FP2020 PARTNERSHIP IN PROGRESS

2013–2014

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Cover Photo: Shina Yasini and other women wait to receive family planning counseling—Gungu Health Center, Kigoma, Tanzania, August 2014

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FP2020 PARTNERSHIP IN PROGRESS

2013–2014

ISSUED NOVEMBER 2014
AMENDED DECEMBER 2014

Since the London Summit, an unprecedented number of countries have demonstrated their commitment and leadership on family planning by developing national family planning strategies and committing new resources to support them. More women than ever have access to the tools and information they need to plan their families, which will help them reach their full potential and generate a ripple effect that will allow whole communities to prosper.

Melinda Gates
Co-Chair, Bill & Melinda Gates Foundation

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EXECUTIVE SUMMARY

All women and girls have the right, and must have the means, to decide freely and for themselves whether and when to have children. Access to voluntary family planning leads to transformational benefits across the development spectrum, and is one of the smartest investments a country can make in its future. At the 2012 London Summit on Family Planning, leaders from around the world committed to expanding contraceptive access to an additional 120 million women and girls in the world's 69 poorest countries by the year 2020. Family Planning 2020 (FP2020) is the movement that carries this global effort forward.

In the two years since the London Summit, FP2020 has made remarkable progress. The first year was a period of formation; the second has been one of growing momentum and measurable results. In this second annual progress report we document the advances made over the past year, including additional commitments from countries, increased disbursements from donors, and progress across multiple sectors. The measurement systems established to track progress are now yielding the first set of annual results.

In November 2013, five more countries made commitments to FP2020, bringing the total number of commitment countries to 29. Additional countries are expected to make commitments before the end of this year. One-half of FP2020 commitment countries now have formal, detailed plans to guide their national family planning strategies, including all nine countries of the Ouagadougou Partnership in francophone West Africa. A dozen FP2020 commitment countries have hosted conferences on family planning in the past year. Profiles for 15 countries are included in this report, illustrating each country's progress toward fulfilling its FP2020 commitments.

In 2013, donor governments disbursed US$1.3 billion in bilateral funding for family planning programs—representing a nearly 20% increase since 2012—as well as US$460 million in core contributions to the United Nations Population Fund (UNFPA). Philanthropic foundations and the private sector followed through on their commitments as well, including allocations for service delivery programs, commodity security, product innovation and access, advocacy, awareness and more. Included in this report are profiles of a cross-section of donors, private sector partners, and civil society organizations, describing their activities in support of FP2020 commitments.

This report also presents our first annual updated estimates for the quantitative indicators we use to measure progress toward the FP2020 goal. In 2013, 8.4 million additional women and girls used modern contraception compared to 2012. While this number is just below our projected benchmark of 9.4 million additional users in the first year, it is still a significant milestone. More women and girls than ever before have access to contraceptives, and the FP2020 collaboration is clearly working. We anticipated that growth would be slowest in the first years of the initiative as countries and partners expand their programs; in many countries, an enormous effort is required simply to maintain existing levels of service. The data show that FP2020 is on the right track and making steady progress; however, we must collectively accelerate our efforts in order to reach 120 million more women and girls by 2020.

FP2020 is on the right track and making steady progress; however, we must collectively accelerate our efforts in order to reach 120 million more women and girls by 2020.

In 2013, across the 69 FP2020 focus countries, we estimate that the use of modern contraception by a total of 274 million women and girls averted 77 million unintended pregnancies, which is two million more unintended pregnancies averted than in 2012. Preventing unintended pregnancies creates substantial health impacts by reducing women's exposure to unsafe abortions and maternal deaths. In 2013, there were 24 million unsafe abortions averted (compared to

23 million in 2012) and 125,000 maternal deaths averted (compared to 120,000 in 2012).

Important progress is being made to overcome barriers and expand access to family planning. This report describes achievements in political advocacy, awareness-raising, youth outreach, market-shaping efforts, supply chain strengthening, service delivery improvements, and technological innovation, with a strong focus on maintaining the rights-based approach at the heart of FP2020.

FP2020 facilitates progress by coordinating and building on existing architecture and frameworks. FP2020 is aligned with United Nations Secretary-General Ban Ki-moon's *Every Woman Every Child* Global Strategy for Women's and Children's Health, and fosters cooperation and strategic alliances among donors, partners, countries, and other stakeholders in the family planning community. An FP2020 focal point network has been established in every commitment-making country, and FP2020 assists in matching countries with the technical and financial resources needed to accelerate progress. Additionally, FP2020 has launched a Rapid Response Mechanism to fund short-term, high-impact projects in response to urgent needs or unforeseen opportunities in FP2020 focus countries.

The commitments made to FP2020 are translating into progress, but there is still much to do. As the global community shapes its post-2015 development agenda, we must keep our focus on the importance of family planning to the lives and health of women and girls—and on its tremendous potential to enable a more prosperous, just and sustainable world.

8.4 MILLION
MORE WOMEN AND GIRLS USING MODERN CONTRACEPTION BRINGING TOTAL USERS IN THE 69 FOCUS COUNTRIES TO 274M WOMEN AND GIRLS

30+ COUNTRIES
MADE COMMITMENTS TO FP2020

77M UNINTENDED PREGNANCIES AVERTED

125,000 WOMEN'S AND GIRLS' LIVES SAVED

IN 2013, DONORS PROVIDED

1.3 BILLION US DOLLARS FOR FAMILY PLANNING

FOREWORD

We live in an age of power and promise. Our capacity to prevent harm and alleviate suffering—to challenge what were once viewed as inevitable conditions of human existence—is unprecedented.

Equally unprecedented—and equally important—is our shared conviction that we can, and must, use this power for the good of all.

The Millennium Development Goals forged a global consensus that we should concentrate our efforts on eight crucial development challenges. Today, at the sunset of the MDG time frame, global poverty has been halved, and 90% of children in developing regions partake in primary education. The likelihood of a child dying before the age of five has been cut in half, and 54% fewer women die from complications due to pregnancy and childbirth. United under the banner of *Every Woman Every Child,* we have improved women's and children's health in the world's poorest countries.

Tragically, one benchmark we are far from reaching is that of achieving, by 2015, universal access to reproductive health. Access to family planning information, services and supplies has not progressed as it should and must.

Herein lies the promise, and the power, of the Family Planning 2020 initiative. FP2020 is galvanizing momentum toward a visionary, achievable goal: expanding access to high-quality contraceptives for 120 million additional women and girls in the world's poorest countries by the year 2020.

The evidence is clear: when women have access to family planning information, services and supplies, their quality of life improves, and entire communities prosper.

There is good news to report. The spirit of collaboration is alive and well: countries are driving progress, and donors delivered US$1.3 billion in funding for family planning in 2013. Additionally, in 2013, there were 8.4 million more women and girls using modern methods of contraception than there were in 2012.

The evidence is clear: when women have access to family planning information, services and supplies, their quality of life improves, and entire communities prosper. When countries provide family planning services to all who want and need them, the result is a cascade of benefits across multiple sectors.

We have arrived at a crucial moment. The progress we've made toward our goal is remarkable, but that progress must accelerate in the next two years if we hope to stay on track. If we revert to business as usual, we will have squandered a precious opportunity to use our collective strength to elevate the most vulnerable among us.

The will to act together, now, to expand access to lifesaving contraceptives for millions of women and girls: this is what FP2020 will deliver. Together, we will succeed.

DR. CHRIS ELIAS

President, Global Development
Bill & Melinda Gates Foundation

DR. BABATUNDE OSOTIMEHIN

Executive Director
United Nations Population Fund

FROM FP2020'S EXECUTIVE DIRECTOR

The 2012 London Summit on Family Planning was a transformational moment. It inspired the FP2020 movement, and now, more than two years later, we are still inspired by the vision of expanding access to contraception to 120 million more women and girls by 2020.

My commitment to improving and expanding family planning began decades earlier. It began before the International Conference on Population and Development, before I worked in family planning centers in Egypt, Greece and Jordan, and before I first volunteered at a Planned Parenthood clinic in the United States.

A deeply personal experience crystallized how the lack of contraception can alter the trajectory of a young woman's life. The ability to decide whether and when to bear a child is one of the most basic human rights. It's a decision that can determine what kind of future a woman will have—and whether she will have one at all. I was fortunate to have the information, services and supplies—and most important, the agency—to decide for myself when I would become a mother. I know how differently my life could have turned out had I not.

Collectively, we have the knowledge and the resources to expand family planning services to nearly all who want them, yet there are still millions of women and girls who go without. Perhaps it is because women and girls are so often left out of decision making. Or perhaps it is because it is easier to disregard sensitive topics of women's empowerment and autonomy. Or perhaps it is because in times of crisis, health interventions that "only" meet the needs of women and girls are not seen as priorities.

FP2020 is more than a goal—it is a promise. A promise to the least fortunate women and girls that we will not forget about their rights and agency, that we won't let contraception get pushed aside because it makes some people uncomfortable.

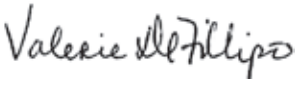
This is why FP2020 is so necessary.

FP2020 is more than a goal—it is a promise. A promise to the least fortunate women and girls that we will not forget about their rights and agency, that we won't let contraception get pushed aside because it makes some people uncomfortable. It's a promise that family planning will not be seen as less important because it "only" affects women and girls, or because there are other, equally urgent health matters.

Last year, 8.4 million more women and girls were able to use modern methods of contraception than the year before. The unique collaboration that is FP2020 required a leap of faith and commitment of effort by so many partners, each of whom played a part in making this possible.

It will not be easy to keep this promise. The road to 2020 is long and arduous. But when we reach our destination, I know we will stand together, millions of us, and look back on what we have accomplished with pride.

VALERIE DEFILLIPO



Executive Director
Family Planning 2020

HIGHLIGHTS OF GLOBAL FAMILY PLANNING PROGRESS 2013–2014

NOVEMBER 2013

- *Third International Conference on Family Planning* is held in Addis Ababa, Ethiopia. Five new country commitments to FP2020 announced: Benin, Democratic Republic of Congo (DR Congo), Guinea, Mauritania and Myanmar
- Zambia launches its *National Family Planning Scale Up 8 Year Plan*
- Ouagadougou Partnership (OP) holds its annual meeting in Addis Ababa

DECEMBER 2013

- Guinea finalizes its *Plan d'Action National de Repositionnement de la Planification Familiale en Guinee 2014–2018*

JANUARY 2014

- The Philippines hosts the *7th Asia Pacific Conference on Reproductive and Sexual Health and Rights* in Manila

FEBRUARY 2014

- FP2020 holds *The Global Stakeholder Meeting*, with video conference and in-person meeting locations in Washington, DC, New York, Seattle, London and Jakarta
- FP2020 Working Group co-leads meet in person in Washington, DC
- DR Congo launches its *Plan Stratégique pour la Planification Familiale: 2014–2020*

MARCH 2014

- Bloomberg Philanthropies fulfills its US$50 million FP2020 pledge. FP2020's Rapid Response Mechanism is established
- FP2020 Country Engagement Working Group holds in-person meeting in Washington, DC
- Advance Family Planning (AFP) hosts its first *Francophone Partners Meeting* in Ouagadougou

APRIL 2014

- The Philippine Supreme Court upholds the Responsible Parenthood and Reproductive Health Act, guaranteeing universal access to contraception, sex education and maternal care
- *Accelerating Contraceptive Choice*, a regional meeting on family planning goals in East Africa, convenes in Nairobi, Kenya
- FP2020 Reference Group holds in-person meeting in Seattle, Washington
- FP2020 Rights & Empowerment Working Group holds in-person meeting in Washington, DC
- *Ouagadougou Partnership Donors Meeting* convenes in Dakar, Senegal
- UNFPA and the Bill & Melinda Gates Foundation sign a memorandum of understanding to boost family planning in developing countries
- OP civil society coalitions meet in Bamako, Mali, to refine their strategy to better contribute to country costed implementation plans (CIPs)

MAY 2014

- FP2020 Performance Monitoring & Accountability Working Group holds in-person meeting in Brussels, Belgium
- Mali launches a national family planning campaign with the theme "Repositionnement de la Planification familiale: les jeunes au cœur des stratégies"
- Tanzania formally launches its *Sharpened One Plan (2014–2015)* to accelerate progress on its FP2020 commitment and the Millennium Development Goals
- Advance Family Planning (AFP) hosts annual partner meeting in Baltimore, Maryland

- FP2020 convenes expert meeting on costed implementation plans (CIPs)

- Togo launches its *Plan d'Action Pour le Repositionnement de la Planification Familiale au Togo 2013–2017*

JUNE 2014

- Tanzania doubles its domestic allocation for family planning from TSh 1 billion (2013/2014) to TSh 2 billion (2014/2015)

- Uganda's National Population Council Bill is signed into law

- *Partnership for Maternal Newborn and Child Health (PMNCH) Partners' Forum* convenes in Johannesburg, South Africa

- Myanmar holds *Family Planning Best Practices Conference*

- *Sécurité Contraceptive en Afrique Francophone* (SECONAF) hosts regional workshop in Dakar on *Total Market Approaches for Family Planning*, with participants from 12 francophone African countries

JULY 2014

- FP2020's Rapid Response Mechanism opens for applications

- Uganda holds national family planning conference in Kampala

- FP2020 stakeholder meeting is held in Nigeria

- Ethiopia holds three-day conference in Addis Ababa to expedite attaining MDG 5, improvement of maternal health

- FP2020 Market Dynamics Working Group holds in-person meeting in London, UK

- Côte d'Ivoire completes its CIP

- Myanmar launches a five-year strategic plan for reproductive health

AUGUST 2014

- 15 county governors in Kenya pledge to accelerate MDG 5, including access to reproductive health care

- SECONAF hosts the annual forum on commodities security in Dakar, Senegal

SEPTEMBER 2014

- Mali launches family planning plan in Bamako

- Tanzania hosts the regional *East Africa Share Fair: Knowledge Exchange to Accelerate Progress Toward FP2020's Goal*

- FP2020 awards first Rapid Response Mechanism grant to the Uganda Protestant Medical Bureau for a faith-based advocacy program to increase contraceptive use

OCTOBER 2014

- *15th Annual RHSC Membership Meeting* convenes in Mexico City, Mexico

- *Network of African Parliamentary Committees of Health (NEAPACOH)* conference convenes in Munyono, Uganda, with the theme "Achieving Family Planning 2020 goals for enhanced demographic dividend in Africa in the post-2015 sustainable development agenda"

NOVEMBER 2014

- FP2020 Reference Group meets in London, UK

- FP2020 releases second progress report and announces 8.4 million additional new users of modern contraception since the *2012 London Summit on Family Planning*

SECTION 1

FAMILY PLANNING 2020

WOMEN AND GIRLS AT THE HEART OF FP2020

Aisha Hassani needed to make a decision. She had just given birth to her first child at the Ujiji Health Care Center, a small rural clinic in western Tanzania. Mother and baby were doing well, but now the nurse was asking an interesting question. Did Aisha want to learn about family planning?

Aisha hesitated. She knew she didn't want to get pregnant again right away; she had seen the tragic toll that unspaced pregnancies and childbearing could take. Her own mother had given birth to 16 children, half of whom died in infancy. The rest had grown up starved for nourishment, with a mother who was always exhausted and weak. Aisha wanted a chance at a different kind of life. She wanted to stay strong and healthy, to go to work and school, and to have a thriving family she could nurture to the fullest.

But she was nervous, too. Back in the village, people said that contraceptives caused cancer. They said that if a woman took contraceptives, she would become permanently sterile. They said other things, too: that only bad, immoral women used contraception; that it was a good woman's duty to bear as many children as possible.

But as the nurse explained how family planning worked and what the different methods were, Aisha's fears began to dissolve. She realized that with modern contraception, she could take charge of her health and have the family she wanted. Aisha and her husband talked over the various methods available, and chose the one that suited them best.

The reaction back home was negative at first. When Aisha's relatives learned that she'd decided to use contraception, they were appalled. Didn't she know how dangerous it was? Didn't she realize she was making a scandal of herself? But Aisha persevered. When she and her husband were ready for their second child, she stopped using contraception and became pregnant again—to her relatives' surprise. Aisha stayed healthy, and so did her children. Her family prospered. The relatives began to realize they had been wrong.

Today, Aisha is a champion for family planning. She is a role model for others in her village, and helps to raise awareness about the benefits of contraception.

"The strength of the women in my community," she says, "is the ability to sustain themselves—to persevere. If given the opportunity, they can work hard and live strong lives. And all women deserve the right to do so."

FP2020 traveled to Tanzania in August 2014 to document the impact of family planning programs in the Western and Lake Regions. The team visited a number of health care facilities supported by Bloomberg Philanthropies, USAID and UNFPA. They also spoke with several policymakers, health care providers and clients. This report captures many of the individual stories of the people who are on the frontlines of progress in Tanzania.

Aisha Hassani
Photo by Dominic Chavez/FP2020

FAMILY PLANNING 2020

Hope has many faces. It is the face of a woman in Tanzania who has borne seven children and finally, for the first time in her life, has access to modern contraception. It is the face of an Ethiopian teenager, married off as a child, who decides to postpone her second baby until she can finish school herself. It is the face of a farmer in Ghana who wishes for only as many children as her small plot of land can support. It is the face of a new bride in Pakistan who plans and saves for the future, confident that she will not get pregnant before she and her husband are ready to start a family.

Family planning is about hope. It is about health, for oneself and one's children. And it is fundamental to ensuring and protecting reproductive rights.

At the 2012 London Summit on Family Planning, leaders from around the world gathered to renew their commitment to that right. Governments, NGOs, multilaterals, civil society and the private sector all converged on the idea that it was time—past time—to put women's reproductive health front and center on the global agenda. They recognized that family planning is both a basic right and a transformative intervention: that it is the key that unlocks our ability to reach our development goals.

When women are able to decide for themselves whether and when to have children, everyone benefits. Women are healthier, more prosperous, and have greater opportunities to pursue education and careers. Their children are stronger, better nourished and more successful in school. Families and communities can invest more in education and health care. Poverty is reduced; lives are saved. Yet despite these well-known and compelling benefits, more than 200 million women across the globe still lack access to modern, effective methods of contraception.

Family planning is about hope. It is about health, for oneself and one's children. And it is fundamental to ensuring and protecting reproductive rights.

Leaders at the London Summit agreed on an ambitious objective: to expand contraceptive access to an additional 120 million women and girls in the world's 69 poorest countries by the year 2020. More than 70 governments, civil society organizations, and private sector entities made commitments at the Summit, and donors pledged billions of dollars. FP2020 is the movement that coordinates and carries forward this enormous international effort.

In the two years since London, FP2020 has made important strides. The first year was a period of formation, in which alliances were built, benchmarks were agreed upon, Working Groups and a Task Team were formed, and the measurement tools needed to track progress were established. Now, in the second year, the momentum has continued to build:

- **In 2013**, the number of women and girls using modern contraception in the 69 focus countries rose by 8.4 million, as compared to 2012. That means 8.4 million more women and girls were able to space their childbearing or prevent pregnancy, as they saw fit. It also means that an additional 2 million unintended pregnancies were averted, 1 million unsafe abortions were prevented, and 5,000 maternal lives were saved.

- **In 2013,** donor governments followed through with their commitments by providing US$1.3 billion in bilateral funding for family planning programs—representing a nearly 20% increase over 2012—and US$460 million in core contributions to the United Nations Population Fund (UNFPA).[1]

- **In November 2013**, five more countries made commitments to FP2020: Benin, Democratic Republic of Congo, Guinea, Mauritania and Myanmar. That brought the total number of pledging countries to 29, representing 40% of the world's 69 poorest countries and 80% of women with unmet need for contraception. And more country commitments are expected before the end of 2014.

- **Since November 2013**, eight more countries have launched national implementation plans for family planning. Fully one-half of all FP2020 commitment countries now have formal, detailed plans in place to guide their family planning strategy, including all nine countries of the Ouagadougou Partnership.

- **In the past year,** a dozen FP2020 commitment countries have hosted national or regional conferences on family planning. Myanmar and Uganda, two countries that had never before committed to family planning, held their first-ever national conferences in 2014.

- **FP2020** has established a network of focal points in every commitment-making country. In keeping with FP2020's intention not to duplicate existing global architecture, the focal points are representatives of agencies already in-country: UNFPA, the United States Agency for International Development (USAID), and the UK Department for International Development (DFID). FP2020 has also developed a protocol for matching country needs with technical and financial resources.

FP2020 is not about numbers. FP2020 is about women and girls. It is about empowering women and girls with health, choice, and opportunity.

- **In July 2014,** FP2020 launched the Rapid Response Mechanism (RRM), opening up a dynamic new source of funding for FP2020 focus countries. The RRM disburses grants for short-term, high-impact projects in response to urgent or unforeseen opportunities. The first RRM grant was issued in September 2014 for a faith-based family planning advocacy program in Uganda.

- **FP2020** continues to cultivate the global conversation on family planning, maintaining the collaborative spirit of the London Summit. In February 2014, the Task Team conducted a Global Stakeholder Consultation in Washington, DC, with simultaneous in-person events in Jakarta, London, New York and Seattle. FP2020 has also begun developing a new interactive web platform that will foster dialogue and increase knowledge-sharing.

These are milestone achievements, but they are not the only successes from the past year. This report contains many profiles of progress: advances in technology, breakthroughs in funding, triumphs in policy. There are stories of individual service providers who are making a difference in their communities. There are snapshot summaries of progress at the country level, and illustrations of how governments, donors, and partners are coming together in new and exciting ways.

There are also reminders throughout this report that FP2020 is about more than just increasing the number of family planning users. Despite all the measurements and statistics, FP2020 is not about numbers. FP2020 is about women and girls. It is about empowering women and girls with health, choice, and opportunity. It is, ultimately, about making sure that every woman and every girl has the right, and the means, to shape her own life—to grow, to thrive and to plan the family she wants.

1. Kaiser Family Foundation.

It's great to see the results of the London Summit on Family Planning, with over eight million more girls and women having access to modern methods of contraception. The whole international community needs to keep up the momentum. We are absolutely focused on helping girls and women around the world having choice over when to get married or have children, having the voice to get the support they need, and having control over their own health and livelihood.

The Right Honourable Justine Greening,
Secretary of State for International Development, United Kingdom

SECTION

COMMITMENTS

Deciding about pregnancy should be by choice, not by chance. Having the information and means to do so is a basic human right. Family planning is one of the best investments that we can make for women's empowerment, gender equality, sustainable development and creating the future we want.

Dr. Babatunde Osotimehin,
Executive Director, UNFPA

Photo by Dominic Chavez/FP2020

At the heart of the FP2020 movement are the commitments: formal pledges by countries, donors and an array of partners to work toward expanding access to family planning.

The commitments are specific statements of intent, outlining what actions will be undertaken and how much money will be spent. As such they are the engine that drives progress forward—and they are crucial to accountability.

When countries make a commitment to FP2020, they join a global community of donors, experts, advocates and implementers. FP2020 is an action-oriented partnership that accelerates the process of matching funds, technical expertise and other resources with critical programmatic needs.

In this section we present progress updates on commitments made by countries, donors, civil society organizations and the private sector. Most of these updates are based on self-reports provided by the commitment makers themselves, buttressed where appropriate with external analysis.

COUNTRIES

FP2020 aims to expand access to family planning information, services and supplies to women and girls in the world's 69 poorest countries.[2] At the 2012 London Summit, 24 of those countries made formal commitments to FP2020.[3] In November 2013, five more countries made commitments, bringing the total number of pledge countries to 29. Each country's commitment includes specific financial, policy, and programmatic pledges that will help expand access to contraceptives.

In preparation for this progress report, each commitment-making country was invited to provide updates on progress made toward fulfilling its pledges. These reports took two forms: interviews conducted by SEEK Development on behalf of FP2020 and the Partnership for Maternal, Newborn & Child Health (PMNCH); and FP2020 self-report questionnaires.

In this section we present summaries of those updates.[4] Where appropriate, the material is augmented by additional information from donors and partners. Each country's report is prefaced by a synopsis of its FP2020 commitment; the full commitments are viewable on the FP2020 website.

In future years, FP2020's interactive web platform—currently in development—will make the reporting process even simpler and more transparent. Commitment makers will be able to provide progress updates online, and stakeholders will have the opportunity to post additional information and reports.

2. These countries are defined as those with a gross national income (GNI) per capita of $2,500 per year or less (based on the World Bank 2010 classification using the Atlas method).

3. South Africa made an FP2020 commitment, but its GNI does not qualify it as one of the world's poorest countries (based on the World Bank 2010 classification using the Atlas method).

4. FP2020 obtained progress updates for 15 countries. Thirteen are summarized in this section.

BURKINA FASO

Burkina Faso is currently implementing a strategic plan to secure reproductive health supplies (2009–2015) with the support of the UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). The government has also increased its budget allocation for family planning, from US$0.9 million in 2008 to US$3 million in 2013.

Massive efforts have been put in place to scale up community-based distribution of contraceptives. The government provides free contraceptives to health centers, and UNFPA-supported community organizations distribute the contraceptives and raise awareness about family planning. Last year, women in over 3,200 villages obtained contraceptives through community-based distribution agents.

In 2013, UNFPA partnered with the local Planned Parenthood affiliate (Association Burkinabè pour le Bien-Être Familial, or ABBEF) and Marie Stopes International to bring mobile clinics to marginalized populations in two regions of the country. UNFPA has also partnered with Jhpiego to launch a postpartum family planning project in 20 health facilities. The Jhpiego project focuses on providing intrauterine devices (IUDs), thus bringing long-term methods of family planning within reach of more women.

Source: UNFPA.

GHANA

At the 2012 London Summit on Family Planning, the government of Ghana pledged to make contraception free in the public sector. In 2013, the government made a step toward fulfilling this commitment by adding contraception to the list of free services provided to women as part of maternal health care. The Ghana Health Service is currently developing a package of family health services that will have key family planning interventions; all interventions in the package will be free of charge.

In the last three years, Ghana has broadened the range of family planning methods that are available, adding IUDs and implants. Nurses are now authorized to offer contraceptive implants, and the Ghana Health Service is considering task-shifting this to additional community health workers.

Efforts to increase family planning counseling have been stepped up, and new campaigns for adolescents and adolescent-friendly services are being developed. An additional 1,300 midwives were trained last year, an increase over prior years.

Source: Ghana Health Service, via SEEK interview.

INDIA

Currently, donor funding accounts for less than 0.3% of India's total health expenditure. India seeks only technical assistance and support from development partners, not funding.

Family planning in India has undergone a paradigm shift, away from the old sterilization-centric emphasis on population control. Family planning is now understood as a critical intervention to improve health and reduce maternal and child mortality. The emphasis is on increasing the basket of choices available to women and on providing information, services and supplies. There is also a focus on other social determinants of health, such as education for all and increasing literacy among girls. To expand family planning access to an additional 48 million women by 2020, India has prepared detailed national and state plans. Scorecards have been introduced for states and high-priority districts to report key indicators on a quarterly basis.

Nearly 900,000 community health workers are distributing contraceptives to households and counseling newly married couples on birth spacing. India has improved the basket of choices of modern contraceptives by introducing a new device (Cu IUCD 375) with five years' efficacy. The postpartum intrauterine contraceptive device has also been introduced.

A new community-based program has been launched with an integrated focus on adolescent health, including the reduction of teen pregnancies. The program is preventive in approach and goes beyond traditional sexual and reproductive health to bring into its ambit five new areas of programming: nutrition, mental health, injuries and violence, substance misuse and non-communicable diseases.

Source: India Ministry of Health and Family Welfare, via SEEK interview.

INDONESIA

Indonesia rolled out universal health coverage at the beginning of 2014. Family planning efforts are delivered through provincial and regional family planning offices. Through coordinated funding mechanisms disbursed from the National Office of Population and Family Planning, family planning is offered at a very low rate, thus making it accessible to the public.

The government reports that funding trends for reproductive, maternal, newborn and child health (RMNCH) are moving in a positive direction. The level of awareness among national and subnational leaders on the importance of health has increased, and this directly affects budget allocation.

In August 2014, the Indonesian National Population and Family Planning Board (BKKBN) signed a Memorandum of Understanding with the Johns Hopkins Bloomberg School of Public Health to revitalize the national family planning program. The partnership will focus on four areas: co-hosting the 4th International Conference on Family Planning, to be held in Jakarta in November 2015; dovetailing BKKBN's family welfare surveys with data-gathering by Performance Monitoring & Accountability 2020 (PMA2020); expanding the success of Advance Family Planning's local, evidence-based advocacy approach; and implementing the *Right Time. Right Method. My Choice*. Partnership to reinvigorate family planning through a demand-supply initiative and leadership development.

Source: Special Envoy of the President of the Republic of Indonesia on the Millennium Development Goals, via SEEK interview; Johns Hopkins Bloomberg School of Public Health.

KENYA

In 2012, the government of Kenya committed to reviewing policy barriers that impede access to contraceptives at community-level health facilities. The Ministry of Health has followed through by issuing revised guidelines allowing community health workers to provide Depo-Provera®. The government has also followed through with its commitment to initiate reforms at the Kenya Medical Supply Agency (KEMSA), transforming it into an authority to give it operational autonomy from the Ministry of Health. The government is now seeking seed money for KEMSA to procure family planning commodities as a revolving fund.

To increase accessibility to family planning services, Kenya has scaled up its health voucher system to four rural and two urban districts. After the re-launch of the family planning campaign in February 2012, the government also scaled up advocacy and awareness activities at the county level to build support and create demand for family planning. Ongoing activities include forums that involve political and executive leaders at the county level and messages aired on local radio and television stations.

The government is also making progress toward its goal of having one Youth Empowerment Center in each constituency to serve as a one-stop shop for youth-friendly information, including family planning. In 2012 there were over 70 Youth Empowerment Centers in operation; now there are 118, with 28 more at various stages of construction.

Source: Kenya National Council for Population and Development, via FP2020 self-report.

MALAWI

The government of Malawi followed through with its commitment to create a family planning budget line in the 2013/2014 budget, and in April 2014 procured 118,000 vials of depot medroxyprogesterone acetate (DMPA). The budget allocation is set to increase in the 2014/2015 fiscal year.

The *Evaluation of Youth-Friendly Health Services in Malawi* (a collaboration between the Ministry of Health, USAID, Evidence to Action and the University of Malawi) was published in June 2014, and the government plans to develop a Sexual and Reproductive Health and Rights strategy for young people. Beginning in September 2014, the primary school curriculum will include age-appropriate sexual and reproductive health information as part of life skills education.

In response to the commitment made in 2012 to strengthen policy leadership, the Reproductive Health Unit within Malawi's Ministry of Health was elevated to a full directorate in December 2012. The national population policy, which was in draft form at the time of the London Summit, was approved in 2013. Currently the government is finalizing consultations on the policy implementation plan.

With financial and technical support from partners, the Ministry of Health is working to ensure an effective and integrated supply chain system for reproductive health commodities, with a focus on improved forecasting and data management. Family planning commodities are being supplied to health facilities using a push system based on Logistics Management Information System reports from each district. By February 2014, stock-out reports were less than 10%.

Malawi has not yet achieved its commitment to raise the legal age for marriage to 18 years. Advocacy sessions have been held with different groups on this topic, and chiefs have since signed a communiqué committing themselves to work with the government to advocate for this change.

Source: Malawi Ministry of Health, via FP2020 self-report.

NIGER

The government of Niger reports that its expenditures on family planning remained flat through 2013, but that it is on track to reach its goal of quadrupling the family planning budget in 2014. Donor funding has increased for health and for RMNCH, especially family planning. However, the government is still working to mobilize resources for the 2013–2020 National Action Plan.

Injectables are now included in the methods that can be provided by community health workers. The Ministry of Health is developing a project with Orange Niger (the telecommunications company) to introduce a mobile program for providing improved postpartum care for pregnant women.

The Ecole des Maris (Schools for Husbands) are considered very successful and are now nationally scaled up with the support of UNFPA (increasing from 11 in 2007 to 610 at the end of 2013; more will continue to be added). The Ministry of Health reports an increase in the use of family planning in the areas with the schools.

The number of youth centers has doubled from 25 to 50 since 2010. At the centers, youth can organize activities, hold discussions and access information on reproductive issues and family planning. Family planning information has been integrated into the school health curriculum in Niger's capital, but contraceptive methods are not yet being offered.

The Ministry of Health is conducting yearly contraceptive coverage surveys—tracking 41 indicators—in all the regions of the country. Software has been implemented in 42 districts to monitor commodities and identify bottlenecks and stock-outs.

Source: Niger Ministry of Health, via SEEK interview.

SIERRA LEONE

Sierra Leone is strengthening its supply chain for family planning commodities with the help of UNFPA's GPRHCS. The 2013 Reproductive Health Commodity Security survey found that more than half of the service delivery points in the country experienced no stock-outs of contraceptives during the last six months of 2013—the first time that has happened. That same survey also found that the percentage of service delivery points offering at least three modern methods of contraception has jumped from 80.5% in 2011 to 96.5% in 2013. Supply chain monitoring and tracking is provided by the civil society organization, Health For All Coalition, with the support of UNFPA.

UNFPA's implementing partner, Marie Stopes Sierra Leone, continues to provide integrated sexual and reproductive health outreach services in hard-to-reach areas. In 2013 Marie Stopes delivered these services by boat to 30,000 inhabitants in the Bonthe Islands, one of the most isolated areas of the country. UNFPA also partnered with the government of Sierra Leone, Marie Stopes and the Health For All Coalition to distribute free family planning products in all 11 chiefdoms of the Bonthe district, including the municipality.

The development of a five-year teenage pregnancy prevention strategy—coordinated by UNFPA under the leadership of the Office of the President of Sierra Leone, in collaboration with other United Nations agencies, government officials and NGOs—has been pivotal in reaching out to young people. UNFPA has also partnered with Population Media Center to air 208 episodes of an entertaining and educational radio drama about sexual and reproductive health issues, including family planning.

Source: UNFPA.

UGANDA

The government of Uganda reports that beginning with the 2014/2015 fiscal year, it has increased its allocation for family planning supplies to US$6.9 million. It has also successfully mobilized an additional US$5 million in donor financing from development partners, primarily UNFPA, USAID and DFID. The National Population Council bill was signed into law in June 2014 and will create a new government body to oversee the country's population, reproductive health and family planning policies. The government is currently in negotiations to develop a voucher program as a form of demand-side financing for family planning and safe motherhood services among the poor. A national health insurance bill is under consideration by the Cabinet.

The Ministry of Health has increased its staffing levels, and mentoring of health workers to offer reproductive health services is ongoing. Village health teams are being mobilized to provide family planning in rural areas, including injectable contraceptives. Youth-friendly services have been scaled up to 50% of the government's Level IV Health Centres and 100% of district hospitals. The government also reports that, with the assistance of its development partners, support has been provided for midwife training, recruitment, symposia and skills lab equipment.

An alternative commodity distribution channel is in place for the private sector through the Uganda Health Marketing Group. The National Drug Authority has been equipped with an additional testing machine to help reduce delays in the post-shipment release of family planning supplies.

Uganda is implementing the Reproductive Maternal, Newborn, and Child Health Sharpened Plan for Uganda, with the goal of improving progress toward MDGs 4 and 5. The plan was launched in November 2013.

Source: Uganda Ministry of Health, via FP2020 self-report.

ZAMBIA

The government reports that its expenditure on family planning increased by 70% from 2012 to 2013. Many more development partners are now offering support, primarily with RMNCH, and there is a strong presence from DFID, USAID and UNFPA. Zambia has a significant skills gap and needs more funding for human resources.

The Ministry of Health is collaborating with John Snow, Inc. (JSI) to strengthen the supply chain for family planning commodities. JSI and the Ministry of Health have recruited a reproductive health logistician and trained 10 provincial pharmacists. Commodity availability is reported to be 100%, with no stock-outs.

The Ministry of Health is working with Jhpiego on a fast-track scale-up of contraceptive implants. In 27 of 72 districts, community health assistants have been trained on implant insertion and counseling. Task-shifting is also being piloted with volunteer community-based distributors.

Zambia is working with chiefs and traditional leaders to increase demand and sensitization. Preliminary data collected for the country scorecard indicate that there is increased demand, especially in areas where there are community-based distributors and active dialogue with traditional leaders has been conducted. The Ministry of Health is still searching for a model to use to engage religious leaders.

Early this year, the government of Zambia approved its first-ever budget line for reproductive health supplies, including contraceptives. The government allocated US$9.3 million for fiscal year 2014 to supplies. Planned Parenthood Association of Zambia was a leading voice in making the case for the budget line, with an advocacy grant from the Opportunity Fund, a flexible source of funding for family planning advocacy managed by Population Action International for Advance Family Planning.

Sources: Zambia Ministry of Health, via SEEK interview; the Bill & Melinda Gates Institute for Population and Reproductive Health.

A CLOSER LOOK: THE DEMOCRATIC REPUBLIC OF CONGO

Omba is 28 years old and has six children. She only wanted two, but when she got married she knew nothing about contraception. She and her husband are unemployed and worried that they won't be able to feed their large family. Recently, Omba heard about the five-year contraceptive implant. She wishes she could get one but has no money to pay for it.[5]

Omba's situation is typical of women in the DR Congo—but it is a situation the present government has vowed to change. In November 2013, DR Congo took an important step forward by making a powerful, public commitment to FP2020. At the International Conference on Family Planning in Addis Ababa, Mr. Kwete Dieudonné, Advisor to the Prime Minister, delivered the government's inspiring new pledge: to triple the number of women with access to modern contraception, to allocate millions of dollars to family planning and to develop programs and policies that will empower women and protect girls.

In the 12 months since that announcement, the government has moved briskly on its commitments. The first step came with the launch of the Plan Stratégique pour la Planification Familiale 2014–2020, unveiled in February 2014. The plan lays out the roadmap for the next six years, with detailed objectives, timetables and clear guidelines for budget allocations and policy provisions. It was the result of painstaking collaboration between the government and numerous stakeholders—NGOs, religious institutions, donors, and the private sector—and represents a genuinely workable vision for the future.

Development partners are stepping up, too. In DR Congo, international donors play a major role in supporting family planning activities. USAID and UNFPA are the largest donors, with important support also provided by the Government of Canada, DFID and the World Bank. Private foundations, including the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation, furnish significant funding as well.

In February 2014, Tulane University announced a new community-based family planning program in Kinshasa. Named the ACQUAL Project (for Access and Quality), the US$1.7 million initiative is funded by the David and Lucile Packard Foundation. Tulane is a longtime development partner of DR Congo, and maintains a detailed website that tracks all the family planning activities in the country. The website even includes an interactive map of clinics and pharmacies in Kinshasa that offer contraceptives.

For DR Congo's ambitious family planning program to succeed, it needs good data. Researchers from the University of Kinshasa School of Public Health and Tulane University are now hard at work mapping contraceptive use across the country. They are using PMA2020, an innovative data-collection project that replaces traditional pencil-and-paper surveys with mobile phone technology. PMA2020's data collectors are local women trained to interview residents and enter the responses into smartphones; the data is then uploaded to a central server. While the legwork can be grueling—the data collectors walk dozens of miles along muddy streets, mapping thousands of homes—the resulting database will be invaluable. PMA2020 issued its first indicator brief for DR Congo in May 2014.

Sources: Bill & Melinda Gates Institute for Population and Reproductive Health; Tulane University School of Public Health and Tropical Medicine; PMA2020.

5. Omba's story is from the Names not Numbers website: http://names-not-numbers.org

Photo by Dominic Chavez/FP2020

A CLOSER LOOK: MYANMAR

The capital of Myanmar is the planned city of Nay Pyi Taw, a vast new metropolis built from scratch in the middle of the country. Gleaming government buildings and color-coded apartment blocks (blue roofs for Ministry of Health employees, green for Ministry of Agriculture) are flanked by acres of scrubland and fields dotted with water buffalo. Modern business-class hotels line the road to the airport.

At one of those hotels, 160 conference delegates gathered this past summer to talk about contraception. The Myanmar Family Planning Best Practices Conference featured panels on everything from condom cue cards for teenagers to the finer points of IUD insertion and removal. Local OB/GYNs compared notes with technical advisors from global NGOs. Terms like "method mix" and "commodity security" peppered the discussions.

Times have changed in Myanmar. After decades of international isolation, the country is rejoining the world community and embarking on modern development goals. Nowhere is the new spirit more evident than in Myanmar's bold commitment to family planning, delivered at the 2013 International Conference on Family Planning in Addis Ababa. Myanmar vowed to halve unmet need for contraception by 2020 and to raise the contraceptive prevalence rate to 60%.

The government has already begun taking concrete steps. The budget for contraceptive commodities was increased from US$1.29 million in 2012/2013 to US$3.27 million in 2013/2014. A five-year strategic plan for reproductive health was launched earlier this year and a national implementation plan was drafted. A working group on family planning was created to coordinate national strategy.

Myanmar pledges to increase the health budget to cover nearly 30 million couples by 2020, and to work toward increasing the resources allocated to family planning in state budgets.

The government has also begun efforts to strengthen supply chains and improve service delivery. UNFPA's GPRHCS is helping to set up a Logistics Management Information System, and pilot projects have already been rolled out to 12 townships. Health care providers are being trained in a greater range of contraceptive methods: state obstetricians and gynecologists are being trained in IUDs, and doctors in private networks are learning about contraceptive implants. Auxiliary midwives are now authorized to dispense oral contraceptive pills and condoms under the supervision of midwives.

In the midst of all this activity, the Best Practices Conference was an important milestone. The three-day conference was designed to make sure that Myanmar benefits from the lessons that have been learned through family planning programs around the world. The Ministry of Health[6] hosted the event, welcoming representatives from the World Health Organization (WHO), UNFPA, the Gates Institute, Stanford University, the Government of Indonesia, and Pathfinder. Teams from 10 townships in Myanmar—medical officers, OB/GYNs, nurses, midwives and NGO partners—provided the local perspective.

On the first day, the international experts led discussions on the global experience with family planning, describing the evidence-based best practices that have emerged. On the second and third days, the township teams described the situation on the ground in Myanmar, identifying the bottlenecks and obstacles that need to be overcome. The conference ended with a set of detailed recommendations for the road ahead.

Sources: Myanmar Ministry of Health, via FP2020 self-report; Pathfinder International.

6. The Myanmar Family Planning Best Practices Conference was organized with the assistance of Pathfinder International, which was also instrumental in securing Myanmar's FP2020 commitment. Financial support for the conference was provided by the David and Lucile Packard Foundation, the 3MDG Fund, FP2020, UNFPA, and WHO. Technical partners included the Bill & Melinda Gates Institute for Population and Reproductive Health, BKKBN of Indonesia, the Futures Group, Myanmar Maternal and Child Welfare Association, Myanmar Partners for Policy and Research, Marie Stopes International, and Population Services International. Merlin/Save the Children, Myanmar Medical Association, Myanmar Nurses and Midwives Association, and Myanmar Women's Affairs Federation were also involved in conference planning.

The announcement of our commitment to FP2020 was an occasion of great hope for Myanmar. Access to contraception is the fundamental right of every woman and community, and we aim to expand family planning services to reach all who need and want them. This journey will not be easy, but thanks to FP2020, we have many partners around the world to help us on our way.

Dr. Thein Thein Htay
Deputy Minister,
Ministry of Health, Myanmar

A CLOSER LOOK: PAKISTAN

In the 1960s, Pakistan was at the vanguard of family planning, becoming one of the first countries in the world to develop a national population policy. In the past two decades, however, that initial wave of progress has stalled. Today only one-fourth of married or in-union Pakistani women use modern contraception.[7]

At the 2012 London Summit on Family Planning, Pakistan committed to increasing the contraceptive prevalence rate to 55% by 2020. The obstacles to success are many—political upheaval, social constraints, women's low status and limited autonomy—yet positive steps are being taken on the national and regional levels.

In the crowded mega-city of Karachi, a new health care program will bring family planning services to one million low-income inhabitants. The Sukh Initiative, which launched in March 2014, will include door-to-door visits from community health workers, 24-hour telephone information lines, postpartum care and counseling in neighborhood clinics, a peer-to-peer awareness campaign, and life skills training for young people. This innovative urban program is a joint partnership between three private foundations—the Pakistan-based Aman Foundation, the Bill & Melinda Gates Foundation and the David and Lucile Packard Foundation—and is implemented by the Karachi-based Aman Health Care Services. The Sukh Initiative is also working closely with the government of Sindh province and other stakeholders to create an enabling environment for family planning.

At the opposite end of the country, in Khyber Pakhtunkhwa province, 110 new Family Welfare Centers are bringing reproductive health care to rural villages. Ministers have begun drafting a bold new population policy for the province, with the goal of doubling contraceptive use in the next 20 years. And next door in Punjab province, a 2013 Population Council study revealed startlingly high levels of enthusiasm for family planning. More than 82% of men and 88% of women expressed approval of contraception, and both men and women told interviewers that they wanted greater access to modern methods.

A jewel in Pakistan's health care landscape is the Lady Health Worker (LHW) program. This army of 100,000 community health workers provides essential frontline services to millions of women and children, dispensing contraceptives, immunizations and other primary care. The workload on the LHWs has increased enormously in recent years, thus one of Pakistan's FP2020 goals is to re-focus priority on the family planning aspect of the program. The government of Sindh province has begun the process, working with the Population Council to develop a comprehensive new training program.

Another bright spot in Pakistan is the new Logistics Modeling Information System (LMIS), implemented with the assistance of the USAID | DELIVER project. LMIS is a web-based system for procurement management, and is part of a whole suite of modernizations USAID has brought to the contraceptive supply chain: barcoding, automated inventory control systems, data visualization and automation of procurement activities. The system has been rolled out nationwide, and health managers in all 143 local districts were able to use it for their 2013–2014 forecasting. Three provincial governments—Sindh, Punjab and Khyber Pakhtunkhwa—have committed more than US$75 million in financing for the next five years.

Pakistan overhauled its constitution in 2010, with the result that responsibility for health policy was shifted from the federal government to the individual provinces. One of Pakistan's FP2020 commitments was to ensure that each province included contraception in its Essential Health Services Package (EHSP); this was achieved in 2013. In January 2014, it was announced that a new National Task Force on Population Welfare would be created at the federal level to help coordinate reproductive health efforts across all provinces.

