of data in select countries. Importantly, FP2020 partners also came together to lay the groundwork for further developing and implementing a transformative measurement agenda over the life of FP2020 that will elevate the role of service statistics, identify innovations in data collection and find new ways to leverage these tools to impact the poorest and hardest-to-reach, and enhance capacity to measure rights-based programming.

15
Family Planning Summit 2012 data sources and methodology for calculating 2012 baseline, 2020 objectives, impacts and costings by Family Planning Summit Metrics Group.

It is my distinct pleasure to be part of the global Family Planning 2020 movement, which has brought fresh energy to cross-sector and cross-border innovation and collaboration. Together, we will surely change the lives of millions of women and girls.

ANURADHA GUPTA
JOINT SECRETARY, MINISTRY OF HEALTH AND FAMILY WELFARE, INDIA

MEASURES OF SUCCESS

FP2020 CORE INDICATORS

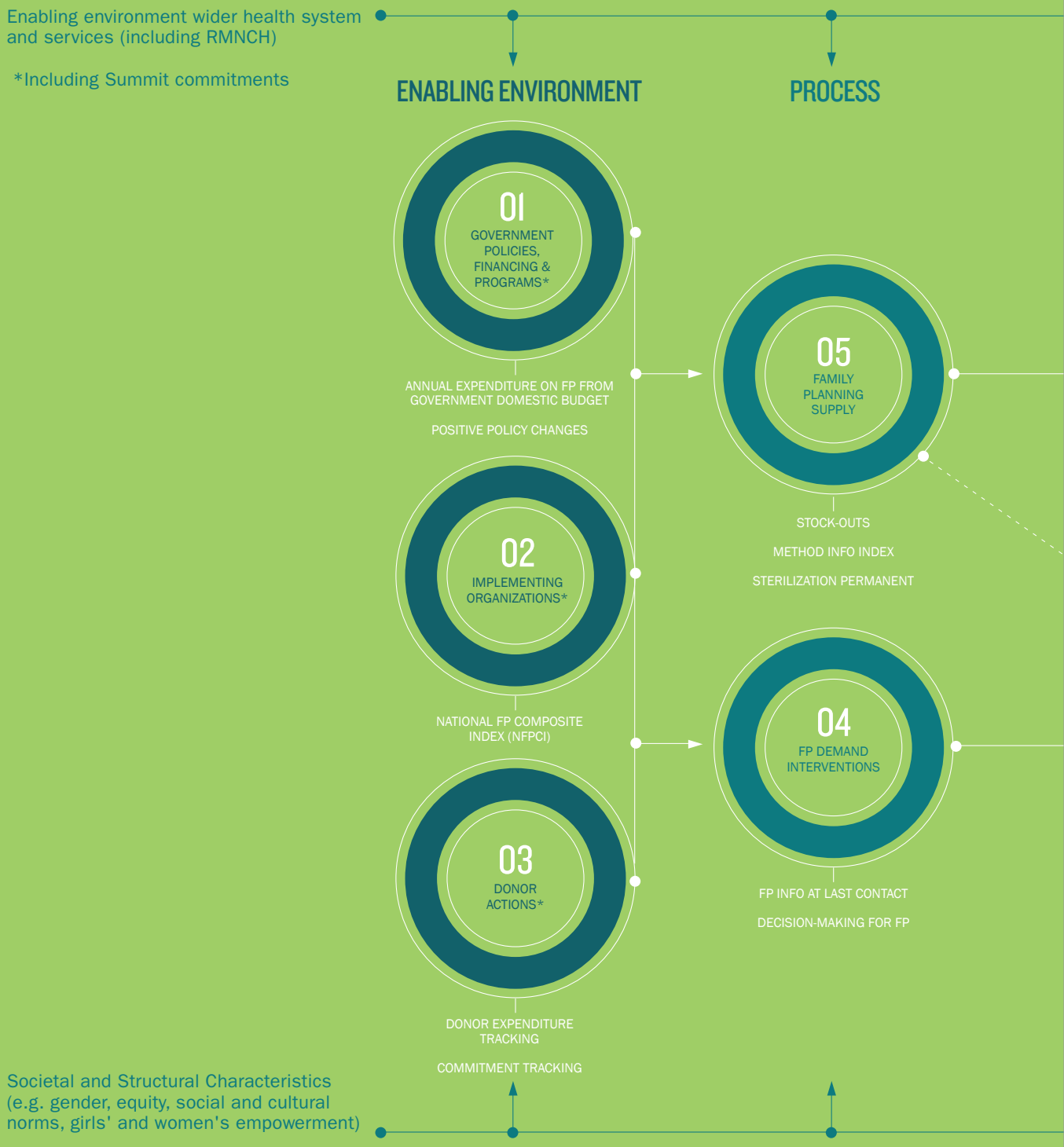
A set of 15 core indicators have been selected through a systematic process over the past 18 months to determine whether countries are on track to reach their goals, to assess strategies and inform decision-making, to provide the tools to answer fundamental questions concerning the overall performance of FP2020 and importantly, to measure how well individual needs are met. Ten will be reported annually for 69 countries. Data sources of and methodology for these indicators will necessarily vary between countries that make a commitment to FP2020 and those that have not, although this distinction is ameliorated as new measurement grants are awarded that relate to FP2020 monitoring, such as the Track20[16] project. Many of these indicators will be modeled, since the data needed is not collected on an annual basis. Therefore, many of the indicators do not reflect direct measurement.

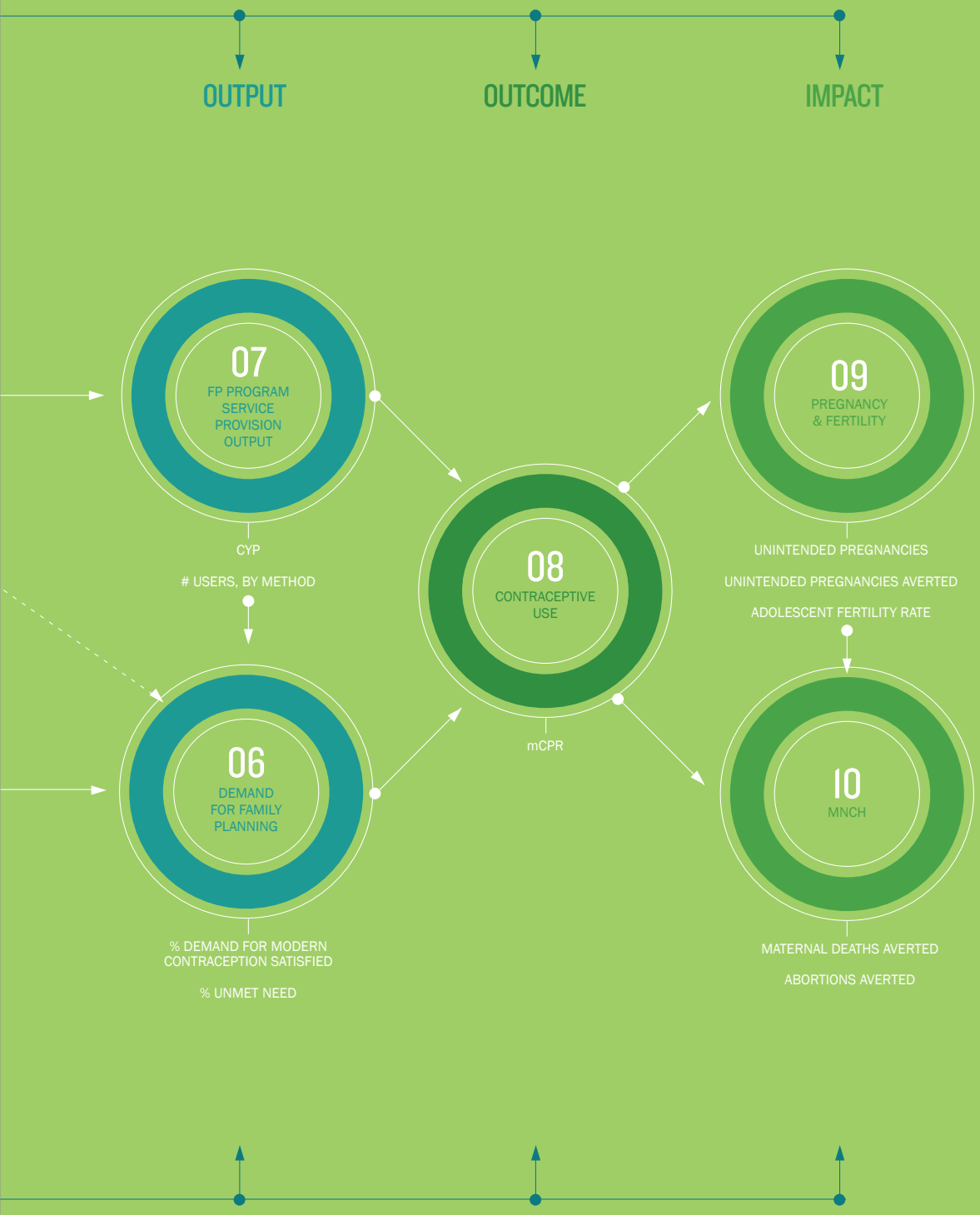
The process of developing FP2020 core indicators began in early 2012 with the creation of a Metrics Working Group that set out to estimate the overall parameters of the FP2020 initiative and establish a baseline for the number of contraceptive users for the 69 FP2020 priority countries. The Metrics Working Group also updated a conceptual framework (See chart on next page) from which indicators would be derived. The framework includes 10 conceptual domains, organized by the standard measurement sequence of enabling environment, process, output, outcome, and impact. Adjustments may be made to this framework upon further review by the Performance Monitoring & Accountability Working Group.

16
Track20 efforts will be concentrated mainly in countries that make a commitment to FP2020, though some technical support will be provided to all 69 FP2020 countries.

FP2020 PM&A Conceptual Framework with Core Indicators

Country level conceptual framework: results chain for family planning inputs, outputs, outcomes and impacts.




OUTPUT
OUTCOME
IMPACT
07
FP PROGRAM SERVICE PROVISION OUTPUT
CYP
USERS, BY METHOD
06
DEMAND FOR FAMILY PLANNING
% DEMAND FOR MODERN CONTRACEPTION SATISFIED
% UNMET NEED
08
CONTRACEPTIVE USE
mCPR
09
PREGNANCY & FERTILITY
UNINTENDED PREGNANCIES
UNINTENDED PREGNANCIES AVERTED
ADOLESCENT FERTILITY RATE
10
MNCH
MATERNAL DEATHS AVERTED
ABORTIONS AVERTED

Following the London Summit on Family Planning and upon the establishment of the FP2020 governance structure, the work of finalizing the indicators was transferred to the FP2020 Reference Group, Task Team, and Working Groups. The Performance Monitoring & Accountability Working Group played a leadership role throughout the execution of this process with substantial input from the Rights & Empowerment Working Group.

The underlying intent of constructing a core set of FP2020 indicators was to provide an annual, global read-out of key progress markers that would be applicable to and available from all 69 countries. The indicators were selected with country M&E and data systems in mind to avoid the creation of a parallel indicator capture and reporting process at the country level. The list was kept short to allow FP2020 to focus on indicators with cross-country (global) relevance, while leaving space for countries to identify indicators that are aligned with their family planning strategies and priorities. For example, if a country is focusing on community-based distribution or the introduction of long-acting reversible contraceptives into their national program, it will be important for that country to include indicators relevant to those programs in their annual monitoring and reporting.

Attention was paid to link indicators with important global platforms in order to foster collaboration with partners and avoid duplication of efforts. FP2020 aligns with *Every Woman, Every Child*, spearheaded by United Nations Secretary-General Ban ki-Moon. Partnerships and initiatives taken into consideration by FP2020 include but are not limited to the International Conference on Population and Development's Programme of Action, the Maputo Plan of Action for the Operationalization of the Continental Policy Framework for Sexual and Reproductive Health and Rights, the Partnership on Maternal, Newborn and Child Health (PMNCH), and the World Health Organization's Indicators development process on Health and Rights.