7. http://dhsprogram.com/publications/publication-fr290-dhs-final-reports.cfm

MOBILIZING RESOURCES TO DRIVE PROGRESS

The 2012 London Summit on Family Planning generated US$2.6 billion in financial commitments from donors, and served as a pivotal moment for the global community to declare that voluntary family planning is one of the best investments a country can make in its future. In fact, family planning is identified in the Global Investment Framework for Women and Children's Health as the intervention with the greatest potential to reduce mortality and generate economic benefits: across 27 countries with very high unmet need for family planning, the economic rate of return from scaling up access to modern contraception from now until 2035 would exceed 8% of their GDP.[8]

This section presents key findings on how donor governments and the private sector are moving forward on their FP2020 commitments. It includes self-reported data and summaries from donors, along with external analyses by the Kaiser Family Foundation, PMNCH and Countdown 2015 Europe.[9]

GLOBAL TRENDS

Disbursements of family planning funds have increased substantially over the past year, and action is being accelerated toward the realization of FP2020 commitments.

The topline findings are:

- Donor governments provided US$1.3 billion for bilateral family planning programs (representing a 19% increase since 2012) and US$460 million in core contributions to UNFPA.[10]
- The US was the largest bilateral donor in 2013, providing US$585 million and accounting for almost half (46%) of total bilateral funding.[11]
- All eight commitment-making donor governments profiled by Kaiser Family Foundation have made progress toward fulfillment of their commitments.[12]
- European donor support to UNFPA increased by nearly 30% from 2009 to 2012, with the UK making a notable surge of investment in line with its commitment at the London Summit on Family Planning. UK support to UNFPA increased from €28 million in 2009 to €94 million in 2012 (an increase of 238%).[13]

These are very encouraging results, but there is still much work to be done. Urgent action must be taken to ensure that donor investments in family planning are not deprioritized upon changes in political leadership or shifts in the economic climate. Support must be given for efforts to monitor progress and hold governments accountable for their family planning commitments.

8. Advancing social and economic development by investing in women's and children's health: a new Global Investment Framework, Karin Stenberg MSc, Henrik Axelson MSc, Peter Sheehan DPhil, Ian Anderson MSc, A Metin Gülmezoglu PhD, Marleen Temmerman PhD, Elizabeth Mason MSc, Howard S Friedman PhD, Prof Zulfiqar A Bhutta PhD, Joy E Lawn PhD, Kim Sweeny PhD, Jim Tulloch MBBS, Peter Hansen PhD, Mickey Chopra MD, Anuradha Gupta MBA, Joshua P Vogel MBBS, Mikael Ostergren MD, Bruce Rasmussen PhD, Carol Levin PhD, Colin Boyle MBA, Shyama Kuruvilla PhD, Marjorie Koblinsky PhD, Neff Walker PhD, Andres de Francisco MD, Nebojsa Novcic MPhil, Carole Presern PhD, Prof Dean Jamison PhD, Flavia Bustreo MD, on behalf of the Study Group for the Global Investment Framework for Women's and Children's Health, The Lancet, 12 April 2014 (Vol. 383, Issue 9925, Pages 1333-1354). doi: 10.1016/S0140-6736(13)62231-X

9. Countdown 2015 Europe is a consortium of 15 leading European nongovernmental organizations working to ensure sexual and reproductive health and rights in developing countries. Countdown 2015 Europe tracks European donor spending on international family planning and works nationally with their own governments to increase support and accountability for family planning and reproductive health.

10. Kaiser Family Foundation.

11. Kaiser Family Foundation.

12. Kaiser Family Foundation.

13. Countdown 2015 Europe.

FINDINGS FROM THE PARTNERSHIP FOR MATERNAL, NEWBORN AND CHILD HEALTH (PMNCH)

The Global Strategy for Women's and Children's Health (Global Strategy) was launched by UN Secretary-General Ban Ki-moon in September 2010, and focuses on accelerating progress toward MDGs 4 (child survival) and 5 (maternal health) in the world's 49 poorest countries.

For the past four years, PMNCH has produced an annual report analyzing commitments to the Global Strategy and its implementation. The 2014 report focused exclusively on financial commitments made during the 2011–2015 time frame. Since there is overlap between commitments to the Global Strategy and to FP2020, PMNCH and FP2020 partnered to gather the data that would inform a financial analysis for the PMNCH 2014 Accountability Report. A subset of this analysis is relevant to FP2020 commitments:

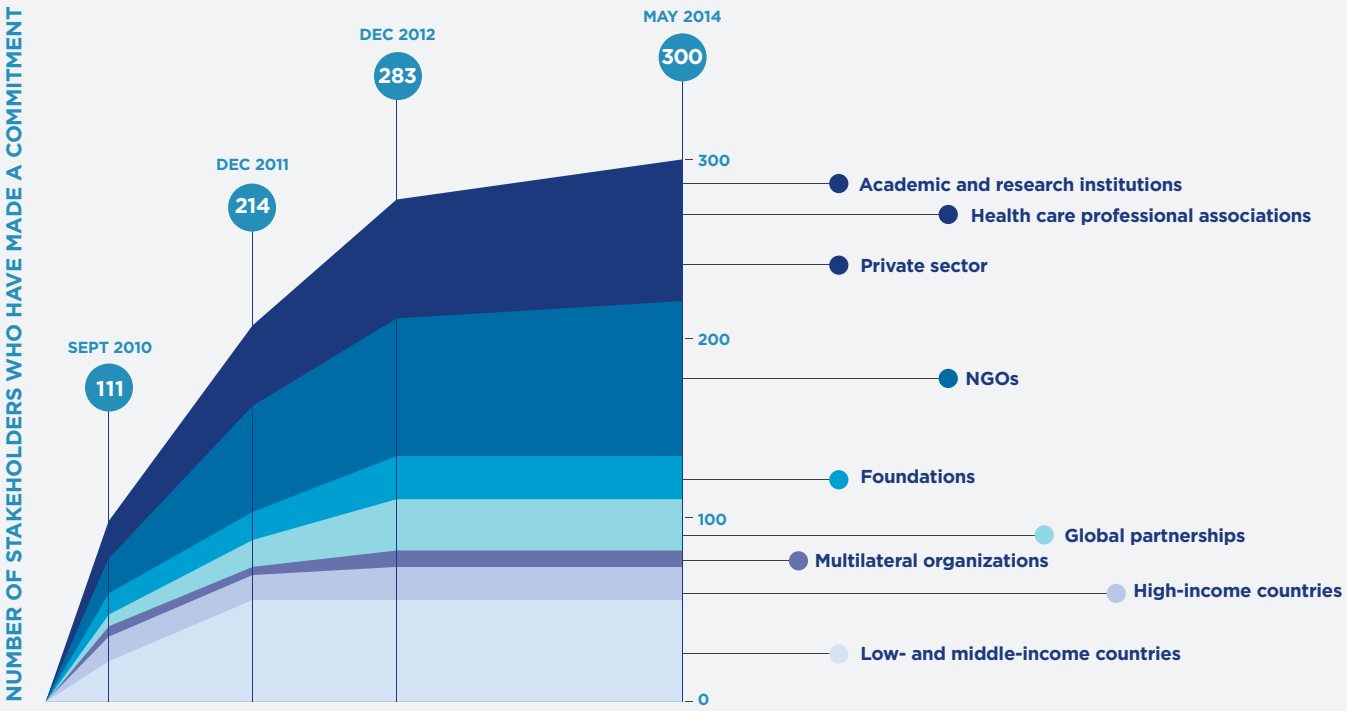
- High-level events like the London Summit on Family Planning have proven effective for raising the profile of and mobilizing new commitments for important issues. The total number of commitment makers to the Global Strategy increased from 111 in September 2010 to 283 in December 2012, many of which can be attributed to the London Summit on Family Planning. Seventeen new stakeholders made commitments from January to May 2014, five of which were attributed to FP2020.

- From 2010 through the end of 2012, donor funding for family planning increased by 52% for the 49 Global Strategy countries.

- During that same period, donor funding for family planning increased by 47% for the 74 Countdown to 2015 countries, which is where more than 95% of all maternal and child deaths occur. Countdown to 2015 is a global initiative to accelerate progress in these countries toward MDGs 4 and 5.

COMMITMENT MAKERS TO THE GLOBAL STRATEGY, BY CONSTITUENCY, SEPTEMBER 2010–MAY 2014

Source: *Every Woman Every Child.*



Being a change maker isn't always easy—or fast. But with the coordinated and future-oriented thinking that drives FP2020, bold endgames are being envisioned and enacted. These efforts will help us close the health gap between wealthy and poor countries within a generation, achieving a historic "grand convergence" in global health. The goals of FP2020 are at the very heart of this vision. Equitable access to contraceptives will most impact those facing the highest risk: the 15- to 19-year-old women in poor countries with little or no access to basic services.

Reducing high-risk pregnancies, curbing unintended pregnancies, and spacing births not only saves women's lives, but it can prevent nearly one-third of all maternal deaths, 600,000 newborn deaths and 500,000 child deaths annually. The health benefits are central; the social and economic benefits enormous. The Grand Convergence is a historical milestone within our grasp and FP2020 partners can be pivotal leaders in making it happen.

Dr. Ariel Pablos-Méndez
Assistant Administrator for Global Health at USAID

DONOR GOVERNMENT FUNDING FOR FAMILY PLANNING IN 2013: KAISER FAMILY FOUNDATION ANALYSIS

Donor governments provide a significant share of global funding for family planning services in low- and middle-income countries.[14] Therefore, tracking donor government expenditures is a key part of accountability efforts and important for informing global stakeholders.

The Kaiser Family Foundation (KFF) initiated a family planning resource-tracking project last year, adapting the methodology it has long used to monitor donor government spending on HIV.[15] Data for the project was first provided for 2012, establishing a baseline for monitoring commitments toward FP2020. This year's report presents data from 2013, the latest year available across donor governments. It is based on data from 26 governments which were members of the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) in 2013 and had reported Official Development Assistance (ODA) to the DAC.[16]

Of these, 11 made specific commitments at the 2012 London Summit to increase funding for family planning: Australia, Denmark, the European Commission, France, Germany, Japan, South Korea, the Netherlands, Norway, Sweden and the United Kingdom.[17] Others, including the United States and Canada, while not making specific financial commitments at the Summit, also provide funding for family planning activities.

KEY FINDINGS FROM 2013 ARE AS FOLLOWS:

In 2013, donor governments provided US$1.3 billion for bilateral family planning programs and US$454 million in core contributions to UNFPA.[18]

Bilateral funding:

- Bilateral funding from donors totaled US$1.3 billion in 2013, representing a 19% increase (+$211.4 million) compared to 2012 (US$1.1 billion).
- Seven donors (Canada, Denmark, Netherlands, Norway, Sweden, US and UK) increased bilateral funding in 2013 (after exchange-rate fluctuations are taken into account), while one (Australia) remained essentially flat and two decreased (France and Germany).
- Most of the bilateral increase was driven by the US, followed by the UK and the Netherlands.
- The US was the largest bilateral donor in 2013, providing US$585 million and accounting for almost half (45%) of total bilateral funding. The UK (US$305.2 million, 23%) was the second largest bilateral donor, accounting for nearly a quarter of all funding, followed by the Netherlands (US$153.7 million, 12%), Sweden (US$50.4 million, 4%), and Canada (US$45.6 million, 3%).

UNFPA core contributions:

- UNFPA core contributions from DAC member governments totaled US$454 million in 2013, representing a US$22 million (5%) increase over 2012 (US$432.2 million). Most of the increase was driven by Norway, along with combined funding from other DAC donor governments.
- Among the donor governments profiled, Norway provided the largest core contribution to UNFPA in 2013 (US$70.6 million), followed by Sweden (US$65.8 million), the Netherlands (US$52.4 million) and Denmark (US$40.4 million).[19]

Progress toward FP2020 commitments:

Among the ten donors profiled by KFF, eight made commitments during the 2012 London Summit on Family Planning: Australia, Denmark, France, Germany, the Netherlands, Norway, Sweden, and the UK. Preliminary estimates indicate that all eight of these donors have made progress toward fulfillment of their commitments.

14.
UNFPA, Financial Resource Flows for Population Activities Report 2011, 2013.

15.
Since 2002, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Kaiser Family Foundation have been tracking donor government assistance for HIV in low- and middle-income countries by the donor government members of the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC). For the methodological approach used to monitor donor government spending on HIV, see: http://kff.org/global-health-policy/report/financing-the-response-to-aids-in-low/

16.
Includes funding from 25 DAC member countries and the European Union (EU); Poland, Slovenia, and the Slovak Republic became DAC members in 2013, but have yet to report Official Development Assistance amounts.

17.
Family Planning 2020, London Summit on Family Planning: Summaries of Commitments, May 2013.

18.
Core contributions by donors to UNFPA are used to support a range of projects for family planning, reproductive health, maternal and newborn health, and HIV by UNFPA; data provided here could not be adjusted to represent an estimated family-planning-specific share.

19.
In 2013, Finland provided the fourth-largest core contribution (US$46.8 million) to UNFPA, followed by Denmark.

Photo by Toni Greaves
©Bill & Melinda Gates Foundation

DONOR GOVERNMENT FAMILY PLANNING DISBURSEMENTS, 2012–2013

COUNTRY	FP2020 SUMMIT COMMITMENT(S)	2012		
		BILATERAL (US$ MILLIONS)	MULTILATERAL–UNFPA CORE CONTRIBUTIONS (US$ MILLIONS)**	TOTAL (US$ MILLIONS)
AUSTRALIA	Plans to spend an additional AU$58 million over five years on family planning, doubling annual contributions to AU$53 million by 2016. This commitment will form a part of Australia's broader investments in maternal, reproductive and child health (at least AU$1.6 billion over five years to 2015)	$43.2	$14.9	$58.1
CANADA	None	$41.5	$17.4	$58.9
DENMARK	An additional US$13 million over eight years	$13.0	$44.0	$57.0
FRANCE	An additional €100 million on family planning within the context of reproductive health through 2015, in nine countries in francophone Africa	$49.6	$0.5	$50.1
GERMANY	€400 million to reproductive health and family planning over four years, of which 25% (€100 million) is likely to be dedicated directly to family planning, depending on partner countries' priorities	$47.6	$20.7	$68.3
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	$105.4	$49.0	$154.4
NORWAY	Doubling its investment from US$25 million to US$50 million over eight years	$3.3	$59.4	$62.7
SWEDEN	Increasing spending on contraceptives from its 2010 level of US$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
UK	Committing £516 million (US$800 million) over eight years	$252.8	$31.8	$284.6
US	None	$485.0	$30.2	$515.2
OTHER DAC COUNTRIES* **	Varies by country	$13.8	$98.0	$111.8
TOTAL		**$1,096.4**	**$432.2**	**$1,528.6**

*During the 2012 London Summit on Family Planning, donors agreed to a revised Muskoka methodology to determine their family planning (FP) disbursements totals. This methodology includes some funding designated for other health sectors including HIV, reproductive health, maternal health and other areas, as well as a percentage of a donor's core contributions to several multilateral organizations including UNFPA, the World Bank, WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Among the donors profiled, Australia and the UK reported FP funding using this revised methodology.

**Total core contributions to UNFPA (contributions from DAC and non-DAC donors) was US$460 million in 2013. UNFPA core contributions have not been adjusted to represent an estimated family-planning-specific share.

***Austria, Belgium, Czech Republic, European Union, Finland, Greece, Iceland, Ireland, Italy, Japan, South Korea, Luxembourg, New Zealand, Portugal, Spain, Switzerland, Poland, Slovenia and Slovakia became DAC members in 2013, but had yet to report Official Development Assistance (ODA) amounts at the time of this analysis.

	2013				
	BILATERAL (US$ MILLIONS)*	MULTILATERAL–UNFPA CORE CONTRIBUTIONS (US$ MILLIONS)**	TOTAL (US$ MILLIONS)	NOTES	PROGRESS TOWARD FP2020 SUMMIT COMMITMENT(S)
	$39.5	$15.6	$55.1	Australia identified AU$43 million in total FP funding for the FY13–14 using the FP2020-agreed methodology, which includes funding from non-FP-specific activities (e.g., HIV, RH, maternal health and other sectors) and a percentage of the donor's core contributions to several multilateral organizations (e.g., UNFPA). For this analysis, Australian bilateral FP funding did not include core contributions to multilateral institutions. However, it was not possible to identify and adjust for funding to other non-FP-specific activities in most cases.	YES
	$45.6	$16.0	$61.6	Bilateral funding is for combined family planning and reproductive health activities in FY12–13; family-planning-specific activities cannot be further disaggregated.	N/A
	$18.8	$40.4	$59.2	Bilateral funding is for family-planning-specific activities in 2013, and includes a specific contribution (in addition to its core contribution) to UNFPA's Reproductive Health Commodities Fund.	YES
	$37.2	$0.0	$37.2	Bilateral funding is new commitment data for a mix of family planning, reproductive health and maternal and child health activities in 2012 and 2013; family-planning-specific activities cannot be further disaggregated.	YES
	$38.2	$24.0	$62.2	Bilateral funding is for family-planning-specific activities in 2013.	YES
	$153.7	$52.4	$206.1	The Netherlands budget provided a total of US$508.1 million in 2013 for "Sexual and Reproductive Health and Rights, including HIV/AIDS," of which an estimated US$153.7 million was disbursed for family planning and reproductive health activities (not including HIV); family-planning-specific activities cannot be further disaggregated.	YES
	$20.4	$70.6	$91.0	Bilateral funding is for family-planning-specific activities.	YES
	$50.4	$65.8	$116.2	Bilateral funding is for combined family planning and reproductive health activities; family-planning-specific activities cannot be further disaggregated.	YES
	$305.2	$31.5	$336.7	The UK identified £211 million in total FP funding for the FY13–14 using the FP2020-agreed methodology, which includes funding from non-FP-specific activities (e.g., HIV, RH, maternal health and other sectors) and a percentage of the donor's core contributions to several multilateral organizations (e.g., UNFPA). For this analysis, UK bilateral FP funding was calculated by removing all core contributions to multilateral organizations. However, it was not possible to identify and adjust for funding for other non-FP-specific activities in most cases.	YES
	$585.0	$28.9	$613.9	Bilateral funding is for combined family planning and reproductive health activities; while USAID estimates that most funding is for family-planning-specific activities only, these cannot be further disaggregated.	N/A
	$13.8	$108.8	$122.6	Bilateral funding was obtained from the Organisation for Economic Co-operation and Development (OECD) Credit Reporting System (CRS) database and represents funding provided in 2012, the most recent year available, and assumes level funding for 2013.	N/A
	$1,307.8	**$454.0**	**$1,761.8**		

METHODOLOGICAL NOTE:

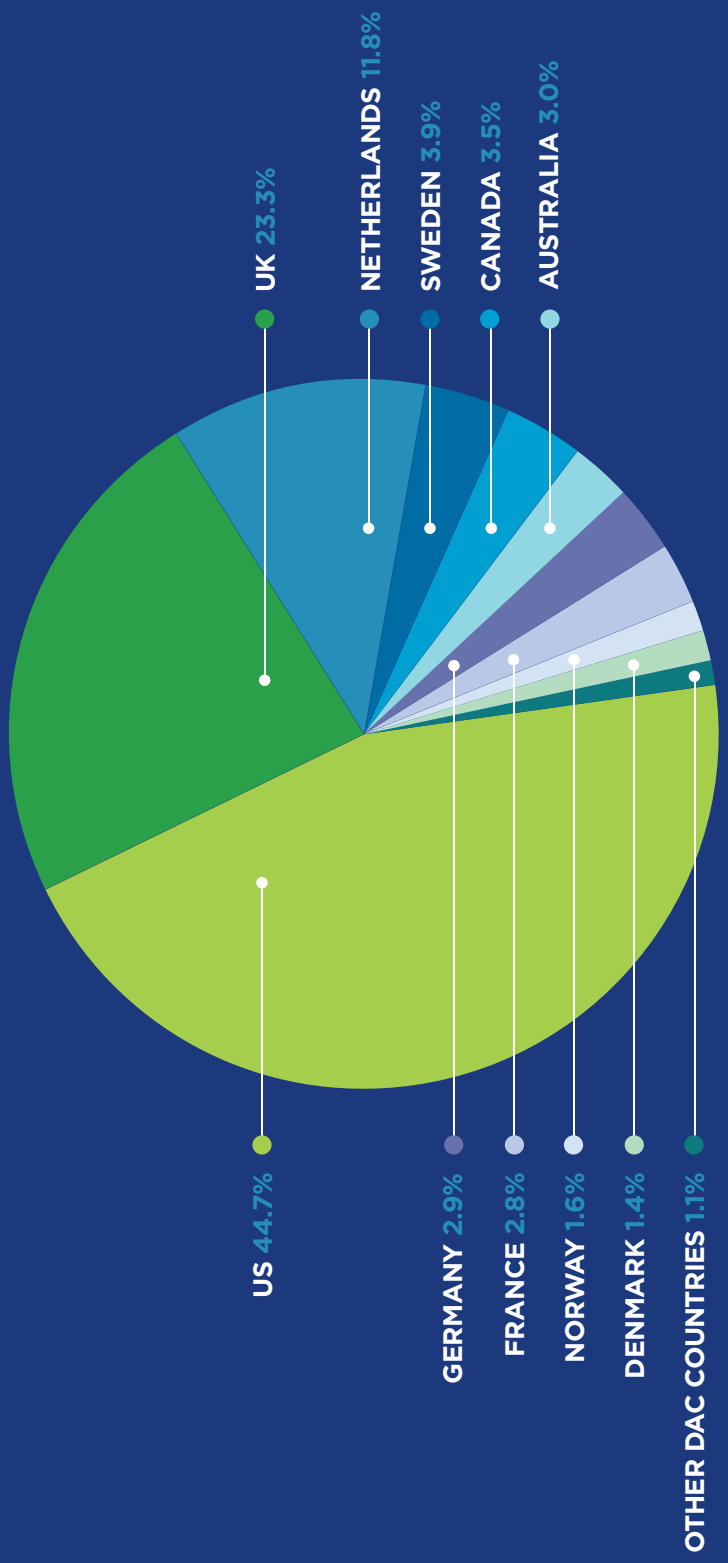
The financial data presented in this analysis represents disbursements defined as the actual release of funds to, or the purchase of goods or services for, a recipient. It was obtained through direct communication with donor governments, analysis of raw primary data and from the OECD Creditor Reporting System (CRS). UNFPA core contributions were obtained from United Nations Executive Board documents; however, KFF was unable to determine what share of these core contributions is attributable to family planning specifically (since such funding is also used to support broader population, reproductive health, maternal and newborn health, HIV 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 (Canada, France, the Netherlands, Sweden and the US do not disaggregate family planning funding from broader reproductive and maternal health 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, KFF 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 make efforts to track donor government support for family planning if such funding was more systematically identified within other activity categories by primary financial systems.

INTERNATIONAL FAMILY PLANNING ASSISTANCE: DONOR GOVERNMENTS AS A SHARE OF BILATERAL DISBURSEMENTS, 2013 (TOTALS IN US$ MILLIONS)

AUSTRALIA $39.5	NETHERLANDS $153.7
CANADA $45.6	NORWAY $20.4
DENMARK $18.8	SWEDEN $50.4
FRANCE $37.2	UK $305.2
GERMANY $38.2	US $585.0
OTHER DAC COUNTRIES $13.8	

TOTAL
US$1.3078 BILLION
BILATERAL DISBURSEMENTS



SPOTLIGHT ON EUROPE

TRENDS AND DEVELOPMENTS FROM SELECT EUROPEAN DONORS

The data show that, with few exceptions, there is a sustained political focus on international family planning in Europe, despite the current challenging political and economic circumstances, which have often led to cuts in official development assistance (ODA) or in countries' overall public spending. In fact, European donor support to UNFPA increased by nearly 30% from 2009 to 2012, with the UK making a notable surge of investment, from providing UNFPA with €28 million in 2009 to €94 million in 2012 (an increase of 238%). This is primarily due to an increase in funding committed to UNFPA's GPRHCS at the London Summit on Family Planning.[20]

FP2020 COMMITMENT MAKERS

DENMARK:
Denmark has met its commitment made at the London Summit and has already provided more than US$13 million since the Summit, as Denmark's contribution to UNFPA has increased by approximately US$18.9 million for the financial years 2012–14 compared to the formerly planned targets.[21]

EUROPEAN COMMISSION:
The Commission reports that the pledge made at the London Summit has been fully achieved and in fact exceeded: €28 million has been committed to a call for proposals on promoting universal access to reproductive health including family planning. Contracts with six selected beneficiaries from this call are currently being signed for actions that will run up to three to five years. Another contract has been signed and fully disbursed (UNFPA's GPRHCS) for €8.3 million. The total realized EU contribution to the Summit pledge is therefore €36.3 million.[22]

FRANCE:
French political commitment to sexual and reproductive health and rights remains strong despite recent changes in government and budgetary constraints. In particular, France's commitment to the Muskoka Initiative and FP2020 defines how it apportions funding to multilaterals, including UNFPA, to work in countries.[23]

NETHERLANDS:
The Netherlands committed €370 million in 2012 for sexual and reproductive health and rights (SRHR), including HIV and health, and pledged to extend this amount to €381 million in 2013 and to €413 million in 2015. The Dutch report that disbursements for SRHR alone have exceeded US$400 million since 2012, including family planning.[24] These financial investments are complemented by the fact that

SRHR and women's rights are one of four priority themes in a policy document released in 2013.[25]

NORWAY:
As of December 2013, Norway disbursed US$742 million against its Global Strategy commitment, with a vast majority of funding disbursed through multilateral channels including UNFPA, landing Norway on the top of the donor list for the institution. Funding disbursed against the specific FP2020 commitment amounts to US$25 million, US$13 million of which is channeled through UNFPA, with further amounts channeled through Marie Stopes International (MSI) and Population Services International (PSI) to scale up contraceptive implants.[26]

SWEDEN:
Sweden's commitment to sexual reproductive health and rights remains robust and is exemplified through policy and financial support. In June 2014, the Ministry of Foreign Affairs released a summary report regarding the health sector ODA report for 2013, pointing to the prioritization of SRHR (including access to modern methods of contraception) and the need for Sweden to take a strong stance on these issues in global forums and through bilateral support to reduce poverty and achieve sustainable development. Sweden has also invested in innovative funding mechanisms such as the Global Health Investment Fund (together with the Bill & Melinda Gates Foundation), and in a price reduction for contraceptive implants in order to lower the prices when ordering in large batches from pharmaceutical companies.[27] Sweden is also on track to fulfill its FP2020 commitment with disbursements for contraceptives amounting to US$45 million in 2013.[28]

NON-COMMITMENT DONORS

While 11 FP2020 pledging donors, in addition to the US, make up a large majority of all international family planning assistance, notable contributions have also been made by non-pledging countries in Europe to address the global unmet need for family planning. Belgian core support to UNFPA, as well as support to specific UNFPA projects, actually increased in 2013 and 2014 compared to previous years.[29] Sexual reproductive health and rights, including family planning, continue to feature strongly in Finnish development policy and despite a freeze on Finnish ODA due to the challenging economic situation, funding has increased for sexual and reproductive health and rights.[30]

20. Countdown 2015 Europe is a consortium of 15 leading European nongovernmental organizations working to ensure sexual and reproductive health and rights in developing countries. Countdown 2015 Europe tracks European donor spending on international family planning and works nationally with their own governments to increase support and accountability for family planning and reproductive health.

21. FP2020 commitment self-report.

22. FP2020 commitment self-report.

23. Countdown 2015 Europe.

24. SEEK interview.

25. Countdown 2015 Europe.

26. SEEK interview.

27. Countdown 2015 Europe.

28. SEEK interview.

29. Countdown 2015 Europe.

30. Countdown 2015 Europe.

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

Since 1965, USAID has pioneered the US government's work in international family planning and reproductive health and has supported sexual and reproductive health and reproductive rights across the globe. Through global advocacy, technical and programmatic innovations, strong field presence, sustained commitment and a wide range of specialized technical assistance, the agency is the preeminent donor in family planning (FP), accounting for some 40% of all donor assistance. This has been done in a highly cost-effective manner: for every dollar spent in family planning, up to US$6 million can be saved in interventions aimed at achieving other development goals.

USAID's family planning program is based on principles of voluntarism, informed choice, rights, and equity. Since the agency began working in the family planning arena, modern contraceptive use in the developing world has more than quadrupled—from less than 10% to more than 40%. In the 28 countries with the largest USAID-sponsored programs, the average number of children per family has declined by one-third, from more than six to less than four. This past year, USAID reached more than 84 million women, preventing 15,000 maternal deaths and saving the lives of more than 230,000 infants.

USAID's evidence-based programs reach women and men with clinic and community-based programs that enhance reach and accessibility, enabling more women and couples to choose the number, timing, and spacing of their children through access to a mix of high-quality contraceptive options that are safe, acceptable, and affordable. USAID has introduced innovations that have increased the accessibility of FP. These program components include:

- Social and behavior change communication
- Promoting positive gender norms and male involvement
- Contraceptive research and development for birth control and for dual-purpose use in preventing pregnancy and HIV transmission
- Contraceptive procurement and supply chain management
- Maximizing quality in service delivery and program improvement through implementation science
- Policy dialogue at the national and district levels to create a supportive environment for FP services, delivery and methods
- Health systems strengthening for sustainability of all health programs
- Contraceptive social marketing programs
- Private-sector engagement to give consumers more health care choices, better-quality services, and to help governments concentrate dwindling resources on poor and hard-to-reach communities
- Strong data collection, monitoring and evaluation

Enabling couples to determine whether, when, and how often to have children is vital to safe motherhood and healthy families. As such, family planning is crucial to the agency's mission of ending extreme poverty and health goals of Ending Preventable Child and Maternal Deaths and creating an AIDS Free Generation. By enabling women and couples to practice healthy timing and spacing of pregnancies, family planning could reduce maternal deaths by 30% and child deaths by 25% globally.

LOOKING TO THE YEAR 2020

As a founding partner of FP2020, USAID continues to envision stronger programs that will allow the family planning community to meet the FP2020 goal of reaching an additional 120 million women and girls with FP programs, services and supplies. USAID's future directions affirm its continued commitment to voluntarism, informed choice, rights, and equity; acknowledge the importance of youth as a key population; and identify five areas where additional work for the next five to seven years can accelerate progress: method choice, social and behavior change communication, product availability, family planning workforce, and total market approach. This work is undertaken with attention to the policy, research, health systems strengthening, and monitoring and evaluation (M&E) dimensions of these focus areas in 24 priority countries plus West Africa, and with an increased emphasis on partnerships.

The five- to seven-year time frame for these focus areas aligns with the FP2020 goal of enabling 120 million additional women and girls to access contraception by 2020. One more lens on these future directions is the post-2015 agenda and the opportunity that exists for a grand convergence by 2030 between the developing and developed world in terms of health statistics and economic well-being. In policy dialogue, USAID will continue to link FP progress to the opportunity for a demographic dividend, and encourage increased domestic resource allocation for family planning and reproductive health in countries that are experiencing rapid economic growth.

METHOD CHOICE

By 2020 more women and couples in USAID's 24 priority countries and the Ouagadougou Partnership countries will be able to meet their reproductive desires for delaying, spacing or limiting births through access to a range of acceptable and affordable contraceptive methods and quality services. These include fertility awareness methods, short-acting (pericoital – 3 months), intermediate-acting (>3 months – 1 year), long-acting reversible (>1 year) and permanent contraceptive methods.

SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

By 2020, USAID-supported behavior change activities in priority countries will consistently reflect proven practices in coordination, design, implementation and evaluation for SBCC and will measurably contribute to increased family planning utilization among priority populations.

FAMILY PLANNING WORKFORCE

By 2020, the family planning workforce in USAID's priority countries will be strengthened and expanded to support and implement the priority interventions of the other family planning focal areas. This will increase public and private sector access to quality family planning services that are gender sensitive and age and developmentally appropriate.

PRODUCT AVAILABILITY

USAID's family planning priority countries possess the capacities to design, implement and sustain high-performing supply chain systems for family planning and reproductive health services.

TOTAL MARKET APPROACH

USAID's family planning priority countries possess the capacities to design, implement and sustain high-performing family planning programs that include all sectors for information, product and service delivery in a rational, efficient and equitable way.

UK DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

The UK has put women's and girls' empowerment at the center of its international development program and considers family planning fundamental to enabling women and girls to take control over their own lives and fulfill their potential. The UK is a proud supporter of FP2020, supporting family planning programs in 20 countries as well as a large global program to enhance reproductive health commodity security. The UK also supports non-governmental organizations such as Marie Stopes International, International Planned Parenthood Federation and Save the Children.

The UK is on track to meet its commitment to increase annual spending on family planning from £90 million per year to £180 million per year by 2020. This increased support has resulted in almost five million additional women being reached with family planning services by mid-2014, almost 4% of the 2020 target.[31] By 2012, DFID programs were estimated to have saved over 16,000 maternal deaths using list modeling.[32] This is good progress but the gains have to be sustained.

The UK is actively involved in the Reference Group and the four working groups of FP2020, and has taken a key role with other FP2020 donors in the global high-level policy dialogue to reduce the prices of key family planning commodities, develop new technologies for drugs that are easier to administer, and ensure high-quality commodities are made available.

The UK has recently approved and begun the tendering process for a new civil society–led program to hold governments accountable to citizens for their FP2020 financial and policy commitments. This will ensure that programs respect and promote women's and girls' rights to determine reproductive choices, and is likely to begin in early 2015.

HIGHLIGHTS: ZAMBIA

DFID began funding a Scaling Up Family Planning Programme (SUFP) in Zambia in 2012. Up until this time, family planning was integrated within broader primary health care, but in reality had not been progressing much as Zambia has one of the highest fertility rates in the region.

The build up to the London Summit enabled all key interested partners in Zambia to come together to discuss possible commitments and a way forward. This was strongly championed by the first lady and the newly formed Ministry of Community Development Mother and Child Health, in collaboration with the Ministry of Health. After the Summit, with the help of partners, including SUFP, Zambia produced its first-ever 8-year family planning scale-up plan, and the issue was firmly placed on the national agenda.

The FP2020 activities in Zambia have been coordinated by UNFPA, largely through the government's active family planning technical working group, and all programs are integrated with the national plan. The Bill & Melinda Gates Foundation, USAID, UNFPA and DFID have also been meeting regularly to discuss supporting the government in the achievement of their objectives.

The UK-funded program SUFP now operates in 26 districts and has reached over 100,000 new users with family planning. Family planning is "out there" in Zambia, being discussed and thought about. The overwhelming response from women, their husbands, traditional chiefs and leaders has been, "we are so glad to hear about this—we need to space our children and prevent young girls from leaving school to have children that they did not plan for."

Zambia has increased its funding to reproductive health commodities and has allowed task-shifting of the delivery of injectable contraceptives to community health assistants, two of its FP2020 commitments.

31. DFID Departmental Results Framework.

32. Lives Saved Analysis for the Department of International Development (DFID) Year 2: Global Programs 2010–2012 and 2010–2015.

UNITED NATIONS POPULATION FUND

UNFPA is the longest-serving multilateral agency in the field of family planning. For over 40 years, UNFPA has supported family planning in more than 150 countries, ensuring that women and girls have the right to make choices that will enable them to fulfill their greatest potential. UNFPA's work in family planning is guided by its corporate strategy Choices not Chance, which is based on principles of human rights, equity, non-discrimination, national ownership, accountability, and innovation. The overall goal is to accelerate universal access to rights-based family planning.

UNFPA works with national governments, civil society, and national institutions to build an enabling environment for family planning, increase demand and improve availability of quality contraceptives, and strengthen service provision and information systems. UNFPA support is provided through coordination and partnerships, advocacy and policy dialogue, procurement, capacity building, and knowledge management.

The key vehicle for implementing Choices not Chance is the flagship Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS). GPRHCS directly supports 46 priority countries where the need for family planning is the greatest. Focused work in these priority countries has led to significant progress in accelerating access to rights-based family planning.

In 2013, contraceptives procured by UNFPA for the 46 priority countries amounted to 35 million couple-years of protection, which have the potential to avert an estimated 9.5 million unintended pregnancies, 6.4 million unintended births, 27,300 maternal deaths, and 1.1 million unsafe abortions.

Better coordination and stronger political commitment: 70% of the priority countries had functional coordinating mechanisms for reproductive health commodity security (RHCS) in place, and 54% had budget lines for reproductive health commodities. Budget allocations increased in a number of countries.

Contraception for young people is on the agenda: 89% of the priority countries carried out resourced action plans for demand generation to reach young people. Seventy-two percent of the priority countries are addressing young people's access to contraceptive services in their health policies.

Expanding access to new users: 80% of the priority countries implemented demand generation activities; 56% carried out integration of sexual and reproductive health and family planning services, helping to expand services in a more effective and efficient manner.

Building capacity for stronger health systems: 67% of the priority countries conducted training for family planning service provision, including long-acting reversible methods. The focus of capacity-building initiatives is on institutional development at the regional and country levels.

Stronger forecasting to avert stock-outs: 70% of the priority countries made no ad hoc request for contraceptives, which means that demand forecasting was effective. In the last six months of 2013, no stock-outs of contraceptives were reported in at least 50% of the service delivery points in Burkina Faso, Lao PDR, Nepal, Nigeria, Niger, DR Congo, and Sierra Leone.

Ensuring human rights in family planning service provision: 85% of the priority countries have developed national guidelines and protocols that include a rights-based approach to RHCS and family planning.

In addition, AccessRH, the UNFPA-managed reproductive health procurement platform and information service, has contributed to a significant reduction in delivery times compared to non-AccessRH sources. In 2013, AccessRH reduced lead times by 87% for fistula kits, 80% for female condoms, and 75% for male condoms.

UNFPA will continue to fulfill its commitments to FP2020, supporting stronger family planning programs at the country level to reach an additional 120 million women and girls by 2020. With a focus on the post-2015 agenda across all programs, UNFPA will continue to place emphasis on upholding reproductive rights and promoting comprehensive, intersectoral, integrated, and inclusive approaches; addressing the needs of adolescents and young people; and directly tackling population dynamics, especially in relation to family planning and the demographic dividend.

BILL & MELINDA GATES FOUNDATION

In 2013, the Bill & Melinda Gates Foundation invested US$133.6 million in family planning and is on track to provide US$148.9 million in support for 2014. The foundation's annual budget is projected to be US$140 million per year from 2015 to 2020, which means it will meet its financial FP2020 commitment of doubling investments in family planning from US$70 million a year to US$140 million a year for eight years.

The foundation recently completed a new family planning strategy in support of the global FP2020 goal and the long-term vision of accelerating universal access to modern contraceptives.

The foundation works with global and local partners who can mobilize and influence governments, civil society, the private sector and the public to raise the visibility and importance of quality family planning counseling and services as an intervention to save the lives of women and children. It also supports national governments that are leading the development and implementation of their own country-specific plans, with input from stakeholders at the national, regional and district levels.

The foundation's strategy outlines plans to help increase funding and improve policies for family planning, create public-private partnerships to expand contraceptive access and options, develop innovative and affordable contraceptive technologies, and support further research to close knowledge gaps. It is also exploring how family planning efforts can better meet the needs of young women and girls.

The foundation works with global and local partners who can mobilize and influence governments, civil society, the private sector and the public to raise the visibility and importance of quality family planning.

The foundation works to ensure that its partners respect the principles of voluntarism, informed choice, participation, accountability and protection against discrimination and coercion.

The foundation will focus its investments in the following countries: India, Nigeria, Indonesia, Pakistan, Ethiopia and DR Congo, as well as two Ouagadougou Partnership countries, Senegal and Niger.

UNITED NATIONS FOUNDATION

At the 2012 London Summit on Family Planning, the United Nations Foundation (UNF) committed to launching and co-leading the Family Planning and Reproductive Health pillar of the Millennium Development Goal Health Alliance. This team works with UNFPA, other UN agencies, and key stakeholders from across the public and private sectors to identify and build partnerships to promote voluntary family planning and access to reproductive health. Recent accomplishments include the 2013 launch of "Family Planning: the Most Cost-Effective Investment in Global Development," an online resource for business and philanthropists; the release of the MDG 4/5 Roadmap, integrating contraception and maternal and newborn health goals; and a new partnership with pharmaceutical manufacturers of contraceptive devices.

UNF's Why We Care project showcases personal stories from global leaders who are committed to advancing reproductive health and rights. First unveiled at the 2012 London Summit, the platform has since been expanded and more than two dozen new champions have been added. UNF also helped launch the Girl Declaration, a call to action for keeping girls in the post-2015 agenda. UNF partnered with Nigeria's Saving One Million Lives (SOML) Initiative in 2013. Launched by President Goodluck Jonathan, the initiative aims to expand access to essential primary health services and commodities for Nigeria's women and children. With the SOML Office, GSMA and Intel, UNF is working closely with the Nigerian government to scale up information communication technologies in support of the initiative.

UNF also hosts the Mobile Alliance for Maternal Action (MAMA), a multi-stakeholder partnership that delivers vital health messages, including information on postpartum family planning, to new and expectant mothers via their mobile phones. MAMA programs in Bangladesh and South Africa have already reached 1.3 million women, and this year the program is being expanded to India.

CHILDREN'S INVESTMENT FUND FOUNDATION

At the London Summit on Family Planning, the Children's Investment Fund Foundation (CIFF) committed to providing both funding and human resources to ensure greater accessibility of long-acting and reversible methods of contraception, and to continuing their work to enable women and governments to acquire these products at affordable prices. CIFF has since enhanced its commitment to focus on preventing harmful pregnancy among adolescent girls, with comprehensive choice as an important pathway.

CIFF is a core member of the guarantor group within the Implants Access Program. In 2013 and 2014, CIFF supported the rollout of long-acting methods in Ethiopia through procurement support to the national family planning program. In 2014, CIFF approved funding to mainstream self-injection of Sayana® Press. Within this program, CIFF is supporting new research on the acceptability, feasibility, and impact of Sayana® Press compared to other options and through self-injection.

This program has a strong accountability goal to ensure that learning on self-injection is disseminated and that findings, if positive, are institutionalized. CIFF completed a comprehensive adolescent reproductive health landscape analysis in 2014. This is contributing to an organizational strategy review process that will be completed by 2015. The landscape review provides an analysis of where CIFF can achieve transformational change, enabling CIFF to focus attention on one or more specific areas within adolescent reproductive health. CIFF attaches particular importance to delaying first birth alongside increasing access to contraception.

BLOOMBERG PHILANTHROPIES

At the London Summit on Family Planning, Bloomberg Philanthropies committed US$50 million to prevent maternal deaths and ensure that women in the world's poorest countries have access to family planning information, contraceptives and services so they can freely and safely make decisions about when to have children. This commitment builds on Bloomberg Philanthropies' work to improve maternal and child health in some of the most isolated parts of Tanzania.

In March 2014, Bloomberg Philanthropies announced the full allocation of the commitment made at the London Summit and has since finalized and rolled out a three-pronged investment strategy. In addition to augmenting its support in Tanzania, Bloomberg Philanthropies is preparing to make investments in four more FP2020 focus countries, including Burkina Faso, Nicaragua, Senegal and Uganda. The program is comprised of:

Integration of comprehensive reproductive health services in Kigoma, Tanzania:
Kigoma is the westernmost region of Tanzania. It has among the poorest maternal and reproductive health indicators in the country and, as such, was identified as a high priority region in the Sharpened One Plan, launched by His Excellency President Kikwete in May 2014. Bloomberg Philanthropies has been working to improve maternal health in Kigoma since 2006 by training non-physicians to provide emergency obstetric care and building operating rooms in remote health centers so that more women have access to emergency care closer to home. Bloomberg Philanthropies is amplifying these efforts through a partnership with the Kigoma Regional Government, the Tanzanian Ministry of Health and Social Welfare, and EngenderHealth to upgrade additional health centers and integrate family planning and comprehensive post-abortion care into all project-supported health centers. In the first nine months of the program, EngenderHealth supported efforts that resulted in 17,463 clients accessing the family planning method of their choice.

New advocacy grants to strengthen reproductive health rights in Burkina Faso, Nicaragua, Senegal and Uganda:
Bloomberg Philanthropies has partnered with Planned Parenthood Global to identify and support promising local organizations and champions to carry out advocacy that leads to improved access to family planning information, contraceptives and reproductive health services for women, particularly marginalized groups such as youth and unmarried women. This component of the strategy—instigated by the opportunity to catalyze vital reproductive health reform and build local capacity along the way—is just getting off the ground.

The establishment of the Rapid Response Mechanism in partnership with FP2020, hosted by the United Nations Foundation:
In July 2014, FP2020 launched the Rapid Response Mechanism (RRM) to provide rapid response funding to fill urgent gaps and unforeseen opportunities to accelerate progress toward FP2020's goal in any of the 69 FP2020 focus countries.

For all our advances in medicine, far too many women still die during childbirth, a tragedy for mothers, their children, and their entire families. By providing critical health services closer to mothers' homes—and by empowering women to make informed choices about when they want to have children—we can help save thousands of lives.

Michael Bloomberg
Founder, Bloomberg Philanthropies

CIVIL SOCIETY

Civil society organizations have a substantial capacity to accelerate change in the family planning community. They are key players in advocacy and service provision, and provide an invaluable voice in holding governments accountable. To ensure the commitments made at the 2012 London Summit on Family Planning are met, DFID intends to appoint a civil society–led consortium to implement an accountability program at the national and local levels. The consortium will independently monitor governments' progress and ensure that programming respects and promotes the human rights of all women and girls. DFID issued its tender in August 2014, with program mobilization scheduled to begin in early 2015.

This section provides updates on three civil society organizations that have strong existing commitments to FP2020: FHI 360, International Planned Parenthood Federation (IPPF) and Marie Stopes International (MSI).

FHI 360

FHI 360 is committed to expanding the evidence base for safe and effective family planning and translating high-quality evidence into policy and practice. FHI 360's collaborative efforts are driving progress toward achieving that commitment. Since the London Summit on Family Planning in 2012, FHI 360 has implemented a wide variety of projects with support from USAID, the Bill & Melinda Gates Foundation and other donors.

FHI 360 works to expand the evidence base for safe and effective family planning through projects like the Advancing Partners & Communities (APC) Project, wherein FHI 360 is studying self-injection of subcutaneous DMPA formulation (Sayana® Press) in Malawi. Also through the APC project, FHI 360 advocates for the scale-up of community-based family planning programs and supports the implementation and monitoring of national costed implementation plans.

FHI 360 works to translate high-quality evidence into policy and practice by providing support to the family planning strategies of local governments. FHI 360 also supports the scale-up of evidence-based practices in multiple countries, including India (Uttar Pradesh state), where FHI 360 leads the Urban Health Initiative. In addition, a new award from the Saving Lives at Birth program will seek to synchronize immunization visits with family planning resupply to improve immunization coverage, promote a more logical infant growth-monitoring schedule, and raise contraceptive prevalence.

INTERNATIONAL PLANNED PARENTHOOD FEDERATION

The International Planned Parenthood Federation (IPPF) has committed to mobilize civil society and governments to improve the legislative, policy, regulatory and financial environment for family planning and to hold governments accountable. IPPF is making headway in reaching these goals.

Through regional-level mobilization, IPPF coordinated and led civil society to influence the 2013 regional reviews of the International Conference on Population and Development (ICPD), resulting in five regional declarations that advanced the ICPD Program of Action. IPPF Member Associations have also contributed to national activities. In DR Congo and Malawi, the advocacy efforts of IPPF Member Associations, in collaboration with national organizations and networkers, resulted in the first-ever budget allocations on the procurement of contraception and the passing of new laws on family planning in areas where, previously, contraceptive procurement depended solely on donor support. In Uganda, an IPPF Member Association helped achieve a task-shifting policy that enables clinical staff to undertake sterilization, an option previously not allowed, and in partnership with Advance Family Planning,

it helped to achieve the pledged budget allocation of US$5 million from the government for contraceptive supplies.

IPPF also assisted in empowering civil society advocacy and accountability for reproductive health and family planning in the Every Newborn Action Plan; Brazil, Russia, India, China and South Africa (BRICS) summit; Maternal, Newborn and Child Health Summit in Canada; World Health Organization campaign for Sexual and Reproductive Health; the Sustainable Development Goals Open Working Group process; and PMNCH Partners' Forum, among other events.

MARIE STOPES INTERNATIONAL

In the years since the London Summit on Family Planning, Marie Stopes International (MSI) has taken critical steps toward its commitment to work in partnership with governments to help identify, address and remove policy, financial and other barriers to accessing contraceptives, information and services. MSI's approach to this commitment includes advocacy, influencing global norms, and registration of low-cost, high-impact family planning technologies.

MSI supported a task-sharing policy change to help expand access to tubal ligation services in Uganda. As a founding member of the Uganda Family Planning Consortium, MSI helped obtain formal endorsement from the Ministry of Health for clinical officers to perform tubal ligation, significantly increasing the number of health professionals able to provide the service. At a global level, MSI's collaboration with the World Health Organization led to the publication in 2013 of a global guide on task sharing of long-term and permanent family planning methods. MSI is now working to ensure adherence at the country level. To date, MSI has successfully registered Sino-implant (II), currently the only officially registered two-rod contraceptive implant, in seven countries, with a final application pending in Vietnam. MSI also has permission to distribute Sino-implant (II) in Papua New Guinea.

Additionally, MSI is improving service delivery by generating community demand, educating potential users of family planning, expanding the number of delivery channels and increasing access for the poorest communities with a global voucher program.

Photo by Dominic Chavez/FP2020

PRIVATE SECTOR

The private sector has an important role to play in the FP2020 movement. As market-based drivers of innovation, private sector entities are uniquely positioned to help bring contraceptive products and services to millions of women and girls with unmet need. Robust private sector participation in family planning contributes to an expanding base of users, more efficient distribution networks and flexible partnerships that support new approaches.

FEMALE HEALTH COMPANY

The Female Health Company is the manufacturer of the FC2 female condom. At the 2012 London Summit on Family Planning, the Female Health Company committed to providing public sector purchasers with free product, equal to 5% of their total annual units purchased. The company also pledged to invest up to US$14 million over the next six years in reproductive health and HIV/AIDS prevention education and training, in collaboration with global agencies.

The Female Health Company fully realized the first component of its commitment in 2012–2014, providing free goods equal to 5% of aggregate public sector units of the FC2 female condoms. The company's SUPPORT team provides programming and training on the use of FC2 and is working with local partners in Brazil, Ghana, Kenya, Malawi, Mozambique, South Africa, Zambia and Zimbabwe to develop country-specific programs.

In Kenya, for example, SUPPORT has partnered with the Muthaa Community Development Foundation (MCDF), a nongovernmental organization, to develop training and educational materials tailored specifically to the country. More than 500 staff members at health facilities, NGOs, CBOs, and student and government offices have been trained in the use and benefits of the FC2 female condom since the beginning of the year. The Female Health Company shipped 1.4 million FC2 female condoms to Kenya in the fourth quarter of FY2014 through UNFPA, reflecting the success of in-country programming efforts.

MERCK FOR MOTHERS

Merck for Mothers is Merck's 10-year, US$500 million initiative to reduce maternal mortality globally. Family planning is a key strategy within this initiative, given its potential to reduce maternal mortality by a third through addressing unmet need.
In partnership with the Bill & Melinda Gates Foundation, Merck formed an eight-year, US$50 million collaboration to expand access to family planning.

Merck has partnered with IntraHealth and the Senegalese Ministry of Health and Social Action to expand an innovative distribution model for contraceptive supplies (the Informed Push Model). This three-year partnership is strengthening the supply chain for family planning products and supporting the government's family planning goals to increase the contraceptive prevalence rate from 12% to 27%.

In India and Uganda, Merck is integrating postpartum family planning services into its maternal health programs to help women space their pregnancies. Merck is working with partners to develop training curricula for private providers, to integrate family planning services through telemedicine and to train health care providers in franchise networks on comprehensive care.

Merck also focuses on broadening the range of service delivery points that offer a mix of family planning options and quality, client-centered care. In Rajasthan, India, Merck and Hindustan Latex and Family Planning Promotion Trust are growing a network of community health workers to help increase access to maternal health services and family planning products for low-income women in urban and rural areas.

The Merck for Mothers Global Giving Program amplifies the reach of the Merck for Mothers initiative by supporting local projects to improve maternal health and access to family planning. In Indonesia, Merck supports the Project HOPE initiative to provide women who work in factories with information on family planning and referrals to external health services. In South Africa, Merck is supporting a capacity-building project to integrate family planning services with primary health care.

When diverse partners unite to achieve a common goal, we believe we will make important progress. By harnessing the power of collaboration to expand and improve family planning programs, FP2020 will change the lives of millions of girls and women.

Kathy Calvin
President and Chief Executive Officer,
United Nations Foundation

COMMITMENTS IN ACTION: TANZANIA

On a brilliant summer day in the city of Mwanza, smiling teenagers march down the street, holding banners emblazoned with a green star. A brass band plays, and photographers snap pictures. It is the local relaunch of the Green Star Family Planning Campaign.

The Green Star has a long history in Tanzania. It was first introduced in 1993, when the government adopted the logo to symbolize its national family planning program.[33] That first program was very successful, but a shifting political landscape and the AIDS crisis in Tanzania upended funding priorities for many years. Now the Green Star program is back. The national relaunch was in October 2013, with regional events—like the one in Mwanza—taking place in the summer of 2014. The campaign slogan, "Follow the Green Star," encourages Tanzanians to seek out family planning information, services, and supplies wherever they see the Green Star logo.

It is all part of Tanzania's reinvigorated focus on family planning. At the 2012 London Summit on Family Planning, the government renewed its commitment to reproductive health and pledged to increase the contraceptive prevalence rate from 27% to 60% by 2015. In August 2014, a small group from the FP2020 Task Team traveled to Tanzania to learn more about how these commitments are translating into action. The group visited a number of health care facilities supported by Tanzania's development partners and spoke with government policymakers, health care providers and clients.

At the 2012 London Summit on Family Planning, the government renewed its commitment to reproductive health and pledged to increase the contraceptive prevalence rate from 27% to 60% by 2015.

Tanzania's overall approach to family planning is guided by the One Plan (official title: National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn and Child Deaths in Tanzania, 2008–2015), which outlines a unified strategy to improve maternal, child and reproductive health.[34] Tanzania's progress on some elements of the One Plan has been excellent—the country has already met its MDG 4 for child survival—but maternal and reproductive health indicators are lagging. The nation still has one of the highest maternal mortality rates in the world. The unmet need for contraception also remains high: one in four Tanzanian women would like to prevent pregnancy or space her childbearing, but has no access to contraception.

To bridge these gaps and bring Tanzania's FP2020 goals within reach, the government met with its partners after the London Summit to draft the Sharpened One Plan.[35] The Sharpened One Plan covers the 2014–2015 period and focuses on high-impact practices to be implemented immediately, such as the Green Star campaign. It also provides a framework for advocacy and accountability and identifies the Western and Lake Zones as the areas of the country needing heightened attention.

The government also significantly ramped up its budget for family planning. In the 2013–2014 fiscal year, the government released TSh 1.5 billion for family planning, an amount over and above the original budget. For the 2014–2015 fiscal year, the government has budgeted TSh 4.6 billion for family planning.[36] This includes TSh 2 billion in domestic allocation, twice the amount allocated in the previous year.

Tanzania's development partners are responding with their own commitments. UNFPA is supporting the Sharpened One Plan through advocacy for family planning, contraceptive procurement and supply, and service delivery, including youth-oriented interventions and mobile outreach in remote areas. USAID's portfolio includes contraceptive security, local capacity building, service delivery, advocacy and demand creation, logistics management, and monitoring and evaluation. Implementing partners such as Marie Stopes Tanzania, EngenderHealth, and Population Services International are on the frontlines, running clinics, outreach programs, and awareness campaigns.

Private foundations play a role as well. At the 2012 London Summit, Bloomberg Philanthropies committed to expanding its maternal health care program in Tanzania to include family planning. Bloomberg Philanthropies has a strong presence in the Kigoma region, where it has built six new operating rooms and upgraded 10 remote health centers. Now, as a result of its FP2020 commitment, Bloomberg Philanthropies is integrating family planning with the other health services at its facilities.

It is still early days, but the numbers are already looking up. In the Western Zone, the Kigoma region's CPR rose from 14.3% in 2010 to 22% in 2013. In the Lake Zone, the Mwanza region's CPR jumped 9 percentage points in just two years—from 14% in 2012 to 23% in June 2014.

Meanwhile, the Green Star campaign is continuing to roll out across the country. The launch events in Mwanza and other Lake Zone regions were a rousing success, with a flurry of television and radio coverage, special mobile clinics and 186,000 new clients reached in just two months. Launch events in the Western Zone are planned for the fall of 2014.

33.
The project was funded by the US Agency for International Development (USAID), with technical assistance provided by the Johns Hopkins Center for Communication Programs, Population Communication Services. http://www.guttmacher.org/pubs/journals/2506099.html

34.
The One Plan was developed with financial support from the European Commission, WHO, UNFPA, UNICEF and the One UN Fund, with additional support from many other partners. The One Plan was bolstered in 2010 with the launch of the National Family Planning Costed Implementation Program (NFPCIP), developed in collaboration with the USAID/FHI 360 PROGRESS project.

35.
The Sharpened One Plan was developed by the Ministry of Health and Social Welfare with support from UNICEF, WHO, UNFPA, USAID and other health partners.

36.
Source: Tanzania Ministry of Health and Social Welfare, via FP2020 self-report.

ENIDYJOY DANIEL

The Kalinzi Dispensary is a small health clinic in one of the most remote regions of western Tanzania. Enidyjoy Daniel stands on the porch, looking out over a buzzing crowd of men, women and children. The head nurse at the dispensary, she is a small, graceful woman. Despite the large number of patients awaiting her attention, she remains unruffled. She was born in a village close by and understands the challenges that women face here.

Enidyjoy has been a nurse for many years, including five years at this particular facility. "The women here ache for their families," she says. "Their greatest challenge is the sickness of their children. There are too many to care for, to keep healthy. The children cannot eat enough and cannot stay warm. They are constantly ill and many of them die too young."

Enidyjoy is one of seven children herself, and remembers her childhood with a touch of sadness. Her mother and father could not support their family. "It was hard to get an education; we had to help provide food, water and firewood," she says. One day, a neighboring orphanage put out a call for workers to help care for the growing number of abandoned children. Enidyjoy's desperate father took her to the orphanage and left her there. Over the years, she helped to care for younger children and became passionate about becoming a nurse. The memory of those years continues to fuel her dedication to her career and to promoting family planning.

With the support of USAID, Bloomberg Philanthropies, and their implementing partner EngenderHealth, the dispensary provides reproductive and child health care to the women and children of Enidyjoy's community. Enidyjoy sees 300 to 400 people a month, a number that can sometimes overwhelm the staff of only four. And Enidyjoy is the only trained family planning provider, which she admits can be exhausting. But she does the best she can, believing that women could lead better lives if they could plan their families.

The women here are strong. They are used to hard lives; they fight to survive.

Enidyjoy says the women here are strong. "They are used to hard lives; they fight to survive," she says. "If given the opportunity, they can put their strong will into creating stronger families, stronger communities. They can reduce sickness in their homes, reduce the number of women and children dying. All they need is access to family planning. From that comes health, education and economic opportunity."

Enidyjoy Daniel
Photo by Dominic Chavez/FP2020

EVANGELINA RUTAZAA

Evangelina Rutazaa arrives at the Gungu Health Center in Mwanza, Tanzania, in a *bajaji*—a three-wheeled motorized vehicle with a small open cab. She steps out with a wide smile on her face and pats down her windblown hair. She is a mobile nurse who travels from the local Marie Stopes International (MSI) headquarters to more remote health care facilities, helping to dispense reproductive health care and family planning services. She has been a *bajaji* nurse with MSI for three years, but has 41 years of nursing experience.

Evangelina is now 65 years old and considers herself retired. Even so, every morning she makes the hour-long trek to pick up her *bajaji,* meet her driver and start her day. The duo braves rough roads and far distances, all out of dedication to the work they do and the communities they serve. Evangelina is skilled in both short-term and long-acting contraceptive methods, and provides a much-needed extra hand to often-understaffed health care centers. Her male driver is also well educated on the various contraceptive methods. As a "vocal local," he provides support and eases the concerns of male clients.

Evangelina had six children of her own before deciding that was enough. She uses herself as an example to the women she consults. To Evangelina, family planning is key to women's and children's health. The most important thing a child needs, she says, is its mother. Family planning helps women delay pregnancies until they are strong enough to survive childbirth. And spaced pregnancies help to ensure that mothers can focus on their children. It is with this passion for her work that Evangelina drives into the hills in her *bajaji* to deliver her message to women near and far.

MSI's *bajaji* nurses have proven to be especially effective at meeting the demand for family planning. *Bajajis* are often used as taxis and can roam the streets without drawing much attention. Women and men can easily and discreetly seek information on family planning services if they know a *bajaji* nurse will be in town. MSI is now deploying *bajaji* nurses to schools and universities as well.

Evangelina Rutazaa
Photo by Dominic Chavez/FP2020

MAURICE HIZA

For more than 20 years, Maurice Hiza has been on the frontlines of family planning in Tanzania, first as a clinical practitioner, then as a trainer and ultimately as a policymaker. He is now the National Family Planning Coordinator for the Ministry of Health, responsible for all family planning services and activities in the country. His background as a service provider gives him insight into the real day-to-day issues in clinics and communities throughout Tanzania—and a strong sense of what needs to happen to make things better.

"When we started to work on awareness-raising, we started by encouraging women," he says. Knowledge of contraception was minimal in most regions of Tanzania, so programs were designed to provide women with basic information about the methods and benefits of family planning. Outreach campaigns carried the message outside the clinic walls and directly into the communities. A particularly successful approach was the decision to offer contraceptives to women when they brought their children in for immunizations. This exposed the problem of husbands forbidding their wives to go to the family planning clinic.

The result has been a marked increase in demand for contraceptives—to the point that stock-outs are now a frequent problem. Mr. Hiza considers it an encouraging sign. "It means that women now are looking for contraceptives," he says. "It was challenging for me to see commodities are moving at a very fast pace, but at the same time, it is a success."

The male attitude to family planning has proven more intractable. Some men in Tanzania mistrust contraception and believe that women do not have the right to make such decisions. To confront these deeply entrenched cultural attitudes head-on, Mr. Hiza's team at the Ministry of Health has launched a high-profile family planning champions initiative.

The champions initiative recruits respected leaders in each community and trains them to be advocates for family planning. "We use the WHO family planning advocacy kit to teach these champions," explains Mr. Hiza. "After their training, they go to the community. These people play a very important role in raising awareness, and they really mobilize the community by telling of the advantages and benefits of family planning."

Maurice Hiza
Photo by Dominic Chavez/FP2020

SECTION

PROGRESS

3

The FP2020 movement is driven by a clear vision, a shared goal—expanding contraceptive access to an additional 120 million women—and powerful commitments from countries, partners and donors.

But how do those commitments get converted into progress? What has to happen—specifically, realistically—for millions of women and girls to gain access to family planning services?

To turn the question on its head, what are the problems that block access to family planning? For every problem, there is a solution—and that is how progress happens. In this section we present a snapshot survey of the many advances that are being made on multiple fronts: from government ministries to local community centers, from computer data centers to remote health clinics, from boardrooms to laboratories. Everywhere a problem is being solved, progress is being made.

Photo by Dominic Chavez/FP2020

ADVOCATING FOR CHANGE

Family planning programs need political support to operate successfully. Government policies, laws, regulations and funding priorities can either help or hinder the delivery of family planning services. Advocates play an essential role: they generate support for family planning policies, build strategic alliances and lobby decision makers for change.

In the Philippines, a 15-year campaign by civil society advocates and political leaders has finally paid off. The Responsible Parenthood and Reproductive Health Act was signed into law in December 2012, guaranteeing universal access to contraception, sex education and maternal care. But church groups immediately filed petitions arguing that the law was unconstitutional, and the Supreme Court halted implementation. Finally, after more than a year of deliberation, the court ruled in April 2014 that the law was constitutional. As a result, virtually all forms of contraception will now be freely available at public health clinics. Sex education will be provided in schools, and public health workers will receive family planning training.

In Uganda, the long-awaited National Population Council bill was signed into law in June 2014. The bill will create a new government body—the National Population Council—to oversee the country's population, reproductive health and family planning policies. Advocates in Uganda have been working toward this result for more than a decade, beginning with recommendations from the government's own Population Secretariat (POPSEC). The final push to move the bill through parliament and onto the president's desk was organized by a consortium of advocates in government and civil society: POPSEC, leaders in parliament, Partners in Population and the Development Africa Regional Office, Reproductive Health Uganda (the local IPPF Member Association) and Advance Family Planning. At Uganda's first National Family Planning Conference, held in July 2014, President Museveni announced his endorsement of family planning as a key strategy for accelerating social and economic transformation.

These are big wins, with national—and international—repercussions. But advocacy is also important at the lower levels of government. Indeed, with decentralization a factor in so many countries, micro-targeted advocacy efforts are essential.

In Indonesia, advocates worked with Advance Family Planning to develop an evidence-based approach to five district mayors. Their goal was to persuade the mayors to increase district budget allocations for family planning. By marshalling and presenting an array of evidence—local service statistics, costed action plans, return-on-investment data—the advocates were able to make their case. All five mayors raised their budget allocations for family planning, with increases ranging from 20% in Bandung district to nearly 80% in Pontianak district (measured from 2010 to 2013).

In Sierra Leone, Marie Stopes Sierra Leone (MSSL) led a successful effort to streamline the process for securing duty waivers on the import of contraceptive commodities. The existing waiver system was cumbersome and slow, and commodities were being held up at port for 21 days to six months. This exacerbated the stock-out situation in the country, while the demurrage charges at port (penalty fees for uncollected shipments) drove up the cost of family planning supplies. With a grant from the Reproductive Health Supplies Coalition, MSSL formed an action committee to lobby the government for change. After months of negotiations, a new policy was put in place: duty waivers would be approved on demand, freeing up the commodities to be cleared within one day of arrival.

RAISING AWARENESS

Cultural attitudes are one of the most important factors in determining whether women and girls have access to family planning. In some countries, there is a lack of good information about contraception and often a harmful abundance of misinformation. Many traditional cultures place a premium on large families and frequent childbearing. Restrictions on women's rights, and notions that it is somehow wrong or immoral for women to plan their families, are serious barriers. Awareness campaigns can help change minds.

In India, the Population Foundation of India (PFI) has developed a multimedia "edutainment" serial called *Main Kuch Bhi Kar Sakti Hoon* (I, a woman, can achieve anything). The serial is designed to promote women's empowerment through carefully crafted dramatic stories that highlight health and social issues. Family planning, reproductive health and rights, and gender equality are the recurring themes. The initiative is funded by DFID, with additional funding from UNFPA to adapt the serial for radio and an Interactive Voice Response System (IVRS). To date about 23 million people have watched *Main Kuch Bhi Kar Sakti Hoon* on television, and the IVRS has logged an overwhelming response. The serial also has a website, a dedicated YouTube channel where all episodes are uploaded, an active Twitter account and a Facebook presence.

In Burkina Faso, journalists are being enlisted to help raise awareness of family planning. The Press Caravan initiative is a joint project between UNFPA, the government and the media. In 2013, a Press Caravan toured six regions of the country, bringing journalists face to face with traditional and religious leaders as well as political and administrative authorities. The journalists acted as advocates and investigators, asking questions about family planning and exposing misconceptions. Thought leaders were given an opportunity to present themselves in the media as supporters of family planning. Television, radio, and newspapers carried stories from the caravan throughout the country.

In the Philippines, IPPF volunteers play an important role as community educators. They help to dispel dangerous myths: that condom use is linked to promiscuity among women and girls, that sexually transmitted infections are carried by mosquitos, that drinking bleach cures sexually transmitted diseases and that the oral contraceptive pill can lead to birth defects. Their efforts have led to a greater use of contraception and an increased client load for the Family Planning Organization of the Philippines (FPOP), the local IPPF Member Association. The volunteers are able to reach geographically isolated populations with information, services, counseling and contraception, and to make referrals to FPOP clinics.

In Niger, the Hewlett Foundation is using commercial marketing techniques to raise awareness and create demand for family planning. The project is implemented by Hope Consulting and will generate a sophisticated market segmentation of women based on their behaviors and preferences about family planning. The insights from the segmentation study will be incorporated into the Ministry of Health's national family planning communications strategy. Hope Consulting is also collaborating with a local social marketing organization to incorporate the findings into the organization's marketing plans.

Kamuli Kazina
Assistant Nursing Officer, Maternity Ward
Gungu Health Center, Mwanza, Tanzania
August 2014

Photo by Dominic Chavez/FP2020

REACHING OUT TO YOUTH

More than one-quarter of the people alive today are under the age of 15. It is the largest generation of youth in history, and they are about to enter their reproductive years. They must be equipped with the information and tools they need to make their own choices and take charge of their futures.

Access to contraception is especially critical for adolescent girls, who are at high risk for health complications from pregnancy and childbirth. Yet girls are typically the least empowered group in society, with limited say over their own reproductive health. To reach these vulnerable young people with lifesaving information and access to contraception, programs must be designed with their unique needs and circumstances in mind.

In Pakistan, the Rahnuma-Family Planning Association of Pakistan (Rahnuma-FPAP) has begun hosting tea parties where girls can talk about reproductive health with their peers, often for the first time. Most girls in Pakistan are raised to believe they should never discuss these topics with others, so the tea parties are organized to provide an informal and safe space where girls can ask questions and talk about their concerns. The parties have been very successful, with one-quarter of the girls who attend going on to use reproductive health services from Rahnuma-FPAP.

Youth must be equipped with the information and tools they need to make their own choices and take charge of their futures.

In Kenya, Deutsche Stiftung Weltbevoelkerung (DSW) is bringing information about reproductive health and rights to young adolescents aged 10 to 14 years. Young adolescents are at especially high risk for illness and death from pregnancy-related complications, HIV infection and other sexually transmitted infections. Unintended pregnancy is often the main reason girls in this age group leave school. The Young Adolescents Project is a three-year partnership with Bayer Health to bring reproductive health education to boys and girls at nine primary schools in Kilifi County, a coastal region in Kenya.

In Mozambique, the mCenas! project uses text messages to educate young people (15 to 24 years old) about contraception. Implemented by Pathfinder with funding from USAID, the program features role-model stories, short informational messages and an interactive menu of frequently asked questions. Users who request follow-up information are referred to a government-run hotline, with operators trained to answer questions about contraception, HIV and other reproductive health issues.

In Zambia, the Hewlett Foundation is funding a human-centered design project to increase youth engagement with reproductive health services. The project is a collaboration between IDEO.org and Marie Stopes International Zambia to design new program offerings and communications that speak to the needs of young people. The innovative designs are geared toward Zambian teen culture and are thoroughly grounded in field research and iterative prototyping.

Young people have the right to know about their own bodies so they can decide their own futures. How will that happen unless they have systematic access to the information, in school and afterwards? Countries and the international community must pick up the challenge they accepted in Cairo—to ensure not only that all children are educated, but that they are educated about their sexual and reproductive health, and how to protect it.

Dr. Nafis Sadik
Special Advisor to the UN Secretary-General

SECURING THE SUPPLY

Family planning programs rely on supply chains to bring contraceptive commodities within reach of the women and girls who need them. Problems at any point in the chain—from initial procurement to local distribution—can lead to empty shelves. A secure supply chain, on the other hand, means fewer stock-outs and bottlenecks and a greater variety of products to offer. It means that women have more choices and a more reliable source of the contraceptive products they prefer.

Market shaping is defined as the attempt to proactively shape the flow of commodities. In the reproductive health sector, market shaping aims to improve women's access to a broad range of affordable, quality contraceptives. This can be achieved by making the products more affordable, improving their design, streamlining the procurement process, simplifying the regulatory environment, strengthening delivery systems and enhancing the data available about commodity logistics. Over 20 organizations are working on family planning market-shaping interventions, with at least US$315 million invested in such efforts since 2006.[37]

Globally, the widest-ranging effort to ensure access to a reliable supply of contraceptives is UNFPA's Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS), which is implemented in 46 countries. GPRHCS takes a wholistic approach to supply, focusing on five key strategies: improving enabling environments, increasing demand for reproductive health commodities, improving efficiency for procurement, improving access to reproductive health and family planning, and strengthening national capacity and systems.

The USAID | DELIVER PROJECT provides technical assistance to strengthen supply chains in more than 30 different countries, working with ministries of health and other organizations. Using best practices and innovative approaches, USAID | DELIVER develops and implements robust logistics solutions, fosters supportive commodity security environments, procures and ships health commodities, and partners with local organizations to build sustainable capacity.

37. Dalberg Global Development Advisors and Reproductive Health Supplies Coalition. 2014. Market Shaping for Family Planning. Downloaded from: http://www.dalberg.com/documents/Market_Shaping_for_Family_Planning.pdf

ELIMINATING STOCK-OUTS WITH TEXT MESSAGES

Monica Milando, a community nurse in Kisumu, Kenya's third-largest city, is a brave woman. To make sure that women visiting her health center would be able to get the contraceptives they needed, she used to handwrite inventory reports and then ride her own bicycle—the only transportation she could afford—to go pick up the contraceptives herself at the district government office.

Not only was it a tiring trip for this 58-year-old woman, but she also often traveled all the way to the district office just to find that the contraceptives were not available. As a result, the health center experienced regular stock-outs.

"Last year, four women came several times for the [Depo-Provera®] shot, but we did not have it," says Monica. "I tried to offer pills, but their husbands would notice the pills, so they didn't use any contraceptives and became pregnant."

Many women in Kenya have to hide their contraceptive use from their husbands, who believe that women should not have access to family planning. They choose injectable contraceptives because they can get the injections without their husbands noticing—unlike pills, which they would have to hide, or implants, which their husbands might detect under their skin. So for many of the women at Monica's clinic, a stock-out of Depo-Provera® means no contraception at all.

But the inventory problem is being solved with technology. In 2012, UNFPA partnered with Pharm Access Africa Limited (PAAL) to implement an SMS-based system of commodity stock reporting. Instead of handwriting inventory reports, now Monica sends text messages by mobile phone to a central system. The text messages are formatted with numerical codes to indicate how much of each contraceptive commodity—injectables, implants, pills, condoms, IUDs—the health center has

Photo by Liz Gilbert
© Bill & Melinda Gates Foundation

in stock, and how much is needed. The contraceptives are then delivered directly to the center.

This simple technology has made a huge contribution to ending stock-outs, at Monica's clinic and at others using the system. Since all the clinics report through PAAL's central system, it is easy to see which clinics have an excess of commodities and which have a shortage, so that commodities can be transferred between health centers. If, for example, Monica has more IUDs than she can use, but a neighboring health center has none, PAAL will send couriers to pick up the IUDs from Monica's clinic and deliver them to the clinic that is short on stock.

The program is still in its infancy, but Monica and her clients have already seen a difference. Beatrice Anyango, 29, relies on Monica's clinic for her contraceptive supply. "Recently, there haven't been any complications," she says. "The Depo is in stock, and everything is okay."

Having a constant supply of contraceptives also allows Monica and other nurses to increase their outreach to neighboring communities. "For outreach, when we go, we know now that we have all the products," Monica says. "It has lessened our workload but also made it so that we can really serve these women, and we are able to get the women the contraceptives they so desperately need."

UNFPA has rolled out the PAAL system to 117 health facilities in Kenya, and at more than 80% of them stock-outs have been completely eliminated. A scale-up of the system to other districts in the country is now being planned.

IMPLANT ACCESS PROGRAM

Contraceptive implants are one of the most effective and convenient methods of preventing pregnancy. These small plastic rods are inserted under the skin on the upper arm, where they release a steady dose of contraceptive hormones. They last for three or five years, making them ideal for women who are unable to make regular visits to a health clinic or pharmaceutical dispensary. They are readily reversible, with fertility resuming immediately after the implant is removed. And they are discreet, which is important in settings where women's right to family planning may be under challenge. Once an implant is inserted, it is virtually invisible, so a woman can maintain privacy about her decision to use contraception.

Implants are popular choices wherever they are included as part of the contraceptive method mix, but their availability has been limited by a number of factors. Price is one issue: the up-front cost of implants is relatively high compared to shorter-acting methods. The supply chain is unreliable in many countries, with stock-outs a frequent problem. A lack of skilled providers is another obstacle, since health workers must be specifically trained to insert the implants correctly, remove them safely—a task that in most countries must be performed at a clinic—and counsel women on their use and possible side effects.

A group of public and private organizations came together in 2013 to tackle these issues. The Implant Access Program (IAP) is a global collaboration to expand access to contraceptive implants in the world's poorest countries, through a combination of price agreements, training and education programs, and supply chain strengthening. The partnership includes the Bill & Melinda Gates Foundation; the Clinton Health Access Initiative (CHAI); the governments of Norway, Sweden, the United Kingdom and the United States; the Children's Investment Fund Foundation; and the United Nations Population Fund (UNFPA).

The first step was securing price reduction agreements with pharmaceutical firms. In January 2013, it was announced that Bayer HealthCare AG would cut the price of its contraceptive implant Jadelle® from US$18 to US$8.50 per unit in more than 50 countries.

The first step was securing price reduction agreements with pharmaceutical firms. In January 2013, it was announced that Bayer HealthCare AG would cut the price of its contraceptive implant Jadelle® from US$18 to US$8.50 per unit wherever it is distributed (currently in more than 50 countries). In May 2013, Merck/MSD announced it would reduce by half the price of its contraceptive implants IMPLANON® and IMPLANON NXT® in the 69 focus countries identified at the 2012 London Summit on Family Planning and in South Africa. The effects have been dramatic: the total number of implants procured across the world's poorest countries has tripled—growing from 2.4 million units in 2011 to 7.7 million units projected for 2014. The global community is expected to realize a cost savings of more than US$140 million in the program's first two years.

But price is only one piece of the puzzle. The IAP organizations are also working to train local health providers, improve service delivery, reduce supply chain disruptions and coordinate with community groups to raise awareness about implants. **In Kenya**, for example, Jhpiego has worked with local organizations to bolster commodity security and provide training for health workers. As a result, the number of health facilities offering implants has increased, as

Photo by Frederic Courbet
© Bill & Melinda Gates Foundation

has the proportion of women choosing implants for their contraceptive needs. **In DR Congo**, EngenderHealth is working with UNFPA and the Ministry of Health to expand access to contraception. Implants were included in the method mix offered during a 2014 mobile outreach campaign, to extremely positive reaction from Congolese women.

The Norway-based RemovAid is developing a new medical device that will make implant removal easier, so that lower-level health workers are able to perform the procedure.

As demand for implants increases and supply chains become more reliable, the need for skilled providers will become ever more acute. A key achievement of IAP has been the implementation of a standardized curriculum module on implants that can be included in existing health worker training programs. By the end of 2013, more than 11,800 providers had been trained on the proper insertion and removal of implants. In 2014, Jhpiego launched the Providing Contraceptive Implants Learning Resource Package (LRP), which includes training materials available for download online. Within the first month, more than 2,200 individuals from over 30 countries had accessed the materials. Meanwhile, CHAI has developed a dashboard tool to help local governments track health worker training.

IAP organizations are also collaborating on best practices and looking for ways to scale up high-impact interventions, such as mobile services and family planning days. Technological innovation is on the horizon as well: the Norway-based RemovAid is developing a new medical device that will make implant removal easier, so that lower-level health workers are able to perform the procedure. The device is currently in development, with clinical testing expected to begin in 2015.

EXPANDING SERVICE

Gaps in the health care system are a reality in the world's poorest countries. Doctors and nurses are scarce and medical facilities are often far from where people live. For family planning programs to be effective, they must draw on the resources and networks that exist.

Many countries rely on **community health workers** (CHWs) to deliver family planning services. CHWs are not medical professionals; they are local residents—usually women—who are trained to provide basic health care, information and referrals. As members of the communities they serve, CHWs establish relationships of trust with their patients, making them ideally suited to provide family planning information. CHWs are often volunteers, but in some countries they are regular salaried employees of the government.

In Ethiopia, for example, the Health Extension Workers (HEWs) are a cadre of 38,000 women who are employed by the Ministry of Health. They receive one year of training at a special vocational school, and then are assigned to a health post in their home region. Because the HEWs work in the area where they grew up, they understand local concerns and can help dispel fears about contraception and other medical interventions. The HEWs typically spend three days a week conducting door-to-door visits in the community and are equipped to provide contraceptive pills, condoms, injectables and implants. The impact of the program has been phenomenal. Contraceptive use in Ethiopia has more than quintupled, with one out of three women now using modern methods.[38] Maternal mortality has been cut in half,[39] and the child mortality rate has been reduced by two-thirds—an MDG 4 goal that Ethiopia met two years ahead of schedule.[40]

Social franchise networks are another service delivery model. **In Pakistan**, for example, Suraj is a social franchise network sponsored by the Marie Stopes Society. The franchisees are private health care providers—midwives, clinics or pharmacies—who pay a small fee to join the network. They receive extensive training from Marie Stopes on reproductive health services, and are provided with affordable, high-quality commodities for their clients. The network includes field-based health educators (FHEs), who go door-to-door to teach women about family planning. The FHEs also distribute vouchers to women who cannot afford to pay for care. The Suraj network now serves over one million women in Pakistan, reaching communities that are underserved by the government's community health worker program.

Faith-based organizations (FBOs) play a major role in sub-Saharan Africa, where they are estimated to provide as much as 40% of health care services.[41] Many FBOs, such as Christian Health Associations in Africa, consider family planning to be central to their missions to support women, children and families. Their provider networks offer contraceptive counseling and supplies as a regular part of their health care services. FBOs can also be key messengers in reaching out to religiously and culturally conservative communities.

38. https://www.k4health.org/blog/post/pma2020-publishes-results-ethiopia

39. http://mariestopes.org/news/ethiopia-family-planning-success-story

40. http://www.unicef.org/ethiopia/events_13459.html

41. Bandy, Gary, Alan Crouch, Claudine Haenni, Paul Holley, Carole J Larsen, and Sian Penlington, eds. Building from Common Foundations. The World Health Organization and Faith-Based Organizations in Primary Healthcare. Edited by Ted Karpf and Alex Ross. 2008: World Health Organization, Geneva.

TASK-SHIFTING

In settings where doctors and nurses are in short supply, task-shifting is an invaluable strategy for expanding service delivery. Task-shifting, also called task-sharing, is the process of delegating tasks to less-specialized health workers, thus employing human resources more efficiently. Community health workers, for example, can be trained to provide injectable contraceptives and even implants. As of March 2014, 14 countries in sub-Saharan Africa were supporting community-based delivery of injectables: Ethiopia, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Nigeria, Rwanda, Senegal, Sierra Leone, Togo, Uganda and Zambia.[42]

In Ethiopia, the HEWs are also trained to insert contraceptive implants, a strategy that has been successful in expanding access to those women with the highest levels of unmet need.[43] Various degrees of task-shifting for implants are also being supported through service delivery investments in Zambia, Nigeria, and Kenya (with support from the Gates Foundation and Jhpiego),[44] as well as Uganda, Tanzania, and DR Congo (with support from the Gates Foundation and EngenderHealth).[45]

42. http://www.advancingpartners.org/sites/default/files/apc_advocacy_pack_1.pdf

43. Asnake, M., Henry, E. G., Tilahun, Y., & Oliveras, E. (2012). Addressing unmet need for long acting family planning in Ethiopia: Uptake of Implanon and characteristics of users. Pathfinder International Research and Evaluation Working Paper Series. Watertown, MA: Pathfinder International.

44. http://www.jhpiego.org/content/kenya

45. http://www.engenderhealth.org/our-work/major-projects/gates-scaling-up-access-project.php

REACHING THE UNREACHED

When Daniel Nanshep Gobgab was in medical school, his mother almost died from a miscarriage. She had already borne eight children including Daniel, but with her ninth pregnancy something went terribly wrong. She nearly bled to death before she reached the hospital. After the crisis had passed, Daniel persuaded his parents to agree to a tubal ligation.

Today, 30 years later, Dr. Gobgab is the Secretary General and Chief Executive Officer of the Christian Health Association of Nigeria (CHAN), the largest faith-based health consortium in the country. And his mother is still alive and enjoying her grandchildren.

As a doctor and a Christian, Dr. Gobgab feels strongly about the importance of family planning. He knows that women, children and families all benefit when women are able to take charge of their fertility. And he is confident that family planning is in line with the values of his faith.

"The same Bible that says we should multiply and fill the earth also says that he who does not take care of his family and provide for their basic needs is worse than an infidel," he points out. In Dr. Gobgab's view, Christians are called to be good stewards of God's creation. That means they should use resources wisely, take care of their own health and have only as many children as they can responsibly support.

It's a message that CHAN promotes through its network of health facilities, mobile clinics, and outreach programs. There are some 500 member institutions under the CHAN umbrella, ranging from large hospitals to tiny mission posts. Twenty-three Christian denominations are represented, both Protestant and Catholic. Their motto is "Reaching the Unreached."

In the varied landscape of Nigerian health care, these faith-based institutions play a crucial role. Dr. Gobgab estimates that at least 40% of medical services in Nigeria are provided by CHAN's member institutions. In remote areas, the figure is closer to 100%.

For rural villagers living far from any government medical facility, CHAN is a lifeline. Mobile clinics bring medicines, vaccines and antenatal care. Outreach lessons at the local church or community center provide important information on health and hygiene. Wherever possible, family planning information and supplies are part of the package.

"We'll start with a word of prayer, letting them know that we are trying to do our best, but it's God that helps to heal people," Dr. Gobgab explains. "And after the prayer session, we give a 10-, 20-, 30-minute at most health talk. And family planning is usually one of the topics that is considered."

CHAN institutions are active throughout Nigeria, offering health care to everyone regardless of religious faith. In the far north, where most people are Muslim and there are very few Christians, CHAN mobile clinics bring much-needed supplies and medical attention.

"We are not establishing the facilities for fellow Christians, but for everybody," says Dr. Gobgab. "We don't discriminate in our services."

INVESTING IN INNOVATION: SAYANA® PRESS

For millions of women in the world's poorest countries, injectable contraceptives are the method of choice for family planning. Pfizer's popular Depo-Provera® is safe, effective, and convenient: a single shot lasts for three months. It is also discreet. With no pills to take and no supplies to store, a woman can exercise her right to contraception in privacy, without having to ask her husband's permission or cope with opposition from in-laws.

Now a new design is making Depo-Provera® even better. Sayana® Press combines Depo-Provera® with Uniject™, a special one-use syringe that was originally developed for vaccines. The Uniject™ device is completely self-contained, with a single, precisely measured dose already stored in the tube. It is designed for safe disposal and a special flap prevents the needle from being reused. For health workers, this means no more need for separate vials and syringes, no need to store quantities of medicine or measure out doses. The whole system is so simple and safe to use that even lower-level health workers can begin administering injections after less than two hours of training.

Sayana® Press also uses a new lower-dose formulation of Depo-Provera® designed for subcutaneous injection, thus eliminating the need for intramuscular shots. Test studies showed that women were very enthusiastic about the change, and health workers preferred it, too.

A woman can exercise her right to contraception in privacy, without having to ask her husband's permission or cope with opposition from in-laws.

The result of all this innovation is a foolproof delivery system that could make injectable contraceptives as ubiquitous as vaccines. PATH, the nonprofit health firm that developed Uniject™ and collaborated on Sayana® Press, hopes that someday women will even be able to inject themselves—with no need for a visit with a health worker at all.[46]

For now, though, Sayana® Press is labeled for delivery by trained community health workers and is being rolled out for pilot projects in Burkina Faso, Niger, Senegal, and Uganda. These countries were selected because demand for injectables was already very high in each, with significant unmet need. In Burkina Faso alone, 250,000 units of Sayana® Press will be distributed in 2014.

The pilot projects will look to see how well Sayana® Press measures up in terms of expanding access to new users and improving contraceptive continuation rates. Cost-effectiveness will be evaluated across a variety of delivery settings, including community-based distribution and social marketing. Evidence from the pilots will help each country decide whether to include Sayana® Press in their family planning programs going forward. Similar pilot projects are also on tap for Southeast Asia.

The Sayana® Press initiative is a collaboration between the Bill & Melinda Gates Foundation, USAID, DFID, UNFPA, Pfizer Inc., and PATH.

46.
Pilot study of self-injection: http://www.sciencedirect.com/science/article/pii/S0010782411005750
Qualitative acceptability study of self-injection in Ethiopia: http://www.sciencedirect.com/science/article/pii/S0010782413007531
FHI 360 is implementing a self-injection feasibility study in Malawi; the RFP summarizes several studies to date: http://www.fhi360.org/sites/default/files/media/documents/Sol_711_122838.pdf

Photo by Dominic Chavez/FP2020

PROGRESS IN ACTION: SENEGAL

"I believe in the life choice family planning creates," says Marieme Yade. "Do you?"

Madame Yade is the head of the maternity ward at the health post in Medina Sabakh, a small rural town in Senegal's peanut-growing region. It is a land of packed red-earth courtyards, whitewashed walls and tin roofs. Madame Yade wears a lab coat over her long skirt, and her hair is tied in a matching headscarf. "With family planning, the women of Medina Sabakh now have a chance to 'do something' with their lives," she says.[47]

At her health post, family planning services are now being integrated with routine child immunizations. Whenever a woman brings a child in to be vaccinated, she is discreetly offered contraceptive counseling and supplies at the same time. This approach neatly sidesteps the obstacles that all too often keep women in Senegal from seeking out contraception: cultural taboos, misinformation and disapproval from men. As a result, contraceptive use is soaring. In the first four months of the project in Medina Sabakh, the number of new family planning users increased by 57%. Now the scenario is being repeated at other health posts across the country, with similar results.

It is one of the many examples of progress underway to bring modern contraception to the women of Senegal. Support comes from the very top: the Minister of Health, Dr. Awa Marie Coll-Seck, is a longstanding champion of family planning.

I believe in the life choice family planning creates. Do you?

At the 2012 London Summit on Family Planning, Dr. Coll-Seck announced Senegal's pledge to raise its contraceptive prevalence rate from 12% to 27% by 2015. Four months later, the government unveiled its National Family Planning Action Plan 2012-2015, a detailed strategy to expand contraceptive access and acceptance. The new plan mobilized a host of resources and commitments throughout the country (see page 88: Decentralization in Action). The early results are good. As of 2013, Senegal's contraceptive prevalence rate had already jumped four percentage points to 16%.[48]

Part of the increase can be chalked up to the striking improvements being made in the supply chain. The successful Informed Push Model of distribution promises to virtually eliminate stock-outs of contraceptive supplies (see page 88: The Informed Push Model). The Informed Push Model was developed in partnership with IntraHealth, and is now being rolled out nationwide. The government has also doubled its budget for the purchase of contraceptive commodities and augmented its fleet of delivery trucks.

Efforts are also underway to improve service delivery and expand method mix. Depo-Provera® is very popular in Senegal—it accounts for 40% of the contraceptive use—but access has been difficult. Until now, the injections have been available only from trained health workers in clinics, so women in remote areas have had to travel long distances for care. But a pilot study demonstrated that community workers could administer Depo-Provera® safely, and the Ministry of Health has approved scale-up of the practice to 14 regions.

Senegal is also one of the four countries in the pilot rollout of Sayana® Press, the new single-dose subcutaneous injectable. Sayana® Press combines Depo-Provera® with Uniject™, a special one-use syringe that is completely self-contained. The Ministry of Health has approved the

introduction of Sayana® Press at 637 health posts in four regions. But improvements to service delivery and the supply chain will only go so far; the cultural taboos and misinformation surrounding contraception must be confronted as well. The government has begun a multi-phase communications campaign designed to raise awareness of family planning, with targeted messages for women, men, and young people. The media blitz includes television and radio spots, call-in shows, posters, and pamphlets. The government is also recruiting a group of prominent local and national figures to serve as family planning champions, touring the country and acting as public advocates.

Men are accepting family planning more and more because they are getting the right information.

Civil society organizations also play a crucial role as advocates. "There is a lot of enthusiasm in Senegal around improving reproductive health," says Fatou Ndiaye Turpin.[49] She is the program director for Réseau Siggil Jigéen (RSJ), a network of organizations dedicated to empowering women. RSJ recently partnered with IntraHealth to develop an advocacy program for six cities in Senegal, part of a five-year program to improve family planning services in urban areas.