Graphics that demonstrate growth rates for contraceptive prevalence, levels of unmet need, and an analysis of method mix in FP2020 countries are presented in this first report. In the future, annual reports will display graphics that will highlight changes in key indicators as the global FP2020 initiative progresses. The analyses behind these graphics will focus on core indicators, and where appropriate, additional information relevant to the progress of FP2020 will be incorporated into the analyses. Where comparisons are appropriate, analyses of multiple indicators together may also be presented.

REPORTED ANNUALLY FOR 69 COUNTRIES

1. Contraceptive Prevalence Rate, Modern Methods (MCPR) (modeled)
2. Total number of contraceptive users by method (modeled)
3. Percent of women whose demand for modern contraception is satisfied (modeled)
4. Percentage of women with unmet need for contraception (modeled)
5. Annual expenditure on family planning from government domestic budget

6. Couple-Year of Protection (CYP)
7. Number of unintended pregnancies (estimated)
8. Number of unintended pregnancies averted due to contraceptive use (estimated)
9. Number of maternal deaths averted due to contraceptive use (estimated)
10. Number of unsafe abortions averted due to contraceptive use (estimated)

REPORTED ANNUALLY FOR A SUBSET OF TEN COUNTRIES AND FOR THE SUBSET OF THE 69 FP2020 COUNTRIES IN YEARS WITH A DHS[17]

11. Percent of women who were provided with information on family planning during their last visit with a health service provider
12. Mean score on Method Information Index[18]
13. Percent of women who make family planning decisions alone or jointly with their husbands / partners or jointly with health service provider
14. Adolescent birth rate
15. Percent informed of the permanence of sterilization

CRITERIA USED TO IDENTIFY CORE INDICATORS:

(1) Progress under each of the Family Planning Summit Monitoring & Accountability Conceptual Framework's five domains is tracked by at least one indicator (the five domains are enabling environment, process, output, outcome, and impact); (2) Indicator is relevant to the domain and methodologically sound (e.g. based to the greatest extent possible on existing definitions and standards and with documentation readily available); and (3) Indicators for which data are most readily available across FP2020 countries[19]. Additionally, special consideration was given to (4) indicators proposed by the Rights and Empowerment Working Group, in line where possible with the WHO Indicators on Health and Rights (to ensure dimensions of availability, accessibility, quality and informed decision making were reflected) and (5) indicators already used by countries to monitor other initiatives or goals (e.g. The Global Strategy for Women's and Children's Health and MDG 5).

THE CORE INDICATOR TABLE IS SEPARATED INTO THREE CATEGORIES:

1. Indicators that will be reported annually for all 69 FP2020 countries. Data sources and methodology will vary between countries that make a commitment to FP2020 and those that have not, based on presence of Track20[20] Project. Indicators 5 and 6 will not have data in year one. Mechanisms to collect this information will be established within the first year.
2. Indicators that are estimates of impacts of family planning using modelling based on real time data from the last DHS or similar national survey and not based on directly collected data.
3. Indicators that will be reported annually in a subset of countries and will be based on the PMA2020 survey or countries that have DHS surveys in the reporting year. PMA2020[21] will collect data in ten countries for which annual data will be collected. Data for all the ten countries will be available in two years. In years when there is a DHS in one of these countries, indicators for the country (with disaggregated figures) will be utilized in annual reporting.

17
Five countries had a DHS in 2012: Côte d'Ivoire, Haiti, Honduras, Indonesia, and Laos.

18
Method Information Index is a new index developed by FP2020 to measure the extent to which women were made aware of alternative methods of contraception and were provided adequate information about them drawing on three questions from DHS/PMA2020 surveys.

19
Most of the indicators referenced in this category are based on modeling that can only be based on assumptions of past trends or past points of real time data such as the last DHS and therefore may not pick up any recent change in annual trends.

20
Track20 efforts will be concentrated for the most part in countries that make a commitment to FP2020. However some technical support will be provided to all 69 FP2020 countries.

21
PMA2020 Countries: Phase 1 countries - Ghana, Ethiopia, Uganda, DR Congo, and Kenya. Phase 2 countries - Nigeria, Senegal, Burkina Faso, India, and Indonesia.

Indicators that will be Reported Annually for all 69 FP2020 Countries

INDICATOR NAME	DEFINITION	DATA SOURCE & AVAILABILITY	CONCEPTUAL FRAMEWORK CATEGORY	DISAGGREGATION	LINKS TO OTHER INITIATIVES
01 CONTRACEPTIVE PREVALENCE RATE, MODERN METHODS (mCPR)	The proportion of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.	Surveys such as the Demographic and Health Surveys (DHS), the CDC-assisted Reproductive Health Surveys (RHS), MICS and other nationally sponsored surveys. Service Statistics	Outcome	When possible (in years with a DHS) by: wealth quintile, age, marital status, urban/rural, ethnicity, region etc.	Contraceptive prevalence rate (any method) is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health. Included in WHO indicators on health and rights list
02 TOTAL NUMBER OF CONTRACEPTIVE USERS BY METHOD	The number of women (or their partners) of reproductive age currently using a contraceptive method.	Modeled using various data sources, including DHS and service statistics	Output	Type of method, source	
03 PERCENT OF WOMEN WHOSE DEMAND FOR MODERN CONTRACEPTION IS SATISFIED (MET NEED FOR CONTRACEPTION)	The percent of women (or their partners) who desire either to have no further children or to postpone the next child who are currently using a modern contraceptive method.	Surveys such as the DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics	Outcome	When possible (in years with a DHS) by: wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.	The proportion of demand for family planning that is satisfied (any method) is a tracking indicator for the Global Strategy for Women's and Children's Health.
04 PERCENTAGE OF WOMEN WITH AN UNMET NEED	The percentage of fecund women of reproductive age who want no children or to postpone having the next child, but are not using a contraceptive method.	Surveys such as the DHS, RHS, MICS, and other nationally sponsored surveys. Modeled using various data sources, including DHS and service statistics	Output	When possible (in years with a DHS) by: method, wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.	The proportion of women (married/union) with an unmet need for family planning is a tracking indicator for MDG 5 target 5B: Achieve, by 2015 universal access to reproductive health. Included in WHO indicators on health and rights list.
05 ANNUAL EXPENDITURE ON FAMILY PLANNING FROM GOVERNMENT DOMESTIC BUDGET	Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government.	Estimate will be derived through contributions from Kaiser Family Foundation, UNFPA/NIDI, WHO/COIA and the DELIVER project. Country availability will depend on COIA and NIDI implementation. All 69 countries are expected to be available at some point.	Enabling Environment		Proportion of SRH budget allocated to FP is a tracking indicator for the Maputo Plan of Action.
06 COUPLE-YEAR OF PROTECTION (CYP)	The estimated protection provided by family planning services during a one year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor, which yields an estimate of the duration of contraceptive protection provided per unit of that method.	Service Statistics	Output	By method	CYP were developed by USAID and most FP donors, international agencies, and service providers report CYPs.

Indicators that Model Impact for all 69 FP2020 Countries

INDICATOR NAME	DEFINITION	DATA SOURCE & AVAILABILITY	CONCEPTUAL FRAMEWORK CATEGORY	DISAGGREGATION	LINKS TO OTHER INITIATIVES
07 NUMBER OF UNINTENDED PREGNANCIES	The number of pregnancies that occurred at a time when women (and their partners) either did not want (additional) children or wanted to delay the next birth. Usually measured with regard to last or recent pregnancies, including current pregnancies.	Estimated using modeling and the last DHS or similar survey as the base	Impact		
08 NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE	The number of unintended pregnancies that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.	Estimated using modeling and the last DHS or similar survey as the base and the last DHS .	Impact		
09 NUMBER OF MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE	The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.	Estimated using modeling and the last DHS or similar survey as the base.	Impact		This indicator is tracked in the ICPD program of action in a slightly different formulation as follows countries should strive to effect significant reductions in maternal mortality by 2015.
10 NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE	The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by contraceptive use during the reference period.	Estimated using modeling and the last DHS or similar survey as the base.	Impact		

Indicators that will be Reported Annually for a Subset of 10 Countries and for the Subset of the 69 FP2020 Countries in Years with a DHS

INDICATOR NAME	DEFINITION	DATA SOURCE & AVAILABILITY	CONCEPTUAL FRAMEWORK CATEGORY	DISAGGREGATION	LINKS TO OTHER INITIATIVES
11 PERCENT OF WOMEN WHO WERE PROVIDED WITH INFORMATION ON FAMILY PLANNING DURING THEIR LAST VISIT WITH A HEALTH SERVICE PROVIDER	The percent of women who were provided information on FP in some form at the time of their last contact with a health service provider. The contact could occur in either a clinic or community setting. Information could have been provided via a number of mechanisms, including counseling, IEC materials or talks/conversations about FP.	PMA2020 Survey DHS in select years	Process		
12 MEAN SCORE ON METHOD INFORMATION INDEX	An index measuring the extent to which women were made aware of alternative methods of contraception and were provided adequate information about them. The index is constructed from three questions (Were you informed about other methods? Were you informed about side effects? Were you told what to do if you experienced side effects?) Information will also be available for each indicator independently.	PMA2020 Survey DHS in select years	Process		Included in WHO indicators on health and rights list
13 PERCENT OF WOMEN WHO MAKE FAMILY PLANNING DECISIONS ALONE OR JOINTLY WITH THEIR HUSBANDS/PARTNERS OR JOINTLY WITH PROVIDER	The percent of women who make decisions on matters, such as whether and when to initiate and terminate contraceptive use and choice of contraceptive method, either by themselves or based upon consensus joint decision-making with their husband/partner/provider.	PMA2020 Survey DHS in select years	Process		
14 ADOLESCENT BIRTH RATE	The number of births to adolescent females, aged 15-19 occurring during a given reference period per 1,000 adolescent females.	PMA2020 Survey DHS, MICS, RHS in select years	Impact		The adolescent birth rate (ages 15-19) is a tracking indicator for MDG 5 target 5B: Achieve, by 2015, universal access to reproductive health.
15 PERCENT INFORMED OF PERMANENCE OF STERILIZATION	Among women who said they were using male or female sterilization, the percent who were informed by the provider that the method was permanent.	PMA2020 Survey DHS is select years (and select countries- not a standard question	Process		

NEW INDICATORS

An important area of contribution of the FP2020 partnership is and will continue to be the identification of new indicators that better measure concepts around informed choice, autonomy, and the extent to which family planning programs are implemented in accordance with human rights principles. Currently, data that are routinely collected through existing mechanisms arguably do not adequately measure these concepts. Both the Rights & Empowerment and Performance Monitoring & Accountability Working Groups have identified indicators that currently are not routinely collected in all countries through existing data collection mechanisms, and would require facility level measures and/or do not have an existing data source that would allow comparison of such indicators on an annual basis among all 69 countries. This work has benefited from collaboration with WHO and FP2020 will align where possible with WHO's upcoming guidance and recommendations on optimizing human rights in the provision of contraceptive information and services.

Many of these indicators are designed to reflect whether and how national family planning programs and services are provided in an atmosphere that respects choice, autonomy, and the principles of human rights. FP2020 Working Groups are committed to building capacity over time by strengthening existing systems and working with countries through a variety of mechanisms to encourage the exploration of new indicators. This kind of indicator work might involve, for example, use of existing data in new ways including disaggregation of data as a way to investigate differentials in family planning program performance and outcomes by population subgroups.