RSJ is also the collaborating partner of Advance Family Planning (AFP), which coordinates a number of advocacy efforts in Senegal. In May 2014, a consortium of advocates led by RSJ and AFP succeeded in winning important new funding commitments from two mayors in Pikine. Following an evidence-based "ask" from the advocacy committee, the mayors each allocated 1 million West African CFA francs (US$2,090) to purchase contraceptive supplies for their district health posts.

Perhaps the most encouraging sign of progress is in the religious quarter. Senegal is a conservative country, with a population that is 94% Muslim. Many people believe that Islam prohibits family planning, a view that some traditional imams share. But in Senegal's dynamic culture, some imams are stepping up to say that they disagree with this interpretation. The 30-year-old Moussé Fall, for example, is a popular "tele imam" who makes frequent appearances on radio and TV. He is adamant about the acceptability of contraception within Islam.[50] He belongs to the Network of Islam and Population, a group of religious leaders that is working hard to get that message out.

"We organize religious conferences where we explain what Muslims can do in terms of family planning," says Imam Fall. "Men are accepting family planning more and more because they are getting the right information."

47. http://babellights.wordpress.com/2012/08/13/medina-sabakh-a-success-in-the-south/

48. https://www.fphighimpactpractices.org/blog/family-planningimmunization-integration-overcomes-obstacles-contraceptive-use-senegal

49. http://advancefamilyplanning.org/news/reseau-siggil-jigeen-to-coordinate-afp-efforts-senegal

50. http://fr.allafrica.com/stories/201311252470.html

THE INFORMED PUSH MODEL

In Senegal, as in many poor countries, one reason women do not use contraceptives is because the products are simply not available. Gaps in the supply chain mean that stock-outs are a frequent occurrence at pharmacies and clinics. That spells serious problems for contraceptive users. When a woman is unable to refill her pills or get her next three-month injectable, her contraceptive protection is gone. Supply limitations also mean that many locations offer only one or two types of products—making it difficult for women to find and stick with a method that works for them. A 2011 study in Senegal found that 84% of women had experienced a stock-out of their preferred contraceptive in the past year.[51]

The Informed Push Model of distribution promises to change all that. Instead of relying on pharmacies and clinics to keep track of their inventory and call in orders, the push model employs the same kind of system that is used in the commercial sector for vending machines. A driver with a truckful 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 that there is sufficient stock at the warehouse and at each site, and to prime the manufacturers to keep pace with demand. On the systemic level, the information can be used by regional and national decision makers to figure out which contraceptives are most popular and where.

The government of Senegal and IntraHealth pilot-tested the Informed Push Model in Pikine between February and July 2012. Stock-outs of contraceptive pills, injectables, implants and IUDs were completely eliminated at the 14 public health facilities in Pikine over the six months of the pilot project. The government then expanded the model to all 140 public facilities in the Dakar region and six months later the stock-out rates in the region dropped below 2%. Now the Informed Push Model is being rolled out nationwide and is expected to be in place across the country by the end of 2015. Funding for the rapid national rollout is being supplied by the Bill & Melinda Gates Foundation and Merck for Mothers.

51. Daff BM, Seck C, Belkhayat H, Sutton P. Informed push distribution of contraceptives in Senegal reduces stock-outs and improves quality of family planning services. Glob Health Sci Pract. 2014;2(2):245-252. http://dx.doi.org/10.9745/GHSP-D-13-00171

DECENTRALIZATION IN ACTION

Decentralization is a watchword in Senegal. It is a guiding philosophy for the government and a driving goal in development. Empowering local actors to set their own agendas—deciding what needs to be done and how—ensures that priorities are aligned with real needs on the ground.

Senegal's approach to family planning is encapsulated by "the 3 Ds": democratize, demedicalize and decentralize. This framework was developed by Senegal in the context of the Ouagadougou Partnership and has been adopted by other countries in the region as well. It ensures that family planning interventions are participatory, unencumbered by policy barriers and effectively managed at the regional, district and community levels.

So when Senegal decided to develop a new national family planning strategy, decentralization was built in from the start. It was understood, of course, that high-level policy would be set at the national level, and that the Ministry of Health would assume responsibility for coordination across all the regions of the country. But it was also expected that each region, and each district within each region, would develop its own implementation plan. With the technical assistance of FHI 360, working through the Advancing Partners and Communities Project, that is exactly what happened.

The National Family Planning Action Plan 2012–2015 was launched by the Ministry of Health in November 2012. From December 2012 to April 2013, regions and districts throughout the country held meetings to decide how to implement the policies outlined in the new national plan. Each district established its own goals and benchmarks for expanding contraceptive access, improving service delivery, and raising awareness. A data measurement template was developed so that districts could track and report their progress as they implemented their plans.

In November 2013, the districts and regions began a second round of meetings, this time to evaluate their progress. The data from the measurement templates showed where the plans were succeeding, where they were falling short and where there were gaps. At the regional meetings, district representatives compared notes and talked through resource issues. The whole process became a rolling collaboration, with everyone sharing ideas and lessons learned.

In the Saint-Louis region, for example, representatives from the Pété district described their great success with TutoratPlus, an on-the-job training program for health care providers. TutoratPlus is offered through IntraHealth with funding by USAID, and is designed to improve provider skills on a range of contraceptive methods. One of the nurses in Pété who received the IUD training went from performing only three IUD insertions per year to performing 12 per month. When the other districts in Saint-Louis learned of this, they decided they should implement the program as well. The result: IUD insertion rates are now up throughout the region.

The district and regional meetings also led to much-needed funding realignments. The Kédougou region, for example, initially had few development partners and very little funding for reproductive health. But the region came up with a compelling, detailed implementation plan for the new family planning initiative, showing clearly what activities were needed. That enabled the Ministry of Health to work with partners such as WHO, Agence Française de Développement (AFD) and the Muskoka Initiative to redirect funds toward Kédougou's new goals.

Photo by Dominic Chavez/FP2020

SECTION

MEASUREMENT, EVIDENCE AND IMPACT

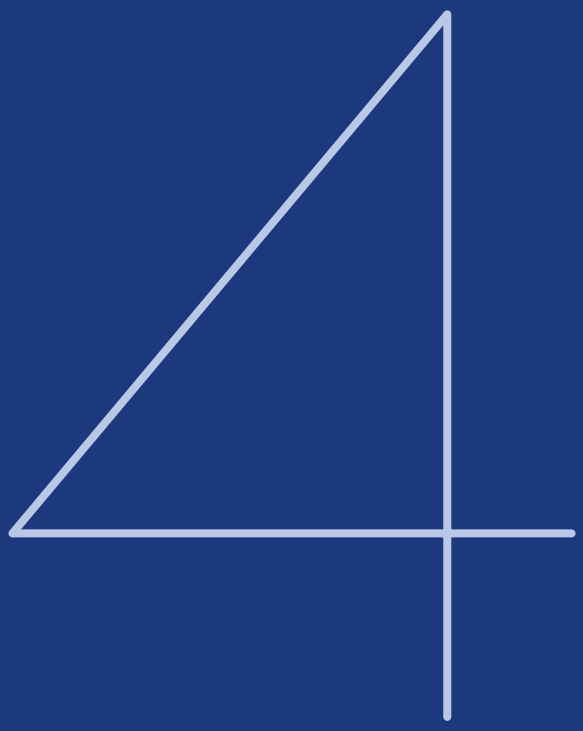


Photo by Tobin Jones/ UN

INTRODUCTION

All women and girls have the right, and must have the means, to plan their own lives, including whether, when and how many children to have. Access to voluntary family planning has transformational benefits for women and girls. It is one of the most cost-effective investments a country can make in its future.

These beliefs are fundamental to FP2020. But the spark that transforms FP2020 from a community of affinity into a movement for change is our shared commitment to achieving the FP2020 goal: enabling an additional 120 million women and girls to use modern methods of contraception by the year 2020.

FP2020's goal serves as a "global rallying cry to mobilize resources and leadership"[52] to improve and expand family planning programs. The goal is measurable, but it does not reduce women and girls to mere numbers. The expert group that developed the FP2020 goal projected that if historical trends were to continue, without accelerated action, the total number of women and girls in the world's poorest countries using modern contraception would grow from 258 million in 2012 to 306 million in 2020—an increase of 48 million. That increase would mean that programs operate to maintain services to the current base of contraceptive users, staying just ahead of population growth.

The implication of continuing with the historical trend is that 72 million additional women and girls with an expressed need to space or limit their children will have minimal access to family planning services. Addressing this requires an expansion of services—an increase in number of users—but just as important, it requires an improvement of service quality. The FP2020 Core Indicators reported in this section reflect both dimensions of the FP2020 goal: service expansion and service improvement.

52.
Brown, Win, Nel Druce, Julia Bunting, Scott Radloff, Desmond Koroma, et al, "Developing the 120 by 2020 Goal for the Global FP2020 Initiative." Studies in Family Planning 45(1), March 2014.

FIGURE 4.1
ADDITIONAL USERS OF MODERN METHODS OF CONTRACEPTION BY REGION, 2012–2013

Numbers are rounded.
South Africa not included in regional total.

TOTAL ADDITIONAL USERS OF MODERN METHODS OF CONTRACEPTION IN FP2020 FOCUS COUNTRIES

8,400,000

CENTRAL AFRICA
308,000
EASTERN AND CENTRAL ASIA
90,000
MIDDLE EAST AND NORTHERN AFRICA
529,000
SOUTH ASIA
4,148,000
EASTERN AND SOUTHERN AFRICA
1,872,000
SOUTHEAST ASIA AND OCEANIA
908,000

SUMMARY

This year, we present the first annual update to the estimates of FP2020's Core Indicators—the quantitative metrics we use to measure progress across the 69 FP2020 focus countries.[53]

Complete tables of the Core Indicator estimates and sources are found in the Annex. During the first year of FP2020's operation we see evidence of progress in enabling more women and girls to use modern methods of contraception.[54] We also observe persistent challenges in delivering method choice and equitable outcomes, especially for vulnerable populations. The data are encouraging, but it is clear that we must accelerate our efforts if we are to meet our goal.[55]

OUR TOPLINE FINDINGS ARE:

- In 2013, 8.4 million additional women and girls were using modern contraception compared to 2012 across the 69 FP2020 focus countries.

- In 2013, across the 69 FP2020 focus countries, the use of modern contraceptives by 274 million[56] women and girls of reproductive age averted 77 million unintended pregnancies, which amounts to 2 million more unintended pregnancies averted compared to 2012.

- Averting 77 million unintended pregnancies created substantial health impacts by reducing women's exposure to unsafe abortions and maternal deaths. In 2013, there were 24 million unsafe abortions averted (compared to 23 million in 2012) and 125,000 maternal deaths averted (compared to 120,000 in 2012) across the 69 FP2020 countries.

- The percentage of women and girls of reproductive age using modern methods of contraception—the modern contraceptive prevalence rate (mCPR)—averaged 23.5% across the 69 FP2020 focus countries. In 12 countries mCPR was greater than 40%; in nearly half (32) of the countries, mCPR was less than 20%.

- The average annual rate of mCPR growth was marginally lower in 2013 (0.65%) than reported in 2012 (0.73%). Some countries had new data that showed they experienced slower or static mCPR growth rates despite expanding their family programs to serve many more women and girls. This can occur when the growth of the population of women and girls of reproductive age outpaces program expansion.

- The average mCPR growth rate across all countries masks some important shifts, such as countries where the growth trajectory is rising. In Bhutan, Djibouti, Ethiopia, Kenya and Rwanda, growth rates exceeded 2.5%.

- Dominance by a single method of modern contraception is a defining feature in more than half of the FP2020 focus countries. In DR Congo, Ethiopia and India, more than 60% of users rely on a single method.

MEASUREMENT SECTION GUIDE

- There was little change in the levels of unmet need and demand satisfied for modern methods of contraception. This is unsurprising given the short window of observation and the potential for efforts to increase demand to also increase levels of unmet need. It was assumed that progress would be slowest in the first year of the FP2020 initiative and that demand for contraception might grow more rapidly than access to services.

- Among women and girls of reproductive age who are married or in union, the level of unmet need is higher for the 15 to 19 age group than it is overall.

53.
Countries with a GNI per capita equal to or less than $2,500 (2010).

54.
Modern methods include pill, injectables, IUD, implants, male and female condoms, LAM, diaphragm, foam/jelly, female and male sterilization, and the Standard Days Method.

55.
All findings are for 2013, across the 69 FP2020 focus countries except where noted.

56.
See methodological note on page 100.

FP2020 is committed to a robust, purpose-driven monitoring and evaluation framework that produces data to inform action. This section of the progress report presents our findings from new data for the FP2020 Core Indicators, including observations on dimensions of equity and contraceptive method mix. We describe emerging evidence and explain our Core Indicator definitions, methodologies and data sources. We also provide updates on two projects launched under the FP2020 initiative that are changing the ways we monitor and evaluate family planning.

- Onward to 2020: More women and girls are using contraception (page 100)
- A closer look at contraceptive prevalence: equity and method mix (page 110)
- Unmet need for modern contraception and percent of demand satisfied (page 120)
- Impact of family planning (page 125)
- Informed choice and adolescent childbearing (page 128)
- Indicators with new, emerging information (page 130)
- Track20 and PMA2020 (pages 134, 135)
- Notes on methodology and data sources (page 152)

Our Core Indicator analysis is tempered by the fact that FP2020's first year is a short window of observation, during which we assumed progress would be slowest and when demand for contraception may be growing faster than access to services. It is also difficult to determine whether certain findings are the result of recent interventions or the continuation of a trajectory that began before the 2012 London Summit on Family Planning. Limited availability of data to inform annual estimates is a constraint, and we relied on statistical modeling to generate estimates where data sources were not current.

FIGURE 4.2
FP2020 CORE INDICATORS

FP2020's Core Indicators are the quantitative metrics we use to measure progress. They were selected in 2013 and refined in 2014. FP2020's **Performance Monitoring & Accountability Working Group** (PMA WG) provides ongoing guidance on the Core Indicator definitions, methodologies and data sources. **Track20**, a project implemented by the **Futures Institute**, calculates the Core Indicator estimates and collaborates in their analysis. Initial estimates for the Core Indicators were published in *FP2020 Progress Report 2012–2013: Partnership in Action*.

INDICATORS THAT ARE REPORTED ANNUALLY FOR 69 FP2020 FOCUS COUNTRIES

INDICATOR TITLE	INDICATOR DEFINITION
1A. CONTRACEPTIVE PREVALENCE RATE, MODERN METHODS (mCPR)	The percentage of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.
1B. PERCENTAGE DISTRIBUTION OF USERS BY MODERN METHOD OF CONTRACEPTION	The percentage of total family planning users using each modern method of contraception.
2. NUMBER OF ADDITIONAL USERS OF MODERN METHODS OF CONTRACEPTION	The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012.
3. PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR MODERN METHODS OF CONTRACEPTION	The percentage of fecund women of reproductive age who want no more children or to postpone having the next child, but are not using a modern contraceptive method, plus women who are currently using a traditional method of family planning. Women using a traditional method are assumed to have an unmet need for modern contraception.
4. PERCENTAGE OF WOMEN WHOSE DEMAND IS SATISFIED WITH A MODERN METHOD OF CONTRACEPTION	The percentage of women (or their partners) who desire either to have no additional children or to postpone birth of next child, and who are currently using a modern method of contraception. Women using a traditional method are assumed to have an unmet need for modern contraception.
5. 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.
6. COUPLE-YEARS 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.
7. 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.

INDICATOR TITLE	INDICATOR DEFINITION
8. NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO MODERN 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.
9. NUMBER OF MATERNAL DEATHS AVERTED DUE TO MODERN 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.
10. NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO MODERN 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.

INDICATORS THAT ARE REPORTED ANNUALLY FOR A SUBSET OF FP2020 FOCUS COUNTRIES

INDICATOR TITLE	INDICATOR DEFINITION
11. PERCENTAGE OF WOMEN WHO WERE PROVIDED WITH INFORMATION ON FAMILY PLANNING DURING THEIR LAST VISIT WITH A HEALTH SERVICE PROVIDER	The percentage of women who were provided information on family planning 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, information, education and communication materials or talks/conversations about family planning.
12. 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 composed of 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?). The index score is equal to the number of women who respond “yes” to all three questions.
13. PERCENTAGE OF WOMEN WHO MAKE FAMILY PLANNING DECISIONS ALONE OR JOINTLY WITH THEIR HUSBANDS/PARTNERS	The percentage 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.
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.
15. PERCENTAGE INFORMED OF PERMANENCE OF STERILIZATION	Among women who said they were using male or female sterilization, the percentage who were informed by the provider that the method was permanent.

FP2020 CORE INDICATORS: KEY FINDINGS FOR 2013

ONWARD TO 2020: MORE WOMEN AND GIRLS ARE USING CONTRACEPTION

Is FP2020 on track to achieve the goal of enabling 120 million more women and girls to use modern methods of contraception by the year 2020? The answer is a qualified "yes."

The Core Indicator for tracking this quantitative measure of progress is #2: **Number of additional users of modern methods of contraception**. To calculate its value, we subtract the estimated number of women and girls using modern contraceptive methods in the current year from the number in 2012, the year of the London Summit on Family Planning. The difference represents change during FP2020's first year.

The available data indicate that across the 69 FP2020 focus countries, 8.4 million more women and girls used modern methods of contraception in 2013 as compared to 2012. About half of these additional users are from increases in contraceptive prevalence, and the other half can be attributed to an increase in the number of women and girls of reproductive age. As shown in **Figure 4.3,** this falls just below the 2013 benchmark goal of 9.4 million and above what was projected from historical growth patterns.

However, it is important to note that the projected buildup of the number of additional modern contraceptive users assumed that progress would be slower in the early years of the initiative, then accelerate as countries mobilize resources and improve national family planning program performance. Therefore, the most appropriate conclusion is that we are still on course but need to accelerate progress in order to have a greater impact on the number of women and girls gaining access to modern methods of contraception.

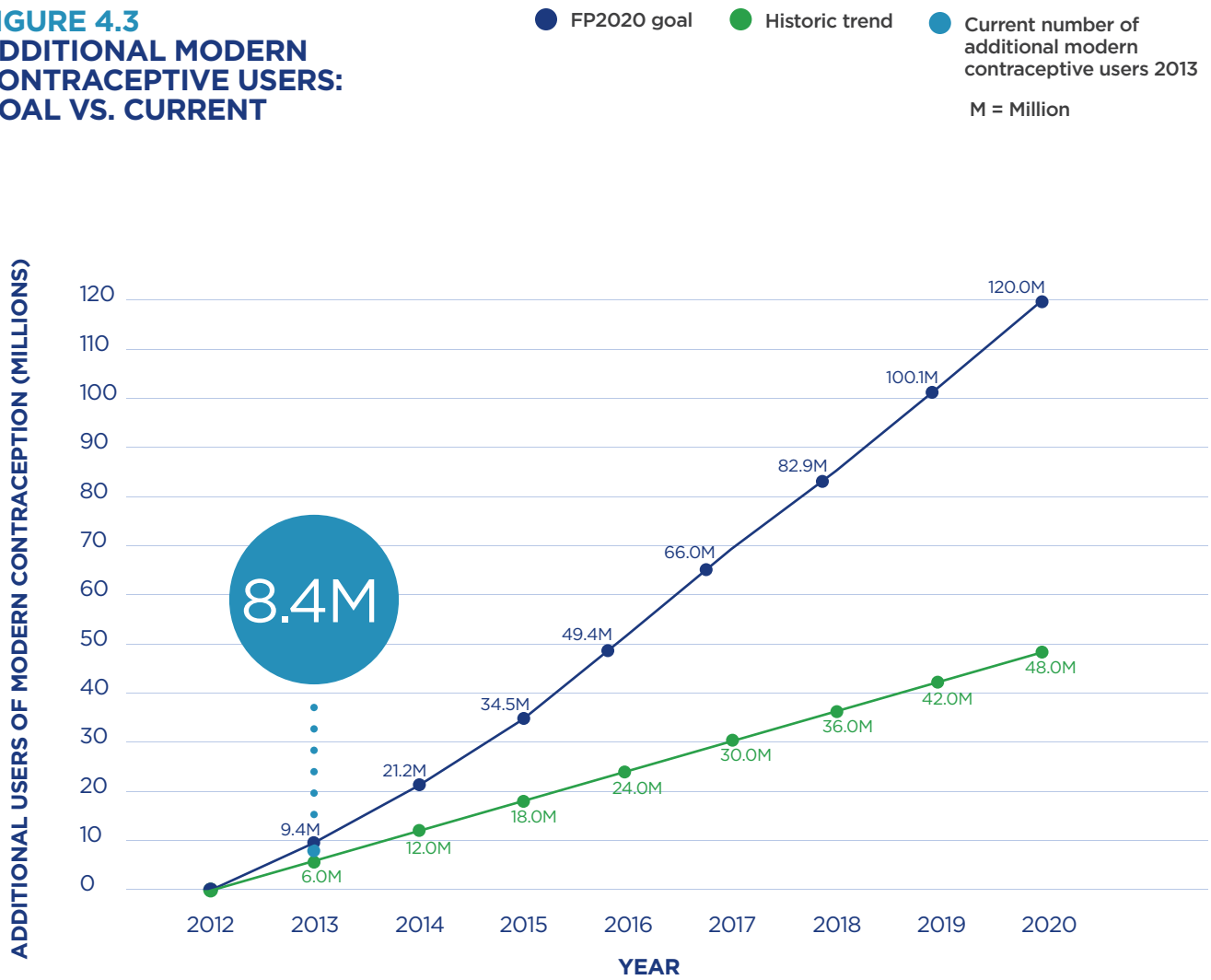
METHODOLOGICAL NOTE: COUNTING ADDITIONAL USERS

The methodology we use to estimate the number of additional users of modern methods of contraception has two important components, both of which confer advantages related to data quality and accuracy. The first is the designation of 2012 as the baseline year or starting point for our calculation—the point at which we appropriately set the number of additional users at zero. For each reporting period, we will compare the total number of users in the current year to the total number of users in the baseline year (2012). The difference between the two totals is the number of additional users.

The second component is the use of a "rolling" baseline, by which we mean we will recalculate our annual estimates (starting with 2012) on an ongoing basis as new data become available. Continuously incorporating new data improves our ability to monitor progress, so that by 2020 our estimates for all years (2012 to 2020) will represent the most comprehensive and accurate data available.

Calculations of the number of additional users depend on mCPR and the population of women of reproductive age (WRA). There is often a lag time of a year, and sometimes longer, before the surveys used to calculate mCPR are released. In addition, updated population estimates (including WRA) often include retrospective modifications of past estimates based on newly released census data and other sources. Consequently, as new data become available, they affect not only current year estimates but those calculated in previous years as well. The advantage of using rolling estimates is seen by comparing the estimate of the number of users of modern contraception that was calculated for the London Summit on Family Planning in 2012 (258 million) to the updated estimate for 2012 that we use now (265 million). Our calculation incorporates new DHS surveys and updated population estimates for 2012 that were not available two years ago, and as a result we now consider the total number of users in 2012 to be 7 million greater than we previously thought. Were we to use the old estimate for 2012, this discrepancy could be misconstrued as an increase of 7 million additional users since 2012.

FIGURE 4.3
ADDITIONAL MODERN CONTRACEPTIVE USERS: GOAL VS. CURRENT



DATA

YEAR	FP2020 GOAL	HISTORIC TREND	NUMBER OF ADDITIONAL MODERN CONTRACEPTIVE USERS
2012	0	0	
2013	9.4M	6.0M	8.4M
2014	21.2M	12.0M	
2015	34.5M	18.0M	
2016	49.4M	24.0M	
2017	66.0M	30.0M	
2018	82.9M	36.0M	
2019	100.1M	42.0M	
2020	120.0M	48.0M	

Source: Developing the '120 by 2020 Goal for the Global FP2020 Initiative.' Studies in Family Planning 45(1), March 2014.

Source: Current value, Track20.

It should be recognized that in most countries, the vast majority of users of modern methods of contraception will not be in the "additional" category. Rather, they will be continuing users from the previous year. Providing quality services to continuing users is important in terms of decreasing discontinuation and ensuring women have continued access to quality services and methods that best meet their reproductive intention needs.[57] Measuring the entire effort and contribution of a country's family planning program requires a more comprehensive look, which is why FP2020 monitors a set of Core Indicators.

Most FP2020 focus countries expanded their family planning programs at least enough to keep pace with population growth. So while 8.4 million additional women and girls of reproductive age (WRA) are using modern methods of contraception, the overall percentage of WRA using modern contraception—the contraceptive prevalence rate for modern methods, or mCPR—grew at a slightly slower pace in 2013 (0.65%) compared to 2012 (0.73%).

Levels of mCPR vary greatly in the 69 FP2020 focus countries, which can be seen in **Figure 4.4**, which lists values for each country for both 2012 and 2013. In 12 countries, mCPR was greater than 40%. In nearly half (32) of the countries, mCPR was less than 20%. The average mCPR across all 69 countries was 23.5%.

FP2020 selected mCPR to be a Core Indicator, rather than the standard indicator of CPR (which measures the use of all methods, traditional as well as modern). We chose to measure mCPR for all women rather than only married and in-union women to underscore the contraceptive needs of unmarried women and girls and to align our measurement framework with countries that offer contraceptive services to all women and that already have strategies in place to reach adolescents.

As noted, in some countries mCPR was relatively static despite an increase in the number of WRA using modern contraception. This can occur when countries expand family planning programs just enough (or slightly less than enough) to keep pace with an increasing number of WRA. It is particularly significant in countries with large populations and rapid population growth, where an enormous effort is required just to continue to serve the number of WRA who already use modern contraceptives.

In Nigeria, for example, the number of WRA using modern contraception increased from 4.14 million in 2012 to 4.25 million in 2013, but the percentage of WRA using modern contraception was virtually unchanged due to the increase in the number of WRA. The available data for 2012 and 2013 indicate that across the 69 FP2020 focus countries, 49% of the estimated number of additional modern method users came from population growth (maintaining mCPR with a growing population) and 51% from program expansion (increasing modern contraceptive prevalence).

57. WHO's working definition of quality encompasses six dimensions that include effectiveness, efficiency, accessibility, acceptability/patient centered, equity and safety. Source: WHO (2006). Quality of Care: A Process for Making Strategic Choices in Health Systems. Downloaded from http://www.who.int/management/quality/assurance/QualityCare_B.Def.pdf

Photo by Dominic Chavez/FP2020

FIGURE 4.4
mCPR (2012 AND 2013) AND ADDITIONAL USERS OF MODERN CONTRACEPTION (2013)

	mCPR 2012	mCPR 2013	ADDITIONAL USERS OF MODERN CONTRACEPTION
EASTERN AND SOUTHERN AFRICA			
BURUNDI	12.2	13.0	26,000
COMOROS	10.8	11.5	2,000
DJIBOUTI	13.7	14.7	3,000
ERITREA	9.4	10.1	15,000
ETHIOPIA	21.6	24.0	711,000
KENYA	30.7	31.3	290,000
LESOTHO	37.6	38.3	8,000
MADAGASCAR	25.8	26.8	104,000
MALAWI	34.5	35.4	75,000
MOZAMBIQUE	13.9	15.0	79,000
RWANDA	26.3	26.9	45,000
SOMALIA	2.5	3.0	13,000
SOUTH AFRICA*	52.8	53.2	78,000
SOUTH SUDAN	1.0	1.1	6,000
TANZANIA	25.6	26.7	207,000
UGANDA	21.5	22.6	159,000
ZAMBIA	24.8	25.7	59,000
ZIMBABWE	41.5	41.9	71,000
TOTAL ADDITIONAL USERS			**1,872,000**

Numbers are rounded.
*South Africa not included in regional total.

	mCPR 2012	mCPR 2013	ADDITIONAL USERS OF MODERN CONTRACEPTION
CENTRAL AFRICA			
CAMEROON	16.9	17.7	69,000
CENTRAL AFRICAN REPUBLIC	14.5	15.3	13,000
CHAD	4.7	5.1	15,000
CONGO (BRAZZAVILLE)	22.9	23.8	14,000
DR CONGO	8.2	9.0	197,000
SAO TOME AND PRINCIPE	28.2	28.7	500
TOTAL ADDITIONAL USERS			**308,000**
MIDDLE EAST AND NORTH AFRICA			
EGYPT	55.1	55.4	238,000
IRAQ	21.4	21.8	99,000
STATE OF PALESTINE	26.6	26.8	12,000
SUDAN	10.4	11.1	88,000
WESTERN SAHARA	N/A	N/A	N/A
YEMEN	17.7	18.6	92,000
TOTAL ADDITIONAL USERS			**529,000**

FIGURE 4.4 CONTINUED

	mCPR 2012	mCPR 2013	ADDITIONAL USERS OF MODERN CONTRACEPTION
WESTERN AFRICA			
BENIN	10.5	11.2	24,000
BURKINA FASO	15.4	16.1	45,000
CÔTE D'IVOIRE	15.0	15.6	50,000
GAMBIA	9.0	9.1	2,000
GHANA	16.4	15.5	0
GUINEA	7.5	8.1	23,000
GUINEA-BISSAU	10.9	11.6	4,000
LIBERIA	19.2	20.9	22,000
MALI	9.6	10.2	29,000
MAURITANIA	7.3	7.7	6,000
NIGER	10.7	11.2	31,000
NIGERIA	10.9	11.6	110,000
SENEGAL	10.7	12.1	59,000
SIERRA LEONE	15.5	18.1	44,000
TOGO	18.3	19.4	27,000
TOTAL ADDITIONAL USERS			**476,000**

Numbers are rounded.

	mCPR 2012	mCPR 2013	ADDITIONAL USERS OF MODERN CONTRACEPTION
EASTERN AND CENTRAL ASIA			
DPR KOREA	42.5	42.5	7,000
KYRGYZSTAN	23.8	24.5	11,000
MONGOLIA	34.9	35.1	3,000
TAJIKISTAN	18.5	19.2	21,000
UZBEKISTAN	43.2	43.3	48,000
TOTAL ADDITIONAL USERS			**90,000**
SOUTH ASIA			
AFGHANISTAN	18.3	19.3	115,000
BANGLADESH	40.3	40.8	475,000
BHUTAN	49.6	50.0	3,000
INDIA	38.2	38.7	3,012,000
NEPAL	34.7	35.5	127,000
PAKISTAN	16.4	16.9	404,000
SRI LANKA	52.3	52.5	12,000
TOTAL ADDITIONAL USERS			**4,148,000**

FIGURE 4.4 CONTINUED

	mCPR 2012	mCPR 2013	ADDITIONAL USERS OF MODERN CONTRACEPTION
SOUTHEAST ASIA AND OCEANIA			
CAMBODIA	23.7	24.4	43,000
INDONESIA	44.5	44.7	429,000
LAO PDR	29.4	30.1	25,000
MYANMAR	30.6	31.4	148,000
PAPUA NEW GUINEA	18.3	18.7	15,000
PHILIPPINES	23.7	24.4	209,000
SOLOMON ISLANDS	22.8	23.1	1,000
TIMOR-LESTE	14.3	14.9	3,000
VIETNAM	44.8	44.8	35,000
TOTAL ADDITIONAL USERS			**908,000**
LATIN AMERICA AND CARIBBEAN			
BOLIVIA	26.3	26.8	29,000
HAITI	21.7	22.3	27,000
HONDURAS	42.6	42.8	25,000
NICARAGUA	50.8	50.7	14,000
TOTAL ADDITIONAL USERS			**95,000**

Numbers are rounded

TOTAL ADDITIONAL USERS, FP2020 FOCUS COUNTRIES

8,400,000

Photo by Dominic Chavez/FP2020

When examining changes in mCPR over time, it is helpful to look at the annual growth rate, which quantifies how fast countries are expanding their family planning programs. Average growth rates calculated for 2012 and 2013 are displayed in **Figure 4.5**. These values were calculated using data from the last two available surveys (DHS, MICS and/or PMA2020) in each country and depict annual growth rates in 2012 and in 2013, not growth between those two years. The differences between the values for 2012 and the values for 2013 are due to new survey data being released since the last FP2020 report, which shows some countries growing faster than previously assumed, and some growing slower. The overall average growth in mCPR across FP2020 countries is estimated to be slightly slower than previously estimated.

The average mCPR growth rate (0.65% annually) masks some important shifts, such as countries where the growth trajectory is rising. In five countries—Bhutan, Djibouti, Ethiopia, Kenya and Rwanda—annual growth rates exceeded 2.5%. Assessment of regional patterns indicates relative stagnation in Central Asia, the Caribbean and Central and South America. The list of countries with annual changes in mCPR of 2% or greater in 2013 is dominated by sub-Saharan African countries. Of particular note is that mCPR growth in francophone West Africa now averages about 1% per year for almost all countries, which is in marked contrast to earlier, lower growth.

Focusing on average growth rates can mask important changes in countries' movements between the different categories of growth. Individual countries show movement in a positive direction. Fewer countries were in the lower growth rate categories (less than 1): 43 in 2013 versus 47 in 2012. More countries entered a higher growth trajectory category (greater than 1): 25 in 2013 versus 21 in 2012 (see **Figure 4.6**).[58]

To be on track to achieve the FP2020 goal, many more countries will need to move into the higher growth categories.

FIGURE 4.5
ANNUAL GROWTH RATES IN mCPR, 2012 AND 2013

Not included: Solomon Islands, Western Sahara

58. The narrative reflects non-rounded values for mCPR. Since the previous FP2020 progress report, 14 countries have newly released survey data that were used to estimate mCPR growth rates.

FIGURE 4.6
ANNUAL GROWTH RATES IN mCPR, 2013

- Countries that moved to a higher mCPR growth rate category in 2013
- Countries that moved to a lower mCPR growth rate category in 2013
- Countries that did not move to a different mCPR growth rate category in 2013

<0

GAMBIA
GHANA
INDIA
IRAQ
KYRGYZSTAN
MONGOLIA
MOZAMBIQUE
NEPAL
NIGERIA
SOUTH SUDAN
TAJIKISTAN
UZBEKISTAN
VIETNAM

0–0.5

BENIN
BOLIVIA
BURUNDI
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
COMOROS
CÔTE D'IVOIRE
DPR KOREA
DR CONGO
EGYPT
ERITREA
GUINEA
INDONESIA
MALI
MAURITANIA
PAPUA NEW GUINEA
SOMALIA
SOUTH AFRICA
SUDAN
ZIMBABWE

0.5–1.0

BURKINA FASO
GUINEA-BISSAU
HAITI
HONDURAS
NICARAGUA
PAKISTAN
PHILIPPINES
SRI LANKA
YEMEN

1.0–1.5

BANGLADESH
CAMBODIA
CONGO
LAO PDR
LESOTHO
LIBERIA
NIGER
STATE OF PALESTINE
TOGO
UGANDA
TANZANIA
ZAMBIA

1.5–2.0

AFGHANISTAN
MADAGASCAR
MALAWI
SENEGAL
SIERRA LEONE

2.0–2.5

MYANMAR
SAO TOME AND PRINCIPE
TIMOR-LESTE

>2.5

BHUTAN
DJIBOUTI
ETHIOPIA
KENYA
RWANDA

Not listed: Solomon Islands, Western Sahara.

A CLOSER LOOK AT CONTRACEPTIVE PREVALENCE: EQUITY AND METHOD MIX

FP2020 is committed to exploring ways to measure the human rights dimensions of family planning. This year, we looked deeper into the available data for findings on equity and contraceptive method mix.

We present first our findings from disaggregating mCPR by the variables of wealth (wealth quintile) and residence (urban or rural). This analysis is critical in the context of expanding resources for family planning programs, as it can help us understand whether investments in health are shared equitably as contraceptive prevalence increases and the extent to which vulnerable groups within national populations are benefiting. This is followed by our findings for Core Indicator 1b: **Percentage distribution of users by modern method of contraception.**

Disaggregation is particularly important because there are few indicators in use in health programs that explicitly monitor elements of rights and empowerment. In its report "Ensuring human rights within contraceptive programs: a human rights analysis of existing quantitative indicators," the World Health Organization (WHO) found that "a systematic, transparent system does not yet exist that explicitly links human rights and health concerns, and then determines their combined impact on the effectiveness and outcomes of health policies and programs." In 2015, FP2020's PMA and Rights & Empowerment (RE) Working Groups will collaborate in an effort to explore new ways of measuring rights and empowerment.

EQUITY

Monitoring changes in contraceptive use at the national level provides an overall measure of country progress but does not illustrate whether these changes are occurring equitably among different segments of the population. It is known that contraceptive use among poor and rural populations is typically lower than overall use due to economic, social and cultural barriers. The analyses presented in **Figures 4.7-4.10** show that countries fit different patterns, and that inequity is more pronounced in some countries than in others. As the use of family planning increases, it is important that we monitor these trends closely to determine whether inequalities are being ameliorated or exacerbated, particularly as urbanization accelerates and income levels rise.

Equity, contraceptive use, and income

Inequality in modern contraceptive use by wealth quintile persists almost everywhere, but is more pronounced in some countries than in others. We examined disparity of modern contraceptive use by estimating the contribution of the lowest wealth quintile to the total mCPR. If use is fully equitable, the percentage contribution will be 20%. Countries that show the most equitable distribution of contraceptive use among wealth quintiles include Bangladesh, Cambodia, Zambia and Zimbabwe, where the poorest 20% of women account for almost 20% of mCPR, as well as Kyrgyzstan, where the poorest 20% account for 21% of mCPR. (See **Figure 4.7**.)

Equity, contraceptive use and residence

Disparities in contraceptive use by urban and rural residence present a clear pattern,[59] particularly in the Central and Western African countries. Differences between urban and rural contraceptive use ranged from a high of 27 percentage points in Ethiopia to a low of 0.1 in Haiti. In 10 countries, rural women were found to have higher rates of modern contraceptive use.[60]

59. Comparisons in mCPR are based on analysis of the most recent surveys, either the DHS or MICS, for the 69 priority countries.

60. The 10 countries where rural use is greater than urban use, in the order of highest to lowest value, include Sao Tome and Principe, Mongolia, Cambodia, Solomon Islands, Uzbekistan, Lao PDR, Bhutan, Vietnam, Indonesia and Comoros.

FIGURE 4.7
CONTRIBUTION OF THE POOREST WEALTH QUINTILE TO mCPR

COUNTRIES IN WHICH USERS OF MODERN CONTRACEPTION IN THE POOREST WEALTH QUINTILE ACCOUNT FOR

LESS THAN 5% OF ALL USERS OF MODERN CONTRACEPTION

GROUP 1

CAMEROON
NIGERIA

5%–10% OF ALL USERS OF MODERN CONTRACEPTION

GROUP 2

BENIN
DR CONGO
ETHIOPIA
KENYA
LIBERIA
MALI
MOZAMBIQUE
SENEGAL
SIERRA LEONE
UGANDA

10%–15% OF ALL USERS OF MODERN CONTRACEPTION

GROUP 3

BOLIVIA
BURKINA FASO
COMOROS
CÔTE D'IVOIRE
GHANA
GUINEA
INDIA
LESOTHO
MADAGASCAR
MALAWI
NEPAL
NIGER
PAKISTAN
TANZANIA
TIMOR-LESTE

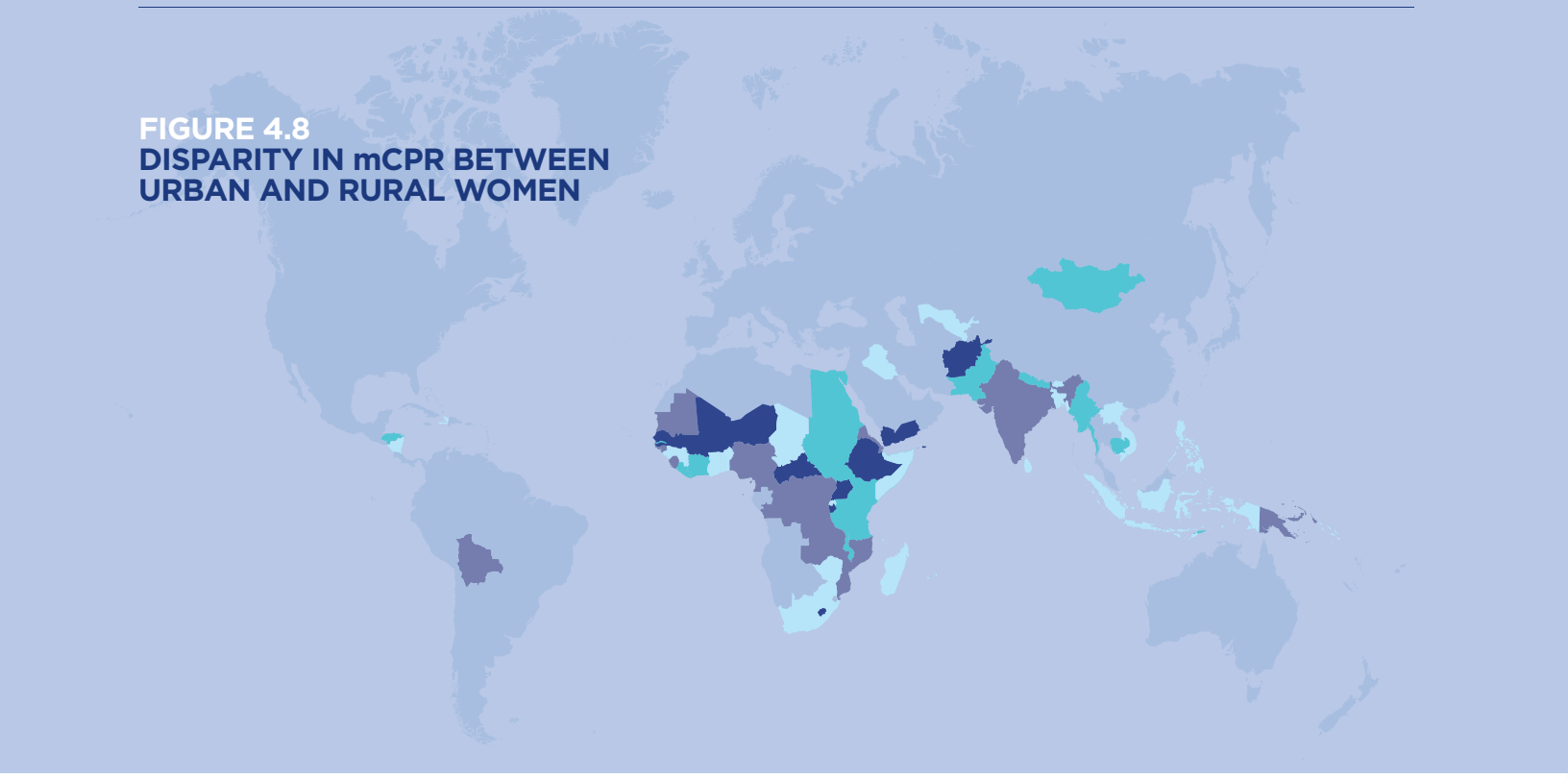
15%–20% OF ALL USERS OF MODERN CONTRACEPTION

GROUP 4

BANGLADESH
BURUNDI
CAMBODIA
EGYPT
HAITI
HONDURAS
INDONESIA
PHILIPPINES
RWANDA
SAO TOME AND PRINCIPE
ZAMBIA
ZIMBABWE

Western Sahara not included.

FIGURE 4.8
DISPARITY IN mCPR BETWEEN URBAN AND RURAL WOMEN



COUNTRIES IN WHICH THE PERCENTAGE POINT DIFFERENCE BETWEEN URBAN AND RURAL USERS OF MODERN CONTRACEPTION IS

LESS THAN 5
GROUP 1

BANGLADESH
BENIN
BHUTAN
CHAD
COMOROS
GHANA
GUINEA
HAITI
INDONESIA
IRAQ
KYRGYZSTAN
LAO PDR
NICARAGUA
PHILIPPINES
RWANDA
SOLOMON ISLANDS
SOMALIA
SOUTH AFRICA
SOUTH SUDAN
SRI LANKA
TAJIKISTAN
TOGO
UZBEKISTAN
VIETNAM
ZIMBABWE

BETWEEN 5 AND 10
GROUP 2

CAMBODIA
CÔTE D'IVOIRE
EGYPT
GAMBIA
HONDURAS
KENYA
LIBERIA
MADAGASCAR
MALAWI
MONGOLIA
MYANMAR
NEPAL
PAKISTAN
SUDAN
TANZANIA
TIMOR-LESTE

BETWEEN 10 AND 15
GROUP 3

BOLIVIA
BURUNDI
CAMEROON
CONGO (BRAZZAVILLE)
DJIBOUTI
DR CONGO
ERITREA
GUINEA-BISSAU
INDIA
MAURITANIA
MOZAMBIQUE
NIGERIA
PAPUA NEW GUINEA
SAO TOME AND PRINCIPE
SIERRA LEONE
ZAMBIA

GREATER THAN 15
GROUP 4

AFGHANISTAN
BURKINA FASO
CENTRAL AFRICAN REPUBLIC
ETHIOPIA
LESOTHO
MALI
NIGER
SENEGAL
UGANDA
YEMEN

Not listed: DPR Korea, State of Palestine, Western Sahara.

The question of whether inequalities in contraceptive use are inevitable was explored in an analysis by the Health Policy Initiative.[61] Using DHS data from 16 countries, the authors found that while differentials by wealth and residence may be inevitable "at some point in program evolution," persistent differentials—especially when wealthier quintiles or urban women have high levels of contraceptive use—should alert us to the need for programmatic action.

Equity, rapid urbanization, and the urban poor

While disparity between urban and rural use (see **Figure 4.8**) is a striking feature of family planning programs, an emerging global concern is the differences between the urban poor and rich in their use of public health services, including family planning. Urbanization is a necessary component of economic development and a reality for most FP2020 countries. The recently published report by the United Nations Children's Fund (UNICEF) on the changing demographics of Africa, for example, points to a "frenetic pace of urbanization" that will require changes in the way public health services are delivered in the next 25 years.[62]

To provide insight into this issue, an analysis was undertaken to assess how equity has kept pace with expanding population growth in urban regions by comparing the difference in utilization between the richest and the poorest in both urban and rural areas. This analysis focuses on four countries where the pace of urbanization is high (projected at 2% or more annually between 2010 and 2015)[63] and where modern contraceptive prevalence for all women was above 15% in the last DHS: Ethiopia, Nepal, Tanzania and Burkina Faso.[64] The results are shown in **Figure 4.9**.