Indicators that are currently being explored include:

- Percent of individuals in community/facility catchment area reporting awareness of, access to, and satisfaction with reproductive health services
- Percent of facilities reliably offering at least one long-term reversible method, at least one short-term method, permanent methods (in place or referral), and emergency contraception
- Percent of facilities equipped to provide easy access for removal of implants and IUDS

FP2020 also intends to add an indicator to monitor contraceptive availability/stock-outs to the core list. The selection of this indicator will be informed by a process led by the DELIVER Project and the Reproductive Health Supplies Coalition (RHSC) Systems Strengthening Working Group Stock-out Indicator Work Stream to identify standard indicators and recommend standard definitions to reduce the current confusion in the field due to different organizations defining contraceptive availability and stock-outs differently, with varying lengths in their reporting systems (six months, 12 months, day of visit) and in whether they report stock-outs for individual methods or types of methods (See chart on next page).

NATIONAL FAMILY PLANNING COMPOSITE INDEX

FP2020 plans to develop a National Family Planning Composite Index (NFPCI) serving as a comprehensive measurement and tool to monitor the enabling environment in a manner that takes into account not merely the existence of policies and guidelines, but also the extent to which family planning program implementation includes measurable dimensions of quality service provision. Future annual reports will report the index findings and country specific information.

The index will be constructed using a modified version of the Family Planning Effort Index (FPE),[22] government policies and protocols, and input from key stakeholders (i.e. government, partners, donors, civil society). Potential indicators that will be included in the index are:

- The existence of a comprehensive, costed action plan for achieving national family planning goals
- Family planning service guidelines and SOPs which reflect latest, updated WHO medical guidelines
- The existence, coverage, and effectiveness of a quality of care monitoring system

22 Ross, John and Ellen Smith. 2010. The Family Planning Effort Index: 1999, 2004, and 2009. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

USAID | Deliver Project and RHSC Systems Strengthening Working Group Stock-out Indicator Work Stream, September 2013

Service Delivery Points (SDPs)

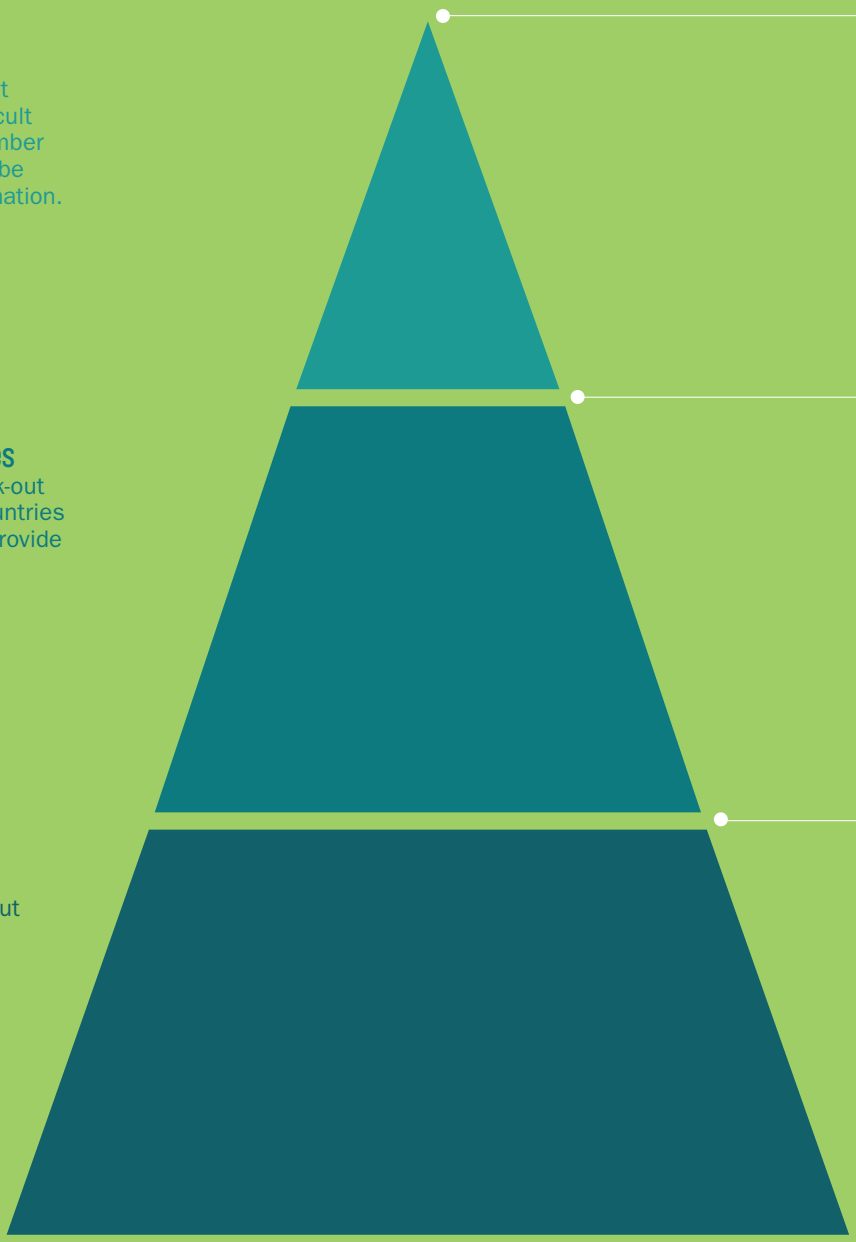
Most robust stock-out indicators, most difficult to collect, fewest number of countries likely to be able to provide information.

Regional/ District Warehouses

Medium-robust stock-out indicators, some countries likely to be able to provide information.

Central Warehouse (CMS)

Least robust stock-out indicators, simplest to collect, greatest number of countries likely to be able to provide information.



SOURCE
USAID | Deliver Project, 2013

BY FP METHOD OFFERED:

Percent of SDPs stocked out on day of visit or most recent LMIS report (determined via physical inspection)

Average number of stock-outs over the year (determined via stock records)

On average, total number of days stocked out over the year (determined via stock records)

BY FP METHOD MANAGED:

Percent of regional/district warehouses stocked out on day of visit or most recent LMIS report (determined via physical inspection)

Average number of stock-outs over the year (determined via stock records)

On average, total number of days stocked out over the year (determined via records)

BY FP METHOD MANAGED:

Whether central warehouse (CMS) stocked out on day of visit or most recent LMIS report (determined via physical inspection)

Number of stock-outs over the year (determined via stock records)

Total number of days stocked out over the year (determined via records)

INDICATOR REGARDING CHOICE OF FAMILY PLANNING METHOD

DELIVER/RHSC recommends the following availability indicator to provide an indication of choice:
Percent of SDPs with at least five modern FP methods in stock on day of visit or day of report

Indicator formula:
[Number of SDPs with at least five modern FP methods in stock on day of visit or report] / [Total number of SDPs] *100

STOCK-OUT INDICATOR CALCULATIONS

If any usable (unexpired, undamaged) stock of the method exists, the method is not considered stocked out. (If there is stock anywhere in the facility—whether in the facility's store room or dispensing area—the facility should not be considered stocked out.)

Along with reporting the percentages, it is recommended that countries include the numerators and denominators used; this will provide more transparency into the calculations and enable a better understanding of changes in the percentages and reporting rates over time.

The denominator for the stock-out calculations should be the number of facilities that offer the method.

Most of the indicators can be measured by brand (e.g., Depo-Provera) or by method type (e.g., injectable contraceptive). We recommend choosing one of these ways to report and doing so consistently across countries.

Indicators on the frequency and duration of stock-outs (measured over the course of the year) can only be collected if records are accurately and consistently kept. Many facilities (especially SDPs) will not have accurate and complete records kept throughout the year. Where calculated, these two indicators can be averaged across facilities of that type, at that level of the supply chain, or within a region or district.

MEASUREMENT ISSUES TO CONSIDER FOR SDP-LEVEL INDICATORS

The availability of contraceptives at service delivery points (SDPs) is based both on:

- The number of facilities that offer the FP method in the first place
- Of the facilities that offer the method, those that have the method in stock

For this reason, DELIVER and RHSC included an SDP-level service provision indicator (regarding the percent of SDPs that offer each method) along with the stock-out indicators.

Along with being reported across all SDPs, the SDP-level indicators can also be reported by type of SDP.

FP2020 CORE INDICATORS: DATA TABLES

INDICATORS THAT WILL BE REPORTED ANNUALLY FOR ALL 69 FP2020 COUNTRIES

Indicator 1
Contraceptive Prevalence Rate, Modern Methods (mCPR)

There are two data points displayed in the table for Indicator 1.

1. The first data point is the mCPR from the most recent survey completed in the country. The source for this information is most often a Demographic and Health Survey (DHS) with additional inputs from Multiple Indicator Cluster (MICS), Reproductive Health Survey (RHS) and/or national surveys. The year of the survey can be found at the bottom of the table. The cell has been left blank in countries where the mCPR rate is only available for married or in union women.

2. The second data point is the 2012 baseline mCPR for each country. The value included for countries with a 2012 DHS survey is derived from the preliminary or final DHS report. For all other countries, the value represents an estimate derived from the Guttmacher and Futures Institutes through a past-trend analysis by linear extrapolation from the last survey using the rate of change between the last two (or more) surveys. The mCPR estimates are based on multiple sources including tabulations of all available DHS country datasets provided by ICF International,[23] Guttmacher Institute tabulations of other national surveys including MICS and RHS datasets, published reports and a database of contraceptive use information for married women compiled from all available sources by the UN.[24]

The final column for the mCPR indicator is blank and serves as a placeholder for countries to adjust their baseline numbers if desired. Track20 will work with FP2020 pledging countries in the upcoming year to either validate or adjust their 2012 baseline mCPR values in order to be more useful for the purpose of performance monitoring against national plan objectives. Any changes will be reported in the next annual report. When available, data represents mCPR among all women 15-49. When surveys only reported on mCPR among married women, a methodology from the Guttmacher Institute was used to estimate contraceptive use among unmarried women that was then added to the married women in order to calculate prevalence among all women 15-49. In order to perform this calculation, the proportion of married women, among women of reproductive age, was required. The total number of women 15-49 by five-year age groups in each country in 2012 was taken from the UN Population Division's World Population Prospects: the 2012 Revision.

For most countries, the proportions of women who were currently married or in union, formerly married or never married (for each 5-year age group 15-49) were taken from a UN compilation of information from national censuses and surveys.[25] These proportions were assumed to apply to 2012, regardless of the year of the relevant census or survey. Age-specific proportions in each marital status group were applied to 2012 age-specific numbers of women and summed to estimate the total number of women 15-49 in 2012 in each developing country who were currently married. For countries with more recent survey information than included in the UN database, marital status proportions of women 15-49 were updated and regional estimates or estimates from a similar nearby country were used for the few countries with no available information on marital status.

Indicator 2
Number of Modern Contraceptive Method Users

Data for this indicator were obtained by multiplying the modern contraceptive prevalence estimate for all women for 2012 by the number of women 15-49. The original analysis prepared for the London Summit on Family Planning estimated there were approximately 260 million modern method users in the 69 poorest countries. New estimates made possible by the release of data following July 2012 shows that there was a slight increase in modern method users (263 million) in 2012. This figure does not include South Sudan, where data were not available, and it does not include South Africa, since it is not one of the 69 poorest countries. This increase in the number of estimated users reflects small revisions to mCPR estimates and revised population projections in some FP2020 countries.

23
Special tabulations of unmet need using revised definition, for all DHS surveys, produced by Trevor N. Croft and Sarah E. K. Bradley, MEASURE DHS, ICF International, February, 2012.

24
United Nations Department of Economic and Social Affairs, Population Division, World Contraceptive Use 2010 (POP/DB/CP/Rev2010), 2011

25
United Nations, Department of Economic and Social Affairs, Population Division. World Marriage Data 2008 (POP/DB/Marr/Rev2008).

GROWTH RATES

The figure below displays countries grouped by their growth rates for contraceptive prevalence. This chart is a way to see whether or not progress is being accelerated in countries over time. If FP2020 is successful over the next eight years, the number of countries that fall in the higher growth categories will increase.

The growth rates were estimated by calculating the annual rate of change between the last two data points. The sources of the data include DHS, MICS, RHS, and national surveys (the same data points that were used to estimate the 2012 mCPR were used to produce this graphic). Western Sahara is not included due to lack of data.

The majority of FP2020 countries (38) fall in the lowest growth category while only six fall in the highest (Rwanda and Djibouti). Over time, this graph will visually represent progress towards the overall achievement of FP2020 demonstrated by a shift towards the higher growth rate categories by a majority of the countries. Countries with smaller population sizes will achieve accelerated growth rates more easily than those with larger populations.

SOURCE
Afghanistan (National survey 2010 and 2007/8), Bangladesh (DHS 2011 and 2007), Benin (DHS 2011/12 and 2006), Bhutan (MICS 2010 and National Survey 2000), Bolivia (DHS 2008 and 2003), Burkina Faso, DHS 2010 and 2003), Burundi (DHS 2010 and 1987), Cambodia (DHS 2010 and 2005), Cameroon (DHS 2011 and 2004), Central African Republic (MICS 2010 and 2006), Chad (MICS 2010 and DHS 2004), Comoros (DHS 2012 and 1996), Congo (DHS 2012 and 2005), Cote d'Ivoire (DHS 2012 and 1998/99), DRC (MICS 2010 and DHS 2001), Djibouti (MICS 2006 and PapFam 2001), Egypt (DHS 2008 and 2005), Eritrea (DHS 2011 and 2005), Ethiopia (DHS 2011 and 2005), Gambia (MICS 2010 and 2000), Ghana (MICS 2011 and DHS 2008), Guinea (DHS 2012 and 2005), Guinea-Bissau (MICS 2010 and 2006), Haiti, DHS 2012 and 2005/6), Honduras (DHS 2011/12 and 2005/6), India (DHS 2006/6 and 1998/99), Indonesia (DHS 2012 and 2007), Iraq (MICS 2011 and 2006), Kenya (DHS 2008/9 and 2003), Kyrgyzstan (DHS 2012 and MICS 2006), Lao (MICS 2011/12 and National Survey 200%0, Lesotho (DHS 2009 and 2004), Liberia (DHS 2007 and 1986), Madagascar (DHS 2008/9 and 2003/4), Malawi (DHS 2010 and 2004), Mali (DHS 2006 and 2001/2), Mauritania (MICS 2007 and DHS 2001), Mongolia (MICS 2010 and 2005), Mozambique (DHS 2011 and 2003), Myanmar (MICHS 2010 and National Survey 2007), Nepal (DHS 2011 and 2006), Nicaragua (RHS 2006/7 and DHS 2001), Niger (DHS 2012 and 2006), Nigeria (MICS 2011 and DHS 2008), North Korea (National Survey 2002 and 1997), Palestine (MICS 2010 and Family Health Survey 2006), Pakistan (DHS 2012/12 and 2006/7), Papua New Guinea (National Survey 2006 and 1996), Philippines (National Family Survey 2011 and DHS 2008), Rwanda (DHS 2010 and 2007/8), Sao Tome and Principe (DHS 2008/9 and MICS 2006), Senegal DHS 2010/11 and 2005), Sierra Leone (MICS 2010 and DHS 2008),

Somalia (MICS 2006 and WCU 1999), South Africa (DHS 2003 and 1998), Sri Lanka (DHS 2007 and 1987), Sudan (MICS 2006), Tajikistan (DHS 2012 and MICS 2005), Timor-Leste (DHS 2009/10 and LSMS 2007), Togo (MICS 2010 and 2006), Uganda (DHS 2011 and 2006), Tanzania (DHS 2010 and 2005/5), Uzbekistan (MICS 2006 and DHS 2002), Vietnam (MICS 2011 and 2006), Yemen (MICS 2006 and PapFam 2003), Zambia (DHS 2007 and 2001/2), Zimbabwe (DHS 2010/11 and 2005/6). Solomon Islands, South Sudan, and Western Sahara are not included because they have only one or no data points. Analysis was done using both mCPR among all women and married women, depending on what data was available for each country. However, the two data points for each country are based on the same population, either all women or married women. If both all women and married women estimates were available for both data points, all women were used for the analysis.

Country Categories

0 - 0.5
Mauritania
Chad
North Korea
Togo
Papua New Guinea
Afghanistan
Burundi
Cameroon
Egypt
Benin
Côte d'Ivoire
Eritrea
Zimbabwe
Senegal
Central African Republic
Liberia
Sudan
Comoros
South Africa
Indonesia
Mali
Bolivia
Guinea
Somalia
Indonesia
India
Gambia
Viet Nam
Uzbekistan
Nepal
Mozambique
Sao Tome and Principe
Iraq
Tajikistan
Mongolia
Kyrgyzstan

0.5 - 1
Philippines
Kenya
Honduras
India
Pakistan
Democratic Republic of the Congo
Nigeria
Burkina Faso
Occupied Palestinian Territory
Sri Lanka
Haiti
Nicaragua

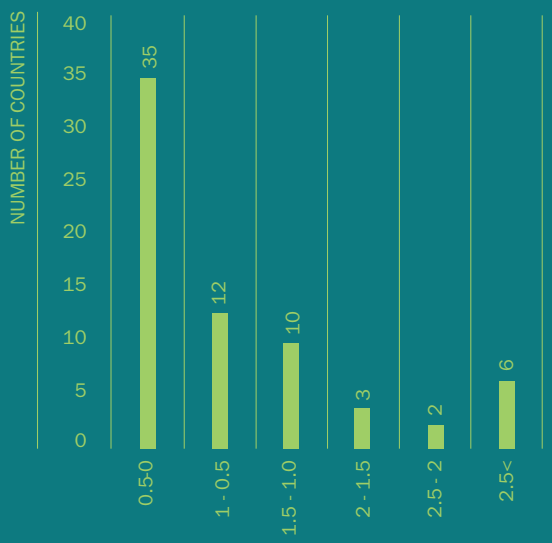
1.0 - 1.5
Ethiopia
Lesotho
Niger
Bangladesh
Congo
Lao People's Democratic Republic
United Republic of Tanzania
Zambia
Cambodia
Uganda

1.5 - 2
Sierra Leone
Madagascar
Malawi

2 - 2.5
Myanmar
Timor-Leste

>2.5
Yemen
Rwanda
Guinea-Bissau
Bhutan
Djibouti
Ghana

Past Annual Growth Rates in McPR



Indicator 3
Percent of married women whose demand for modern contraception is satisfied

Indicator 4
Percentage of married women with an unmet need
The data for indicators 3-4 were provided by the United Nations Population Division.[26] These indicators are traditionally reported for women who are married or in union, so estimates reflect demand and unmet need among married/in union women and are therefore not strictly comparable with the mCPR and number of user reported in the table. Going forward, FP2020 intends to report these indicators for all women.

In 11 countries, twenty percent or less of the current demand for family planning among married women were met. Of these 11, seven are in West Africa, a region where indicators of family planning performance tend to fall below the overall averages for other regions of Africa and for Western and South Central Asia. In 31 countries between 25 and 50 percent of demand among married women were met. The countries that fall into this category are more regionally diverse and include twenty-two Africa countries, with the remaining from the Middle East, Central Asia, and South America.

Percentages with an unmet need are harder to translate because these can reflect both a need for contraception as well as high desired rates of fertility. For example, Chad has the lowest estimated mCPR in 2012 (1.6) and an estimated unmet need that is lower than the median for the FP2020 countries (Chad is 26 and the median is 31). In contrast, South Africa has the highest mCPR and the lowest unmet need, representing the expected mCPR unmet need relationship for a location further along the demographic transition.

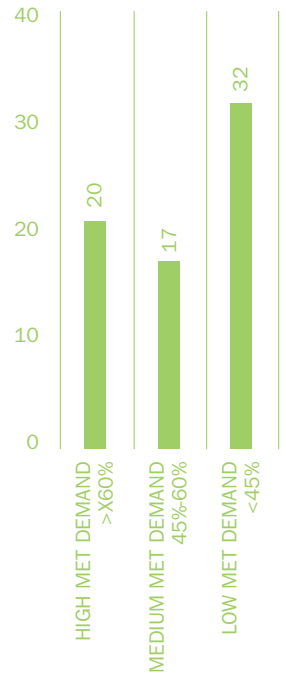
The methodology used to estimate the 2012 modern contraceptive prevalence rates, unmet need, and percent of demand satisfied (Indicators 1, 3, and 4) will be modified for the next report. The new methodology will modify the Bayesian hierarchical model currently used by the UN Population Division that produces country specific contraceptive prevalence.[27] The modifications will allow for the inclusion of country produced data, such as service statistics and commodity data, to the data already included from cross-sectional surveys. In addition to a modification of the methodology, the process of applying the model will be introduced in FP2020 pledging countries to increase transparency and allow countries to make decisions about what country level data is included in the analysis.

The final two core indicators that will be reported every year include:

Indicator 5
Couple-years of protection (CYP)

Indicator 6
Annual expenditures on family planning from the government domestic budget
These indicators are not included in this report because the processes necessary for data collection are currently being developed and implemented. CYP data will be collected by service statistics from both the public and private sector. The process under development for estimating family planning expenditures is described later on in the report, but data on country expenditures are not yet available

Number of Countries with Low, Medium, and High Percent of Demand Satisfied



26
United Nations, Department of Economic and Social Affairs, Population Division (2013). Model-based Estimates and Projections of Family Planning Indicators: 2013 Revision. New York: United Nations.

27
Alkema, L., V. Kantorova, C. Menozzi, and A. Biddlecom. 2013. "National, Regional, and Global Rates and Trends in Contraceptive Prevalence and Unmet Need for Family Planning Between 1990 and 2015: A Systematic and Comprehensive Analysis." The Lancet. www.thelancet.com.

Number of Married Women, Age 15-49, with an Unmet Need for Family Planning

SOURCE
Percent of women with an unmet need is from the United Nations Population Division data, the same as displayed in Table 1 above. This percentage was multiplied by the number of women aged 15-49 from the 2012 UN Population Prospects and the percent of women married was taken from the 2008 UN marriage database and DHS surveys.

UNMET NEED

FP2020 countries have high levels of unmet need with more than 140 million married women estimated to have an unmet need for family planning in 2012.[28] These are married women who are not currently using family planning but who have expressed that they either do not wish to have an (additional) child/children or they wish to wait at least two years before having a child. While there are different methodologies used to produce estimates of unmet need, this number is derived from the UN Population Division's methodology because it produces country specific estimates as opposed to regional estimates.

The figure to the left shows the number of women with an unmet need in 67 of the 69 FP2020 countries (South Sudan and Western Sahara are omitted due to lack of data). The circle representing India has been reduced in size so that it does not obscure surrounding countries. It should be noted that the FP2020 pledge to reach 120 million additional women with modern methods aims to increase access among these 140 million women, as well as unmarried women with an unmet need, and, women currently using traditional methods who may want to change to a modern form of contraception.

28
Calculated from United National Population Division Data on Unmet Need among Married Women and Married Women of Reproductive Age, 15-49.