The data in **Figure 4.9** indicate that equity in these four countries varies greatly. In the lowest wealth quintile for both urban and rural women, the difference in mCPR is about 10% for all four countries. However, in Ethiopia, Nepal and Tanzania, women in the highest quintile have comparable contraceptive use, whether urban or rural, to those in the poorest. In Burkina Faso, the rural wealthy have significantly lower use compared to the urban wealthy. In Nepal, there is less disparity in contraceptive use: differences in contraceptive use between the quintiles are considerably less than in other countries, for both rural and urban dwellers.

61. Foreit, Karen, M. Karra, and T. Pandit-Rajani. September 2010. *Disentangling the Effects of Poverty and Place of Residence for Strategic Planning*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

62. UNICEF (August 2014). Division of Data, Research and Policy. Generation 2030|Africa. Retrieved from http://www.unicef.org/publications/files/UNICEF_Africa_Generation_2030_en_11Aug.pdf

63. United Nations, Department of Economic and Social Affairs, Population Division (2014) World Urbanization Prospects: The 2014 Revision, Highlights (ST/ESA/SER.A/352).

64. Data Sources: Burkina Faso 2010 DHS, Ethiopia 2011 DHS, Nepal 2011 DHS, Tanzania 2010.

FIGURE 4.9
mCPR DISAGGREGATED BY RELATIVE WEALTH AND RESIDENCE

		OVERALL mCPR	mCPR BY WEALTH QUINTILE				
			LOWEST	SECOND	MIDDLE	FOURTH	HIGHEST
BURKINA FASO	URBAN	25.9	16.5	22.7	28.5	31.3	27.7
	RURAL	10.0	6.1	7.4	8.3	9.9	17.4
ETHIOPIA	URBAN	25.6	19.4	29.8	26.2	33.8	18.9
	RURAL	16.5	10.4	14.5	16.1	18.2	22.8
NEPAL	URBAN	35.1	37.9	33.3	39.4	32.3	33.1
	RURAL	32.9	27.5	31.5	33.1	34.0	34.9
TANZANIA	URBAN	27.3	25.7	26.1	30.3	24.8	29.5
	RURAL	22.1	16.7	20.7	18.4	23.6	29.9

Source: Track20 (secondary DHS analysis).

Equity in the context of rapid progress
Another way to examine whether overall quantitative progress is occurring with equity is to examine countries showing rapid growth in mCPR. We examined the contribution of the poorest quintile to mCPR for Ethiopia, Liberia, Rwanda, Senegal and Sierra Leone (see **Figure 4.10**). The concern is that as countries grow their mCPR, inequalities in use might expand between the poor and other wealth quintiles.[65] This trend appears to be true for the countries evaluated here with the exception of Rwanda, which has achieved a higher degree of equity with rapid growth in mCPR.

65.
Gakidou, E. and E. Vayena (2007). Use of modern contraception by the poor is falling behind. PLOS Medicine 4(2): e31.

FIGURE 4.10
2013 mCPR GROWTH RATES AND CONTRIBUTION OF THE POOREST WEALTH QUINTILE TO mCPR, SELECT COUNTRIES

COUNTRY	mCPR GROWTH RATE	% TOTAL mCPR ATTRIBUTED TO THE POOREST WEALTH QUINTILE
ETHIOPIA	3.07	9.60%
LIBERIA	1.47	6.90%
RWANDA	3.56	16.70%
SIERRA LEONE	1.73	9.40%
SENEGAL	2.00	7.70%

CONTRACEPTIVE METHOD MIX

Why method mix matters
Contraceptive method mix shows the percentage distribution of contraceptive users by type of method used. Countries typically use this indicator for planning, especially for commodities and logistics planning.

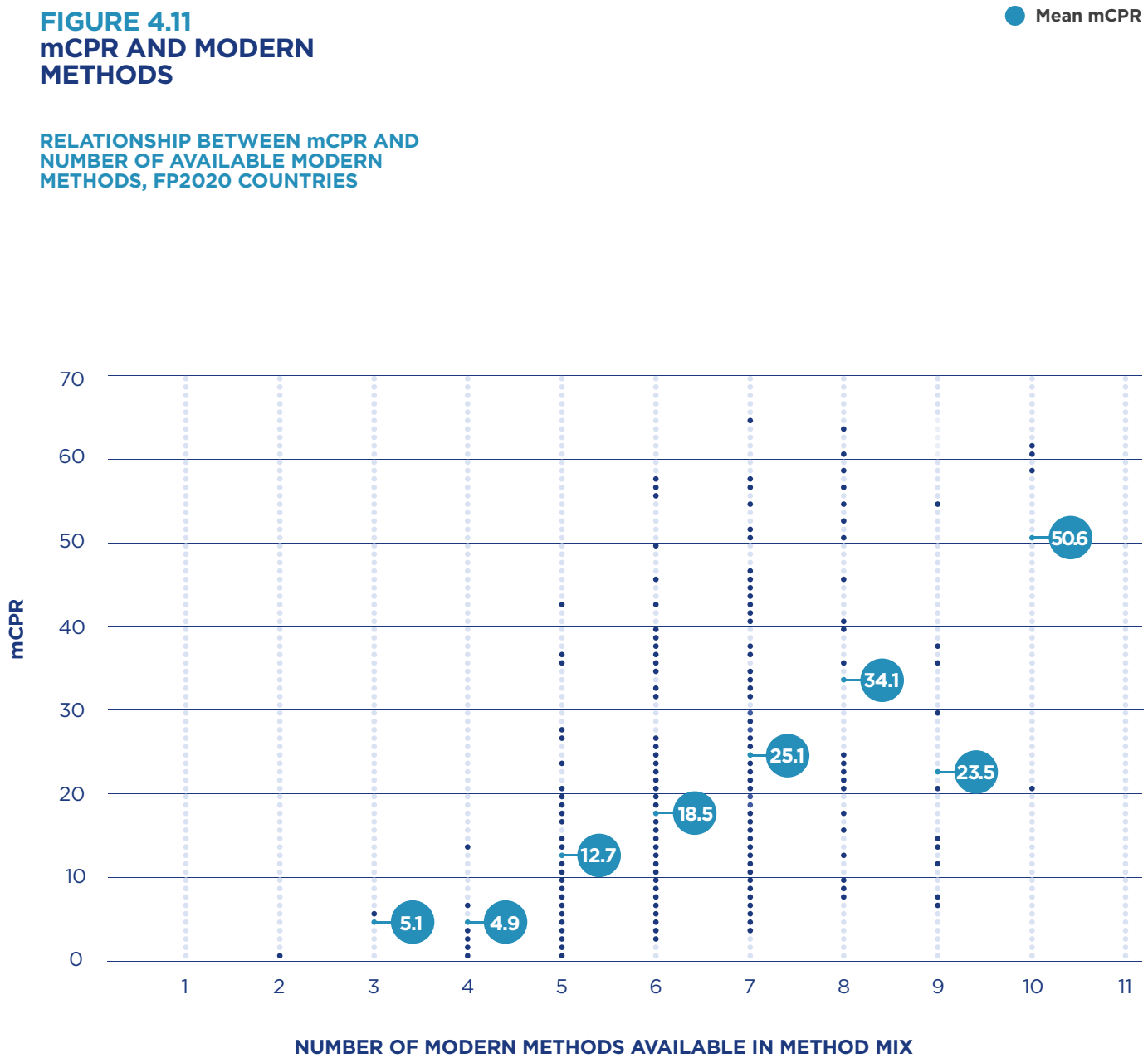
A more diverse method mix helps meet the individual and varied family planning needs of women and couples. Contraceptive preferences vary according to the stage in the reproductive cycle and reflect differing needs based on age, levels of exposure to risk of pregnancy, parity, economic activity and sociocultural norms. Having the option of many different modern methods allows a woman to select a method based on her specific needs and preferences.

Analysis has shown that countries offering more modern methods in their programs have higher mCPRs. This relationship is seen both over time and cross-sectionally each year. **Figure 4.11** presents the relationship between the number of modern methods in the method mix and mCPR. Each data point represents cross-sectional data for an FP2020 country, from surveys between 1986 and 2013.* A total of 238 data points from 68 of the FP2020 countries are included. The numbers at the top of each group of points represent the mean mCPR in countries with the corresponding number of modern methods in the mix. The graph demonstrates that modern contraceptive prevalence tends to be higher when there are more methods in the method mix.

*The table of values for each data point is included in the Annex.

FIGURE 4.11
mCPR AND MODERN METHODS

RELATIONSHIP BETWEEN mCPR AND NUMBER OF AVAILABLE MODERN METHODS, FP2020 COUNTRIES



METHOD "SKEW"

Method mix within a country is influenced by a variety of factors: methods available within the family planning program, user preferences, provider preferences, accessibility of different types of methods in terms of cost and decentralized services, and other social and systemic realities.

While method mix values themselves may not necessarily provide any specific insights, the distribution of use among methods can indicate that additional examination is necessary.

For example, consider an analysis of method skew—the dominance of one method within a country. Although the presence of method skew does not automatically tell us why it exists, it does alert to the need for further investigation. Are women choosing the dominant method because they lack information on other methods? Are other methods unavailable? Are women choosing the method, or is it being chosen for them? Or is there another explanation for this pattern?

Figure 4.12 groups countries by the percentage of their method mix that is attributed to one method. In 27 FP2020 countries, 40% to 60% of contraceptive users rely on a single method. Compared to the previous report, only three of the 14 countries with new method mix data moved between the categories shown in this graphic. The Philippines is no longer in the 40% to 60% category because the proportion of pill usage decreased below 40%. In Liberia, the use of injectables among married women increased to greater than 40% of the method mix, so it was added to the 40% to 60% category (Liberia's method mix data in the previous report was for all women). The use of traditional methods of contraception increased in DR Congo, which resulted in its shift from the lower to the higher category.

Recent research supports these observations of method skew. Analysis of global trends describes an unbalanced mix of modern methods in Central Asia, Southern Asia, Eastern Africa and Western Europe. Again, one must be mindful of the caveat that these data do not tell us whether a skewed method mix reflects consumer preferences, including reluctance to adopt new methods, or if it has more to do with supply-side factors.

Figure 4.13 categorizes countries according to the number of modern methods that account for 20% or more of their method mix. In 37 of the FP2020 countries, 20% or more of the method mix is accounted for by either zero or one modern method ("zero" implies traditional method dominance). Twenty-seven of the countries present method mix profiles in which two modern methods account for 20% or more of the mix. And in four countries, the method mix profile is slightly more diverse, with 20% or more of the method mix being accounted for by three methods. Compared to last year's report, the position of three countries (out of 15 countries with new data) changed in this graphic. Liberia and Yemen (which had married-women values in both reports) shifted to a slightly less diverse method mix by moving to the next lower category. Togo, based on new survey data, shifted from one to two modern methods with 20% or more of the mix, and thus was slightly more diverse compared to the previous year.

Emerging evidence suggests that "there are large benefits from making things easy/automatic"[66] for people. This is particularly important for groups that may be poorly served by standard programs, including adolescents, young married couples and subpopulations residing in hard-to-reach areas. Making it easier to understand contraceptive choices and to switch methods when needed, and offering services that take into account the social and cultural attributes of a community or age group, are key aspects of program quality.

METHODOLOGICAL NOTE
Method mix data was obtained from the most recent DHS, MICS or national survey, for all women or for married women of reproductive age, depending on availability. Fifteen[67] of the 69 FP2020 focus countries have new survey data from DHS released since the previous FP2020 progress report, including data from 2011, 2012 and 2013.

66.
Banerjee, A and Duflo, E. Health: Low Hanging Fruit? downloaded from http://pooreconomics.com/sites/default/files/Lecture8_LowHangingFruit.pdf

67.
Countries with new method mix data since the previous FP2020 progress report are Benin, Comoros, Congo, DR Congo, Ghana, Kyrgyzstan, Liberia, Niger, Nigeria, Philippines, Senegal, Sierra Leone, Tajikistan, Togo and Yemen.

FIGURE 4.12
CONTRACEPTIVE METHOD DOMINANCE IN FP2020 FOCUS COUNTRIES

- LAM
- Condom
- Pill
- Injectable
- IUD
- Female sterilization
- Traditional

COUNTRIES IN WHICH 40–60% OF THE METHOD MIX IS DOMINATED BY ONE CONTRACEPTIVE METHOD*	DOMINANT METHOD
AFGHANISTAN	Injectable
BANGLADESH	Pill
BHUTAN	Injectable
BOLIVIA	Traditional
BURUNDI	Injectable
CAMEROON	Condom
CHAD	LAM
CONGO	Traditional
EGYPT	IUD
GAMBIA	Injectable
HAITI	Injectable
INDONESIA	Injectable
KENYA	Injectable
LAO PDR	Pill
LIBERIA	Injectable
MADAGASCAR	Injectable
MALAWI	Injectable
MONGOLIA	IUD
MYANMAR	Injectable
NIGER	Pill
RWANDA	Injectable
SIERRA LEONE	Injectable
SOMALIA	Pill
SOUTH AFRICA	Injectable
SOUTH SUDAN	Traditional
STATE OF PALESTINE	IUD
UGANDA	Injectable

COUNTRIES IN WHICH ≥60% OF THE METHOD MIX IS DOMINATED BY ONE CONTRACEPTIVE METHOD*	DOMINANT METHOD
DPR KOREA	IUD
DR CONGO	Traditional
DJIBOUTI	Pill
ETHIOPIA	Injectable
INDIA	Female sterilization
KYRGYZSTAN	IUD
MAURITANIA	Pill
TAJIKISTAN	IUD
TIMOR-LESTE	Injectable
UZBEKISTAN	IUD
ZIMBABWE	Pill

*Modern and traditional methods.
Data unavailable for Sudan and Western Sahara.

FIGURE 4.13
COUNTRIES WITH ≥20% OF THE METHOD MIX* ATTRIBUTED TO 0, 1, 2 OR 3 MODERN METHODS

A
COUNTRIES IN WHICH 0 MODERN METHODS ACCOUNT FOR ≥20% OF THE METHOD MIX*

BOLIVIA
DR CONGO
SOUTH SUDAN

B
COUNTRIES IN WHICH 1 MODERN METHOD ACCOUNTS FOR ≥20% OF THE METHOD MIX*

BANGLADESH
BENIN
BHUTAN
BURUNDI
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
COMOROS
CONGO (BRAZZAVILLE)
DPR KOREA
DJIBOUTI
EGYPT
ETHIOPIA
GUINEA
INDIA
IRAQ
KENYA
MADAGASCAR
MAURITANIA
NEPAL
NIGERIA
PHILIPPINES
RWANDA
SOMALIA
SOUTH AFRICA
STATE OF PALESTINE
TAJIKISTAN
TANZANIA
TIMOR-LESTE
UGANDA
UZBEKISTAN
VIETNAM
YEMEN
ZIMBABWE

C
COUNTRIES IN WHICH 2 MODERN METHODS ACCOUNT FOR ≥20% OF THE METHOD MIX*

AFGHANISTAN
BURKINA FASO
CAMBODIA
CÔTE D'IVOIRE
ERITREA
GAMBIA
GHANA
GUINEA-BISSAU
HAITI
HONDURAS
INDONESIA
KYRGYZSTAN
LAO PDR
LIBERIA
MALAWI
MONGOLIA
MYANMAR
NICARAGUA
NIGER
PAKISTAN
PAPUA NEW GUINEA
SENEGAL
SIERRA LEONE
SOLOMON ISLANDS
SRI LANKA
TOGO
ZAMBIA

D
COUNTRIES IN WHICH 3 MODERN METHODS ACCOUNT FOR ≥20% OF THE METHOD MIX*

LESOTHO
MALI
MOZAMBIQUE
SAO TOME AND PRINCIPE

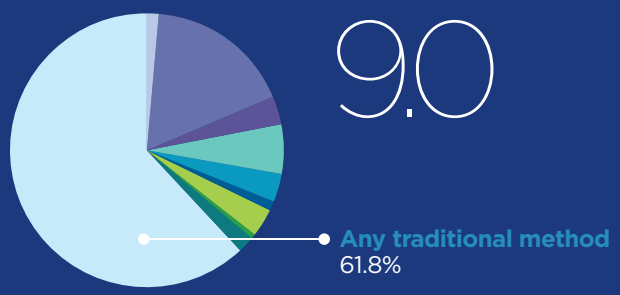
*All or married users, both modern and traditional methods.

Data unavailable for Western Sahara and Sudan.

mCPR AND METHOD MIX FOR SELECT COUNTRIES

A DR CONGO
0 MODERN METHODS ACCOUNT FOR ≥20% OF THE METHOD MIX

METHOD MIX

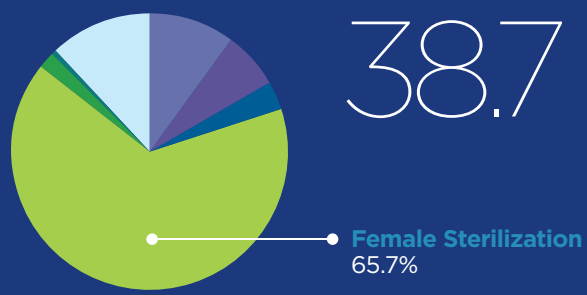


mCPR

9.0

B INDIA
1 MODERN METHOD ACCOUNTS FOR ≥20% OF THE METHOD MIX

METHOD MIX

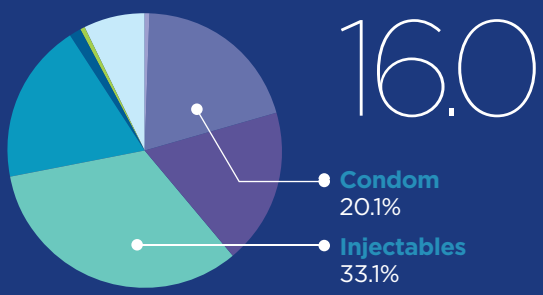


mCPR

38.7

C BURKINA FASO
2 MODERN METHODS ACCOUNT FOR ≥20% OF THE METHOD MIX

METHOD MIX

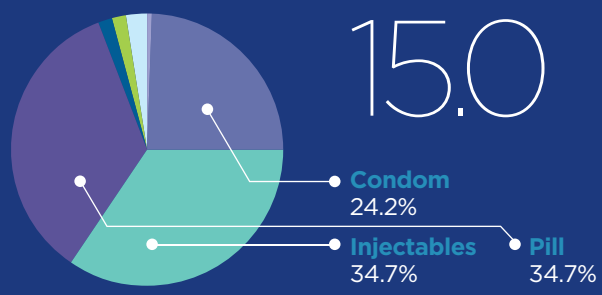


mCPR

16.0

D MOZAMBIQUE
3 MODERN METHODS ACCOUNT FOR ≥20% OF THE METHOD MIX

METHOD MIX



mCPR

15.0

METHOD MIX	DR CONGO	INDIA	BURKINA FASO	MOZAMBIQUE
STANDARD DAYS METHOD	1.5	0	0	0
LAM	0	0	0.6	0.8
CONDOM	17.2	10.1	20.1	24.2
PILL	3.4	6.6	18.2	34.7
INJECTABLES	5.9	0	33.1	34.7
IMPLANTS	3.4	0	18.8	0
IUD	1.0	3.3	1.3	1.6
FEMALE STERILIZATION	3.4	65.7	0.6	1.6
MALE STERILIZATION	0.5	2.0	0	0
OTHER MODERN METHODS	2.0	0.6	0	0
ANY TRADITIONAL METHOD	61.8	11.7	7.1	2.4

UNMET NEED FOR MODERN CONTRACEPTION AND PERCENT OF DEMAND SATISFIED

One criterion for assessing the performance of national family planning programs concerns the extent to which programs enable women of reproductive age and their spouses or partners to satisfy their childbearing preferences. Fecund women of reproductive age are said to have an unmet need for modern contraception if they desire no more children or wish to delay their next child by two years or more, but are not using a modern contraceptive method.

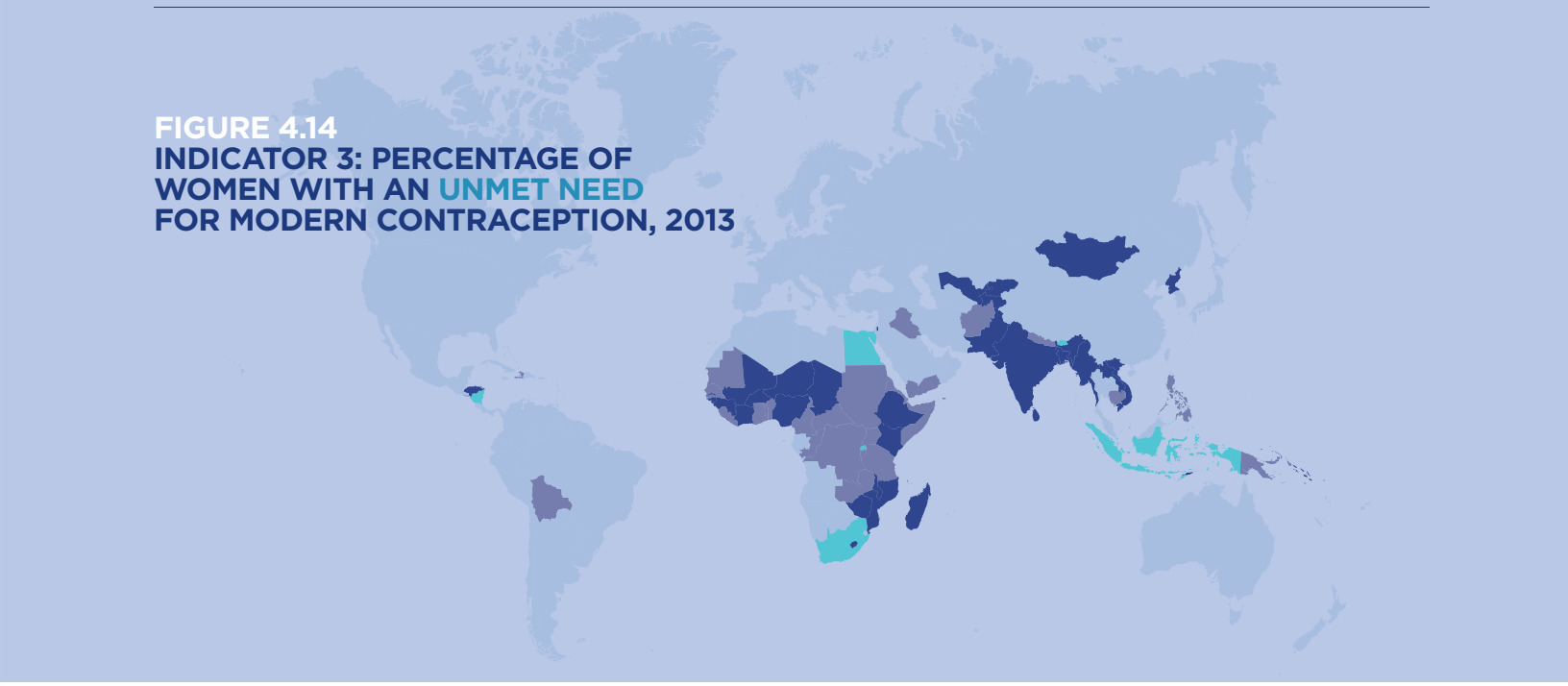
Figure 4.14 displays data on estimated percentages of women of reproductive age with an unmet need for modern contraception in 2013. Unmet need ranged from a low of 11% in Nicaragua to a high of 47% in Somalia. The data indicate that although modern contraceptive use is increasing, many women still have an unmet need. Of the FP2020 focus countries, 31 had levels of unmet need of 30 percent or higher, while nearly half of the countries had unmet need levels between 15% and 30%. The data indicate little change in unmet need between 2012 and 2013, which is reasonable given the short window of observation. Nevertheless, Rwanda showed a large reduction, which moved it to the lowest category of less than 15% and Côte d'Ivoire and Timor-Leste showed a small reduction in unmet need, shifting to the 15% to 30% category.

Unmet need among girls 15 to 19 (married or in union) is higher than for women and girls 15 to 49 (married or in union) in more than half of the 69 FP2020 focus countries. The level of disparity between adolescents' need and overall unmet need is highest in the Caribbean and Latin America, and lowest in Eastern and Central Asia. Countries with the highest disparities include Ghana and Mali in Western Africa; the Congo in Central Africa; Comoros and Eritrea in Eastern and Southern Africa; Bhutan, India and Nepal in South Asia; the Philippines and Vietnam in Southeast Asia and Oceania; and Bolivia and Haiti in the Caribbean and Latin America (see **Figure 4.15**).

The FP2020 Core Indicator 4: **Percent of demand satisfied by modern contraception use** provides another perspective on the extent to which family planning programs are enabling women and couples to satisfy their reproductive intentions. The indicator relates the level of current modern contraceptive use to total demand for modern contraception, which is defined as the sum of current modern contraceptive use plus unmet need for modern contraception. **Figure 4.16** displays data on this indicator.

Since results for current use of modern contraception and for unmet need have already been presented, the associated results for percent of demand satisfied by modern contraception show the expected pattern. Of the 69 FP2020 focus countries, 32 (46%) were able to satisfy less than 45% of total demand in 2013. Very little change in the proportion of demand satisfied by modern method use was observed between 2012 and 2013, although Kenya and Nepal increased their percent satisfied and moved from the 45% to 60% category to the greater-than-60% category. Haiti and Timor-Leste also increased their percent satisfied and moved from the less than 45% category to the 45% to 60% satisfied category.

FIGURE 4.14
INDICATOR 3: PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR MODERN CONTRACEPTION, 2013



COUNTRIES IN WHICH THE PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR MODERN CONTRACEPTION IS

<15%

BHUTAN
EGYPT
INDONESIA
NICARAGUA
RWANDA
SOUTH AFRICA

15%–30%

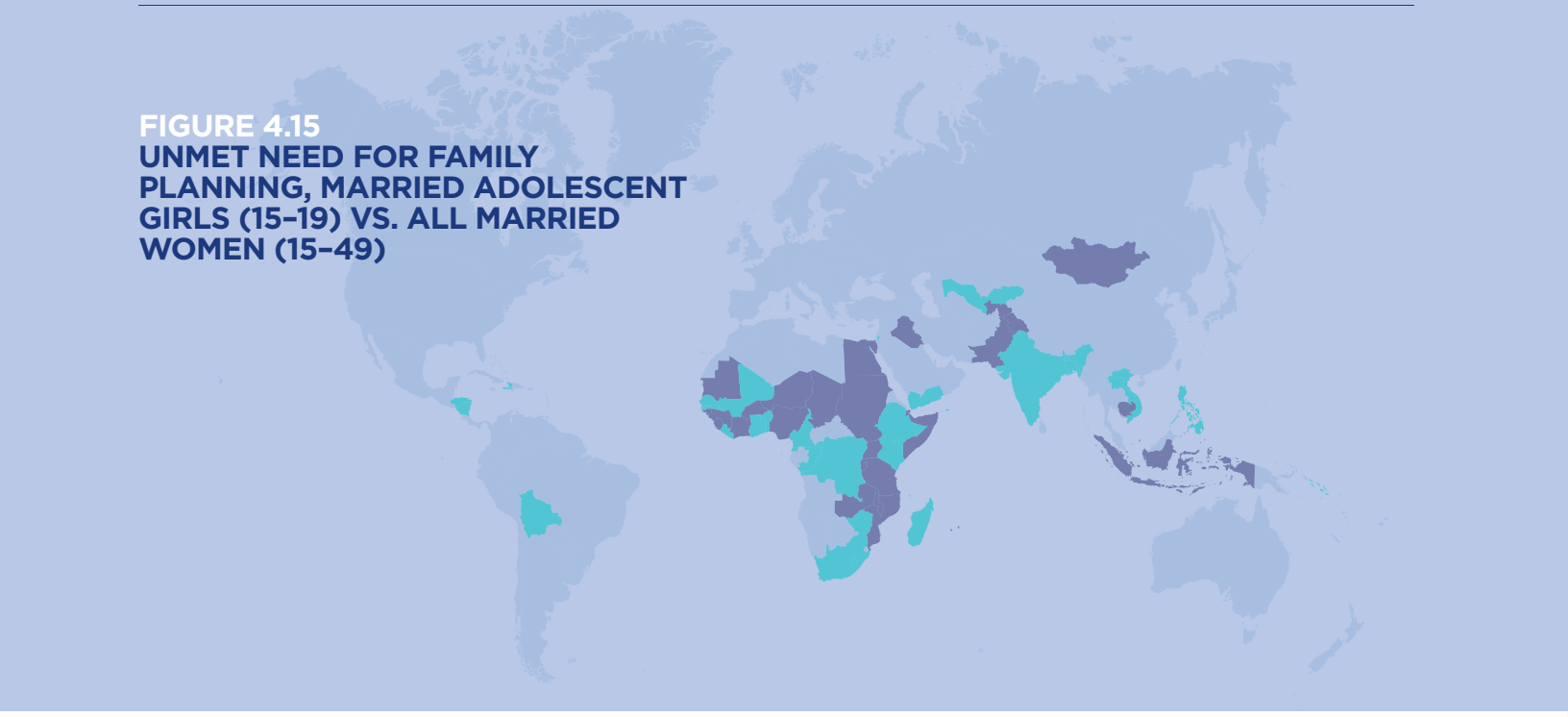
BANGLADESH
BURKINA FASO
CHAD
CÔTE D'IVOIRE
DPR KOREA
ETHIOPIA
GAMBIA
GUINEA
GUINEA-BISSAU
HONDURAS
INDIA
KENYA
KYRGYZSTAN
LAO PDR
LESOTHO
MADAGASCAR
MALAWI
MALI
MONGOLIA
MOZAMBIQUE
MYANMAR
NIGER
NIGERIA
PAKISTAN
SOLOMON ISLANDS
SRI LANKA
STATE OF PALESTINE
TAJIKISTAN
TIMOR-LESTE
UZBEKISTAN
VIETNAM
ZIMBABWE

≥30%

AFGHANISTAN
BENIN
BOLIVIA
BURUNDI
CAMBODIA
CAMEROON
CENTRAL AFRICAN REPUBLIC
COMOROS
CONGO (BRAZZAVILLE)
DR CONGO
DJIBOUTI
ERITREA
GHANA
HAITI
IRAQ
LIBERIA
MAURITANIA
NEPAL
PAPUA NEW GUINEA
PHILIPPINES
SAO TOME AND PRINCIPE
SENEGAL
SIERRA LEONE
SOMALIA
SOUTH SUDAN
SUDAN
TANZANIA
TOGO
UGANDA
YEMEN
ZAMBIA

Data unavailable for Western Sahara.

FIGURE 4.15
UNMET NEED FOR FAMILY PLANNING, MARRIED ADOLESCENT GIRLS (15–19) VS. ALL MARRIED WOMEN (15–49)



COUNTRIES IN WHICH THE UNMET NEED IS

LOWER IN ADOLESCENT GIRLS THAN ALL WOMEN

GROUP 1

BURKINA FASO
BURUNDI
CAMBODIA
CHAD
CÔTE D'IVOIRE
DJIBOUTI
EGYPT
GUINEA
GUINEA-BISSAU
INDONESIA
IRAQ
KYRGYZSTAN
MALAWI
MAURITANIA
MONGOLIA
MOZAMBIQUE
NIGER
NIGERIA
PAKISTAN
RWANDA
SIERRA LEONE
SOMALIA
SOUTH SUDAN
SUDAN
TAJIKISTAN
TANZANIA
TIMOR-LESTE
UGANDA
ZAMBIA

HIGHER IN ADOLESCENT GIRLS THAN ALL WOMEN

GROUP 2

BANGLADESH
BENIN
BHUTAN
BOLIVIA
CAMEROON
COMOROS
CONGO (BRAZZAVILLE)
DR CONGO
ERITREA
ETHIOPIA
GHANA
HAITI
HONDURAS
INDIA
KENYA
LAO PDR
LESOTHO
LIBERIA
MADAGASCAR
MALI
NEPAL
NICARAGUA
PHILIPPINES
SAO TOME AND PRINCIPE
SENEGAL
SOLOMON ISLANDS
SOUTH AFRICA
STATE OF PALESTINE
TOGO
UZBEKISTAN
VIETNAM
YEMEN
ZIMBABWE

Not listed: Afghanistan, Central African Republic, DPR Korea, Gambia, Myanmar, Papua New Guinea, Sri Lanka and Western Sahara.

FIGURE 4.16
INDICATOR 4: PERCENTAGE OF WOMEN WHOSE DEMAND IS SATISFIED WITH A MODERN METHOD OF CONTRACEPTION, 2013

COUNTRIES IN WHICH THE PERCENTAGE OF DEMAND SATISFIED FOR MODERN METHODS OF CONTRACEPTION IS

<45%

AFGHANISTAN
BENIN
BURKINA FASO
BURUNDI
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
COMOROS
CONGO
CÔTE D'IVOIRE
DR CONGO
DJIBOUTI
ERITREA
GAMBIA
GHANA
GUINEA
GUINEA-BISSAU
LIBERIA
MALI
MAURITANIA
MOZAMBIQUE
NIGER
NIGERIA
SENEGAL
SIERRA LEONE
SOMALIA
SOUTH SUDAN
SUDAN
TOGO
UGANDA
YEMEN

45%–60%

BOLIVIA
CAMBODIA
ETHIOPIA
HAITI
IRAQ
MADAGASCAR
PAKISTAN
PAPUA NEW GUINEA
PHILIPPINES
SAO TOME AND PRINCIPE
SOLOMON ISLANDS
TAJIKISTAN
TANZANIA
TIMOR-LESTE
ZAMBIA

>60%

BANGLADESH
BHUTAN
DPR KOREA
EGYPT
HONDURAS
INDIA
INDONESIA
KENYA
KYRGYZSTAN
LAO PDR
LESOTHO
MALAWI
MONGOLIA
MYANMAR
NEPAL
NICARAGUA
RWANDA
SOUTH AFRICA
SRI LANKA
STATE OF PALESTINE
UZBEKISTAN
VIETNAM
ZIMBABWE

Data unavailable for Western Sahara.

Photo by Brent Stirton
© Bill & Melinda Gates Foundation

IMPACT OF FAMILY PLANNING

THE HEALTH BENEFITS OF CURRENT USE OF MODERN CONTRACEPTION

The use of modern contraception not only allows couples to plan the number and timing of their children, but also saves lives by avoiding the risks associated with unintended pregnancies.

In 2013, across all FP2020 focus countries, the use of modern contraceptives by 274 million women and girls of reproductive age averted 77 million unintended pregnancies, which amounts to 2 million more unintended pregnancies averted compared to 2012.

Averting 77 million unintended pregnancies created substantial health impacts by reducing women's exposure to unsafe abortions and maternal deaths. In 2013, there were 24 million unsafe abortions averted and 125,000 maternal deaths averted (see **Figure 4.17**).

These estimates of the benefits of modern contraceptive use are generated by considering what would happen if modern contraception were not available to anyone. Some unintended pregnancies occur to women using modern contraception as a result of method failure, but these rates are generally quite low.[68]

If contraception were not available, approximately one-third of women who are currently using modern contraception would become pregnant within a year.[69] We assume that all of these pregnancies would be unintended. Approximately 13% of these pregnancies would end in miscarriage or stillbirths.[70] The rest would result either in live births or termination by abortion. Across all developing countries, about 47% of unintended pregnancies are terminated by abortion.[71] This figure ranges from approximately 30% in some parts of sub-Saharan Africa to as high as 80% in East Asia. More than half of these abortions would be unsafe.[72]

Each of these pregnancy outcomes carries a risk of maternal mortality. In developing countries, the risk of maternal death is approximately 220 per 100,000 unsafe abortions,[73] approximately 2 per 100,000 safe abortions and approximately 230 per 100,000 live births[74] and miscarriages.

In order to estimate the maternal mortality and unsafe abortions that would result from the absence of contraceptive use, we have used data that are both country-specific (modern contraceptive use and maternal mortality ratios for live births) and regional averages (abortion rates and mortality due to safe and unsafe abortion).[75] We have assumed that lack of modern contraception would not be replaced by traditional methods and that all resulting pregnancies could be considered to be unintended.

The full benefits of averting maternal deaths may well be underestimated. Recent research suggests they include long-term, "intergenerational impacts on the nutritional status, health and education of children, as well as the economic capacity of families."[76,77]

68. Trussell J, Contraceptive Failure in the United States, Contraception, May 2011; 83(5): 397-404 and Cleland J, Ali MM and Shah I, Dynamics of contraceptive use, in: United Nations Department of Economic and Social Affairs, Population Division, Levels and Trends of Contraceptive Use as Assessed in 2002, New York: United Nations, 2006, pp. 87–115, Table 22, page 98.

69. The Population Council, Measuring the Impact of Contraceptive Use on Unintended Pregnancy and Other Health Outcomes, STEP-UP Brief, April 2014.

70. Bongaarts J, Potter RG. 1983. Fertility, Biology and Behavior: An Analysis of the Proximate Determinants. New York: Academic Press.

71. Darroch J, Singh S. Adding It Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health: Estimation Methodology. Guttmacher Institute, October 2011.

72. Sedgh G, Singh S, Shah IH, Ahman E, Henshaw S, Bankole A, Induced abortion: incidence and trends worldwide from 1995 to 2008, Lancet, 2012; 379: 625-632.

73. WHO. Unsafe abortion: Global and regional estimates of the incidence of unsafe abortions and associated mortality in 2008. 6th Edition. WHO 2008.

74. WHO. Trends in maternal mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Geneva: World Health Organization, 2014.

75. The methodology used, which was agreed upon in a series of meetings between individual and institutions with expertise in this domain, is documented in the FP2020 Handbook of Indicators.

76. Yamin AE, Boulanger VM, Falb KL, Shuma J, Leaning J (2013) Costs of Inaction on Maternal Mortality: Qualitative Evidence of the Impacts of Maternal Deaths on Living Children in Tanzania. PLOS ONE 8(8): e71674.doi:10.1371/journal. pone.0071674

77. Ronsmans C, Chowdhury ME, Dasgupta SK, Ahmed A, Koblinsky M (2010) Effect of parent's death on child survival in rural Bangladesh: a cohort study. Lancet 375: 2024–2031.

FIGURE 4.17
IMPACT OF FAMILY PLANNING BY REGION IN 2013*

INDICATOR 8
NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO MODERN CONTRACEPTIVE USE 2013

TOTAL
77,430,000

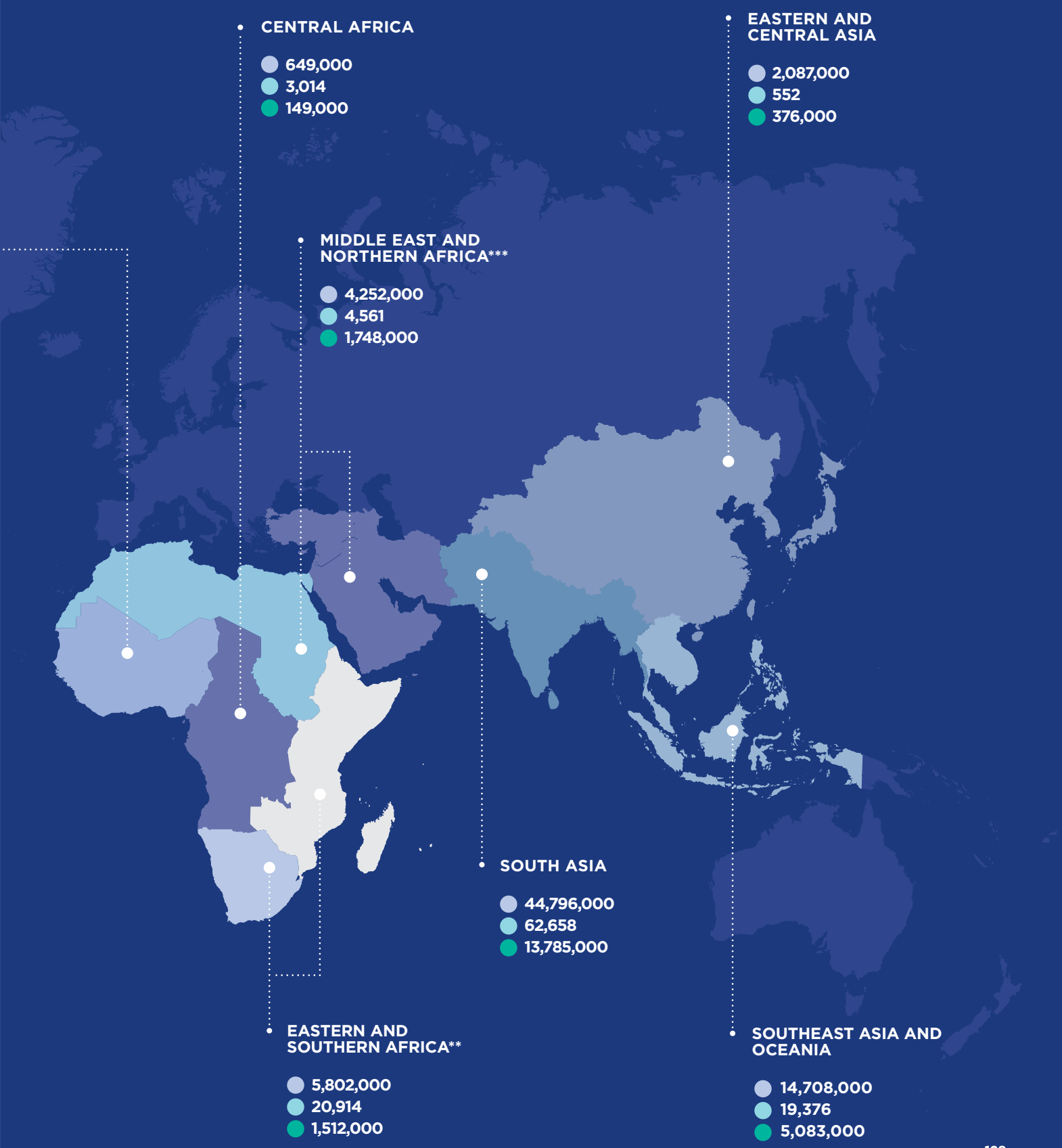
INDICATOR 9
NUMBER OF MATERNAL DEATHS AVERTED DUE TO MODERN CONTRACEPTIVE USE 2013

TOTAL
125,415

INDICATOR 10
NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO MODERN CONTRACEPTIVE USE 2013

TOTAL
24,376,000

*Indicators 8 and 10: numbers are rounded.
**South Africa not included.
***Data unavailable for Western Sahara.


CENTRAL AFRICA
649,000
3,014
149,000
EASTERN AND CENTRAL ASIA
2,087,000
552
376,000
MIDDLE EAST AND NORTHERN AFRICA***
4,252,000
4,561
1,748,000
SOUTH ASIA
44,796,000
62,658
13,785,000
EASTERN AND SOUTHERN AFRICA**
5,802,000
20,914
1,512,000
SOUTHEAST ASIA AND OCEANIA
14,708,000
19,376
5,083,000

INFORMED CHOICE AND ADOLESCENT CHILDBEARING

INFORMED CHOICE

Informed choice in the family planning context has been defined as "the fundamental right and ability of individuals to choose and access the contraceptive methods that meet their needs and preferences without either barriers or coercion."[78] Current survey data, however, provide limited means to fully measure this concept.

This section summarizes the available data measuring the degree to which family planning clients are fully informed, which represents one dimension of informed choice, the engagement of women in family planning decisions and outcomes among adolescents. Data for a subset of FP2020 countries that undertook a DHS recently are considered. The 12 countries with a recent survey (11 DHS and one PMA2020) are located in a range of areas including francophone Africa, Asia and the Caribbean.

Two FP2020 Core Indicators reflect aspects of informed choice. The first, **Indicator 11**, measures the extent to which provision of information on family planning has been institutionalized and prioritized within the health system. Recent DHS results show that, on average, one-third of women reported receiving family planning information during their last interaction with a health care provider. Although it is not expected that all interactions should include the exchange of family planning information, the low levels suggest that there are missed opportunities to provide information and services on modern methods at the time when women interact with the formal health system.

The other relevant FP2020 Core Indicator, **Indicator 12**, provides a summary measure of the adequacy of information being provided to women by service providers at the time when they chose their current method of family planning. It is used as a partial indicator of the quality of family planning counseling services.

The index is constructed from three questions asked of current contraceptive users with regard to the time when they chose the method they are currently using:

- Were you informed about other methods?
- Were you informed about side effects?
- Were you told what to do if you experienced side effects?

The index value is the proportion of respondents answering "yes" to all three questions.

Data from 12 countries indicate that most women tend not to be fully informed about family planning methods when they seek services. The average index score in the 12 countries was less than 50%, but this masks the fact that in six of the 12 countries, fewer than one-third of women report being informed about other methods, side effects and what to do about side effects.

In some countries, the mCPR could be high while the method information index value is low. At issue is whether this is a reasonable situation explained by knowledge saturation among users or an opportunity to address gaps in counseling services.

MEASURING INFORMED CHOICE — A CAUTIONARY NOTE

There is currently no single measure available to evaluate informed choice in family planning. The method information index described in this section is an attempt to use existing survey questions to construct a proxy estimate of informed choice that is comparable across countries. The index measures what type of information is being made available when women present themselves for services. Even with the low values seen here, we can assume that the extent of informed choice is actually underestimated by this indicator. The lack of provision of basic information on a routine basis argues the need for strong programmatic efforts and need for further analysis of the quality of services. The World Bank's Service Delivery indicators measure quality and efficiency of services in health and education and may provide a starting point for understanding the extent to which informed choice can become a reality in family planning.[79]

78. The RESPOND Project. 2013. A fine balance: Contraceptive choice in the 21st century—an action agenda. Report of the September 2012 Bellagio conference. New York: EngenderHealth/The RESPOND Project. Downloaded from http://champions4choice.org/wp-content/uploads/2013/07/Bellagio-Report-February2013-FINAL.pdf

79. International Bank for Reconstruction and Development/The World Bank (2013). Service Delivery Indicators Education|Health, http://www.sdindicators.org/

FIGURE 4.18
INDICATORS 11–14

	INDICATOR 11: FP INFORMATION Percentage of women who say they were provided with information on family planning during their last visit with a health service provider	INDICATOR 12: METHOD INFORMATION INDEX Method Information Index (an index measuring the extent to which women say they were made aware of alternative methods of contraception and were provided adequate information about them)	INDICATOR 13: DECISION MAKING Percentage of women who say they make family planning decisions alone or jointly with their husbands/ partners	INDICATOR 14: ADOLESCENT BIRTH RATE Adolescent birth rate (the number of births to adolescent females aged 15–19 occurring during a given reference period per 1,000 adolescent females)
BENIN	35%	31%	82%	94
COMOROS	38%	30%	88%	101
CONGO (BRAZZAVILLE)	20%	35%	87%	147
GHANA	N/A	19%	90%	64
GUINEA	10%	33%	92%	146
KYRGYZSTAN	41%	60%	95%	44
MALI	47%	38%	81%	172
NIGER	27%	31%	77%	206
NIGERIA	49%	51%	85%	122
PAKISTAN	44%	20%	92%	44
SENEGAL	25%	58%	89%	80
TAJIKISTAN	44%	65%	86%	54

ADOLESCENT CHILDBEARING

WHO estimates that 16 million adolescent girls give birth each year and that 95% of these births occur in developing countries. Pregnancy among girls is not an uncommon experience, and complications from pregnancy and childbirth are a leading cause of death for girls aged 15 to 19. WHO estimates that over three million unsafe abortions occur annually among adolescent girls.