Table I Indicators that will be Reported Annually for All 69 FP2020 Countries, Pledging Countries

PLEDGING COUNTRIES	MCPR (ALL WOMEN AGED 15-49)			# USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)	% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)	% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)
	MOST RECENT ESTIMATE	2012 ESTIMATE	ADJUST BASELINE FOR 2012 COUNTRY INPUT			
BANGLADESH	N/A	42.2		17,965,000	70	22.6
BURKINA FASO	14.3	15.6		642,000	38	27.0
CÔTE D'IVOIRE	13.9	13.9		676,000	27	35.9
DRC	6.7	10.8		1,713,000	14	42.8
ETHIOPIA	18.7	20.2		4,317,000	50	28.6
GHANA	13.5	22.5		1,409,000	32	40.7
INDIA	38	42.5		137,860,000	71	20.8
INDONESIA	42.7	42.7		12,175,000	79	15.1
KENYA	28	31.4		3,241,000	59	29.4
MALAWI	32.6	36.0		1,269,000	61	28.1
MOZAMBIQUE	12.1	12.1		689,000	34	25.9
NIGER	N/A	10.8		391,000	35	22.5
NIGERIA	10.5	14.2		5,435,000	26	27.4
PAKISTAN	N/A	18.1		8,482,000	43	33.9
PHILIPPINES	21.8	24.3		6,020,000	51	35.6
RWANDA	25.2	32.3		891,000	60	29.0
SENEGAL	8.9	9.3		298,000	30	31.5
SIERRA LEONE	8.2	17.6		268,000	23	31.0
SOLOMON ISLANDS	N/A	19.1		26,000	51	28.6
SOUTH AFRICA	50.1	51.5		6,953,000	82	13.2
UGANDA	20.7	21.8		1,705,000	42	37.6
ZAMBIA	24.6	30.1		921,000	48	35.5
ZIMBABWE	40.5	40.9		1,373,000	79	15.4

Stephanie Freid-Perenchio
photography/SFP STUDIO

Indicators that will be Reported Annually for All 69 FP2020 Countries, Non-Pledging Countries

NON-PLEDGING COUNTRIES	MCPR (ALL WOMEN AGED 15-49)			# USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)	% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)	% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)
	MOST RECENT ESTIMATE	2012 ESTIMATE	ADJUST BASELINE FOR 2012 COUNTRY INPUT			
AFGHANISTAN	N/A	15.6		1,148,000	35	35.2
BENIN	N/A	9.3		206,000	20	35.2
BHUTAN	N/A	52.8		104,000	82	13.4
BOLIVIA	24	24.2		629,000	47	41.9
BURUNDI	11	11.9		273,000	35	35.8
CAMBODIA	21.7	23.8		962,000	55	31.5
CAMEROON	N/A	16.5		822,000	31	33.9
CENTRAL AFRICAN REPUBLIC	3.5	13.5		151,000	25	37.7
CHAD	1.5	5.0		135,000	8	25.9
COMOROS	N/A	9.8		18,000	49	33.9
CONGO (BRAZZAVILLE)	N/A	21.9		224,000	31	44.7
DJIBOUTI	N/A	24.9		61,000	41	32.0
EGYPT	N/A	39.5		8,603,000	80	14.4
ERITREA	5.2	8.2		116,000	27	34.2
GAMBIA	N/A	7.4		34,000	25	32.9
GUINEA	7.0	7.0		169,000	16	26.5
GUINEA-BISSAU	N/A	66.3		251,000	29	26.7
HAITI	21.6	21.6		579,000	45	38.8
HONDURAS	42.9	43.3		896,000	71	23.2
IRAQ	N/A	22.3		1,741,000	51	33.1
KYRGYZSTAN	N/A	21.8		331,000	72	19.2
LAOS	N/A	29.6		516,000	63	25.5
LESOTHO	34.9	39.3		224,000	68	23.2
LIBERIA	11.7	12.8		127,000	27	35.2

NON-PLEDGING COUNTRIES	MCPR (ALL WOMEN AGED 15-49)			# USERS OF MODERN CONTRACEPTION (2012 ESTIMATE)	% WOMEN WITH SATISFIED DEMAND FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)	% WOMEN WITH UNMET NEED FOR MODERN CONTRACEPTION (2012 ESTIMATE, MARRIED/IN UNION)
	MOST RECENT ESTIMATE	2012 ESTIMATE	ADJUST BASELINE FOR 2012 COUNTRY INPUT			
MADAGASCAR	23	29.3		1,528,000	52	29.3
MALI	6.2	6.7		249,000	23	30.1
MAURITANIA	3.1	6.3		57,000	25	33.6
MONGOLIA	N/A	36.4		278,000	71	20.9
MYANMAR	N/A	31.4		4,406,000	68	21.2
NEPAL	33.2	33.2		2,707,000	59	31.1
NICARAGUA	46.9	49.9		806,000	82	14.6
NORTH KOREA	N/A	50.2		3,269,000	75	19.3
PALESTINE	N/A	26.4		274,000	58	30.3
PAPUA NEW GUINEA	N/A	20.0		356,000	45	33.7
SAO TOME AND PRINCIPE	N/A	22.4		9,000	47	38.9
SOMALIA	N/A	3.6		82,000	7	47.4
SOUTH SUDAN	N/A	2.0		49,000	6	33.7
SRI LANKA	N/A	38.6		2,102,000	69	23.6
SUDAN	N/A	8.6		772,000	26	31.5
TAJIKISTAN	N/A	16.0		305,000	48	29.9
TANZANIA	23.6	25.8		2,787,000	49	31.4
TIMOR-LESTE	12.8	17.4		45,000	43	30.7
TOGO	7.9	16.4		262,000	28	40.0
UZBEKISTAN	36.6	41.3		3,139,000	79	16.0
VIET NAM	N/A	40.1		10,399,000	80	16.6
WESTERN SAHARA	N/A	N/A		N/A	N/A	N/A
YEMEN	N/A	31.5		1,906,000	37	43.1

For most recent estimates, the year of the last survey: 1995; Central African Republic; 1996: Uzbekistan; 1998: Togo; 2001: Mauritania; 2002: Eritrea; 2003: South Africa; 2004: Chad; 2006: India, Mali; 2007: DRC, Liberia, Nicaragua, Zambia ; 2008: Bolivia, Nigeria, Philippines, Sierra Leone; 2009:Ghana, Kenya, Lesotho, Madagascar; 2010: Burkina Faso, Burundi, Cambodia, Malawi, Rwanda, Tanzania, Timor-Leste; 2011: Cameroon, Ethiopia, Mozambique, Nepal, Senegal, Uganda, Zimbabwe; 2012: Côte d'Ivoire, Guinea, Haiti, Honduras, Indonesia

Table 2 presents data on Indicators 1, 3 and 4 in the five countries with a DHS survey in 2012 disaggregated by age. The figures for unmet need and demand used in this table/graph differ from those in Table 1 as they come directly from the DHS to allow for further analysis within each country by providing the ability to disaggregate by important socio-economic factors in addition to age like wealth quintile and urban/rural status. The figures in Table 1 are derived from UNPD data to allow for a common methodology to be used across countries since there are a limited number of countries that have a DHS in any given year. In addition, the mCPR estimates in Table 2 are for married women only, rather than all women as shown above as the DHS only publishes the breakdowns of CPR by characteristic for married women.

Data on the four indicators mCPR, number of users of modern methods, unmet need and demand satisfied) presented in subsequent annual reports will be obtained directly from countries, in some cases with the assistance of the Monitoring & Evaluation officers in-country and in some cases through electronic methods (see TRACK20 and PMA2020 Highlight box). Annual figures will be estimated through two FP2020 innovations, one that utilizes technology for annual data collection and analysis (PMA2020) and one that is introducing country-specific processes that analyze and model available data to issue estimates (Track20). The presence of these activities is limited to FP2020 pledging, or a subset of pledging countries, so methodologies will differ for non-pledging countries. These processes will provide the data to complete tables 1 and 2 in subsequent years.

Table 2

Stephanie Freid-Perenchio
photography/SFP STUDIO

Table 3 Indicators that Model Impact for all 69 FP2020 Countries, Pledging Countries

Estimated number (000s) of unintended pregnancies in developing countries in 2012, the numbers (000s) of unintended pregnancies and of unsafe abortions averted by modern contraceptive use in 2012 and the number of maternal deaths averted by modern contraceptive use in 2012 for 69 poorest countries.

PLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000S)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000S)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000S)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE	PLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000S)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000S)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000S)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE
BANGLADESH	3,518	5,069	1,508	366	NIGER	77	110	31	366
BURKINA FASO	126	181	51	5,436	NIGERIA	1,064	1,533	429	5,436
CÔTE D'IVOIRE	132	191	53	3,501	PAKISTAN	1,661	2,393	712	3,501
DRC	335	48	152	946	PHILIPPINES	1,179	1,698	832	946
ETHIOPIA	845	1,218	171	481	RWANDA	174	251	88	481
GHANA	276	398	111	175	SENEGAL	58	84	24	175
INDIA	26,993	38,895	11,571	379	SIERRA LEONE	52	76	21	379
INDONESIA	2,384	3,435	1,683	4	SOLOMON ISLANDS	5	7	0	4
KENYA	635	914	320	839	UGANDA	334	481	168	839
MALAWI	248	358	125	643	ZAMBIA	180	260	91	643
MOZAMBIQUE	135	194	68	1,242	ZIMBABWE	269	387	136	1,242

INDICATORS THAT MODEL IMPACT FOR ALL 69 FP2020 COUNTRIES

The second category includes **Indicators 7-10** which will be modeled to produce annual estimates. For this report, these estimates are based on analysis done by the Guttmacher Institute. Their analysis found that in 2012 in the 69 FP2020 countries there were 51.3 million unintended pregnancies. In addition, the impact of modern contraceptive use was estimated to be: 73.9 million unintended pregnancies averted, 23.8 million unsafe abortions averted, and 92,715 maternal deaths averted. [29]

The numbers were estimated by looking at two scenarios. Scenario one is the current situation in terms of modern contraceptive use by women ages 15-49 compared to a scenario two where none of these women were using contraception but remained at risk of unintended pregnancy.

To produce country specific estimates, the Guttmacher Institute totals for the 69 countries were proportioned to each country. For the first two indicators, number of unintended pregnancies and number of unintended pregnancies averted due to contraceptive use, the totals were distributed to each country based on the number of users in each country (reported in Table 3 in this report). Numbers are reported in thousands and are influenced by the contraceptive prevalence in each country as well as the size of the population of women of reproductive age. This is illustrated by the highest numbers being reported for India, which has the largest population and very high contraceptive prevalence. The third indicator, number of unsafe abortions averted due to contraceptive use, was based on distributing the total for the 69 countries by both the number of users and the WHO 2008 regional abortion rates. The fourth indicator, number of maternal deaths averted due to contraceptive use, was calculated by distributing the total for the 69 countries by both the number of users and the UN 2010 maternal mortality ratios.

Indicators that Model Impact for all 69 FP2020 Countries, Non-Pledging Countries

NON-PLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000S)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000S)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000S)	# MATERNAL DEATHS AVERTED DUE TO CON-TRACEPTIVES USE
AFGHANISTAN	225	324	96	838
BENIN	40	58	16	114
BHUTAN	20	29	9	30
BOLIVIA	123	177	134	190
BURUNDI	53	77	27	347
CAMBODIA	188	271	133	382
CAMEROON	161	232	73	900
CENTRAL AFRICAN REPUBLIC	30	43	13	213
CHAD	26	38	12	236
COMOROS	4	5	2	8
CONGO (BRAZZAVILLE)	44	63	20	199
DJIBOUTI	12	17	6	19
EGYPT	1,684	2,427	765	901
ERITREA	23	33	11	44
GAMBIA	7	10	3	19
GUINEA	33	48	13	164
GUINEA-BISSAU	49	71	20	315
HAITI	113	163	63	322
HONDURAS	175	253	150	142
IRAQ	341	491	138	174
KYRGYZSTAN	65	93	28	37
LAOS	101	146	71	385
LESOTHO	44	63	11	220
LIBERIA	25	36	10	155

NON-PLEDGING COUNTRIES	# UNINTENDED PREGNANCIES (000S)	# UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE (000S)	# UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE (000S)	# MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE
MADAGASCAR	299	431	151	582
MALI	49	70	20	213
MAURITANIA	11	16	5	46
MONGOLIA	54	78	0	28
MYANMAR	863	1,243	609	1,399
NEPAL	530	764	227	731
NICARAGUA	158	227	135	122
NORTH KOREA	640	922	0	420
PALESTINE	54	77	22	28
PAPUA NEW GUINEA	70	100	5	130
SAO TOME AND PRINCIPE	2	3	1	1
SOMALIA	16	23	8	130
SOUTH SUDAN	N/A	N/A	N/A	N/A
SRI LANKA	412	593	176	117
SUDAN	151	218	69	895
TAJIKISTAN	60	86	26	31
TANZANIA	546	786	275	2,035
TIMOR-LESTE	9	13	6	21
TOGO	51	74	21	125
UZBEKISTAN	615	886	263	140
VIET NAM	2,036	2,934	1438	974
WESTERN SAHARA	3	4	1	2
YEMEN	373	538	151	605

29
Guttmacher Institute, 2013, tabulations for data for Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012

SOURCE
1. Number of users taken from Table 1, see citations above.
2. Guttmacher Institute, 2013, tabulations for data for Singh S and Darroch JE, Adding It Up: Costs and Benefits of Contraceptive Services—Estimates for 2012, New York: Guttmacher Institute and United Nations Population Fund (UNFPA), 2012
3. Trends in Maternal Mortality: 1990 to 2010. WHO, UNICEF, UNFPA and The World Bank estimates
4. Unsafe abortion: Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008. Sixth Edition. World Health Organization

INDICATORS THAT WILL BE REPORTED ANNUALLY IN 10 COUNTRIES AND FOR THE SUBSET OF THE 69 FP2020 COUNTRIES IN YEARS WITH A DHS

Indicators 11-15 will be reported annually in the ten countries in which PMA2020[30] collects data and in any country with a DHS in the reporting year. These indicators measure whether women are receiving information on family planning, women's roles in decision-making and fertility rates among adolescents.

PMA2020 data was not available in time for this report, but efforts are underway to make these innovative survey findings available for countries in subsequent reports. For this report, only countries with a fully released DHS are included because the information is not included in preliminary DHS reports. However, age specific fertility rates are included in preliminary reports and this information is reflected in table below. These data show the age pattern of fertility and are reported per 1,000 women. For example, there were 94 births per 1,000 women aged 15-19 in Benin.

The percent of women provided with family planning information during last provider visit are among those who visited a health facility, for a variety of reasons, within the last twelve months. This information is important for measurement of integration of services, but it cannot be assumed that all of these women should have been provided with family planning information, so the maximum should not be seen as one hundred. For the Method Information Index there were three variables included in the analysis, (1) whether women were informed about other methods, (2) whether women were told of side effects and (3) whether they were told what to do if experiencing side effects. The value in the table represents the percentage of women who responded yes to all three of these questions.

Indicators to be Reported Annually in 10 Countries and for Subset of 69 FP2020 Countries in Years with a DHS

COUNTRIES	% WOMEN PROVIDED WITH FP INFO DURING LAST PROVIDER VISIT	MEAN SCORE ON METHOD INFORMATION INDEX	% WOMEN MAKING FP DECISIONS ALONE OR WITH PARTNER	ADOLESCENT AGE-SPECIFIC FERTILITY RATE (15-19)	% INFORMED OF PERMANENCE OF STERILIZATION
BENIN				94	
COMOROS				70	
CONGO (BRAZZ)				147	
CÔTE D'IVOIRE	19	31	81.6	129	
GUINEA				146	
HAITI	40	55	91.4	66	
HONDURAS	35	30	88.0	101	87
INDONESIA	23	24	91.5	48	87
KYRGYZSTAN				44	
LAOS				94	
NIGER				206	

30 PMA2020 Countries/Partners: Ghana (Kwame Nkrumah University of Science & Technology), Ethiopia (Addis Ababa University School of Public Health), Uganda (Makerere University School of Public Health), Nigeria (Obademi Awolowo University & University of Ibadan), DR Congo (University of Kinshasa School of Public Health), Kenya (TBD), Senegal (TBD), Burkina Faso (TBD), India (TBD), Indonesia (TBD).

HIGHLIGHT

TRACK20

Implemented by Futures Institute, the Track20 Project supports national efforts to collect, analyze and use data to track progress in family planning and develop effective program strategies and plans. The project seeks to work with governments to transform current practices that rely heavily on large national household surveys conducted every five years or so to a system in which data collected by governments are used to produce annual estimates on a range of key indicators including modern contraceptive prevalence, commodity security, choice, quality and family planning expenditures. This approach will make greater use of service statistics and other data collected through the public and private sector, taking into account their limitations, and will work with governments to install an annual process that reviews the data and issues official estimates.

PERFORMANCE MONITORING AND ACCOUNTABILITY 2020

Implemented by the Bill & Melinda Gates Institute of Population and Reproduction at the Johns Hopkins Bloomberg School of Public Health, PMA2020 is designed to facilitate annual progress reporting in support of the goals and principles of FP2020 across 10 countries in Africa and Asia, using an innovative mobile-Assisted Data and Dissemination System (mADDS) that:

- Employs innovative mobile technology
- Supports low-cost, rapid-turnaround surveys
- Generates annual (or semi-annual) indicators
- Is expandable to other health sectors
- Provides consistency with Demographic and Health Survey measures
- Introduces new indicators of quality, choice, and access
- Creates community feedback loops to prompt program improvement
- Strengthens local capacity

METHOD MIX

Figure XA and XB to the right shows the FP2020 countries in which 20% or more of the method mix (where the method mix includes modern methods and traditional methods) is attributed to 0 or 1 modern method, 2 modern methods, or 3 modern methods. Figure XA shows that there is relatively low method mix in many of the FP2020 countries. In almost all countries, only one or two methods represent more than 20 percent of the method mix. In many of these countries, more than 25 percent of method use is attributed to the composite of traditional methods. Five of the FP2020 countries have three methods that each represents greater than 20 percent of the method mix. This graphic suggests a possible association between modern method mix and traditional method use: countries with high rates of traditional method use are in higher proportion among the countries with limited modern method mix.

Figure XB, showing countries with a large proportion of users using only one method. In this figure, the composite of traditional methods is included in the analysis. Figure XB shows twenty-eight countries (two-fifths of all FP2020 countries) in which 40 to 60 percent of contraceptive users rely on one method. For four of those countries, that method is traditional, and not modern. The second column in Figure XB lists the eleven countries in which 60 percent or more of all contraceptive users rely on only one method of contraception.

There are many different reasons why a few methods dominate the method mix in so many FP2020 countries including access, availability and preferences. Further research at the country level can help FP2020 countries better understand the needs of women in the country, and, why some methods are being chosen more than others. By ensuring the availability of a full range of modern family planning methods, FP2020 will play an important role in diversifying the method mix in those places where access and availability are limited.

Figure XA Countries with ≥ 20% of the Modern Method Mix All Users, Both Modern and Traditional Methods) Attributed to 1, 2, or 3 Modern Methods

Countries where Traditional Method Use ≥ 25% of the Method Mix are highlighted in white.

≤ 1 Method

Bangladesh
Benin
Bhutan
Bolivia
Burundi
Cameroon
CAR
Chad
Comoros
Congo (Brazzaville)
Djibouti
DRC
Egypt
Ethiopia
Guinea
India
Iraq
Kenya
Madagascar
Mauritania
Nepal
Nigeria
North Korea
Palestine
Philippines
Rwanda
Somalia
South Africa
Tajikistan
Tanzania
Timor-Leste
Togo
Uganda
Uzbekistan
Vietnam
Zimbabwe

2 Methods

Afghanistan
Burkina Faso
Cambodia
Côte d'Ivoire
Eritrea
Gambia
Ghana
Guinea-Bissau
Haiti
Honduras
Indonesia
Kyrgyzstan
Laos
Malawi
Mongolia
Myanmar
Nicaragua
Niger
Pakistan
Senegal
Sierra Leone
Solomon Islands
Sri Lanka
Yemen
Zambia

3 Methods

Lesotho
Liberia
Mali
Mozambique
Sao Tome and Principe

Figure XB Countries with Indicated % of Method Mix (All Users: Modern and Traditional Methods) Composed of Only One Method

Countries highlighted in white indicate that this one method is the composite of traditional methods.

40% - 60%

Afghanistan
Bangladesh
Bhutan
Bolivia
Burundi
Cameroon
Chad
Congo (Brazzaville)
DRC
Egypt
Gambia
Haiti
Indonesia
Kenya
Laos
Madagascar
Malawi
Mongolia
Myanmar
Niger
Palestine
Philippines
Rwanda
Sierra Leone
South Africa
South Sudan
Togo
Uganda

≥ 60%

Djibouti
Ethiopia
India
Kyrgyzstan
Mauritania
North Korea
Somalia
Tajikistan
Timor-Leste
Uzbekistan
Zimbabwe

SOURCE
Source: Method mix data was unavailable for Papua New Guinea, Sudan and Western Sahara. For countries where method mix data for all women was unavailable, data for women married/in union was used. Method mix data sources were the same as for the most recent mCPR estimates in Table 1, with the following exceptions: Afghanistan (MICS 2011), Bangladesh (DHS 2011), Benin (DHS 2012), Bhutan (MICS 2010), CAR (MICS 2010), Chad (MICS 2010), Comoros (DHS 2012), Congo-Brazzaville (DHS 2012), DRC (MICS 2010), Djibouti (MICS 2008), Egypt (DHS 2008), Gambia (DHS 2013), Ghana (MICS 2011), Guinea-Bissau (MICS 2010), India (XXXXX) Iraq (MICS 2011), Kyrgyzstan (DHS 2012), Laos (MICS/DHS 2012), Mali (DHS 2013), Mauritania, (MICS 2007), Mongolia (MICS 2010), Myanmar (MICS 2010), Niger (DHS 2012), Nigeria (MICS 2011), Palestine (FHS 2006), Pakistan (DHS 2013), Philippines (FHS 2011), Sierra Leone (MICS 2010), Sao Tome and Principe (DHS 2009), Solomon Islands (National Survey 2007), Somalia (MICS 2006) South Sudan (SHHS2 2010), Sri Lanka (DHS 2007), Tajikistan (DHS 2012), Timor-Leste (DHS 2010), Togo (MICS 2010), Uzbekistan (MICS 2006), Vietnam (MICS 2011), Yemen (MICS 2006). Original sources for North Korea and Solomon Islands could not be located; for these two countries method mix data was obtained from the UN Population Division World Contraceptive Use 2012.

MONITORING FAMILY PLANNING EXPENDITURES

Monitoring family planning expenditures is an important means of holding stakeholders accountable to their commitments and to measure progress in mobilizing sufficient resources needed to achieve FP2020 goals. Historically, family planning expenditures have been estimated at certain points in time through special expenditure studies and National Health Accounts applications.

However, there has not yet been a unified process in place to comprehensively and consistently track all resource flows specifically for family planning, including sometimes overlooked sources such as out-of-pocket consumer spending, sub-national governments, and the private sector.

NEW COLLABORATIVE TO TRACK EXPENDITURES

Building upon successful approaches utilized to track expenditures in the fields of HIV/AIDS, malaria and others, a collaborative with Track20, the Kaiser Family Foundation, UNFPA and the Netherlands Interdisciplinary Demographic Institute, WHO and COIA, and the DELIVER project established a process to comprehensively collect, consolidate and analyze data that when taken as a whole will demonstrate the best possible estimate of family planning expenditures by country and globally on an annual basis. This effort has already generated some new information in 2013 and estimates in 2014 and onwards will be even more comprehensive.