FP2020 Core Indicator 14, the adolescent birth rate, provides a measure of the rate at which adolescent females are bearing children. The adolescent birth rate is defined as the number of births per 1,000 women aged 15 to 19. Adolescent birth rates in FP2020 countries range from a low of less than one birth per 1,000 women in DPR Korea to a high of 206 births per 1,000 young women in Niger. The highest rates are in francophone Africa, a reflection of early marriage and low levels of contraceptive use among all women in that region.

INDICATORS WITH NEW, EMERGING INFORMATION

TRACK20 IS CURRENTLY DEVELOPING ITS METHODOLOGIES AND DATA SOURCES FOR CORE INDICATORS 5 AND 6:

INDICATOR 5
Annual expenditures on family planning from government domestic budget. The first applications of family planning sub-accounts, a collaboration between Track20 and WHO, were completed in 2013.

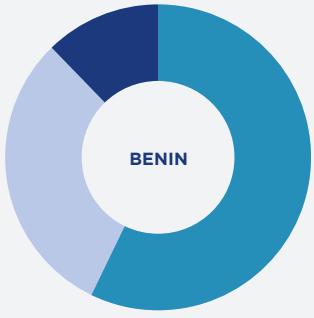
INDICATOR 6
Couple-years of protection (CYP). Five countries that participated in Track20 consensus meetings were able to use data from service statistics to estimate CYPs. This indicator will have more robust data in the next FP2020 progress report (see **data table in Annex**).

ANNUAL EXPENDITURES ON FAMILY PLANNING FROM GOVERNMENT DOMESTIC BUDGET

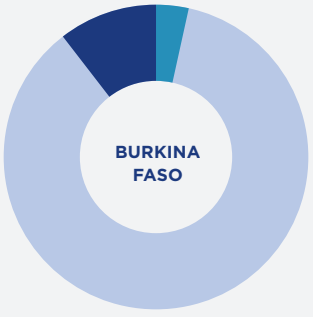
Track20 is developing FP2020's approach for reporting **Core Indicator 5: Annual expenditure on family planning from government domestic budget**. They are collaborating with WHO, which uses a System of Health Accounts (SHA) framework to provide information for planning and monitoring health expenditures, to develop detailed sub-accounts for family planning.

The first applications of the family planning sub-accounts were completed this year. The goal is to have detailed information on family planning expenditures from all countries within the next few years. Information from the first four countries to report data is summarized in **Figure 4.19**. Total expenditure on family planning in 2012 was US$0.6 million in Benin, US$2.8 million in Liberia, US$6.4 million in Burkina Faso and US$17.6 million in Tanzania. The source of funding for family planning varies widely across the

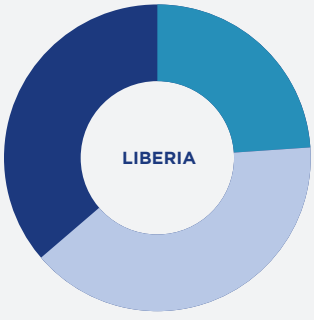
FIGURE 4.19
DISTRIBUTION OF FAMILY PLANNING EXPENDITURES BY SOURCE, 2012



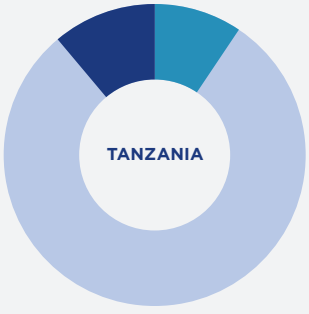
TOTAL FAMILY PLANNING EXPENDITURE
$580,000



TOTAL FAMILY PLANNING EXPENDITURE
$6,400,000



TOTAL FAMILY PLANNING EXPENDITURE
$2,810,000



TOTAL FAMILY PLANNING EXPENDITURE
$17,600,000

	BENIN	BURKINA FASO	LIBERIA	TANZANIA
GOVERNMENT	57%	3%	24%	9%
EXTERNAL	31%	87%	40%	78%
PRIVATE	12%	10%	36%	11%

four countries, as shown in **Figure 4.19**. In Benin, the government is the largest funder of family planning services, while external support accounts for 87% and 78% of expenditures in Burkina Faso and Tanzania, respectively. Liberia has roughly equal shares coming from the government, external sources and private funding.

The amount of family planning expenditure per user of modern contraception varies from just over $4 in Benin to over $40 in Liberia. Family planning does not represent a major health expenditure in any of these four countries. The percentage of health expenditure going to family planning ranges from 0.2% in Benin to 2.3% in Liberia.

FIGURE 4.20
TOTAL FAMILY PLANNING EXPENDITURES PER MODERN METHOD USER*

*All current users

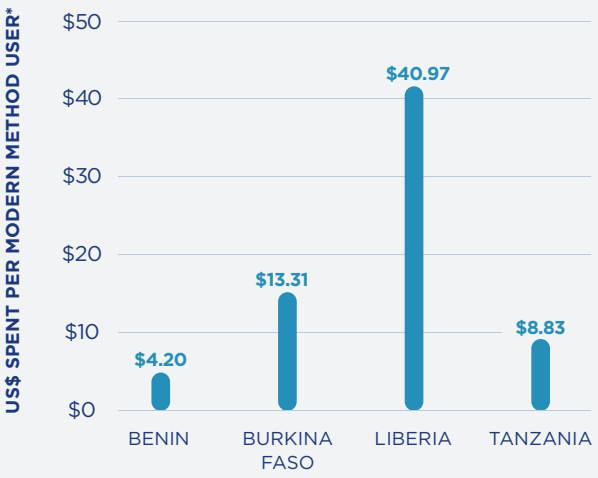


FIGURE 4.21
TOTAL FAMILY PLANNING EXPENDITURES PER WOMAN OF REPRODUCTIVE AGE*

*All women ages 15-49

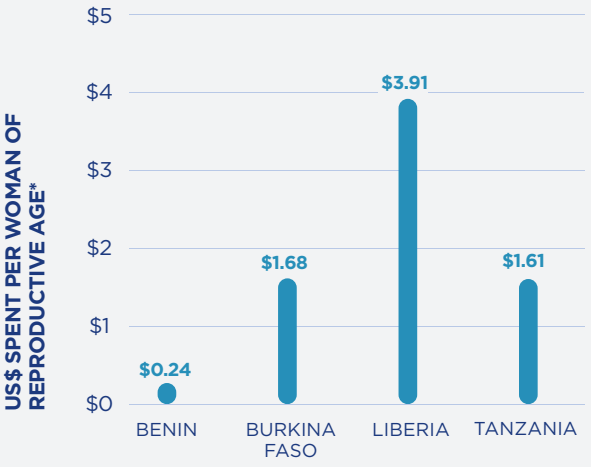
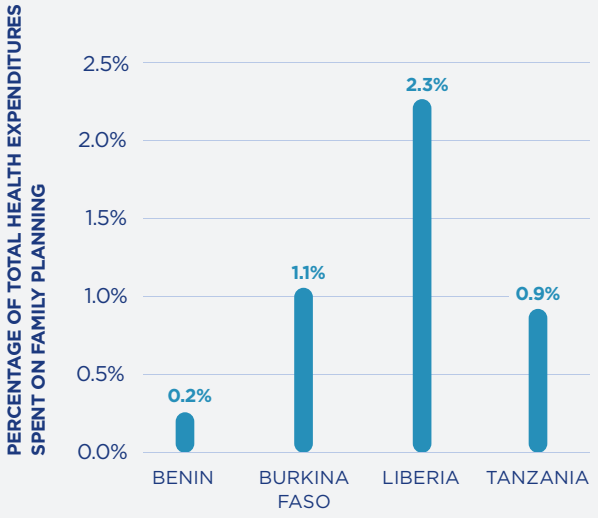


FIGURE 4.22
FAMILY PLANNING AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURES



To achieve the goal of FP2020, we cannot simply assume there will be enough affordable, high-quality contraceptives in place to meet the diverse needs of 120 million additional women and girls. The momentum of FP2020 and the determined actions of global partners, including buyers and suppliers, will be critical to making FP2020's goal a reality.

John Skibiak
Director, Reproductive Health Supplies Coalition

INDICATOR 5
ANNUAL FP EXPENDITURE FROM GOVERNMENT DOMESTIC BUDGET

COUNTRY	2012	2013	SOURCE
INDIA	$465,000,000	$465,000,000	MOH
MYANMAR	$1,290,000	$3,270,000	MOH
UGANDA	$3,300,000	$3,300,000	MOH

In the table above, the amount for India is national government family planning expenditures, including all costs. The estimate includes expenditures through the Ministry of Health and Family Welfare and expenditures through the National Rural Health Mission. Items specific to family planning were extracted and family planning was allocated 10% of shared expenditures. Additional expenditures by state governments, NGOs and out of pocket are not captured.

The amount for Myanmar was submitted by the Ministry of Health as family planning expenditures.

For Uganda, the amount is almost exclusively for family planning commodities. It results from a World Bank loan for reproductive health commodities over a five-year period. Starting a couple of years ago, the government began sending the allocated funds directly to the Division of Medical Stores, so budgetary allocations and actual expenditures are nearly identical.

Most countries participating in the Track20 Data Consensus Workshops did not report family planning expenditures from government budgets. Similarly, most countries do not currently disaggregate these expenditures from general reproductive health spending.

However, in the coming years, when more countries report on family planning expenditures and trends over time become available, the cross-country comparisons will be more useful for understanding normal ranges of these indicators and the factors that influence them.

TRACK20

Track20 provides annual estimates for FP2020's Core Indicators for all 69 countries and intensive support in commitment-making countries to support country-level data collection, analysis and use. This includes a variety of activities that focus on building a cohort of trained and effective family planning M&E experts that drive country efforts around family planning data.

Track20 is working with FP2020 commitment-making countries to recruit and train dedicated family planning M&E officers in pledging countries. Officers are placed in the country's Ministry of Health, Office of Population or other relevant office. The intent is for the M&E officer to become the point person for family planning data from both the public and private sectors. The M&E officer collates, analyzes and disseminates family planning data for reporting, program improvement and strategic decision making. They play a leading role in building consensus around estimates for annual reporting on family planning progress to FP2020. Track20 provides ongoing capacity building for these officers in the form of regional trainings, country visits and direct responses to specific technical requests.

In 2014, Track20 facilitated its first training workshop for M&E officers from 13 countries. The training, which lasted a week, included detailed sessions discussing family planning data available in countries, introducing methodologies and tools used to calculate FP2020 Core Indicators and monitoring efforts currently being supported by global partners. This venue provided the first opportunity for these M&E officers to meet counterparts from other countries and engage in critical discussions about the availability and quality of family planning data in their countries. The training will be repeated later in 2014 with remaining pledging countries.

Also in 2014, Track20 organized the first series of Data Consensus Workshops to produce annual estimates for FP2020 Core Indicators, as well as other country-specific family planning data, and to introduce the process of hands-on annual monitoring of family planning progress. The workshops were held in 10 countries (Côte d'Ivoire, DR Congo, Ethiopia, India, Indonesia, Malawi, Nigeria, Pakistan, Philippines and Rwanda).

The Data Consensus Workshops are of paramount importance in ensuring that annual monitoring is a country-driven process. Dedicating a specific time to generate and evaluate data using new and innovative estimation tools makes it possible for family planning program decision makers to have timely access to the data that they need to be able to take stock of progress and, if necessary, improve their strategies. Track20 M&E officers are the in-country drivers of this process and sit within government structures that collect, analyze and use family planning data. Data Consensus Workshops also provide an important opportunity for transparency for governments and partners about data and methodologies used in-country and internationally, with a focus on synergizing estimates that are used by all partners.

The organization, content and guest list for Data Consensus Workshops is a country-driven process led by the Ministry of Health—usually the reproductive health unit—with support from the Track20 M&E officers. The workshops brought together public and private-sector technical experts including UN, bilateral donor and NGO partners. Overall, the workshops serve as a platform to discuss the family planning data, including Core Indicator definitions and methodologies; to review locally produced data and identify data gaps; to run statistical models and analyze the outcomes; and, ultimately, to support the use of data in country-level decision making to improve program implementation and quality of services. Data produced during the meeting is shared with FP2020 to show annual progress.

PMA2020

What can you accomplish with a mobile phone? If you're one of PMA2020's resident enumerators in Ghana, you can change the world—or at least your corner of it.

The resident enumerators are local women employed by PMA2020 to collect data on family planning in their communities. This is an innovative program that uses mobile phone technology instead of traditional pencil and paper demographic surveys. The enumerators interview people at home, enter the results into smartphones and then upload the data to a central server. Planners can see what is happening in local communities in real time and make program changes and supply-chain adjustments as necessary.

Ghana was the first country to implement the program, and the enumerators there are proud of their work. They know they are bringing positive change to their communities. They are also transforming their own lives as women, becoming more self-assured and empowered, and dreaming bigger dreams for the future.

"My life has changed so greatly in this program!" says Francisca Ansoba, an enumerator in the Ahafo Region. Wearing a white polo shirt embroidered with the PMA2020 logo, she explains that she has gone from being shy and tongue-tied to feeling confident in her own abilities. "Because of this program, there is no more shyness," she says with a laugh. She is now planning to become a nurse or a teacher.

"It feels like we are actually part of something," says Roselyn Vashitna, an enumerator in the Volta Region. A vibrant young woman who hopes to someday own her own business, Roselyn gestures enthusiastically as she describes her work with PMA2020. "I have this inner feeling that I am feeding [the researchers] with information that will be used to help the people. So I am contributing to that!" She smiles. "I feel really proud to be doing that."

Marianne Agbelengor is an economics student at Central University in Accra. "Doing the survey, I realized most women had no idea about family planning," she says. Marianne's passion is improving the lives of women and children, and she hopes to have a career in philanthropy. She is confident that the data she is collecting for PMA2020 will help bring education and empowerment to her community.

I want to be an ambassador for this great vision.

It is a theme that crops up frequently. Barbara Donkor is a poised, polished college graduate who works as an enumerator in Accra. She is inspired by what the FP2020 movement means—not only for Ghana, but for women around the world. "To get 120 million women to be part of family planning services..." Her voice trails off and she suddenly smiles, as if she has just caught a glimpse of something wonderful. "I want to be an ambassador for this great vision."

Photo by Dominic Chavez/ FP2020

Implemented in partnership with local universities and research organizations, PMA2020 uses innovative mobile technology to conduct low-cost, rapid-turnaround, nationally representative surveys to monitor key indicators for family planning and water and sanitation.

With the goal of complementing the Demographic Health Survey (DHS), which reports data in five-year intervals, PMA2020 survey results are released semi-annually and provide consistent progress tracking on contraceptive need, use, quality, choice and access against the FP2020 Core Indicators. PMA2020 survey findings deliver valuable information necessary for timely reporting, program planning, operational decisions and advocacy at the community, national and global levels.

PMA2020 employs a cluster-based network of female resident enumerators to conduct household and health-facility interviews, as well as interviews with women and girls. The resident enumerators are the backbone of PMA2020. As data collectors, they serve as the frontline workers and play the crucial role of linking the project to their respective communities. The resident enumerator cohort is composed primarily of young women who have completed secondary school. To date, PMA2020 has successfully trained 570 resident enumerators in data collection techniques and has enlisted local health care providers to educate the resident enumerators about a range of contraceptive methods to ensure that they are fluent in all aspects of the survey in order to collect quality data, particularly in the health service facilities. Resident enumerators in Ghana, PMA2020's launch country, were expected to interview up to 42 households, approximately 34 females of reproductive age, and three or four health service delivery points. Since joining the project one year ago, Ghanaian resident enumerators report that their involvement in PMA2020 has improved their confidence and interpersonal skills.

During year one of the project, PMA2020 completed at least one round of data collection in DR Congo (Kinshasa), Ethiopia, Ghana, Kenya and Uganda. New cadres of resident enumerators are currently being trained in Burkina Faso and Nigeria, with data collection slated to begin in the fall of 2014. The year 2015 will see the expansion of PMA2020 to India (Uttar Pradesh and Bihar), Indonesia, Niger and Pakistan.

FIGURE 4.23
PMA2020 FINDINGS: PERCENTAGE OF RECENT/CURRENT USERS WHO PAID FOR FAMILY PLANNING SERVICES, BY WEALTH QUINTILE: GHANA

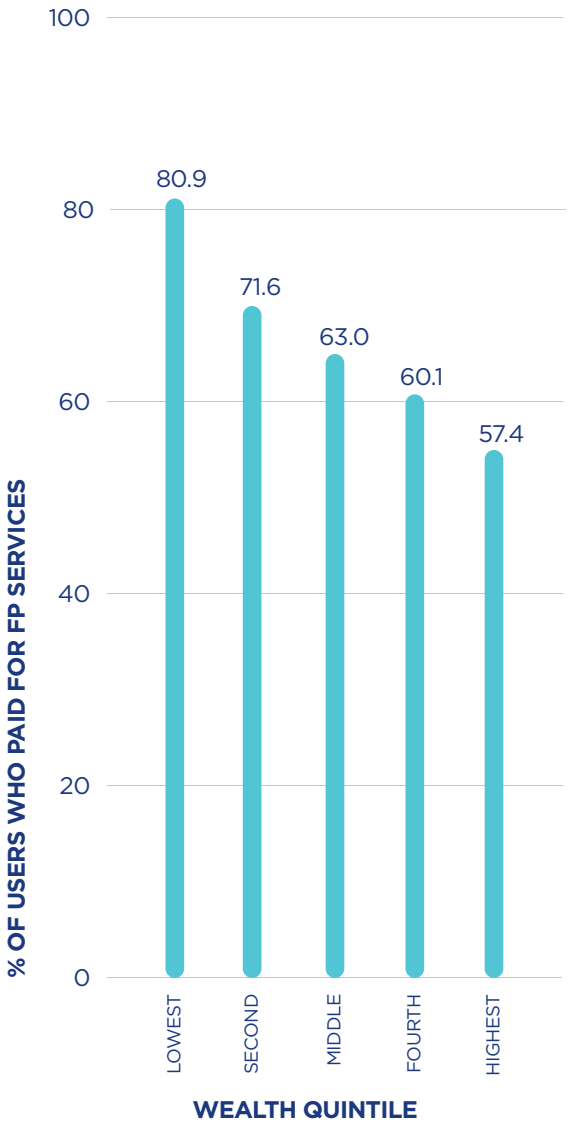
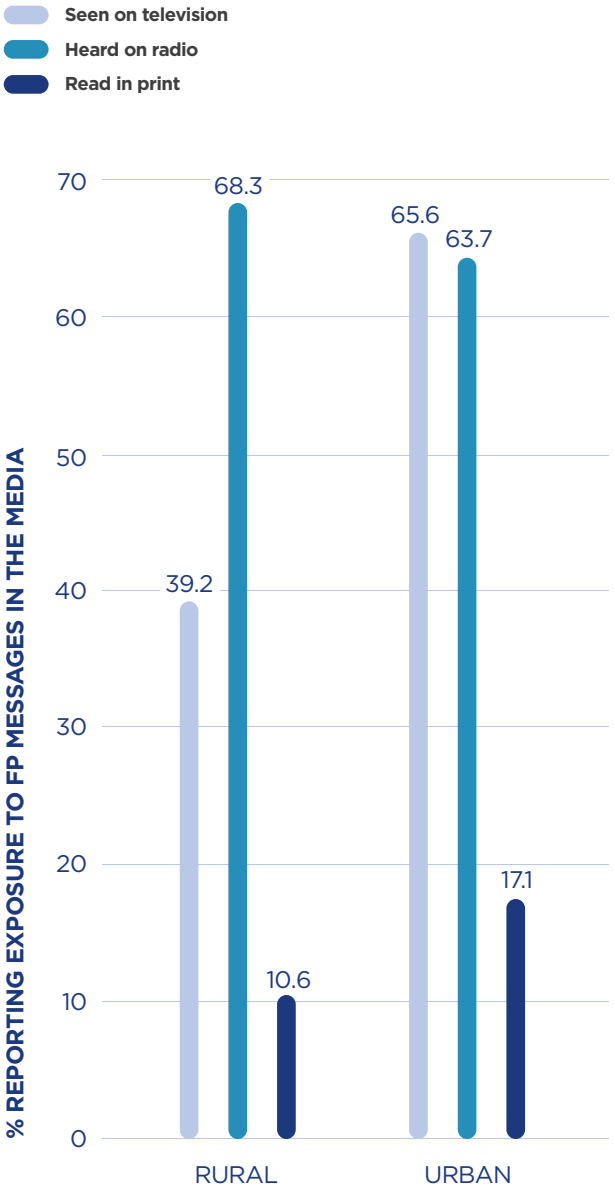


FIGURE 4.24
PMA2020 FINDINGS: PERCENTAGE OF WOMEN AGED 15–49 REPORTING EXPOSURE TO FAMILY PLANNING MESSAGES ON RADIO, TELEVISION OR IN PRINT, BY RESIDENCE: GHANA



Source: Performance Monitoring and Accountability 2020 (PMA2020) Project, Kwame Nkrumah, University of Science and Technology (KNUST). 2013. Detailed Indicator Report: Ghana 2013. Baltimore, MD: PMA2020.

SECTION

FP2020 AT WORK

FP2020 STRUCTURE

The international effort for family planning involves hundreds of partner organizations: governments, multilateral organizations, civil society organizations, philanthropic foundations, the private sector, and the research and development communities. FP2020's role is to coordinate the efforts of these many diverse participants, helping to ensure that agendas are aligned, knowledge is shared and new cooperative strategies are pursued.

FP2020's organizational structure is deliberately light-touch, consisting of only three components: a Reference Group for strategic direction, a small Task Team for day-to-day administration, and four expert Working Groups that provide technical guidance and support.

The Reference Group is responsible for overall strategic direction and coordination. The 18 members of the Reference Group represent national governments, multilateral organizations, civil society, donor foundations and the private sector. The current Co-Chairs are Dr. Chris Elias, President of Global Development at the Gates Foundation, and Dr. Babatunde Osotimehin, Executive Director of the United Nations Population Fund (UNFPA).

The Task Team is led by the executive director and reports directly to the Reference Group. It is responsible for the day-to-day administration of FP2020. Hosted by the UN Foundation, the Task Team manages daily operations, administers the Rapid Response Mechanism, and supports the strategies of the Working Groups.

The four Working Groups are at the core of FP2020. Each group focuses on a key element of the overall initiative:

The Country Engagement Working Group concentrates on ensuring that countries get the support they need to develop, implement and monitor their family planning programs.

The Market Dynamics Working Group partners with the health care sector to ensure that a broad range of high-quality, affordable contraceptive methods are available to the women who need them.

The Performance Monitoring & Accountability Working Group collects and analyzes the data necessary to measure FP2020's progress and ensure that partner commitments are kept.

The Rights & Empowerment Working Group ensures that a fundamental respect for the rights of women and girls underpins all of FP2020's efforts.

FP2020 spurs progress by building on existing partnerships and architecture and avoids creating redundant structures or new reporting requirements. Wherever possible, FP2020 works with organizations, frameworks and mechanisms that are already in place, at both the global and country level.

FP2020 is aligned with United Nations Secretary-General Ban Ki-moon's *Every Woman Every Child* Global Strategy for Women's and Children's Health, and a commitment to FP2020 is counted as a commitment to *Every Woman Every Child*.

RAPID RESPONSE MECHANISM

FP2020's Rapid Response Mechanism (RRM), launched in July 2014, opens up a dynamic new source of support for family planning programs in the 69 focus countries. The RRM disburses short-term grants in response to critical emergencies, urgent needs and unforeseen opportunities. The RRM was established through the generosity of Bloomberg Philanthropies and is administered directly by the FP2020 Task Team.

The RRM is geared toward fast turnarounds: applications are submitted on the FP2020 website, funds are disbursed rapidly and projects are expected to be completed within a brief time frame (no more than one year from initial financial disbursement). The RRM is not a substitute for long-range planning, nor is it designed to fulfill ongoing needs. Instead, the emphasis is on immediate yet potentially catalytic opportunities.

Programs at the regional, national and local level are eligible as long as they serve to advance FP2020 goals. Grants are available in four thematic areas:

- Discreet training (example: training health workers to deliver a new type of contraception)
- Advocacy and education (example: capitalizing on an unforeseen opportunity to increase support for family planning)
- Increasing access for hard-to-reach and marginalized groups, including youth (example: an outreach campaign to promote a new contraceptive product)
- Other urgent need in support of FP2020 goals (example: a time-sensitive, local adaptation of contraceptive guidelines)

FP2020 issued its first RRM grant in September 2014. The Uganda Protestant Medical Bureau (UPMB) is a faith-based network that provides health care to poor and rural populations. The grant from FP2020 will fund UPMB's Faith in Action: Advocacy for Access to Family Planning project in the Busoga region of Uganda. Activities will include community education programs about family planning, radio spots, training and sensitization of health workers, and cultivation of religious leaders as advocates. The project will run for one year, with a benchmark goal of increasing contraceptive use by 5%.

WORKING GROUPS
COUNTRY ENGAGEMENT WORKING GROUP

FP2020 works through its Country Engagement Working Group (CE WG) to help governments develop, implement and monitor their family planning programs. In order to ensure a responsive country-engagement strategy, the CE WG is vested in developing a process that is grounded in country-level perspectives and needs.

One of the cornerstones of FP2020 is the efficient use of existing structures and mechanisms wherever possible. In keeping with this philosophy, the CE WG has established an FP2020 focal point network that consists of UNFPA, USAID and DFID representatives who are already in-country. Government focal points are designated by ministries of health. The donor focal points work with the government to identify gaps in implementation, align resources to goals and ensure that FP2020 is grounded in work that is consistent with government priorities and complements efforts by existing partners. The focal point network also contributes to an increased level of coordination between donor agencies, often through the government-led coordinating committees.

The CE WG has developed an algorithm to guide the process of brokering resources to countries for assistance with their family planning programs. The algorithm, which is included with each country's FP2020 welcome kit, outlines the steps involved in matching resources with a country's requests for funding or technical assistance.

Countries need to have costed implementation plans (CIPs) in place to guide their family planning strategies and to facilitate the matching of funds and resources. The CE WG works with countries to help them develop, strengthen, review and cost their plans. The CE WG is in the process of compiling a resource kit with the information and tools needed to develop a CIP, including a library of real-world CIPs for reference and an inventory of best practices.

The CE WG monitors countries' family planning progress by completing landscape questionnaires based on countries' own plans and data from partners, by working with focal points to track implementation of family planning plans and by developing implementation reports for countries without country plans.

Photo by Dominic Chavez/FP2020

COSTED IMPLEMENTATION PLANS

To expand access to contraception, leaders must be strategic in how to invest limited resources among competing priorities. As a result, governments have invested in family planning CIPs to accelerate their progress. A CIP is a multiyear strategic plan that maps and coordinates the investments and activities among partners toward achieving the country's family planning goals.

Governments in West Africa, as part of the Ouagadougou Partnership, and in East Africa began investing in CIPs as early as 2010. Since then, 15 governments globally have begun implementing CIPs as a road map to coordinate the work of their partners. Key elements of a CIP include: 1) interventions needed to meet the country's priority goals, 2) the costs associated with the interventions, 3) donor information to mobilize the needed resources, and 4) a strategy to monitor progress toward the goals. Currently, seven additional governments are developing CIPs.

There are three sequential phases to the CIP process: plan, develop and implement. Throughout the process, stakeholder engagement, advocacy and capacity-building are essential cross-cutting components in achieving success.

- The planning phase includes securing government and stakeholder buy-in. An initial identification and engagement of key stakeholders is conducted; the approach, tools and techniques are defined (i.e., the how, by whom and when); and resources for the development of the CIPs are secured.

- The development phase involves creating the strategy and planning for the transition into the execution phase. The development process is iterative and cyclical and involves defining priority issues, interventions and activities and generating budgetary costs. It also includes defining institutional arrangements for implementation, developing a performance-monitoring mechanism and conducting advocacy.

- In the final phase, the CIP is implemented, monitored and managed. Implementation involves several steps that occur in tandem to ensure a sustained commitment from leaders and stakeholders at all levels: leading and managing plan implementation, resource mobilization, advocacy and monitoring progress toward goals. This phase also ensures that the CIP is a dynamic document, subject to periodic review and revision based on results and changes in the internal and external environment.

Partners globally have been providing support to governments since the inception of the CIP process. To collect and unify the knowledge and learning that has been gained, FP2020 convened global experts in May 2014 to share their experiences and expertise. During the meeting, experts agreed on a consensus package of information and tools that will be included in a resource kit for the creation of new plans as well as the support of existing plans. The CIP resource kit will be available in early 2015.

SPOTLIGHT: COUNTRY ENGAGEMENT WORKING GROUP MEMBERS

"India's greatest challenge is its diversity," says Dr. S.K. Sikdar, Deputy Commissioner in charge of family planning in India's Ministry of Health and Family Welfare. "Whereas some policies do wonderfully well in some regions of the country, the same policies may not do as much in other regions." Dr. Sikdar has been involved in family planning for a decade, and he notes that the Ministry of Health has scored a number of wins in its efforts to adapt to local conditions. "When you make policies and programs keeping the women in the far-flung villages in mind," he says, "you are very likely to succeed."

Nevertheless, many challenges remain. Dr. Sikdar feels that the FP2020 movement has come at exactly the right time. "Countries across the world have been doing a lot in family planning over the last three to four years, but FP2020 has been a catalyst to the whole movement," he says. "In our country we are really embracing FP2020 in a very big way as an advocacy and enabling mechanism, to provide family planning services to all our women."

The key, says Dr. Sikdar, is that FP2020 is a broad-based coalition that unites partners across sectors and across the globe. The possibilities are immense. "For the first time, all the countries of the world—with different cultures, different creeds, different capacities—have really come together on a single platform for a common, unified goal."

Fatimata Sy is the Coordination Unit Director for the Ouagadougou Partnership, a regional coalition to expand family planning in nine francophone nations of West Africa. "Most of the francophone West African countries are really lagging behind in terms of family planning," she says. "We have the lowest contraceptive prevalence rates compared to lusophone and anglophone countries in the same region."

But the Ouagadougou Partnership, which was inaugurated in 2011, is sparking a transformation. "[It] is helping countries to reposition family planning," says Ms. Sy. Government commitment and donor coordination have increased throughout West Africa, and contraceptive prevalence rates are starting to rise. Each of the nine countries in the Ouagadougou Partnership has developed a costed implementation plan.

"We are now creating momentum at the country level and global level around family planning," says Ms. Sy. "I believe in this movement because we're now seeing a great interest from donors and countries to talk about family planning, linking family planning to other strategies that will decrease maternal mortality and strengthen the rights of women and girls."

As Ms. Sy points out, family planning interventions require significant resources, both technical and financial. Coordination among donors and partners is key. The Ougadougou Partnership and FP2020 are working to ensure that collaborations are efficient, taking advantage of existing resources whenever possible. "I think we're already doing some excellent things together—the same action plan, using the same focal points, calling meetings that advance the family planning agenda in francophone West Africa."

MARKET DYNAMICS WORKING GROUP

The Market Dynamics Working Group (MD WG) works to improve global and national markets to ensure that women in FP2020 focus countries have access to a broad range of high-quality, affordable contraceptive methods. FP2020's attention to market dynamics is driven by the need to ensure that family planning commodities are available to meet the goal of 120 million new users, and that the market is healthy enough to sustain this demand after 2020.

A key initiative of the MD WG in the past year has been the launch of the Global Markets Visibility Project, a multi-year undertaking that will provide valuable insights into the family planning commodities market (see box below). The project is a collaboration between the Clinton Health Access Initiative (CHAI) and the Reproductive Health Supplies Coalition (RHSC), and it was developed in close cooperation with the MD WG. The project aims to provide a data-driven, real-world image of market flows in family planning commodities, highlighting gaps between supply and demand and enabling better planning by partners, countries and suppliers.

To improve procurement and regulatory practices, the MD WG has begun a procurement-priorities research project to assess the value stakeholders ascribe to various product offerings. The MD WG identified a representational sample of procurers, donors and procurement agencies to be surveyed, and drafted questionnaires to be finalized and distributed in the fall of 2014.

GLOBAL MARKETS VISIBILITY PROJECT

As part of their efforts to expand access to a wide choice of family planning methods, the CHAI and the RHSC, in cooperation with the FP2020 Market Dynamics Working Group, are implementing a Global Markets Visibility Project. The project will address information gaps in the reproductive health commodities market, consolidate and analyze consumption and shipment data, and monitor and report market trends by product.

Since 2004, the RHSC has collected and published data on contraceptive orders and shipments. Building on this base, the RHSC and CHAI are developing a data-repository program that will enable shipment data to be de-identified and then aggregated for global analysis of market trends. CHAI will collect and manage the supplier shipment data at the global level, keeping supplier data confidential. Key shipment metrics include:

- shipments by country and region (Africa, Asia Pacific, Latin America, etc.)
- shipments by product (implants, injectables, oral contraceptives, etc.)

Working with industry, donors, and the RHSC, CHAI will publish reports that provide insight into the family planning market. Using supplier data together with in-country source data on consumption, the reports will validate actual supply and demand in the market.

The resulting insights will enable suppliers to make better decisions about capacity planning and investments. Partners will be able to identify shortfalls and excesses, and develop plans to improve family planning product markets. Countries will be able to track their progress and determine what is needed to realize their FP2020 commitments.

PERFORMANCE MONITORING & ACCOUNTABILITY WORKING GROUP

The Performance Monitoring & Accountability Working Group (PMA WG) provides technical guidance in three critical areas: measuring progress toward FP2020's goal, encouraging the use of data to inform decision making, and identifying gaps in the evidence needed to improve family planning programs and policies.

In 2013–2014, the PMA WG provided technical guidance to reevaluate and refine FP2020's Core Indicator definitions, methodologies and data sources. They subsequently reviewed the 2013 Core Indicator estimates and key findings that are presented in this progress report.

Earlier this year, the PMA WG initiated two projects. The first project is evaluating whether and how an FP2020 "scorecard" might encourage advocates and decision makers on the country level to incorporate data in their strategies. The second project will examine what we currently know about contraceptive discontinuation and how we can add to this body of knowledge.

The PMA WG is currently working with the RE WG to identify new options for measuring dimensions of rights and empowerment in the context of family planning. The PMA WG is collaborating with the Reproductive Health Supplies Coalition on the definitions and data sources for two new FP2020 indicators of contraceptive supply availability and supply stock-outs. Moving forward, the PMA WG will continue to guide the development of an index that quantifies the degree to which a country's policy environment enables family planning programming, and will consider new strategies for encouraging data utilization at the national and subnational levels.

RIGHTS & EMPOWERMENT WORKING GROUP

A consistent thread that runs through all FP2020 activities is that the rights of women and girls must be observed and their agency respected. The principles of voluntarism and informed choice are at the center of FP2020's work, which is fully aligned with the reproductive rights framework established by the International Conference on Population and Development (ICPD) in 1994. Ensuring that the focus on rights remains uppermost is the special task of the RE WG.

The RE WG works closely with the other three Working Groups, offering guidance and recommendations on how to ground efforts in a rights-based approach. In 2014 the RE WG finalized a set of foundational materials to shape a unified understanding of rights-based programming, including a statement of universal principles and a guide to help stakeholders navigate resources related to rights and empowerment. These materials will be core components of the CIP Resource Kit being developed by the CE WG. They were informed by existing and emerging frameworks, including WHO's *Ensuring Human Rights in the Provision of Contraceptive Information and Services* guidance,[80] UNFPA's forthcoming operational guide on human rights in contraceptive services, and the *Voluntary Family Planning Programs that Respect, Protect and Fulfill Human Rights: A Conceptual Framework User's Guide*[81] developed by Futures Group and EngenderHealth.

Collaboration between the RE WG and the PMA WG has been especially fruitful, with the result that the Core Indicators have been carefully refined over the past year to better reflect principles of rights and empowerment. The RE WG also helped bring a rights-based perspective to FP2020's National Composite Index on Family Planning, and in April 2014 participated in a regional training session of Track20's Monitoring & Evaluation Officers

to get feedback on rights and empowerment indicators that have data sources and would be useful at the country level.

With support from the MD WG, the RE WG led an effort to develop a survey to gauge if and how contraceptive manufacturers encourage and facilitate the participation of end-users in their product and market planning. The survey was administered in August 2014, and the results were first disseminated at the 15th General Membership Meeting of the Reproductive Health Supplies Coalition in October 2014.

Importantly, the RE WG is also producing a guide for civil society to use in monitoring family planning programs, based on WHO's *Ensuring Human Rights in the Provision of Contraceptive Information and Services* guidance. In September–October 2014, grassroots women's groups and other local experts in India and Indonesia were consulted on a draft version of the guide. These consultations also served as a platform to explore how FP2020 should respond to human rights violations, if they occur. This approach builds upon FP2020's collaborative spirit, engaging country stakeholders and ensuring that any forthcoming strategy will be developed from the ground up.

80. http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/

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

82. Hardee, K, Newman, K, Bakamjian, L, Kumar, J, Harris, S, Rodriguez, M, and Willson, K., Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework, Washington, DC: Futures Group. 2013.
Now published in Studies in Family Planning: Hardee, K, Kumar, J, Newman, K, Bakamjian, L, Harris, S, Rodríguez, M., and Brown, W. 2014. Voluntary, Human Rights–Based Family Planning: A Conceptual Framework. Studies in Family Planning Volume 45, Issue 1.

83. http://www.futuresgroup.com/files/publications/Voluntary_Rights-Based_FP_Users_Guide_FINAL.pdf

84. http://www.who.int/reproductivehealth/publications/family_planning/human-rights-contraception/en/

KEEPING HUMAN RIGHTS AT THE CENTER

The FP2020 movement is grounded in a human rights–based approach to family planning. That means investing in programs that honor the rights of individuals to decide, freely and for themselves, whether and when to have children. It means respecting the agency of women and girls, and empowering them with full information about contraception, universal access to services and supplies, and a wide range of choices. But how can policymakers and administrators be sure to incorporate these principles in their programs?

In the wake of the 2012 London Summit on Family Planning, researchers from Futures Group, EngenderHealth and the Gates Foundation set out to answer that question. The resulting *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: A Conceptual Framework*[82] was published in August 2013. The framework presents a practical, holistic approach to developing and evaluating family planning programs through a human rights lens. Over the past year, the process of operationalizing the framework at the country level has begun.

In India and Kenya, national and regional stakeholders met with members of the Futures Group/EngenderHealth team in early 2014 to discuss applying the rights-based framework to their family planning programs. These consultations led to the development of a user's guide, designed to help stakeholders translate the principles in the framework into specific program activities. The *Voluntary Family Planning Programs that Respect, Protect, and Fulfill Human Rights: Conceptual Framework User's Guide* (September 2014) contains an orientation module and a program planning module that covers program assessment, design, monitoring and evaluation, and accountability.[83]

The orientation module was field-tested in Togo, where EngenderHealth is applying the rights framework to the USAID-funded Agir pour la Planification Familiale and Fistula Care Plus projects. It received another trial run in Uganda, during an August 2014 workshop conducted by EngenderHealth and the Ministry of Health (with support from the William and Flora Hewlett Foundation and USAID). The purpose of the workshop was to integrate rights into existing programs; the workshop also helped ministry officials understand how to follow through with the rights-based language included in draft versions of their Family Planning Costed Implementation Plan (FP CIP). The resulting recommendations will be included in the final FP CIP.

WHO GUIDANCE ON RIGHTS-BASED FAMILY PLANNING

In March 2014, WHO launched a new guide, *Ensuring Human Rights in the Provision of Contraceptive Information and Services*,[84] designed to help countries make sure that human rights are respected in family planning programs. The guidance recommends that every person who wants contraception should be able to obtain accurate information and a variety of services and products. It also underlines the need for no discrimination, coercion or violence, with special attention given to ensuring access for those who are disadvantaged and marginalized. To implement the guidance, UNFPA and WHO are developing an operationalization guide that will be launched in countries at the end of 2014.

SPOTLIGHT: RIGHTS & EMPOWERMENT WORKING GROUP MEMBER

"My work has taught me that the human rights community and the sexual and reproductive health and rights community can achieve so much more if they collaborate," says Elly Leemhuis-de Regt, who represents the Dutch Ministry of Foreign Affairs. "That's why I wanted to be in the Rights & Empowerment Working Group." According to Ms. Leemhuis, the Dutch government has prioritized sexual and reproductive health and rights over the past 10 to 15 years, and played an active role at the *2012 London Summit*. She views the partnerships established by FP2020 as critical for the future of family planning. "FP2020 can bring about change because it involves many people with an enormous, diverse set of experiences," she says. "It's interesting what people bring together and learn from each other. I think that togetherness will bring FP2020 further."

For Ms. Leemhuis, quality is an essential family planning concern, particularly in terms of the skills and attitudes of service providers. But she draws inspiration from the stories of women who access family planning even against great odds. "The creativity of women is a success story," she says. "It's always amazing and also very inspiring to learn from the women how they find their own solutions to get to the contraceptives they want."

AFTERWORD: THE POST-2015 AGENDA

In 2015, the world will mark a turning point. The Millennium Development Goals, which have shaped the global development agenda for the past decade and a half, will draw to a close. It will be time for a new development agenda, one that addresses a broader spectrum of needs—with sustainability at the core—and that draws on the lessons we have learned.

Family planning is essential to health, freedom and prosperity. We know that family planning empowers women and improves health, but we also know that it has countless ripple effects across society. Family planning plays a central role in poverty reduction, sustainable development, economic growth, gender equality, social inclusion and environmental stewardship.

For all of these reasons, and more, we believe that family planning must be included in the next global development agenda. In 1994, the International Conference on Population and Development (ICPD) called for voluntary universal access to a full range of safe, reliable family planning methods. Twenty years later, that goal is still unfinished business. Together with partners, UNFPA and USAID have worked to propose a post-2015 measure and benchmark to track progress in increasing access to family planning: at least 75% of demand for family planning is satisfied with modern contraceptives in all countries by 2030.

FP2020 has shown that a broad alliance between countries, donors, NGOs, civil society and the private sector can build powerful momentum for family planning. Consensus is mounting that access to family planning is both crucial to promoting and protecting human rights and a linchpin of successful, sustainable development.

As we enter the post-2015 era, the world would be best served by an agenda that acknowledges the centrality of contraception to sexual and reproductive health and rights; that enshrines voluntarism, informed choice and universal access as core concepts; and that recognizes the importance of family planning to human, economic and environmental development goals.

SECTION

6

ANNEXES

Data Tables, Charts and Sources
FP2020 Reference Group and Working Group Members
FP2020 Commitment Makers
Acronyms
FP2020 Focus Countries

ANNEX 1 NOTES ON METHODOLOGIES AND DATA SOURCES

DATA LIMITATIONS

Data limitations present a significant challenge to tracking key indicators on an annual basis. The preferred source of data for several of the Core Indicators (e.g., mCPR, number of additional users of modern contraceptives, unmet need for modern contraception) has been large-scale, population-based surveys such as the DHS or MICS. However, few countries undertake large-scale population-based surveys on an annual basis. Only one country had data available from a 2013 DHS at the time this report was written.[85] The emergence of PMA2020 helps to derive survey-based national estimates on an annual basis. For this report, PMA2020 data were used from two countries, Ghana and Ethiopia.

Program data and service statistics are available annually and are thus a potential source of annual tracking data, but such data provide a basis for measuring only some of the Core Indicators and are also subject to data-quality issues that vary considerably from country to country. The remaining plausible alternative is statistical modeling.

The 2013 estimates for four of the seven FP2020 annual tracking indicators presented in this report were derived via modeling for the large majority of FP2020 countries. The methodology used in calculating the estimates, which is based upon a methodology that is being used by the United Nations Population Division (UNPD), is described in the following section. These represent the best available estimates in the absence of new survey data for 2013. The fact that they are estimates based upon modeling should be borne in mind when interpreting the results.[86]

FAMILY PLANNING ESTIMATION TOOL (FPET)

To calculate mCPR, Unmet Need and Demand Satisfied where data were lacking, Track20 used statistical modeling to estimate the trends in these indicators for 2012 and 2013. The modeling, called the Family Planning Estimate Tool or FPET, is based on an estimation approach[87] used by the United Nations Population Division (UNPD) that draws on data for 194 countries and areas worldwide. Experience to date working with the methodology indicates that while the model sometimes produces estimates of mCPR that differ from estimates derived from DHS or comparable surveys in any given year, the differences tend to be small, and the DHS estimates almost always fall within the 95% uncertainty limits about the model prediction and are thus within the bounds of what may be attributed to random sampling error.[88]

FPET was adapted to work with a single country at a time and to accept service statistics as well as survey data to establish trends. The adaptation used was prepared by Jin Rou New and Leontine Alkema of the National University of Singapore. FPET is a Bayesian, hierarchical model that fits logistic growth curves to historical data in order to determine the long-term trend, and adds a time series model with autocorrelation to capture the deviations around the long-term trend.

This model not only determines the most likely trend through the data but also estimates the uncertainty range around the trend so that each estimate contains a median estimate as well as a 95% confidence range, as is shown in the figure to the right (**Figure AX.1**) The model is available as a web application at the following link: fpet.track20.org.