For more information about the role of the **Kaiser Family Foundation,** please refer to page 30.

UNFPA/NIDI

UNFPA and the Netherlands Demographic Institute (NIDI) have been tracking financial flows for population activities since 1997 through the Resource Flows Project. The Resource Flows Project—established in 1997 by UNFPA and the Netherlands Demographic Institute (NIDI)—monitors spending on population activities, disaggregated by the four components of the costed population package specified in the ICPD Programme of Action: family planning service; basic reproductive health services; STD/HIV/AIDS prevention programme; and basic research, data, and population and development policy analysis.

The Track20 project is now working with UNFPA and NIDI to get even more family planning specific information to their data collection efforts. These efforts are focused on adding more family planning elements, such as the inclusion of out-of-pocket expenditures, to the standard questionnaire. National consultants will be used to implement the questionnaire in each country. Pilot tests of the new questionnaire will be conducted in late 2013 in Ethiopia and Tanzania. Based on the results of the pilot test, the revised questionnaire can be implemented in the 2014 round of data collection. This process should produce estimates of family planning expenditures from international donors and most developing countries. Major challenges to be addressed include developing new approaches to estimating out-of-pocket expenditures and properly allocating shared expenditures to family planning.

WHO/COIA

The World Health Organization as part of the implementation of the Commission on Information and Accountability (COIA) recommendations is supporting the enhancement of Member States' tracking of health expenditures. WHO promotes the use of health accounts software, which collects and maps all expenditures following the standard System of Health Accounts (SHA) 2011 categories. Program-specific expenditures are estimated by collecting earmarked flow of funds data and distributing non-earmarked spending using allocation algorithms, based on information such as number of health visits. The collection of family planning specific expenditure data has been incorporated into WHO overall work on tracking of expenditures. Unrolling of training and technical assistance started in 2013 with applications in about 20 countries. Ultimately, his should expand to additional countries in the next few years to a total of about 70 low and middle-income countries.

DELIVER

The USAID-funded DELIVER project has developed a tool to assist countries to track financing for contraceptive commodities. The Contraceptive Finance Tracking Guide has been piloted in Ghana and Uganda. DELIVER is also developing a training curriculum and a web-based guide. Track20 will work with DELIVER to provide training to family planning M&E officers in the use of the tool. This should ensure that financing for family planning commodities is tracked carefully in key countries.

It is inspiring to see Tanzania's growing commitment to family planning. The government and the private sector are working together to meet the unmet need for family planning. The future looks bright for women and girls in my country.

HALIMA SHARIFF
COUNTRY DIRECTOR TANZANIA,
ADVANCE FAMILY PLANNING,
JOHNS HOPKINS BLOOMBERG SCHOOL
OF PUBLIC HEALTH CENTER
FOR COMMUNICATIONS PROGRAM

Stephanie Freid-Perenchio
photography/SFP STUDIO

04

SECTION 04

Annexes
FP2020 Reference Group & Working Group Members
FP2020 Commitment Makers
69 Focus Countries
Abbreviations

ANNEX I
As of October, 2013

REFERENCE GROUP
The Reference Group's purpose is to provide strategic direction and oversight of FP2020.

CO-CHAIR -
DR. CHRIS ELIAS,
Bill & Melinda Gates Foundation

CO-CHAIR -
DR. BABATUNDE OSOTIMEHIN,
UNFPA

DR. WAPADA BALAMI,
Ministry of Health, Nigeria

DR. TEWODROS BEKELE,
Ministry of Health, Ethiopia

DR. FLAVIA BUSTREO,
World Health Organization

KATHY CALVIN,
United Nations Foundation

DR. AWA MARIE COLL-SECK,
Ministry of Health, Senegal

JANE EDMONDSON,
United Kingdom Department for International Development

DR. TORE GODAL,
Ministry of Foreign Affairs, Norway

ANURADHA GUPTA,
Ministry of Health and Family Welfare, India

DR. KELLY HENNING,
Bloomberg Philanthropies

JANE WAMBUI KIRAGU,
Satima Consultants, Ltd., Kenya

TEWODROS MELESSE,
International Planned Parenthood Foundation

POONAM MUTTREJA,
Population Foundation of India

DR. ARIEL PABLOS-MENDEZ,
U.S. Agency for International Development

DR. CAROLE PRESERN,
Partnership for Maternal and Newborn Child Health

JOHN SKIBIAK,
Reproductive Health Supplies Coalition

DR. JULIANTO WITJAKSONO,
National Population Family Planning Agency, Indonesia

COUNTRY ENGAGEMENT WORKING GROUP (CE WG)
The Country Engagement Working Group will facilitate access to funding, technical assistance, and country- to-country support for transformational, country-owned family planning programs.

CO-LEAD -
DR. KECHI OGBUAGU,
United Nations Population Fund

CO-LEAD -
ELLEN STARBIRD,
United States Agency for International Development

DR. ABOSEDE ADENIRAN,
Federal Health Ministry, Nigeria

DR. MUHAMMED ASLAM,
Bayer

DR. ARTHUMAN BAKER NDUGGA MAGGWA,
FHI360

DR. RITA COLUMBIA,
United Nations Population Fund

DR. BOCAR DAFF,
Ministry of Health, Senegal

DR. SITI FATHONAH,
National Population and Family Planning Coordinating Board, Indonesia

DR. ABU JAMIL FAISEL,
EngenderHealth

DR. JILL KEESBURY,
Alliance for Reproductive, Maternal and Newborn Health

MONICA KERRIGAN,
The Bill & Melinda Gates Foundation

DR. ABDISSA KURKIE,
Ministry of Health, Ethiopia

DR. JEAN-PIERRE MANSHANDE,
MSD/Merck

DR. JOTHAM MUSINGUZI,
Partners in Population and Development

GRETHE PETERSEN,
Marie Stopes International

SARA RUSLING,
UK Department for International Development

HALIMA SHARIFF,
Johns Hopkins University Center for Communications Programs

DR. S K SIKDAR,
Ministry of Health and Family Welfare, India

VINCENT SNIJDERS,
Government of Netherlands, Netherlands

FATIMATA SY,
IntraHealth International

MARKET DYNAMICS WORKING GROUP (MD WG)

The Market Dynamics Working Group will improve the availability, affordability, and variety of quality family planning methods.

CO-LEAD -
JOHN SKIBIAK,
Reproductive Health Supplies Coalition

CO-LEAD -
ALAN STAPLE,
Clinton Health Access Initiative

SHARAD AGARWAL,
Hindustan Latex Family Planning Promotion Trust, India

FRANCOISE ARMAND,
Abt Associates

WOLFGANG BECKER JEZUITA,
Bayer Pharma AG

TRACEY BRETT,
Marie Stopes International

KRISHNA JAFA BHUSHAN,
Population Services International

FABIO CASTANO,
Management Sciences for Health

LESTER CHINERY,
Concept Foundation

LESTER COUTINHO,
The David & Lucile Packard Foundation

JAMES DROOP,
UK Department for International Development

IMANOL ECHEVARRIA,
Pfizer

MARCEL HENDRICKS,
I+ Solutions

THOMAS HOW,
International Planned Parenthood Federation

VENKATESWARAN IYER,
Famy Care Limited

YONG LI,
Zizhu Pharmaceuticals

BEATRICE MUTALI,
Merck

NORA QUESADA,
John Snow Inc.

MARK RILLING,
U.S. Agency for International Development

SANGEETA RAJA,
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TRISHA WOODS SANTOS,
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The Performance Monitoring & Accountability Working Group will enable the data collection and analysis necessary to bolster accountability for implementing financial, policy and programming commitments.

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DR. ELIYA ZULU,
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The Rights & Empowerment Working Group will provide guidance and support to all FP2020 Working Groups on rights-based approaches to family planning.

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Population Action International

CO-LEAD - SIVANANTHI THANENTHIRAN,
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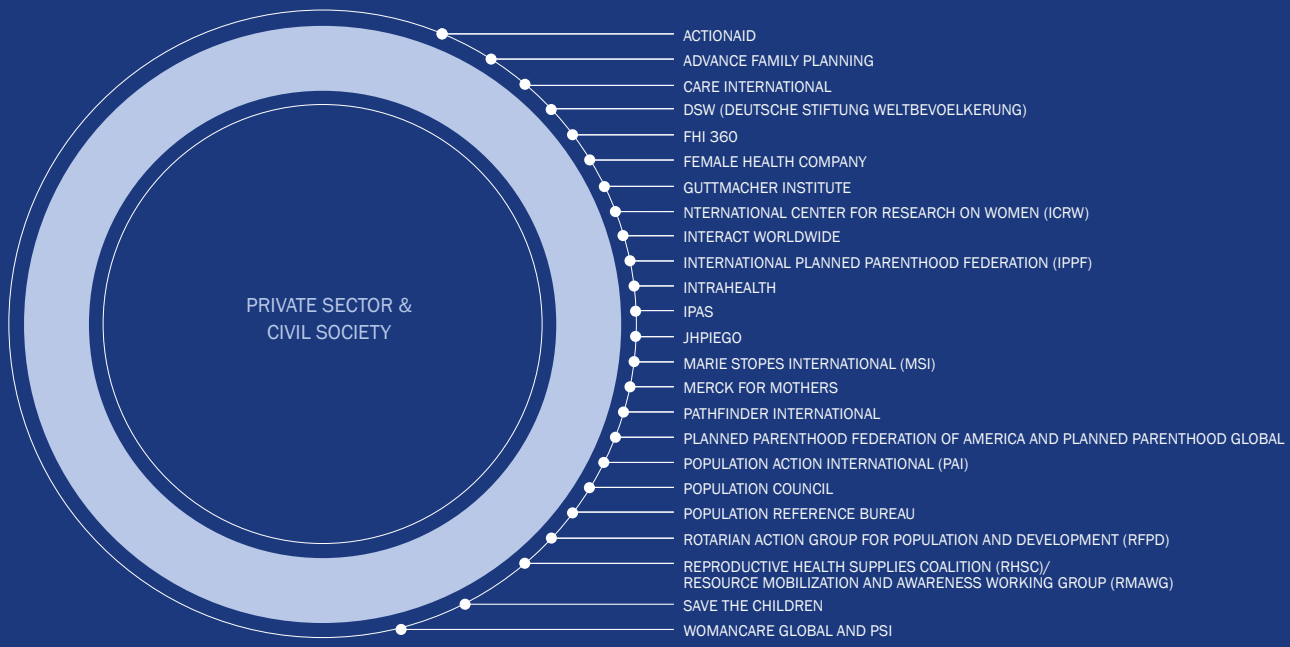
Working Group Manager

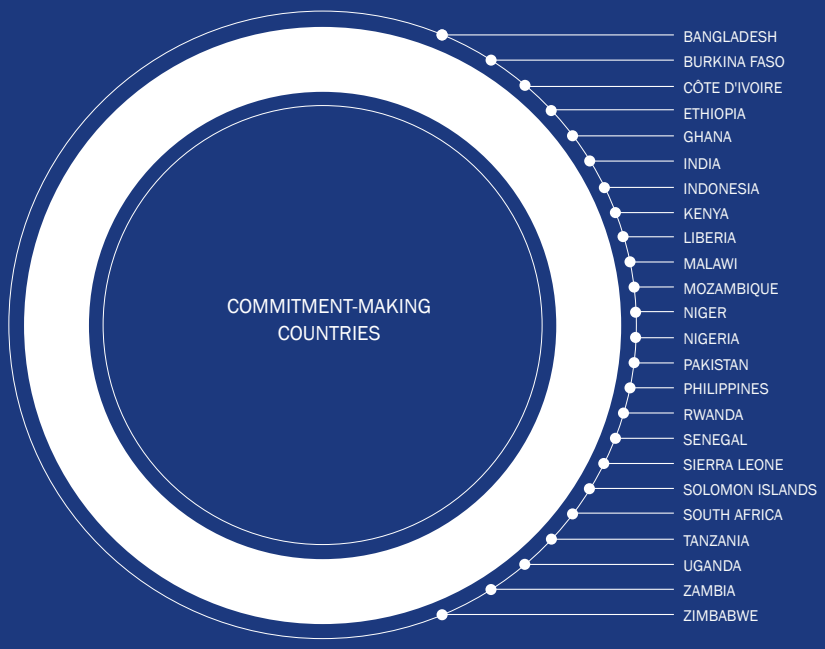
EMILY SMITH,
Program Associate

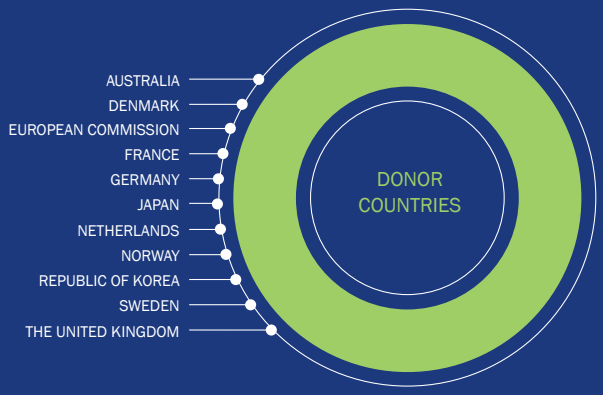
ERIKA STUDT,
Working Group Associate

Stephanie Freid-Perenchio
photography/SFP STUDIO

ANNEX 2 COMMITMENT MAKERS
As of October, 2013



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NETHERLANDS
NORWAY
REPUBLIC OF KOREA
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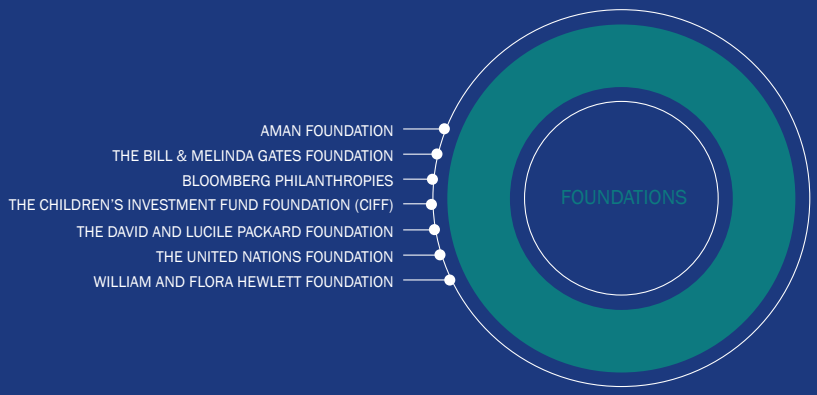
DONOR COUNTRIES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THE CHILDREN'S INVESTMENT FUND FOUNDATION (CIFF)
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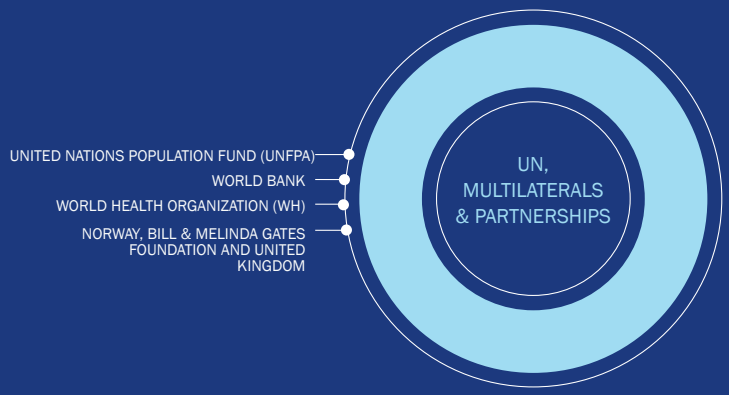
WILLIAM AND FLORA HEWLETT FOUNDATION
FOUNDATIONS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WORLD BANK
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NORWAY, BILL & MELINDA GATES FOUNDATION AND UNITED KINGDOM
UN, MULTILATERALS & PARTNERSHIPS

ANNEX 3
List of 69 Poorest Countries

List of the 69 poorest countries in the developing world by region and sub-region (with 2010 gross national per capita annual income less than or equal to US $2,500)

EASTERN AFRICA
Burundi
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Madagascar
Malawi
Mozambique
Rwanda
Somalia
Uganda
Tanzania, United Rep. of
Zambia
Zimbabwe

MIDDLE AFRICA
Cameroon
Central African Republic
Chad
Congo
Congo, Dem. Rep. of the
Sao Tome and Principe

SOUTHERN AFRICA
Lesotho

WESTERN AFRICA
Benin
Burkina Faso
Côte d'Ivoire
Gambia
Ghana
Guinea
Guinea-Bissau
Liberia
Mali
Mauritania
Niger
Nigeria
Senegal
Sierra Leone
Togo

NORTHERN AFRICA
Egypt
Sudan
Sudan, South
Western Sahara

EASTERN ASIA
Korea, Dem. Rep. of
Mongolia
Central Asia
Kyrgyzstan
Tajikistan
Uzbekistan

SOUTH ASIA
Afghanistan
Bangladesh
Bhutan
India
Nepal
Pakistan
Sri Lanka

SOUTH-EASTERN ASIA
Cambodia
Indonesia
Lao People's Dem. Rep.
Myanmar
Philippines
Timor-Leste
Viet Nam

WESTERN ASIA
Iraq
Palestinian Territory, Occupied
Yemen

CARIBBEAN
Haiti

CENTRAL AMERICA
Honduras
Nicaragua

SOUTH AMERICA
Bolivia

OCEANIA
Melanesia
Papua New Guinea
Solomon Islands

ABBREVIATIONS

AUSAID	Australian Agency for International Development
AFP	Advance Family Planning
BMGF	Bill & Melinda Gates Foundation
CE WG	Country Engagement Working Group (FP2020)
CH	Child Health
CHW	Community Health Worker
COIA	Commission on Information and Accountability
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
CYP	Couple-Year of Protection
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DRC	Democratic Republic of Congo
EWEC	Every Woman Every Child
FP	Family Planning
FP2020	Family Planning 2020 initiative
FPEI	Family Planning Effort Index
ICPD	International Conference on Population and Development
IERG	Independent Expert Review Group
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
IPPF	International Planned Parenthood Federation
KFF	Kaiser Family Foundation
LARC	Long Acting Reversible Contraceptive
MADDS	Mobile-Assisted Data and Dissemination System
MAF	MDG Acceleration Framework
MCPR	Contraceptive Prevalence Rate, Modern Methods
MDG	Millennium Development Goals
MD WG	Market Dynamics Working Group (FP2020)
M&E	Measurement and Evaluation
MH	Maternal Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NFPCI	National Family Planning Composite Index
NGO	Non-Governmental Organization
NHA	National Health Account
NIDI	Netherlands Interdisciplinary Demographic Institute
ODA	Official Development Assistance
OECD DAC	Organization for Economic Cooperation and Development's Development Assistance Committee
PMA WG	Performance, Monitoring, and Accountability Working Group (FP2020)
PMA2020	Performance, Monitoring, and Accountability 2020 (Project)
PMNCH	Partnership for Maternal, Newborn, and Child Health
RH	Reproductive Health
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
RG	Reference Group (FP2020)
RMNCH+A	Reproductive, Maternal, Newborn, and Child Health plus Adolescents
RE WG	Rights and Empowerment Working Group (FP2020)
SHA	System of Health Accounts
SOP	Standards of Practice
SRH	Sexual and Reproductive Health
TFR	Total Fertility Rate
UN	United Nations
UNF	United Nations Foundation
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization

FP2020

WWW.FAMILYPLANNING2020.ORG

Family Planning 2020 (FP2020) is a global partnership that supports the rights of women and girls to decide, freely, and for themselves, whether, when, and how many children they want to have. FP2020 works with governments, civil society, multi-lateral organizations, donors, the private sector, and the research and development community to enable 120 million more women and girls to use contraceptives by 2020. FP2020 is an outcome of the 2012 London Summit on Family Planning where more than 20 governments made commitments to address the policy, financing, delivery and socio-cultural barriers to women accessing contraceptive information, services and supplies. Donors also pledged an additional US$2.6 billion in funding.

Led by an 18-member Reference Group, guided technically by Working Groups, operated daily by a Task Team and hosted by the United Nations Foundation, FP2020 is based on the principle that all women, no matter where they live, should have access to lifesaving contraceptives. FP2020 is in support of the UN Secretary-General's global effort for women and children's health, *Every Woman Every Child*.

UNITED NATIONS FOUNDATION

WWW.UNFOUNDATION.ORG

The United Nations Foundation builds public-private partnerships to address the world's most pressing problems, and broadens support for the United Nations through advocacy and public outreach. Through innovative campaigns and initiatives, the Foundation connects people, ideas, and resources to help the UN solve global problems. The Foundation was created in 1998 as a U.S. public charity by entrepreneur and philanthropist Ted Turner and now is supported by global corporations, foundations, governments, and individuals.

CORE PARTNERS

FP2020 PARTNERSHIP IN ACTION ACKNOWLEDGEMENTS

FP2020 Partnership in Action benefited from many individuals and organizations whose assistance proved invaluable in creating this report. We are deeply grateful for the guidance and support of our partners at the UK Department for International Development, the Bill & Melinda Gates Foundation, the United Nations Population Fund, and the United States Agency for International Development. We wish to acknowledge in particular the Performance Monitoring & Accountability (PMA) Working Group co-leads Zeba Sathar (Population Council) and Marleen Temmerman (World Health Organization), as well as the focal points of the PMG Working Group sub-group on indicators Win Brown (Bill & Melinda Gates Foundation) and Michelle Weinberger (Marie Stopes International) for their substantive inputs and review of the measurement section of this report. Tremendous thanks to Bridget Anyafulu of the International Centre for Women's Empowerment and Child Development and member of the Rights & Empowerment Working Group for reminding us why women need to remain at the heart of global development.

Special thanks to Advance Family Planning, Bill & Melinda Gates Institute for Population and Reproductive Health at the Johns Hopkins Bloomberg School of Public Health, Futures Institute, the International Planned Parenthood Federation, the Kaiser Family Foundation, Marie Stopes International, Pathfinder International, and Women Deliver for providing the insights and research that helped us to more clearly depict the global family planning landscape.

Additionally, we are grateful to humanitarian documentary photographer, Stephanie Freid-Perenchio, for generously donating her photographs for use in this report. In the course of her career, Stephanie has explored Africa's tribal cultures and its endangered wildlife, has born witness to the impact of war on women and children in Afghanistan, and has honored U.S. Navy SEALs and their families in her published book of photographs, SEAL: The Unspoken Sacrifice. To view more of Stephanie's work please visit www.stephaniefreidperenchio.com.

Finally and fundamentally, our deep appreciation goes to the women who shared details of their lives to inform this research, and to the countries that strive to better the lives of women, girls and families by advancing access to family planning worldwide.

FEEDBACK

FP2020 holds the strong belief that the family planning community's biggest asset is the energy and passion of its leaders, experts, advocates and implementers. This progress report documents only a portion of the incredible work being done by partners. If you have any questions or comments about the contents of this report we welcome your feedback via email at **info@familyplanning2020.org**.

We also strongly encourage partners to share their progress stories with us so we may promote them to the family planning community through the FP2020 website, newsletters and social networks.

Stephanie Freid-Perenchio
photography/SFP STUDIO