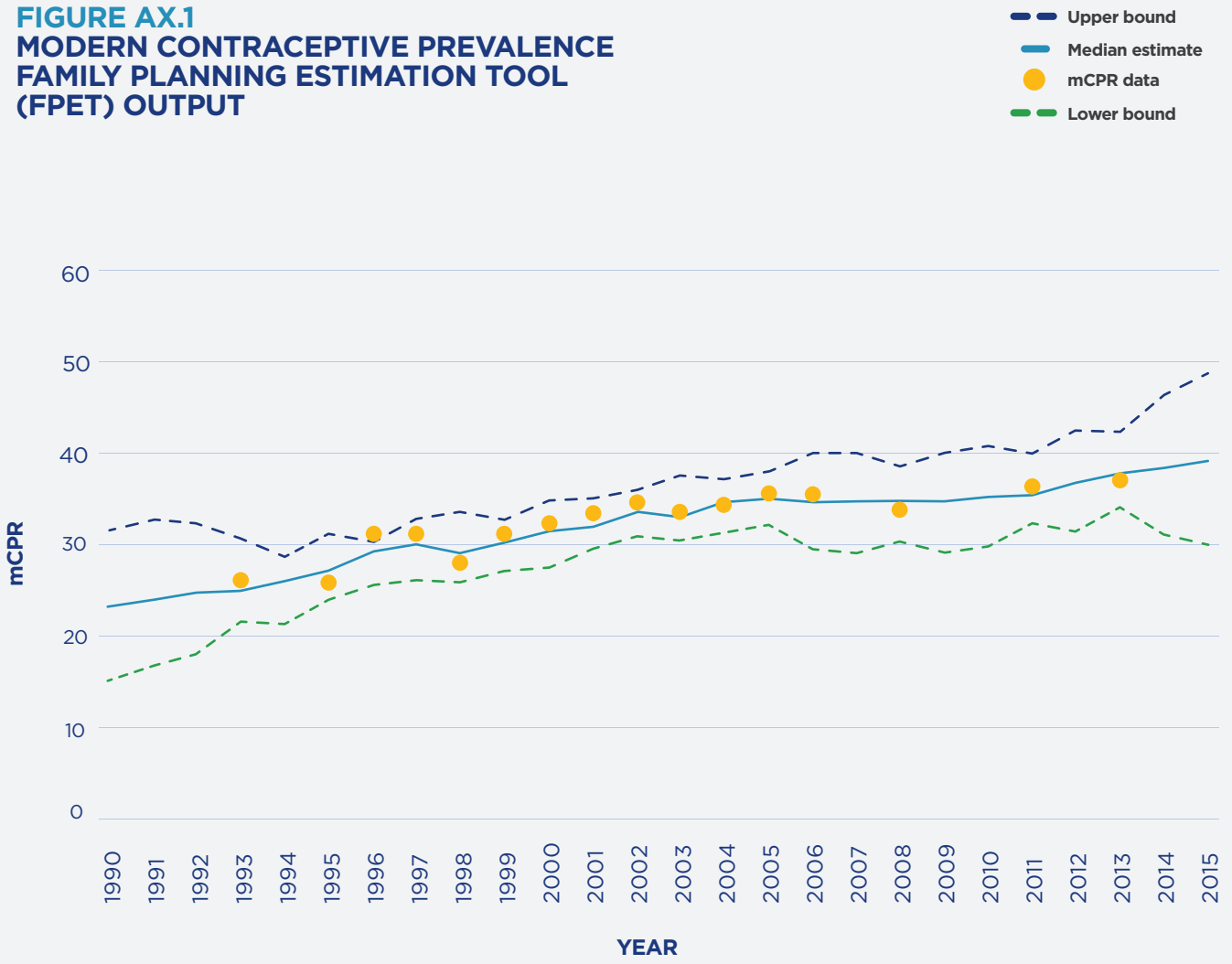
85. Other countries conducted DHS or other large-scale surveys in 2013, but the results were not yet available at the time that this report was assembled.

86. United Nations, Department of Economic and Social Affairs, Population Division (2014). Model-based Estimates and Projections of Family Planning Indicators 2014. New York: United Nations. http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

87. Alkema L, Kantorova V, Menozzi C, Biddlecom A. 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 2013 May 11;381(9878):1642-52. doi: 10.1016/S0140-9736(12)62204-1.

88. United Nations, Department of Economic and Social Affairs, Population Division (2014). Model-based Estimates and Projections of Family Planning Indicators 2014. New York: United Nations. http://www.un.org/en/development/desa/population/theme/family-planning/cp_model.shtml

FIGURE AX.1
MODERN CONTRACEPTIVE PREVALENCE FAMILY PLANNING ESTIMATION TOOL (FPET) OUTPUT



Source: Track20.

MODERN CONTRACEPTIVE PREVALENCE RATE, ALL WOMEN

Values for modern contraceptive prevalence for all women (Indicator 1a) were produced using FPET that was informed by three potential types of data: nationally representative estimates derived from methodologies using household-based interviews (e.g., DHS, PMA2020, MICS), nationally representative estimates derived from interviews and observations conducted at public and private service delivery points (e.g., the DHS SPA, PMA2020), and service statistics (e.g., health management information systems), including supply-side data on contraceptive commodities (e.g., logistics management information systems).

FPET currently produces estimates for mCPR among married or in-union women, which are then converted to estimates of use among all women of reproductive age (WRA). Track20 is in the process of updating FPET so that it produces "all women" estimates so this conversion will not be necessary in the future.

For countries with a previous DHS, the ratio of mCPR for all and married women from that DHS was used to convert the married women mCPR from FPET to an all-women value. In countries with no previous all-women estimate (Bangladesh, Bhutan, DPR Korea, Djibouti, Gambia, Guinea-Bissau, Lao PDR, Mongolia, Myanmar, Papua New Guinea, Somalia and Vietnam), a regional estimate was used. In some countries, no unmarried use was assumed (Afghanistan, India, Iraq, Pakistan, South Sudan, State of Palestine and Yemen), and the number of married modern-method users was divided by the population of women of reproductive age to produce an all-women mCPR estimate.

For countries that held Data Consensus Workshops, there was an option of including country-specific service statistics in FPET. Countries with service-statistics data of reasonable consistency and quality were able to include these data in the FPET run to estimate mCPR for married/in-union women. Married-women values were converted to all-women values as described above. Countries which incorporated service-statistics data are Côte d'Ivoire and Ethiopia. This option requires entry of multiple years of data, including at least one year that overlaps with a DHS or MICS survey, to calibrate the model. The HMIS data is used to inform the trend after the last cross-sectional data point.

UPDATES TO THE CORE INDICATORS

The following updates to FP2020's Core Indicator set were approved in 2014.

Indicator 2 has been changed to the number of additional modern-contraceptive users from total number of contraceptive users by method. The reasons for this change are discussed in the report.

Indicator 1b (percent distribution of users by modern method) was created. This is a result of the change to Indicator 2. This indicator shows the method mix among modern users.

The definition of **Indicator 3** (percentage of women with an unmet need for modern contraception) has been modified to include traditional methods. The assumption is that all traditional-method users are in need of a modern method.

The definition of **Indicator 4** (percentage of women whose demand is satisfied with a modern method) has also been modified to include traditional methods. Women using traditional methods are assumed to not have their demand for contraception satisfied.

Photo by Dominic Chavez/FP2020

FIGURE AX.2
INDICATORS THAT ARE REPORTED ANNUALLY FOR 69 FP2020 FOCUS COUNTRIES

INDICATOR TITLE	INDICATOR DEFINITION
1A.CONTRACEPTIVE PREVALENCE RATE, MODERN METHODS (mCPR)	The percentage of women of reproductive age who are using (or whose partner is using) a modern contraceptive method at a particular point in time.
1B. PERCENTAGE DISTRIBUTION OF USERS BY MODERN METHOD OF CONTRACEPTION	The percentage of total family planning users using each modern method of family planning.
2. NUMBER OF ADDITIONAL USERS OF MODERN METHODS OF CONTRACEPTION	The number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to 2012.
3. PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR MODERN METHODS OF CONTRACEPTION	The percentage of fecund women of reproductive age who want no more children or to postpone having the next child, but are not using a modern contraceptive method, plus women who are currently using a traditional method of family planning. Women using a traditional method are assumed to have an unmet need for modern contraception.
4. PERCENTAGE OF WOMEN WHOSE DEMAND IS SATISFIED WITH A MODERN METHOD OF CONTRACEPTION	The percentage of women (or their partners) who desire either to have no additional children or to postpone the next child and who are currently using a modern contraceptive method. Women using a traditional method are assumed to have an unmet need for modern contraception.
5. 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.
6. COUPLE-YEARS 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.
7. 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.
8. NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO MODERN 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.

DATA SOURCE AND AVAILABILITY	DISAGGREGATION
Surveys such as the DHS, MICS, PMA2020, RHS and other nationally sponsored surveys; modeling using surveys and survey statistics	When possible (in years with a DHS or data from PMA2020) by wealth quintile, age, marital status, urban/rural, ethnicity, etc.
Surveys such as the DHS, RHS, MICS and other nationally sponsored surveys; service statistics	
Estimated using data from surveys such as the DHS, RHS, MICS, PMA2020 and other nationally sponsored surveys; service statistics and population data	
Surveys such as the DHS, MICS, PMA2020, RHS and other nationally sponsored surveys; modeling using surveys and survey statistics	When possible (in years with a DHS or data from PMA2020) by method, wealth quintile (comparing the lowest to the highest quintile), age, marital status, parity, urban/rural, ethnicity, etc.
Surveys such as the DHS, MICS, PMA2020, RHS and other nationally sponsored surveys; modeling using surveys and survey statistics	When possible (in years with a DHS or data from PMA2020) by wealth quintile (comparing the lowest to the highest quintile), age, marital status, urban/rural, ethnicity, etc.
COIA, NIDI, Kaiser Family Foundation; country availability will depend on COIA and NIDI implementation. All 69 countries are expected to be available in future.	
Service statistics	
Estimated using modeling	
Estimated using modeling	

FIGURE AX.2 CONTINUED

INDICATOR TITLE	INDICATOR DEFINITION
9. NUMBER OF MATERNAL DEATHS AVERTED DUE TO MODERN CONTRACEPTIVE USE	The number of maternal deaths that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.
10. NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO MODERN CONTRACEPTIVE USE	The number of unsafe abortions that did not occur during a specified reference period as a result of the protection provided by modern contraceptive use during the reference period.

INDICATORS THAT ARE REPORTED ANNUALLY FOR A SUBSET OF FP2020 FOCUS COUNTRIES

INDICATOR TITLE	INDICATOR DEFINITION
11. PERCENTAGE OF WOMEN WHO WERE PROVIDED WITH INFORMATION ON FAMILY PLANNING DURING THEIR LAST VISIT WITH A HEALTH SERVICE PROVIDER	The percentage of women who were provided information on family planning 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, information, education and communication materials or talks/conversations about family planning.
12. 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 composed of 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?) The index score is equal to the number of women who respond "yes" to all three questions.
13. PERCENTAGE OF WOMEN WHO MAKE FAMILY PLANNING DECISIONS ALONE OR JOINTLY WITH THEIR HUSBANDS/ PARTNERS	The percentage 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.
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.
15. PERCENTAGE 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.

DATA SOURCE AND AVAILABILITY	DISAGGREGATION
Estimated using modeling	
Estimated using modeling	

DATA SOURCE AND AVAILABILITY	DISAGGREGATION
DHS, PMA2020 Survey in select years	Disaggregate where possible (in years with a DHS or data from PMA2020) by wealth quintile, age, marital status and parity
DHS, PMA2020 Survey in select years	Disaggregate where possible (in years with a DHS or PMA2020) by wealth quintile, age, marital status and parity
DHS, PMA2020 Survey in select years	Disaggregate where possible (in years with a DHS or PMA2020) by wealth quintile, age and parity
DHS, MICS, PMA2020, RHS in select years	
DHS, PMA2020 Survey in select years for select countries (this is not a standard question)	Disaggregate where possible (in years with a DHS or PMA2020) by wealth quintile, age, marital status and parity

FIGURE AX.3
ALL SOURCES

	INDICATOR	
	1A, 2, 3, 4	1B
	CORRESPONDING TABLE	
	AX.4, AX.9, AX.10	AX.3, AX.18
	SOURCE:	SOURCE:
AFGHANISTAN	FPET	2010-11 MICS (MW)
BANGLADESH	FPET+	2011 DHS (MW)
BENIN	FPET	2011-12 DHS (AW)
BHUTAN	FPET	2010 MICS (MW)
BOLIVIA	FPET	2008 DHS (AW)
BURKINA FASO	FPET	2010 DHS (AW)
BURUNDI	FPET	2010 DHS (AW)
CAMBODIA	FPET	2010 DHS (AW)
CAMEROON	FPET	2011 DHS (AW)
CENTRAL AFRICAN REPUBLIC	FPET	2010 MICS (MW)
CHAD	FPET	2010 MICS (MW)
COMOROS	FPET	2012 DHS (AW)
CONGO (BRAZZAVILLE)	FPET	2011-12 DHS (AW)
CÔTE D'IVOIRE	FPET+	2011-12 DHS (AW)
DJIBOUTI	FPET	2006 MICS (MW)
DPR KOREA	FPET	2002 RHS (N/A)
DR CONGO	FPET+	2013-14 PDHS (MW)
EGYPT	FPET	2008 DHS (MW)
ERITREA	FPET	2002 DHS (AW)
ETHIOPIA	FPET+	2011 DHS (AW)
GAMBIA	FPET	2013 PDHS (MW)
GHANA	FPET/PMA2020	2013 PMA2020 (MW)
GUINEA	FPET	2012 DHS (AW)
GUINEA-BISSAU	FPET	2010 MICS (MW)
HAITI	FPET	2012 DHS (AW)
HONDURAS	FPET	2012 DHS (AW)
INDIA	FPET+	2007-08 DLHS-3 (MW)
INDONESIA	FPET+	2012 DHS (AW)
IRAQ	FPET	2011 MICS (MW)
KENYA	FPET/PMA2020	2008-09 DHS (AW)
KYRGYZSTAN	FPET	2012 DHS (AW)
LAO PDR	FPET	2012 MICS/DHS (MW)
LESOTHO	FPET	2009 DHS (AW)
LIBERIA	FPET	2013 PDHS (MW)
MADAGASCAR	FPET	2009 DHS (AW)

INDICATOR				
1A (DISAGGREGATED)	3, 4 (DISAGGREGATED)	6	7, 8, 9, 10	11, 12, 13, 14, 15
CORRESPONDING TABLE				
AX.5	AX.11, AX.13	AX.14	AX.15	AX.16
SOURCE:	SOURCE:	SOURCE:	SOURCE:	SOURCE:
			MODELED	
			MODELED	
2011-12 DHS (MW)	2011-12 DHS (MW)		MODELED	2011-12 DHS (AW)
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
2012 DHS (MW)	2012 DHS (AW)		MODELED	2012 DHS (AW)
2011-12 DHS (MW)	2011-12 DHS (MW)		MODELED	2011-12 DHS (AW)
		CW, MOH	MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
2013 PMA2020 (AW)	2013 PMA2020 (AW)		MODELED	2013 PMA2020
2012 DHS (MW)	2012 DHS (AW)		MODELED	(AW)
			MODELED	2012 DHS (AW)
			MODELED	
			MODELED	
		CW, MOH	MODELED	
			MODELED	
			MODELED	
			MODELED	
2012 DHS (MW)	2012 DHS (MW)		MODELED	
			MODELED	2012 DHS (AW)
			MODELED	
			MODELED	
			MODELED	

FIGURE AX.3 CONTINUED

	INDICATOR	
	1A, 2, 3, 4	1B
	CORRESPONDING TABLE	
	AX.4, AX.9, AX.10	AX.3, AX.18
	SOURCE:	SOURCE:
MALAWI	FPET+	2010 DHS (AW)
MALI	FPET	2012-13 DHS (AW)
MAURITANIA	FPET	2007 MICS (MW)
MONGOLIA	FPET	2010 MICS (MW)
MOZAMBIQUE	FPET	2011 DHS (AW)
MYANMAR	FPET	2010 MICS (MW)
NEPAL	FPET	2011 DHS (AW)
NICARAGUA	FPET	2007 RHS (AW)
NIGER	FPET	2012 DHS (AW)
NIGERIA	FPET+	2013 DHS (AW)
PAKISTAN	FPET+	DHS 2013 (MW)
PAPUA NEW GUINEA	FPET	2006 NATIONAL SURVEY (AW)
PHILIPPINES	FPET+	2013 PDHS (MW)
RWANDA	FPET+	2010 DHS (AW)
SAO TOME AND PRINCIPE	FPET	2009 DHS (AW)
SENEGAL	FPET+	2012-13 DHS (MW)
SIERRA LEONE	FPET	2013 PDHS (MW)
SOLOMON ISLANDS	FPET	2006-07 DHS (AW)
SOMALIA	FPET	2006 MICS (MW)
SOUTH AFRICA	FPET+	2003 DHS (AW)
SOUTH SUDAN	FPET	2010 MICS (MW)
SRI LANKA	FPET	2007 DHS (MW)
STATE OF PALESTINE	FPET	2010 MICS (MW)
SUDAN	FPET	N/A
TAJIKISTAN	FPET	2012 DHS (AW)
TANZANIA	FPET	2010 DHS (AW)
TIMOR-LESTE	FPET	2010 DHS (AW)
TOGO	FPET	2013 PDHS (MW)
UGANDA	FPET+	2011 DHS (AW)
UZBEKISTAN	FPET	2006 MICS (MW)
VIETNAM	FPET	2011 MICS (MW)
WESTERN SAHARA	N/A	N/A
YEMEN	FPET	2013 PDHS (MW)
ZAMBIA	FPET	2007 DHS (AW)
ZIMBABWE	FPET	2011 DHS (AW)

INDICATOR				
1A (DISAGGREGATED)	3, 4 (DISAGGREGATED)	6	7, 8, 9, 10	11, 12, 13, 14, 15
CORRESPONDING TABLE				
AX.5	AX.11, AX.13	AX.14	AX.15	AX.16
SOURCE:	SOURCE:	SOURCE:	SOURCE:	SOURCE:
		CW, MOH	MODELED	
2012-13 DHS (MW)	2012-13 DHS (MW)		MODELED	2012-13 DHS (AW)
			MODELED	
			MODELED	
			MODELED	
		MOH	MODELED	
			MODELED	
			MODELED	
2012 DHS (MW)	2012 DHS (MW)		MODELED	2012 DHS (AW)
2013 DHS (MW)	2013 DHS (MW)	CW, MOH	MODELED	2013 DHS (AW)
2012-13 DHS (MW)	2012-13 DHS (MW)	CW, MOH	MODELED	2012-13 DHS (AW)
			MODELED	
			MODELED	
			MODELED	
			MODELED	
2012-13 DHS (MW)	2012-13 DHS (MW)		MODELED	2012-13 DHS (AW)
			MODELED	
			MODELED	
			MODELED	
		MOH	MODELED	
			MODELED	
			MODELED	
			MODELED	
			MODELED	
2012 DHS (MW)	2012 DHS (MW)		MODELED	2012 DHS (AW)
			MODELED	
			MODELED	
			MODELED	
		MOH	MODELED	
			MODELED	
			MODELED	
			N/A	
			MODELED	
			MODELED	
			MODELED	

FIGURE AX.3 CONTINUED

	TOPIC	
	ANNUAL GROWTH, mCPR	
	RELATED TABLE	
	AX.6	
	FIRST SURVEY:	SECOND SURVEY:
AFGHANISTAN	2007.5 NATIONAL SURVEY (MW)	2010.5 MICS (MW)
BANGLADESH	2007 DHS (MW)	2011 DHS (MW)
BENIN	2006 DHS (AW)	2011.5 DHS (AW)
BHUTAN	2000 NATIONAL SURVEY (MW)	2010 MICS (MW)
BOLIVIA	2003 DHS (AW)	2008 DHS (AW)
BURKINA FASO	2003 DHS (AW)	2010 DHS (AW)
BURUNDI	1987 DHS (AW)	2010 DHS (AW)
CAMBODIA	2005 DHS (AW)	2010 DHS (AW)
CAMEROON	2004 DHS (AW)	2011 DHS (AW)
CENTRAL AFRICAN REPUBLIC	2006 MICS (MW)	2010 MICS (MW)
CHAD	2004 DHS (MW)	2010 MICS (MW)
COMOROS	1996 DHS (MW)	2012 DHS (MW)
CONGO (BRAZZAVILLE)	2005 DHS (AW)	2011.5 DHS (AW)
CÔTE D'IVOIRE	1998.5 DHS (AW)	2011.5 DHS (AW)
DJIBOUTI	2002 PAPFAM (MW)	2006 MICS (MW)
DPR KOREA	1997 NATIONAL SURVEY (MW)	2002 RHS (MW)
DR CONGO	2007 DHS (MW)	2013.5 PDHS (MW)
EGYPT	2005 DHS	2008 DHS
ERITREA	1995 DHS (AW)	2002 DHS (AW)
ETHIOPIA	2011 DHS (AW)	2014 DHS (AW)
GAMBIA	2010 MICS (MW)	2013 PDHS (MW)
GHANA	2011 MICS (MW)	2013 PMA2020 (MW)
GUINEA	2005 DHS (AW)	2012 DHS (AW)
GUINEA-BISSAU	2006 MICS (MW)	2010 MICS (MW)
HAITI	2005.5 DHS (AW)	2012 DHS (AW)
HONDURAS	2005.5 DHS (AW)	2011.5 DHS (AW)
INDIA	2005.5 DHS (MW)	2007.5 DHS (MW)
INDONESIA	2007 DHS (MW)	2012 DHS (MW)
IRAQ	2006 MICS (MW)	2011 MICS (MW)
KENYA	2008.5 DHS (AW)	2014 PMA2020 (AW)
KYRGYZSTAN	2006 MICS (MW)	2012 DHS (MW)
LAO PDR	2005 NATIONAL SURVEY (MW)	2011.5 MICS/DHS (MW)
LESOTHO	2004 DHS (AW)	2009 DHS (AW)
LIBERIA	2007 DHS (MW)	2013 PDHS (MW)
MADAGASCAR	2003.5 DHS (MW)	2008.5 DHS (MW)

TOPIC		
mCPR DISAGGREGATED BY RESIDENCE	mCPR DISAGGREGATED BY WEALTH QUINTILE	UNMET NEED (15-19 AND 15-49)
RELATED TABLE		
AX.7	AX.8	AX.12
SOURCE:	SOURCE:	SOURCE:
2010-11 MICS (MW)		2010 MICS (MW)
2011 DHS (MW)	2011 DHS (MW)	2011 DHS (MW)
2011-12 DHS (MW)	2011-12 DHS (MW)	2011-12 DHS (MW)
2010 MICS (MW)		2010 MICS (MW)
2008 DHS (MW)	2008 DHS (MW)	2008 DHS (MW)
2010 DHS (MW)	2010 DHS (MW)	2010 DHS (MW)
2010 DHS (MW)	2010 DHS (MW)	2010 DHS (MW)
2010 DHS (MW)	2010 DHS (MW)	2010 DHS (MW)
2011 DHS (MW)	2011 DHS (MW)	2011 DHS (MW)
2010 MICS (MW)		2010 MICS (MW)
2010 MICS (MW)		2010 MICS (MW)
2012 DHS (MW)		2012 DHS (MW)
2011-12 DHS (MW)	2011-12 DHS (MW)	2011-12 DHS (MW)
2011-12 DHS (MW)	2011-12 DHS (MW)	2011-12 DHS (MW)
2006 MICS (MW)		2006 MICS (MW)
2009 MICS (MW)		2009 MICS (MW)
2013 PDHS (MW)	2007 DHS (MW)	2013 PDHS (MW)
2008 DHS (MW)	2008 DHS (MW)	2008 DHS (MW)
2002 DHS (MW)		2002 DHS (MW)
2011 DHS (MW)	2011 DHS (MW)	2011 DHS (MW)
2013 PDHS (MW)		2013 PDHS (MW)
2013 PMA2020	2008 DHS (MW)	2013 PMA2020 (MW)
2012 DHS (MW)	2012 DHS (MW)	2012 DHS (MW)
2010 MICS (MW)		2010 MICS (MW)
2012 DHS (MW)	2012 DHS (MW)	2012 DHS (MW)
2012 DHS (MW)	2011-12 DHS (MW)	2012 DHS (MW)
2005-06 DHS (MW)	2005-6 DHS (MW)	2005-06 DHS (MW)
2012 DHS (MW)	2012 DHS (MW)	2012 DHS (MW)
2011 MICS (MW)		2011 MICS (MW)
2008-09 DHS (MW)	2008-9 DHS (MW)	2008-09 DHS (MW)
2012 DHS (MW)	2012 DHS (MW)	2012 DHS (MW)
2012 MICS/DHS (MW)		2012 MICS/DHS (MW)
2009 DHS (MW)	2009 DHS (MW)	2009 DHS (MW)
2013 PDHS (MW)	2009 DHS (MW)	2013 PDHS (MW)
2008-09 DHS (MW)	2008-9 DHS (MW)	2008-09 DHS (MW)

FIGURE AX.3 CONTINUED

	TOPIC	
	ANNUAL GROWTH, mCPR	
	RELATED TABLE	
	AX.6	
	FIRST SURVEY:	SECOND SURVEY:
MALAWI	2004 DHS (MW)	2010 DHS (MW)
MALI	2006 DHS (MW)	2012.5 DHS (MW)
MAURITANIA	2000.5 DHS (MW)	2007 MICS (MW)
MONGOLIA	2005 MICS (MW)	2010 MICS (MW)
MOZAMBIQUE	2003 DHS (MW)	2011 DHS
MYANMAR	2007 NATIONAL SURVEY (MW)	2010 MICS
NEPAL	2006 DHS (MW)	2011 DHS
NICARAGUA	2001 DHS (MW)	2006.5 RHS
NIGER	2006 DHS (MW)	2012 DHS
NIGERIA	2011 MICS (MW)	2013 DHS
PAKISTAN	2006.5 DHS (MW)	2012.5 DHS
PAPUA NEW GUINEA	1996 NATIONAL SURVEY (MW)	2006 DHS
PHILIPPINES	2008 DHS (MW)	2013 PDHS
RWANDA	2007.5 DHS (MW)	2010 DHS (MW)
SAO TOME AND PRINCIPE	2006 MICS (MW)	2008.5 DHS (MW)
SENEGAL	2010.5 DHS (MW)	2012.5 DHS (MW)
SIERRA LEONE	2010 MICS (MW)	2013 PDHS (MW)
SOLOMON ISLANDS	N/A	N/A
SOMALIA	1999 WCU (MW)	2006 MICS (MW)
SOUTH AFRICA	1998 DHS (MW)	2003 DHS (MW)
SOUTH SUDAN	2006 MICS (MW)	2010 MICS (MW)
SRI LANKA	1987 DHS (MW)	2007 DHS (MW)
STATE OF PALESTINE	2006 FAMILY HEALTH SURVEY (MW)	2010 MICS (MW)
SUDAN	N/A	N/A
TAJIKISTAN	2005 MICS (MW)	2012 DHS (MW)
TANZANIA	2004.5 DHS (MW)	2010 DHS (MW)
TIMOR-LESTE	2007 LSMS (MW)	2009.5 DHS (MW)
TOGO	2010 MICS (MW)	2013 PDHS (MW)
UGANDA	2006 DHS (MW)	2011 DHS (MW)
UZBEKISTAN	2002 DHS (MW)	2006 MICS (MW)
VIETNAM	2006 MICS (MW)	2011 MICS (MW)
WESTERN SAHARA	N/A	N/A
YEMEN	2006 MICS (MW)	2013 DHS (MW)
ZAMBIA	2001.5 DHS (MW)	2007 DHS (MW)
ZIMBABWE	2005.5 DHS (MW)	2010.5 DHS (MW)

TOPIC		
mCPR DISAGGREGATED BY RESIDENCE	mCPR DISAGGREGATED BY WEALTH QUINTILE	UNMET NEED (15-19 AND 15-49)
RELATED TABLE		
AX.7	AX.8	AX.12
SOURCE:	SOURCE:	SOURCE:
2010 DHS (MW)	2010 DHS (MW)	2010 DHS (MW)
2012-13 PDHS (MW)	2006 DHS (MW)	2012-13 PDHS (MW)
2007 MICS (MW)		2007 MICS (MW)
2010 MICS (MW)		2010 MICS (MW)
2011 DHS (MW)	2011 DHS (MW)	2011 DHS (MW)
2010 MICS (MW)		2010 MICS (MW)
2011 DHS (MW)	2011 DHS (MW)	2011 DHS (MW)
2006-07 RHS (MW)		2006-07 RHS (MW)
2012 DHS (MW)	2012 DHS (MW)	2012 DHS (MW)
2013 PDHS (MW)	2008 DHS (MW)	2013 PDHS (MW)
2012-13 DHS (MW)	2012-13 DHS (MW)	2012-13 DHS (MW)
2006 DHS (MW)		2006 DHS (MW)
2008 DHS (MW)	2008 DHS (MW)	2008 DHS (MW)
2010 DHS (MW)	2010 DHS (MW)	2010 DHS (MW)
2008-09 DHS (MW)	2008-9 DHS (MW)	2008-09 DHS (MW)
2013 DHS (MW)	2012-13 DHS (MW)	2013 DHS (MW)
2013 PDHS (MW)	2007 DHS (MW)	2013 PDHS (MW)
2007 DHS (MW)		2007 DHS (MW)
2006 MICS (MW)		2006 MICS (MW)
2003 DHS (MW)		2003 DHS (MW)
2010 MICS (MW)		2010 MICS (MW)
1987 DHS (MW)		1987 DHS (MW)
2010 MICS (MW)		2010 MICS (MW)
1989-90 DHS (MW)		1989-90 DHS (MW)
2012 DHS (MW)		2012 DHS (MW)
2010 DHS (MW)	2010 DHS (MW)	2010 DHS (MW)
2010 DHS (MW)	2009-10 DHS (MW)	2010 DHS (MW)
2009-10 DHS (MW)		2009-10 DHS (MW)
2011 DHS (MW)	2011 DHS (MW)	2011 DHS (MW)
2006 MICS (MW)		2006 MICS (MW)
2011 MICS (MW)		2011 MICS (MW)
N/A		N/A
2013 PDHS (MW)		2013 PDHS (MW)
2007 DHS (MW)	2007 DHS (MW)	2007 DHS (MW)
2010-11 DHS (MW)	2010-11 DHS (MW)	2010-11 DHS (MW)

FIGURE AX.4
INDICATORS 1A AND 1B

	INDICATOR 1A		INDICATOR 1B			
	mCPR		SDM	LAM	CONDOM	PILL
	2012	2013				
AFGHANISTAN	18.3	19.3	-	3.9	7.4	27.1
BANGLADESH	40.3	40.8	-	-	10.6	52.4
BENIN	10.5	11.2	-	4.5	36	14.6
BHUTAN	49.6	50.0	-	-	8.4	11.5
BOLIVIA	26.3	26.8	-	2.1	15	10
BURKINA FASO	15.4	16.1	-	0.7	21.7	19.6
BURUNDI	12.2	13.0	-	-	7.3	12.7
CAMBODIA	23.7	24.4	-	-	7.8	45.2
CAMEROON	16.9	17.7	-	1.2	67.7	9.9
CENTRAL AFRICAN REPUBLIC	14.5	15.3	-	23.3	20	49.2
CHAD	4.7	5.1	-	64.4	2.2	11.1
COMOROS	10.8	11.5	-	5.1	19.4	20.4
CONGO (BRAZZAVILLE)	22.9	23.8	-	-	69.5	11.7
CÔTE D'IVOIRE	15.0	15.6	-	2.9	35.7	43.6
DJIBOUTI	13.7	14.7	-	-	1.2	79.5
DPR KOREA	42.5	42.5	-	-	10	6.4
DR CONGO	8.2	9.0	3.8	-	44.9	9
EGYPT	55.1	55.4	-	-	1.2	20.7
ERITREA	9.4	10.1	-	26.9	11.5	19.2
ETHIOPIA	21.6	24.0	-	-	1.6	8
GAMBIA	9.0	9.1	-	-	7.4	25.9
GHANA	16.4	15.5	-	-	7.9	28.2
GUINEA	7.5	8.1	-	15.5	33.8	22.5
GUINEA-BISSAU	10.9	11.6	-	21.2	24.2	9.1
HAITI	21.7	22.3	-	0.9	26.9	7.9
HONDURAS	42.6	42.8	-	-	8.4	17.2
INDIA	38.2	38.7	-	-	11.4	7.5

*Other modern methods include foam/jelly and diaphragms.

SDM Standard Days Method
LAM Lactational Amenorrhea Method
IUD Intrauterine Device

INJECTABLE	IMPLANT	IUD	FEMALE STERILIZATION	MALE STERILIZATION	OTHER MODERN METHODS*
47.3	3.9	5.9	3	1	0.5
21.6	2.1	1.3	9.6	2.3	-
19.1	9	4.5	1.1	-	11.2
44.2	0.2	5.7	10.9	19.3	-
30.8	-	23.3	17.9	0.4	0.4
35.7	20.3	1.4	0.7	-	-
57.3	3.6	15.5	3.6	-	-
30	1.4	8.8	6.9	-	-
14.3	3.1	1.2	2.5	-	-
4.2	1.7	-	1.7	-	-
20	-	-	2.2	-	-
37.8	11.2	-	6.1	-	-
8.5	0.4	-	0.4	-	9.4
13.6	0.7	0.7	0.7	-	2.1
14.6	-	2.3	2.3	-	-
-	-	73.5	7.6	1.4	1.2
15.4	9	2.6	9	1.3	5.1
12.8	0.9	62.7	1.7	-	-
34.6	-	5.8	1.9	-	-
74.9	12.3	1.1	2.1	-	-
48.1	7.4	3.7	7.4	-	-
37.4	15	3	2.7	-	5.7
22.5	1.4	2.8	1.4	-	-
11.4	-	30.3	-	-	3.8
54.2	5.1	-	4.2	0.5	0.5
26.1	-	10.7	37.1	0.5	-
-	-	3.7	74.4	2.3	0.6

FIGURE AX.4 CONTINUED

	INDICATOR 1A		INDICATOR 1B			
	mCPR		SDM	LAM	CONDOM	PILL
	2012	2013				
INDONESIA	44.5	44.7	-	-	3	23.4
IRAQ	21.4	21.8	-	6.4	5.3	43.8
KENYA	35.5	37.2	-	1.4	9.3	16.8
KYRGYZSTAN	23.8	24.5	-	0.4	23.6	4.9
LAO PDR	29.4	30.1	-	1.4	2.6	49.5
LESOTHO	37.6	38.3	-	-	30.4	22.3
LIBERIA	19.2	20.9	-	-	2.1	26
MADAGASCAR	25.8	26.8	-	3.4	4.3	20.7
MALAWI	34.5	35.4	-	-	8.6	5.8
MALI	9.6	10.2	-	-	2.1	27.7
MAURITANIA	7.3	7.7	-	-	5.3	75
MONGOLIA	34.9	35.1	-	0.4	13.9	24.6
MOZAMBIQUE	13.9	15.0	-	0.8	24.8	35.5
MYANMAR	30.6	31.4	-	0.2	0.9	25.2
NEPAL	34.7	35.5	-	-	9.9	9.6
NICARAGUA	50.8	50.7	-	1.3	5.8	18.1
NIGER	10.7	11.2	-	31.8	0.9	45.5
NIGERIA	10.9	11.6	0.9	2.7	40.2	17
PAKISTAN	16.4	16.9	-	5.7	33.6	6.1
PAPUA NEW GUINEA	18.3	18.7	-	-	7.3	18.4
PHILIPPINES	23.7	24.4	0.5	1.3	5.1	50.8
RWANDA	26.3	26.9	1.2	1.2	7.1	15.5
SAO TOME AND PRINCIPE	28.2	28.7	-	1.5	25.9	38.3
SENEGAL	10.7	12.1	-	0.6	3.7	31.7
SIERRA LEONE	15.5	18.1	-	5.8	1.3	25.2
SOLOMON ISLANDS	22.8	23.1	-	0.5	9.8	4.4
SOMALIA	2.5	3.0	-	-	-	72.7

*Other modern methods include foam/jelly and diaphragms.

SDM Standard Days Method
LAM Lactational Amenorrhea Method
IUD Intrauterine Device

INJECTABLE	IMPLANT	IUD	FEMALE STERILIZATION	MALE STERILIZATION	OTHER MODERN METHODS*
55	5.6	7	5.6	0.2	-
8.6	0.3	26	8.6	-	1.1
52.9	4.6	3.6	11.4	-	-
1.3	-	64.9	4.9	-	-
31.8	0.2	3.7	10.7	-	-
38.4	0.3	3.7	4.9	-	-
58.3	10.9	-	1.6	-	1
60.8	5.2	1.3	3.9	0.4	-
58.7	3.4	0.6	22.9	-	-
40.4	25.5	3.2	1.1	-	-
13.2	-	3.9	1.3	-	1.3
9.1	0.6	45	5.5	0.8	0.2
35.5	-	1.7	1.7	-	-
60.2	0.2	4.6	7.9	0.9	-
21	2.7	3	35.7	18	-
31.8	-	5.3	37.3	0.4	-
17.3	2.7	0.9	0.9	-	-
22.3	2.7	7.1	2.7	-	4.5
10.7	-	8.8	33.2	1.1	0.8
36.9	-	-	35.8	1.7	-
9.8	-	9.3	22.6	0.3	0.3
57.9	14.3	0.8	2	-	-
29.9	-	1.1	3.3	-	-
38.5	16.8	6.2	1.9	-	0.6
48.4	15.5	0.6	3.2	-	-
32.2	-	6.8	45.4	1	-
18.2	-	9.1	-	-	-

FIGURE AX.4 CONTINUED

	INDICATOR 1A		INDICATOR 1B			
	mCPR		SDM	LAM	CONDOM	PILL
	2012	2013				
SOUTH AFRICA	52.8	53.2	-	0.2	12.4	17.9
SOUTH SUDAN	1.0	1.1	-	29.4	23.5	17.6
SRI LANKA	52.3	52.5	-	0.2	10.4	15
STATE OF PALESTINE	26.6	26.8	-	6.3	11.5	15.2
SUDAN	10.4	11.1				
TAJIKISTAN	18.5	19.2	-	0.6	8.6	8.6
TANZANIA	25.6	26.7	-	4.3	17.9	21.7
TIMOR-LESTE	14.3	14.9	-	-	0.8	7.8
TOGO	18.3	19.4	-	-	12.2	12.8
UGANDA	21.5	22.6	-	0.5	15.5	10.1
UZBEKISTAN	43.2	43.3	-	4.2	3.6	3.7
VIETNAM	44.8	44.8	-	0.3	21.2	16.8
WESTERN SAHARA	N/A	N/A				
YEMEN	17.7	18.6	-	13.7	1.7	39.7
ZAMBIA	24.8	25.7	-	16.7	20.4	30.2
ZIMBABWE	41.5	41.9	-	0.2	9.4	67.2

*Other modern methods include foam/jelly and diaphragms.

SDM Standard Days Method
LAM Lactational Amenorrhea Method
IUD Intrauterine Device

INJECTABLE	IMPLANT	IUD	FEMALE STERILIZATION	MALE STERILIZATION	OTHER MODERN METHODS*
53.2	-	1.2	14.5	0.6	-
23.5	-	-	5.9	-	-
28.5	0.6	12	32.1	1.3	-
1.6	-	59.5	5.9	-	-
7.5	-	72.4	2.3	-	-
36.2	7.7	1.7	10.6	-	-
75	3.9	6.3	3.9	-	2.3
41.3	27.3	4.7	1.7	-	-
51.7	9.2	1.9	10.6	0.5	-
4.4	0.2	80.3	3.4	0.2	0.2
2.8	0.3	51.7	6.5	0.2	0.2
14.4	2.1	20.2	7.9	0.3	-
25.3	1.2	0.4	5.7	-	-
15	5.4	0.5	2.2	-	-

FIGURE AX.5
mCPR DISAGGREGATION IN COUNTRIES WITH 2012 OR 2013 DHS OR PMA2020 DATA

JSS Junior Secondary School
AW All Women
MW Married Women

	mCPR BY WEALTH QUINTILE					mCPR BY RESIDENCE	
	LOWEST WEALTH QUINTILE	SECOND WEALTH QUINTILE	MIDDLE WEALTH QUINTILE	FOURTH WEALTH QUINTILE	HIGHEST WEALTH QUINTILE	URBAN	RURAL
BENIN (MW)	4.6	6.4	7.8	8.6	11.9	9.5	6.8
COMOROS (MW)	10.9	13.2	14.1	17.8	14.2	20.6	11.0
CONGO (BRAZZAVILLE) (MW)	9.5	15.4	22.7	22.9	28.8	24.6	11.7
GHANA (AW)	14.2	15.5	14.1	13.4	11.7	11.3	16.2
GUINEA (MW)	2.3	3.9	4.0	5.0	8.8	7.4	3.5
KYRGYZSTAN (MW)	36.4	35.2	32.6	30.5	34.0	34.2	33.4
MALI (MW)	3.3	5.0	5.6	12.8	23.3	21.8	6.8
NIGER (MW)	8.9	7.7	8.3	12.8	23.7	27.0	9.7
NIGERIA (MW)	0.9	3.7	9.1	14.4	23.4	16.9	5.7
PAKISTAN (MW)	18.1	22.9	26.9	30.3	31.6	32.0	23.1
SENEGAL (MW)	5.9	8.7	15.8	20.7	30.3	27.3	9.2
TAJIKISTAN (MW)	23.3	22.7	23.7	25.8	22.3	24.8	29.0

*Secondary and higher are combined.
**None and primary are combined.

mCPR BY MARITAL STATUS		mCPR BY EDUCATION						
MARRIED/ IN UNION	UNMARRIED SEXUALLY ACTIVE	NONE	PRIMARY	BASIC GENERAL	MIDDLE/ JSS	SECONDARY	PROFESSIONAL PRIMARY/ MIDDLE	HIGHER
7.9	24.4	6.5%	10.2%			12.4%		14.8%
14.2	31.6	10.7%	15.3%			17.4%*		
20.0	43.2	10.5%	15.7%			20.7%		28.7%
18.4	10.2	14.5%	10.4%		14.7%	13.8%*		
4.6	41.1	3.9%	6.10%			8.8%*		
33.7	N/A			27.0%		33.9%	37.0%	34.0%
9.9	33.5	7.8%	12.8%			26.5%*		
12.9	39.9	10.4%	18.4%			30.0%*		
9.8	54.9	1.7%	13.6%			18.7%*		22.4%
26.1	N/A	23.4%	28.8%		29.5%	31.1%		29.7%
16.1	N/A	11.6%	24.4%			29.2%*		
25.8	N/A		19.9%**	20.0%		28.0%	30.2%	37.4%

FIGURE AX.6
ANNUAL GROWTH, mCPR

AW All Women
MW Married Women

	ANNUAL RATE OF CHANGE IN mCPR, 2012	mCPR FROM FIRST SURVEY USED TO CALCULATE ANNUAL RATE OF CHANGE IN mCPR, 2013	mCPR FROM SECOND SURVEY USED TO CALCULATE ANNUAL RATE OF CHANGE IN mCPR, 2013	ANNUAL RATE OF CHANGE IN mCPR, 2013
AFGHANISTAN (MW)	0.44	15.2	20.3	1.70
BANGLADESH (MW)	1.15	47.5	52.1	1.15
BENIN (AW)	0.33	6.9	9.0	0.38
BHUTAN (MW)	3.47	30.7	65.4	3.47
BOLIVIA (AW)	0.06	23.7	24.0	0.06
BURKINA FASO (AW)	0.66	9.7	14.3	0.66
BURUNDI (AW)	0.43	1.0	11.0	0.43
CAMBODIA (AW)	1.06	16.4	21.7	1.06
CAMEROON (AW)	0.37	13.5	16.1	0.37
CENTRAL AFRICAN REPUBLIC (MW)	0.23	11.2	12.1	0.23
CHAD (MW)	0.48	1.6	4.5	0.48
COMOROS (MW)	0.18	11.4	14.2	0.18
CONGO (BRAZZAVILLE) (AW)	1.12	13.5	22.3	1.35
CÔTE D'IVOIRE (AW)	0.30	9.8	13.9	0.32
DJIBOUTI (MW)	2.83	5.8	17.1	2.83
DPR KOREA (MW)	0.48	55.8	58.2	0.48
DR CONGO (MW)	0.70	5.8	7.8	0.31
EGYPT (MW)	0.37	56.5	57.6	0.37
ERITREA (AW)	0.30	3.1	5.2	0.30
ETHIOPIA (AW)	1.50	18.7	27.9	3.07
GAMBIA (MW)	-0.02	8.5	8.1	-0.13
GHANA (MW)	2.77	24.9	18.4	-3.25
GUINEA (AW)	0.03	6.8	7.0	0.03
GUINEA-BISSAU (MW)	3.53	9.6	13.1	0.88
HAITI (AW)	0.57	17.9	21.6	0.57
HONDURAS (AW)	0.87	37.7	42.9	0.87
INDIA (MW)	0.81	48.5	48.2	-0.15
INDONESIA (MW)	0.10	57.4	57.9	0.10
IRAQ (MW)	-0.80	39.9	35.9	-0.80
KENYA (AW)	0.96	28.0	43.6	2.84
KYRGYZSTAN (MW)	-2.53	45.8	33.7	-2.02
LAO PDR (MW)	1.09	35.0	42.7	1.18
LESOTHO (AW)	1.46	27.6	34.9	1.46

	ANNUAL RATE OF CHANGE IN mCPR, 2012	mCPR FROM FIRST SURVEY USED TO CALCULATE ANNUAL RATE OF CHANGE IN mCPR, 2013	mCPR FROM SECOND SURVEY USED TO CALCULATE ANNUAL RATE OF CHANGE IN mCPR, 2013	ANNUAL RATE OF CHANGE IN mCPR, 2013
LIBERIA (MW)	0.22	10.3	19.1	1.47
MADAGASCAR (MW)	1.80	14.0	23.0	1.80
MALAWI (MW)	1.70	22.4	32.6	1.70
MALI (MW)	0.09	6.9	9.9	0.46
MAURITANIA (MW)	0.48	5.1	8.0	0.45
MONGOLIA (MW)	-2.08	60.6	50.4	-2.04
MOZAMBIQUE (MW)	-0.26	14.2	12.1	-0.26
MYANMAR (MW)	2.43	38.4	45.7	2.43
NEPAL (MW)	-0.24	34.4	33.2	-0.24
NICARAGUA (MW)	0.55	43.9	46.9	0.55
NIGER (MW)	1.20	4.5	11.0	1.08
NIGERIA (MW)	0.67	11.7	9.8	-0.95
PAKISTAN (MW)	0.73	21.7	26.1	0.73
PAPUA NEW GUINEA (MW)	0.47	19.6	24.3	0.47
PHILIPPINES (MW)	0.97	34.0	37.6	0.72
RWANDA (MW)	3.56	16.3	25.2	3.56
SAO TOME AND PRINCIPE (MW)	2.20	28.2	33.7	2.20
SENEGAL (MW)	0.24	12.1	16.1	2.00
SIERRA LEONE (MW)	1.85	10.4	15.6	1.73
SOLOMON ISLANDS (MW)	N/A	NA	20.5	N/A
SOMALIA (MW)	0.03	1.0	1.2	0.03
SOUTH AFRICA (MW)	0.16	49.3	50.1	0.16
SOUTH SUDAN (MW)	-0.40	3.3	1.7	-0.40
SRI LANKA (MW)	0.60	40.6	52.5	0.60
STATE OF PALESTINE (MW)	0.63	38.9	44.2	1.33
SUDAN (MW)	N/A	5.5	0.0	N/A
TAJIKISTAN (MW)	-1.04	36.2	25.8	-1.49
TANZANIA (MW)	1.09	17.6	23.6	1.09
TIMOR-LESTE (MW)	2.12	15.8	21.1	2.12
TOGO (MW)	0.48	13.6	17.3	1.23
UGANDA (MW)	1.06	15.4	20.7	1.06
UZBEKISTAN (MW)	-0.23	62.8	61.9	-0.23
VIETNAM (MW)	-0.20	61.0	60.0	-0.20
WESTERN SAHARA (MW)	N/A	N/A	N/A	N/A
YEMEN (MW)	3.87	25.0	29.2	0.60
ZAMBIA (MW)	1.09	18.6	24.6	1.09
ZIMBABWE (MW)	0.28	39.1	40.5	0.28

FIGURE AX.7
mCPR BY RESIDENCE, MARRIED WOMEN (BASED ON MOST RECENT SURVEY DATA)

	mCPR	
	URBAN	RURAL
AFGHANISTAN	34.8	17.3
BANGLADESH	54	51.4
BENIN	9.5	6.8
BHUTAN	63.5	66
BOLIVIA	40.2	25.7
BURKINA FASO	30.8	10.8
BURUNDI	28.8	16.7
CAMBODIA	30.7	35.8
CAMEROON	20.8	8.7
CENTRAL AFRICAN REPUBLIC	21.9	5.8
CHAD	7.9	3.4
COMOROS	20.1	20.6
CONGO (BRAZZAVILLE)	24.7	11.6
CÔTE D'IVOIRE	16.3	9.8
DPR KOREA	N/A	N/A
DR CONGO	14.6	4.5
DJIBOUTI	17.6	3.1
EGYPT	61.6	54.8
ERITREA	15.1	3.2
ETHIOPIA	49.5	22.5
GAMBIA	11.9	4.3
GHANA	15.7	20.6
GUINEA	7.4	3.5
GUINEA-BISSAU	19.9	8.5
HAITI	31.3	31.2

	mCPR	
	URBAN	RURAL
HONDURAS	67.3	60.6
INDIA	55.8	45.3
INDONESIA	57	58.7
IRAQ	36.4	34.9
KENYA	46.6	37.2
KYRGYZSTAN	34.2	33.4
LAO PDR	40.9	43.5
LESOTHO	57.2	40.7
LIBERIA	21.5	16.2
MADAGASCAR	35.6	28
MALAWI	49.6	40.7
MALI	21.8	6.7
MAURITANIA	13.6	3.3
MONGOLIA	46.7	55.7
MOZAMBIQUE	21.1	7.2
MYANMAR	50.8	43.5
NEPAL	49.8	42.1
NICARAGUA	71.3	68
NIGER	27	9.7
NIGERIA	16.9	5.8
PAKISTAN	32	23.1
PAPUA NEW GUINEA	36.7	22.3
PHILIPPINES	35.3	32.7
RWANDA	47	44.9
SAO TOME AND PRINCIPE	28	40.1

	mCPR	
	URBAN	RURAL
SENEGAL	27.3	9.1
SIERRA LEONE	24.7	12.3
SOLOMON ISLANDS	23.2	28
SOMALIA	16.2	12.6
SOUTH AFRICA	65.8	61.8
SOUTH SUDAN	2.8	1.4
SRI LANKA	41	40.5
STATE OF PALESTINE	N/A	N/A
SUDAN	11.3	2.2
TAJIKISTAN	29	24.8
TANZANIA	34.1	25.2
TIMOR-LESTE	28.2	18.7
TOGO	16	12.2
UGANDA	39.2	23.4
UZBEKISTAN	59.2	63.2
VIETNAM	58.4	60.67
WESTERN SAHARA	N/A	N/A
YEMEN	40.1	24
ZAMBIA	42	27.6
ZIMBABWE	60.4	55.7

FIGURE AX.8
CONTRIBUTION OF THE POOREST WEALTH QUINTILE TO mCPR*

	PERCENTAGE CONTRIBUTION OF THE POOREST WEALTH QUINTILE TO mCPR
AFGHANISTAN	N/A
BANGLADESH	18.2%
BENIN	8.9%
BHUTAN	N/A
BOLIVIA	11.2%
BURKINA FASO	12.1%
BURUNDI	16.1%
CAMBODIA	19.9%
CAMEROON	3.4%
CENTRAL AFRICAN REPUBLIC	N/A
CHAD	N/A
COMOROS	13.4%
CONGO (BRAZZAVILLE)	9.2%
CÔTE D'IVOIRE	12.7%
DPR KOREA	N/A
DR CONGO	9.1%
DJIBOUTI	N/A
EGYPT	16.2%
ERITREA	N/A
ETHIOPIA	9.6%
GAMBIA	N/A
GHANA	13.9%
GUINEA	10.4%
GUINEA-BISSAU	N/A

	PERCENTAGE CONTRIBUTION OF THE POOREST WEALTH QUINTILE TO mCPR
HAITI	16.7%
HONDURAS	16.1%
INDIA	13.4%
INDONESIA	16.3%
IRAQ	N/A
KENYA	7.6%
KYRGYZSTAN	20.9%
LAO PDR	N/A
LESOTHO	10.2%
LIBERIA	6.9%
MADAGASCAR	11.2%
MALAWI	14.1%
MALI	7.6%
MAURITANIA	N/A
MONGOLIA	N/A
MOZAMBIQUE	5.1%
MYANMAR	N/A
NEPAL	14.3%
NICARAGUA	N/A
NIGER	13.4%
NIGERIA	2.0%
PAKISTAN	13.4%
PAPUA NEW GUINEA	N/A
PHILIPPINES	15.0%

	PERCENTAGE CONTRIBUTION OF THE POOREST WEALTH QUINTILE TO mCPR
RWANDA	16.7%
SAO TOME AND PRINCIPE	16.0%
SENEGAL	7.7%
SIERRA LEONE	9.4%
SOLOMON ISLANDS	N/A
SOMALIA	N/A
SOUTH AFRICA	N/A
SOUTH SUDAN	N/A
SRI LANKA	N/A
STATE OF PALESTINE	N/A
SUDAN	N/A
TAJIKISTAN	N/A
TANZANIA	12.8%
TIMOR-LESTE	12.7%
TOGO	N/A
UGANDA	9.6%
UZBEKISTAN	N/A
VIETNAM	N/A
WESTERN SAHARA	N/A
YEMEN	N/A
ZAMBIA	19.4%
ZIMBABWE	17.8%

*Analysis only includes countries whose most recent survey was a DHS and there was an available dataset that included a wealth quintile variable. Ghana was calculated from the 2008 DHS.

FIGURE AX.9
INDICATOR 2: ADDITIONAL (SINCE 2012) USERS OF MODERN CONTRACEPTION

	ADDITIONAL USERS		ADDITIONAL USERS		ADDITIONAL USERS
AFGHANISTAN	115,000	INDIA	3,012,000	SOLOMON ISLANDS	1,000
BANGLADESH	475,000	INDONESIA	429,000	SOMALIA	13,000
BENIN	24,000	IRAQ	99,000	SOUTH AFRICA*	78,000
BHUTAN	3,000	KENYA	290,000	SOUTH SUDAN	6,000
BOLIVIA	29,000	KYRGYZSTAN	11,000	SRI LANKA	12,000
BURKINA FASO	45,000	LAO PDR	25,000	STATE OF PALESTINE	12,000
BURUNDI	26,000	LESOTHO	8,000	SUDAN	88,000
CAMBODIA	43,000	LIBERIA	22,000	TAJIKISTAN	21,000
CAMEROON	69,000	MADAGASCAR	104,000	TANZANIA	207,000
CENTRAL AFRICAN REPUBLIC	13,000	MALAWI	75,000	TIMOR-LESTE	3,000
CHAD	15,000	MALI	29,000	TOGO	27,000
COMOROS	2,000	MAURITANIA	6,000	UGANDA	159,000
CONGO (BRAZZAVILLE)	14,000	MONGOLIA	3,000	UZBEKISTAN	48,000
CÔTE D'IVOIRE	50,000	MOZAMBIQUE	79,000	VIETNAM	35,000
DJIBOUTI	3,000	MYANMAR	148,000	WESTERN SAHARA	N/A
DPR KOREA	7,000	NEPAL	127,000	YEMEN	92,000
DR CONGO	197,000	NICARAGUA	14,000	ZAMBIA	59,000
EGYPT	238,000	NIGER	31,000	ZIMBABWE	71,000
ERITREA	15,000	NIGERIA	110,000		
ETHIOPIA	711,000	PAKISTAN	404,000		
GAMBIA	2,000	PAPUA NEW GUINEA	15,000		
GHANA	—	PHILIPPINES	209,000		
GUINEA	23,000	RWANDA	45,000		
GUINEA-BISSAU	4,000	SAO TOME AND PRINCIPE	500		
HAITI	27,000	SENEGAL	59,000		
HONDURAS	25,000	SIERRA LEONE	44,000		

TOTAL
8,400,000

*Not included in total.
Numbers are rounded.

FIGURE AX.10
INDICATORS 3–4

	INDICATOR 3 PERCENTAGE OF WOMEN* WITH AN UNMET NEED FOR MODERN CONTRACEPTION		INDICATOR 4 PERCENTAGE OF WOMEN* WHOSE DEMAND IS SATISFIED WITH A MODERN METHOD OF CONTRACEPTION	
	2012	2013	2012	2013
AFGHANISTAN	31.3%	31.0%	41.5%	43.0%
BANGLADESH	22.6%	22.3%	69.9%	70.4%
BENIN	33.1%	32.9%	21.7%	23.0%
BHUTAN	13.0%	12.7%	83.2%	83.7%
BOLIVIA	42.3%	41.5%	47.2%	48.2%
BURKINA FASO	26.6%	26.7%	37.9%	38.8%
BURUNDI	35.5%	35.0%	35.7%	37.4%
CAMBODIA	31.7%	31.3%	54.5%	55.7%
CAMEROON	33.9%	34.0%	30.9%	31.8%
CENTRAL AFRICAN REPUBLIC	31.3%	31.4%	29.8%	30.8%
CHAD	24.8%	25.1%	16.8%	17.7%
COMOROS	36.6%	36.4%	29.8%	31.2%
CONGO (BRAZZAVILLE)	43.3%	42.8%	32.2%	33.3%
CÔTE D'IVOIRE	30.3%	30.0%	31.0%	32.0%
DPR KOREA	31.7%	31.5%	78.2%	78.3%
DR CONGO	17.5%	17.4%	14.7%	16.0%
DJIBOUTI	38.3%	37.7%	37.0%	38.7%
EGYPT	14.4%	14.3%	80.5%	80.6%
ERITREA	33.7%	33.7%	27.2%	28.6%
ETHIOPIA	26.8%	25.8%	54.0%	57.6%
GAMBIA	25.5%	25.2%	25.7%	26.1%
GHANA	38.0%	37.5%	34.7%	33.7%
GUINEA	25.0%	25.2%	15.8%	17.4%
GUINEA-BISSAU	26.9%	27.1%	28.8%	29.7%
HAITI	38.5%	37.8%	44.9%	46.1%
HONDURAS	19.8%	19.5%	76.2%	76.5%

*Married women of reproductive age.

	INDICATOR 3 PERCENTAGE OF WOMEN* WITH AN UNMET NEED FOR MODERN CONTRACEPTION		INDICATOR 4 PERCENTAGE OF WOMEN* WHOSE DEMAND IS SATISFIED WITH A MODERN METHOD OF CONTRACEPTION	
	2012	2013	2012	2013
INDIA	20.3%	20.3%	65.0%	66.0%
INDONESIA	13.9%	13.8%	81.3%	81.1%
IRAQ	33.0%	32.7%	51.7%	52.4%
KENYA	24.2%	22.7%	67.3%	69.7%
KYRGYZSTAN	20.7%	20.6%	63.0%	63.8%
LAO PDR	25.9%	25.3%	63.1%	64.2%
LESOTHO	23.2%	22.7%	67.9%	68.9%
LIBERIA	34.6%	34.4%	32.8%	34.8%
MADAGASCAR	29.5%	29.1%	52.6%	54.0%
MALAWI	28.1%	27.3%	58.2%	59.6%
MALI	29.9%	29.8%	24.8%	26.1%
MAURITANIA	33.3%	33.2%	24.9%	26.0%
MONGOLIA	20.2%	20.1%	71.9%	72.1%
MOZAMBIQUE	28.8%	28.9%	31.1%	32.6%
MYANMAR	20.9%	20.5%	68.8%	69.7%
NEPAL	31.2%	30.2%	59.1%	60.5%
NICARAGUA	11.3%	11.3%	87.0%	86.9%
NIGER	18.7%	19.1%	38.9%	39.4%
NIGERIA	22.5%	22.8%	31.0%	32.0%
PAKISTAN	29.7%	29.1%	46.4%	47.6%
PAPUA NEW GUINEA	33.3%	33.2%	45.3%	45.9%
PHILIPPINES	36.3%	36.1%	58.4%	51.3%
RWANDA	30.5%	29.9%	73.0%	76.5%
SAO TOME AND PRINCIPE	38.9%	38.3%	47.1%	48.0%
SENEGAL	31.5%	31.5%	25.0%	28.0%
SIERRA LEONE	31.0%	31.1%	29.1%	32.2%

FIGURE AX.10 CONTINUED

	INDICATOR 3 PERCENTAGE OF WOMEN* WITH AN UNMET NEED FOR MODERN CONTRACEPTION		INDICATOR 4 PERCENTAGE OF WOMEN* WHOSE DEMAND IS SATISFIED WITH A MODERN METHOD OF CONTRACEPTION	
	2012	2013	2012	2013
SOLOMON ISLANDS	28.4%	28.4%	51.7%	52.1%
SOMALIA	47.2%	47.4%	6.7%	7.9%
SOUTH AFRICA	13.5%	13.4%	82.0%	83.0%
SOUTH SUDAN	32.6%	32.9%	6.9%	7.8%
SRI LANKA	23.6%	23.4%	69.8%	70.1%
STATE OF PALESTINE	27.4%	27.2%	61.6%	62.0%
SUDAN	31.2%	31.3%	26.4%	27.6%
TAJIKISTAN	25.1%	25.0%	52.1%	53.1%
TANZANIA	37.8%	37.0%	48.7%	50.2%
TIMOR-LESTE	31.3%	30.8%	43.8%	45.3%
TOGO	30.1%	29.7%	29.6%	31.2%
UGANDA	38.5%	38.0%	42.0%	43.0%
UZBEKISTAN	16.0%	15.8%	79.1%	79.3%
VIETNAM	16.9%	16.8%	80.0%	80.1%
WESTERN SAHARA	N/A	N/A	N/A	N/A
YEMEN	37.5%	36.7%	42.7%	44.5%
ZAMBIA	35.7%	35.0%	48.0%	49.4%
ZIMBABWE	15.6%	15.5%	79.0%	79.3%

*Married women of reproductive age.

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FIGURE AX.11
UNMET NEED DISAGGREGATION IN COUNTRIES WITH 2012 OR 2013 DHS OR PMA2020 DATA

AW All Women
MW Married Women

	UNMET NEED BY WEALTH					UNMET NEED BY AGE						
	LOWEST WEALTH QUINTILE	SECOND WEALTH QUINTILE	MIDDLE WEALTH QUINTILE	FOURTH WEALTH QUINTILE	HIGHEST WEALTH QUINTILE	15-19	20-24	25-29	30-34	35-39	40-44	45-49
BENIN (MW)	32.1	30.7	131.4	35.6	33.0	34.6	33.7	34.0	35.6	34.5	29.6	16.8
COMOROS (AW)	26.9	20.8	21.3	17.3	14.5	8.2	23.4	23.2	28.5	27.9	17.3	13.5
CONGO (BRAZZAVILLE) (MW)	19.6	21.4	15.6	20.4	13.9	34.8	22.9	19.2	17.7	12.7	13.9	9.7
GHANA (AW)	31.1	31.9	26.0	24.9	18.8	17.4	31.6	33.5	30.7	32.3	27.0	15.8
GUINEA (AW)	20.1	19.6	20.5	22.6	18.0	14.7	21.6	20.0	25.6	22.6	26.2	11.6
KYRGYZSTAN (MW)	15.7	17.8	19.8	21.8	14.5	9.7	22.9	20.2	18.6	18.4	16.5	11.0
MALI (MW)	25.1	25.5	28.3	27.6	23.4	23.3	24.5	26.0	30.5	27.7	27.2	16.8
NIGER (MW)	17.7	15.4	15.2	16.0	15.9	13.1	18.4	16.4	16.2	13.6	18.9	14.1
NIGERIA (MW)	14.3	15.4	20.0	18.7	13.0	13.1	16.6	16.8	17.1	17.6	16.8	11.5
PAKISTAN (MW)	24.5	23.2	19.0	18.8	15.3	14.9	20.6	22.1	21.4	21.2	19.7	14.3
SENEGAL (MW)	31.6	32.1	30.5	26.4	25.8	31.2	31.5	27.7	28.6	29.0	31.3	26.7
TAJIKISTAN (MW)	26.8	21.72	22.4	24.2	19.5	12.8	28.2	28.3	26.0	20.1	18.1	12.3

*Indicators secondary and higher are combined.
**Indicates none and primary are combined.

UNMET NEED BY RESIDENCE		UNMET NEED BY MARITAL STATUS		UNMET NEED BY EDUCATION						
URBAN	RURAL	MARRIED/ IN UNION	UNMARRIED SEXUALLY ACTIVE	NONE	PRIMARY	BASIC GENERAL	MIDDLE/ JSS	SECONDARY	PROFESSIONAL PRIMARY/ MIDDLE	HIGHER
33.2	32.1	18.2	4.8	32.3%	34.5%			33.8%		26.5%
15.1	22.1			27.8%	23.0%			13.4%*		
17.7	19.1			25.0%	19.8%			17.6%		14.5%
24.6	30.7			32.9%	32.3%		27.0%	20.3%*		
18.7	20.9	23.7	41.9	21.0%	22.3%			15.4%*		
16.3	18.8					22.6%		18.3%	19.2%	15.4%
23.9	26.5			26.3%	26.5%			22.5%*		
17.3	15.8			15.9%	17.5%			15.7%*		
14.9	16.8			14.9%	19.3%			17.3%*		11.7%
17.1	21.6			21.9%	19.1%		20.2%	16.7%		14.6%
26.1	31.3			30.1%	27.0%			28.6%*		
21.0	23.4				27.7%**	25.9%		20.9%	22.0%	20.4%

FIGURE AX.12
PERCENTAGE OF WOMEN WITH AN UNMET NEED FOR CONTRACEPTION (MARRIED WOMEN 15–19 AND 15–49) ALL FP2020 FOCUS COUNTRIES (MOST RECENT SURVEY DATA)

	PERCENTAGE OF MARRIED WOMEN 15–19 WITH AN UNMET NEED FOR CONTRACEPTION	PERCENTAGE OF MARRIED WOMEN 15–49 WITH AN UNMET NEED FOR CONTRACEPTION
AFGHANISTAN	N/A	N/A
BANGLADESH	17.0%	13.5%
BENIN	34.6%	32.6%
BHUTAN	27.4%	11.7%
BOLIVIA	37.9%	20.1%
BURKINA FASO	21.7%	24.5%
BURUNDI	18.8%	32.4%
CAMBODIA	16.0%	16.9%
CAMEROON	25.7%	23.5%
CENTRAL AFRICAN REPUBLIC	N/A	N/A
CHAD	25.1%	28.3%
COMOROS	47.4%	31.6%
CONGO (BRAZZAVILLE)	34.8%	18.2%
CÔTE D'IVOIRE	26.5%	27.1%
DPR KOREA	16.1%	22.0%
DR CONGO	N/A	N/A
DJIBOUTI	26.1%	24.2%
EGYPT	7.0%	11.6%
ERITREA	43.6%	28.5%
ETHIOPIA	32.8%	26.3%
GAMBIA	N/A	N/A
GHANA	60.4%	37.2%
GUINEA	23.4%	23.7%
GUINEA-BISSAU	5.8%	6.0%
HAITI	56.6%	35.3%
HONDURAS	17.7%	10.7%
INDIA	27.1%	13.9%
INDONESIA	6.7%	11.4%
IRAQ	7.6%	8.0%
KENYA	29.7%	25.6%
KYRGYZSTAN	9.7%	18.0%
LAO PDR	22.6%	19.9%
LESOTHO	29.6%	23.3%
LIBERIA	40.4%	35.6%
MADAGASCAR	26.8%	19.0%
MALAWI	25.2%	26.2%
MALI	23.3%	26.0%
MAURITANIA	17.5%	24.6%
MONGOLIA	14.4%	22.3%
MOZAMBIQUE	23.2%	28.5%
MYANMAR	N/A	N/A
NEPAL	41.6%	27.5%
NICARAGUA	16.7%	10.7%
NIGER	13.1%	16.0%
NIGERIA	13.1%	16.1%
PAKISTAN	14.9%	20.1%
PAPUA NEW GUINEA	N/A	N/A
PHILIPPINES	33.7%	22.0%
RWANDA	6.4%	20.8%
SAO TOME AND PRINCIPE	48.3%	37.6%

	PERCENTAGE OF MARRIED WOMEN 15–19 WITH AN UNMET NEED FOR CONTRACEPTION	PERCENTAGE OF MARRIED WOMEN 15–49 WITH AN UNMET NEED FOR CONTRACEPTION
SENEGAL	31.2%	29.3%
SIERRA LEONE	22.2%	27.6%
SOLOMON ISLANDS	15.0%	11.1%
SOMALIA	20.8%	26.2%
SOUTH AFRICA	17.7%	13.8%
SOUTH SUDAN	25.7%	26.3%
SRI LANKA	N/A	N/A
STATE OF PALESTINE	21.7%	15.6%
SUDAN	18.3%	28.9%
TAJIKISTAN	12.8%	22.9%
TANZANIA	16.3%	25.3%
TIMOR-LESTE	27.4%	31.5%
TOGO	49.8%	37.2%
UGANDA	31.3%	34.3%
UZBEKISTAN	9.8%	7.8%
VIETNAM	15.6%	4.3%
WESTERN SAHARA	N/A	N/A
YEMEN	29.2%	28.7%
ZAMBIA	22.6%	26.6%
ZIMBABWE	18.5%	14.6%

FIGURE AX.13
DEMAND SATISFIED DISAGGREGATION IN COUNTRIES WITH 2012 OR 2013 DHS OR PMA2020 DATA

AW All Women
MW Married Women

	DEMAND SATISFIED BY MODERN METHODS BY WEALTH					DEMAND SATISFIED BY AGE						
	LOWEST WEALTH QUINTILE	SECOND WEALTH QUINTILE	MIDDLE WEALTH QUINTILE	FOURTH WEALTH QUINTILE	HIGHEST WEALTH QUINTILE	15-19	20-24	25-29	30-34	35-39	40-44	45-49
BENIN (MW)	11.3	15.3	17.6	17.3	23.4	9.9	13.2	16.6	16.4	19.8	20.6	25.6
COMOROS (AW)	21.2	27.2	30.7	35.8	30.7	26.0	26.0	30.4	27.5	33.3	36.8	27.0
CONGO (BRAZZAVILLE) (MW)	16.2	24.7	36.8	34.1	44.8	37.1	33.5	33.8	30.9	32.4	26.3	16.1
GHANA (AW)	32.1	36.0	35.2	37.0	40.8	40.8	34.0	34.5	43.1	35.2	33.9	32.8
GUINEA (AW)	12.1	16.9	18.5	22.2	41.1	21.6	31.7	30.9	21.7	21.2	14.0	16.2
KYRGYZSTAN (MW)	68.0	64.2	59.7	56.2	62.7	34.8	43.7	57.9	68.9	64.3	68.1	68.7
MALI (MW)	11.5	16.3	16.4	31.2	49.1	21.6	28.8	26.4	27.7	29.6	27.2	24.0
NIGER (MW)	31.5	31.8	33.4	41.0	56.7	29.4	38.3	46.8	43.1	50.1	30.8	18.0
NIGERIA (MW)	5.3	18.1	27.4	34.6	47.0	39.3	44.4	37.8	37.8	36.5	38.3	35.7
PAKISTAN (MW)	40.0	43.3	47.1	50.2	51.8	27.3	35.5	39.3	49.8	53.0	52.1	55.0
SENEGAL (MW)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TAJIKISTAN (MW)	45.1	49.2	49.9	48.8	60.2	12.0	25.0	45.2	55.9	65.8	62.0	53.8

*Secondary and higher are combined.
**None and primary are combined.

FIGURE AX.14
INDICATOR 6

INDICATOR 6: COUPLE-YEARS OF PROTECTION (CYP)

	2012	2013
CÔTE D'IVOIRE	674,336	746,400
ETHIOPIA	10,045,332	N/A
INDIA	102,858,750	98,120,275
MALAWI	1,061,204	1,110,594
MYANMAR	3,044,648	3,501,539
NIGERIA	702,023	1,361,269
PAKISTAN	8,503,764	9,801,206
SOUTH AFRICA	N/A	6,487,272
UGANDA	1,939,036	2,284,326

DEMAND SATISFIED BY RESIDENCE		DEMAND SATISFIED BY MARITAL STATUS		DEMAND SATISFIED BY EDUCATION						
URBAN	RURAL	MARRIED/ IN UNION	UNMARRIED SEXUALLY ACTIVE	NONE	PRIMARY	BASIC GENERAL	MIDDLE/ JSS	SECONDARY	PROFESSIONAL PRIMARY/ MIDDLE	HIGHER
19.7	15.5			15.0%	20.7%			23.0%		30.2%
40.4	23.4			23.7%	31.1%			33.8%*		
38.4	19.2	31.8	52.4	17.8%	24.9%			32.8%		44.6%
33.6	37.9			47.6%	56.0%		64.0%	39.4%*		
36.7	15.9	15.8	45.3	16.9%	23.5%			45.5%*		
62.1	61.9					53.1%		62.3%	62.9%	63.6%
46.7	20.1			22.5%	32.3%			53.0%*		
58.3	35.7			37.2%	48.3%			62.6%*		
48.5	28.9			9.8%	34.7%			40.2%*		46.0%
51.7	44.3			44.9%	48.0%		48.3%	51.2%		50.8%
N/A	N/A									
55.2	49.4				41.4%**	41.9%		55.1%	53.9%	60.2%

FIGURE AX.15
INDICATORS 7-10

	INDICATOR 7 NUMBER OF UNINTENDED PREGNANCIES*		INDICATOR 8 NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE*	
	2012	2013	2012	2013
AFGHANISTAN	302,000	300,000	311,000	341,000
BANGLADESH	1,158,000	1,154,000	4,452,000	4,582,000
BENIN	83,000	84,000	55,000	60,000
BHUTAN	120,000	121,000	246,000	253,000
BOLIVIA	253,000	255,000	187,000	194,000
BURKINA FASO	64,000	65,000	156,000	167,000
BURUNDI	169,000	173,000	79,000	87,000
CAMBODIA	74,000	75,000	251,000	262,000
CAMEROON	230,000	234,000	199,000	215,000
CENTRAL AFRICAN REPUBLIC	77,000	78,000	32,000	35,000
CHAD	265,000	270,000	12,000	14,000
COMOROS	10,000	10,000	5,000	5,000
CONGO (BRAZZAVILLE)	57,000	58,000	48,000	50,000
CÔTE D'IVOIRE	215,000	221,000	201,000	213,000
DJIBOUTI	18,000	18,000	8,000	9,000
DPR KOREA	19,000	19,000	789,000	791,000
DR CONGO	1,098,000	1,131,000	322,000	332,000
EGYPT	317,000	319,000	3,203,000	3,270,000
ERITREA	70,000	71,000	27,000	30,000
ETHIOPIA	1,028,000	1,038,000	1,307,000	1,507,000
GAMBIA	23,000	24,000	10,000	11,000
GHANA	375,000	377,000	269,000	260,000
GUINEA	80,000	82,000	41,000	46,000
GUINEA-BISSAU	18,000	18,000	8,000	9,000
HAITI	182,000	183,000	150,000	156,000
HONDURAS	120,000	121,000	246,000	253,000
INDIA	4,616,000	4,571,000	35,246,000	36,116,000
INDONESIA	829,000	825,000	8,055,000	8,171,000
IRAQ	232,000	236,000	425,000	449,000
KENYA	881,000	890,000	1,004,000	1,082,000
KYRGYZSTAN	6,000	6,000	98,000	101,000
LAO PDR	24,000	25,000	134,000	141,000
LESOTHO	44,000	44,000	50,000	52,000

*Numbers are rounded.

INDICATOR 9 NUMBER OF MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE		INDICATOR 10 NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE*	
2012	2013	2012	2013
925	1,014	95,000	104,000
7,845	7,449	1,360,000	1,400,000
164	164	18,000	19,000
173	179	98,000	101,000
214	223	71,000	74,000
570	614	50,000	54,000
510	557	24,000	26,000
233	243	87,000	91,000
936	1,011	46,000	49,000
221	239	7,000	8,000
102	115	3,000	3,000
15	17	1,000	1,000
154	163	11,000	12,000
1,059	1,120	64,000	68,000
17	19	2,000	3,000
154	154	3,000	3,000
1,442	1,481	74,000	76,000
2,195	2,240	1,475,000	1,506,000
91	101	8,000	9,000
4,504	5,192	219,000	253,000
38	40	3,000	3,000
834	806	86,000	83,000
236	261	13,000	15,000
41	44	3,000	3,000
40	42	25,000	26,000
173	179	98,000	101,000
48,361	49,543	10,768,000	11,034,000
15,815	16,042	2,801,000	2,841,000
861	909	82,000	86,000
3,331	3,590	299,000	322,000
58	60	30,000	31,000
162	170	47,000	49,000
204	212	10,000	10,000

FIGURE AX.15 CONTINUED

	INDICATOR 7 NUMBER OF UNINTENDED PREGNANCIES*		INDICATOR 8 NUMBER OF UNINTENDED PREGNANCIES AVERTED DUE TO CONTRACEPTIVE USE*	
	2012	2013	2012	2013
LIBERIA	55,000	55,000	51,000	57,000
MADAGASCAR	539,000	551,000	347,000	373,000
MALAWI	369,000	378,000	344,000	365,000
MALI	1,199,000	1,226,000	1,851,000	1,943,000
MAURITANIA	46,000	46,000	16,000	18,000
MONGOLIA	3,000	3,000	77,000	78,000
MOZAMBIQUE	180,000	182,000	202,000	222,000
MYANMAR	240,000	239,000	1,261,000	1,300,000
NEPAL	192,000	192,000	728,000	764,000
NICARAGUA	66,000	66,000	294,000	301,000
NIGER	703,000	728,000	67,000	72,000
NIGERIA	663,000	679,000	1,008,000	1,101,000
PAKISTAN	1,199,000	1,226,000	1,851,000	1,943,000
PAPUA NEW GUINEA	50,000	50,000	91,000	95,000
PHILIPPINES	1,284,000	1,313,000	1,540,000	1,622,000
RWANDA	202,000	204,000	201,000	213,000
SAO TOME AND PRINCIPE	4,000	4,000	3,000	3,000
SENEGAL	501,000	511,000	96,000	112,000
SIERRA LEONE	70,000	70,000	59,000	71,000
SOLOMON ISLANDS	14,000	14,000	9,000	9,000
SOMALIA	183,000	187,000	14,000	18,000
SOUTH AFRICA	764,000	762,000	2,040,000	2,061,000
SOUTH SUDAN	87,000	90,000	6,000	8,000
SRI LANKA	84,000	84,000	793,000	795,000
STATE OF PALESTINE	29,000	30,000	71,000	74,000
SUDAN	1,021,000	1,029,000	182,000	199,000
TAJIKISTAN	16,000	17,000	109,000	116,000
TANZANIA	613,000	625,000	715,000	768,000
TIMOR-LESTE	7,000	7,000	9,000	10,000
TOGO	69,000	70,000	83,000	90,000
UGANDA	928,000	950,000	466,000	509,000
UZBEKISTAN	31,000	31,000	988,000	1,001,000
VIETNAM	440,000	438,000	3,091,000	3,099,000
WESTERN SAHARA	N/A	N/A	N/A	N/A
YEMEN	165,000	168,000	240,000	261,000
ZAMBIA	353,000	362,000	168,000	180,000
ZIMBABWE	261,000	269,000	358,000	376,000

*Numbers are rounded.

INDICATOR 9 NUMBER OF MATERNAL DEATHS AVERTED DUE TO CONTRACEPTIVE USE		INDICATOR 10 NUMBER OF UNSAFE ABORTIONS AVERTED DUE TO CONTRACEPTIVE USE*	
2012	2013	2012	2013
275	308	16,000	18,000
1,351	1,454	103,000	111,000
1,308	1,387	107,000	113,000
3,069	3,222	638,000	670,000
44	47	5,000	6,000
12	12	300	300
891	977	60,000	66,000
1,363	1,405	438,000	452,000
1,023	1,074	222,000	233,000
175	179	118,000	120,000
266	287	21,000	23,000
5,068	5,537	323,000	352,000
3,069	3,222	638,000	670,000
135	141	4,000	5,000
817	860	536,000	564,000
527	559	42,000	45,000
5	5	1,000	1,000
221	257	31,000	36,000
553	661	19,000	23,000
7	7	400	400
105	129	4,000	5,000
7,965	8,048	390,000	394,000
118	142	2,000	2,000
177	177	242,000	243,000
25	26	14,000	14,000
783	857	84,000	92,000
38	40	33,000	35,000
2,596	2,789	213,000	229,000
14	15	3,000	3,000
321	349	27,000	29,000
1,685	1,840	139,000	151,000
282	286	302,000	306,000
492	493	1,075,000	1,077,000
N/A	N/A	N/A	N/A
487	529	46,000	50,000
392	421	50,000	54,000
1,457	1,528	107,000	112,000

FIGURE AX.16
INDICATORS 11–15

	INDICATOR 11 FP INFORMATION Percentage of women who say they were provided with information on family planning during their last visit with a health service provider	INDICATOR 12 METHOD INFORMATION INDEX Percentage of women who respond "yes" to 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?	INDICATOR 13 DECISION MAKING Percentage of women who say they make family planning decisions alone or jointly with their husbands/ partners	INDICATOR 14 ADOLESCENT BIRTH RATE Adolescent birth rate (the number of births to adolescent females aged 15–19 occurring during a given reference period per 1,000 adolescent females)	INDICATOR 15 STERILIZATION Percentage of women 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)
BENIN	35%	31%	82%	94	N/A
COMOROS	38%	30%	88%	101	88%
CONGO (BRAZZAVILLE)	20%	35%	87%	147	N/A
GHANA	N/A	19%	90%	64	100%
GUINEA	10%	33%	92%	146	N/A
KYRGYZSTAN	41%	60%	95%	44	N/A
MALI	47%	38%	81%	172	N/A
NIGER	27%	31%	77%	206	N/A
NIGERIA	49%	51%	85%	122	N/A
PAKISTAN	44%	20%	92%	44	N/A
SENEGAL	25%	58%	89%	80	N/A
TAJIKISTAN	44%	65%	86%	54	N/A

FIGURE AX.17
FAMILY PLANNING (FP) EXPENDITURES, FOUR FP2020 FOCUS COUNTRIES (US$)

WRA Women of Reproductive Age (15–49 years)

	BENIN	BURKINA FASO	LIBERIA	TANZANIA
TOTAL FP EXPENDITURE	$580,000	$6,400,000	$3,810,000	$17,600,000
WRA	2,389,000	3,818,000	975,000	10,901,000
FP EXPENDITURE PER WRA	$0.24	$1.68	$3.91	$1.61
GOVERNMENT	57%	3%	24%	9%
EXTERNAL	31%	87%	40%	78%
PRIVATE	12%	10%	36%	11%
FP AS A PERCENTAGE OF TOTAL HEALTH EXPENDITURES	0.20%	1.10%	2.30%	0.90%
USERS	138,000	481,000	93,000	1,994,000
DOLLARS SPENT PER USER	$4.20	$13.31	$40.97	$8.83

Source: WHO, National Health Accounts.

FIGURE AX.18
METHOD MIX FROM MOST RECENT SURVEY

COUNTRY	SDM	LAM	CONDOM	PILL	INJECTABLE
AFGHANISTAN	-	3.8	7	25.8	45.1
BANGLADESH	-	-	9	44.5	18.3
BENIN	-	2.9	22.9	9.3	12.1
BHUTAN	-	-	8.4	11.4	44.1
BOLIVIA	-	1.2	8.7	5.8	17.8
BURKINA FASO	-	0.6	20.1	18.2	33.1
BURUNDI	-	-	6	10.4	47
CAMBODIA	-	-	5.4	31.2	20.7
CAMEROON	-	0.8	46	6.8	9.7
CENTRAL AFRICAN REPUBLIC	-	18.4	15.8	38.8	3.3
CHAD	-	59.2	2	10.2	18.4
COMOROS	-	3.7	14	14.7	27.2
CONGO (BRAZZAVILLE)	-	-	35	5.9	4.3
CÔTE D'IVOIRE	-	2	25.3	30.8	9.6
DJIBOUTI	-	-	1.1	76.4	14
DPR KOREA	-	-	10	6.4	-
DR CONGO	1.5	-	17.2	3.4	5.9
EGYPT	-	-	1.2	19.8	12.3
ERITREA	-	24.1	10.3	17.2	31
ETHIOPIA	-	-	1.5	7.7	71.4
GAMBIA	-	-	6.7	23.3	43.3
GHANA	-	-	7.3	26.1	34.6
GUINEA	-	12.8	27.9	18.6	18.6
GUINEA-BISSAU	-	19.7	22.5	8.5	10.6
HAITI	-	0.8	24.6	7.2	49.6
HONDURAS	-	-	7.4	15.2	23
INDIA	-	-	10.1	6.6	-

SDM Standard Days Method
LAM Lactational Amenorrhea Method
IUD Intrauterine Device

IMPLANT	IUD	FEMALE STERILIZATION	MALE STERILIZATION	OTHER MODERN METHODS	TRADITIONAL METHODS
3.8	5.6	2.8	0.9	0.5	4.7
1.8	1.1	8.2	2	-	15.1
5.7	2.9	0.7	-	7.1	36.4
0.2	5.6	10.8	19.2	-	0.3
-	13.5	10.4	0.2	0.2	42.2
18.8	1.3	0.6	-	-	7.1
3	12.7	3	-	-	17.9
1	6.1	4.8	-	-	30.9
2.1	0.8	1.7	-	-	32.1
1.3	-	1.3	-	-	21.1
-	-	2	-	-	8.2
8.1	-	4.4	-	-	27.9
0.2	-	0.2	-	4.7	49.7
0.5	0.5	0.5	-	1.5	29.3
-	2.2	2.2	-	-	3.9
-	73.5	7.6	1.4	1.2	-
3.4	1	3.4	0.5	2	61.8
0.8	60	1.7	-	-	4.3
-	5.2	1.7	-	-	10.3
11.7	1	2	-	-	4.6
6.7	3.3	6.7	-	-	10
13.9	2.8	2.5	-	5.3	7.5
1.2	2.3	1.2	-	-	17.4
-	28.2	-	-	3.5	7
4.7	-	3.8	0.4	0.4	8.5
-	9.4	32.6	0.4	-	12.1
-	3.3	65.7	2	0.6	11.7

FIGURE AX.18 CONTINUED

COUNTRY	SDM	LAM	CONDOM	PILL	INJECTABLE
INDONESIA	-	-	2.8	21.9	51.4
IRAQ	-	4.4	3.6	30	5.9
KENYA	-	1.3	8.1	14.7	46.3
KYRGYZSTAN	-	0.4	21.9	4.5	1.2
LAO PDR	-	1.2	2.2	42.7	27.4
LESOTHO	-	-	29.4	21.7	37.2
LIBERIA	-	-	2	24.6	55.2
MADAGASCAR	-	2.5	3.1	15	44.2
MALAWI	-	-	7.9	5.4	54.2
MALI	-	-	2	26	38
MAURITANIA	-	-	4.7	66.3	11.6
MONGOLIA	-	0.4	12.7	22.5	8.4
MOZAMBIQUE	-	0.8	24.2	34.7	34.7
MYANMAR	-	0.2	0.9	25	59.8
NEPAL	-	-	8.6	8.4	18.3
NICARAGUA	-	1.2	5.5	17.4	30.5
NIGER	-	28	0.8	40	15.2
NIGERIA	0.6	1.9	28.1	11.9	15.6
PAKISTAN	-	4.2	24.8	4.5	7.9
PAPUA NEW GUINEA	-	-	5.4	13.8	27.5
PHILIPPINES	0.4	0.9	3.5	34.7	6.7
RWANDA	1	1	6.3	13.6	51
SAO TOME AND PRINCIPE	-	1.3	23.2	34.3	26.8
SENEGAL	-	0.6	3.4	28.5	34.6
SIERRA LEONE	-	5.4	1.2	23.5	45.2

SDM Standard Days Method
LAM Lactational Amenorrhea Method
IUD Intrauterine Device

IMPLANT	IUD	FEMALE STERILIZATION	MALE STERILIZATION	OTHER MODERN METHODS	TRADITIONAL METHODS
5.3	6.6	5.3	0.2	-	6.6
0.2	17.8	5.9	-	0.8	31.5
4.1	3.1	10	-	-	12.5
-	60.3	4.5	-	-	7
0.2	3.2	9.3	-	-	13.9
0.3	3.6	4.7	-	-	3.1
10.3	-	1.5	-	1	5.4
3.8	0.9	2.8	0.3	-	27.3
3.1	0.6	21.2	-	-	7.6
24	3	1	-	-	4
-	3.5	1.2	-	1.2	11.6
0.5	41.3	5.1	0.7	0.2	8.2
-	1.6	1.6	-	-	2.4
0.2	4.6	7.8	0.9	-	0.7
2.3	2.6	31.1	15.7	-	13.1
-	5.1	35.9	0.4	-	3.9
2.4	0.8	0.8	-	-	12
1.9	5	1.9	-	3.1	30
-	6.5	24.5	0.8	0.6	26.2
-	-	26.7	1.3	-	25.4
-	6.4	15.5	0.2	0.2	31.6
12.6	0.7	1.7	-	-	11.9
-	1	2.9	-	-	10.5
15.1	5.6	1.7	-	0.6	10.1
14.5	0.6	3	-	-	6.6

FIGURE AX.18 CONTINUED

COUNTRY	SDM	LAM	CONDOM	PILL	INJECTABLE
SOLOMON ISLANDS	-	0.4	7.6	3.4	25.1
SOMALIA	-	-	-	44.4	11.1
SOUTH AFRICA	-	0.2	12.4	17.9	53.2
SOUTH SUDAN	-	12.5	10	7.5	10
SRI LANKA	-	0.1	8.1	11.6	22.1
STATE OF PALESTINE	-	5.3	9.7	12.8	1.3
SUDAN	-	-	-	-	-
TAJIKISTAN	-	0.5	8	8	6.9
TANZANIA	-	3.5	14.6	17.8	29.6
TIMOR-LESTE	-	-	0.7	7.4	71.1
TOGO	-	-	10.6	11.1	35.9
UGANDA	-	0.4	13.5	8.9	45.1
UZBEKISTAN	-	4	3.4	3.5	4.2
VIETNAM	-	0.3	16.3	13	2.2
WESTERN SAHARA	-	-	-	-	-
YEMEN	-	11.9	1.5	34.6	12.5
ZAMBIA	-	13.7	16.7	24.7	20.7
ZIMBABWE	-	0.2	9.2	65.9	14.7

SDM Standard Days Method
LAM Lactational Amenorrhea Method
IUD Intrauterine Device

IMPLANT	IUD	FEMALE STERILIZATION	MALE STERILIZATION	OTHER MODERN METHODS	TRADITIONAL METHODS
-	5.3	35.4	0.8	-	22.1
-	5.6	-	-	-	38.9
-	1.2	14.5	0.6	-	-
-	-	2.5	-	-	57.5
0.4	9.3	24.9	1	-	22.4
-	50.2	5	-	-	15.6
-	-	-	-	-	-
-	67	2.1	-	-	7.4
6.3	1.4	8.7	-	-	18.1
3.7	5.9	3.7	-	2.2	5.2
23.7	4	1.5	-	-	13.1
8	1.7	9.3	0.4	-	12.7
0.2	76.6	3.2	0.2	0.2	4.6
0.3	39.8	5	0.1	0.1	22.9
-	-	-	-	-	-
1.8	17.6	6.9	0.3	-	12.8
1	0.3	4.7	-	-	18.1
5.3	0.5	2.2	-	-	1.9

ANNEX 2
REFERENCE GROUP AND WORKING GROUP MEMBERS AS OF OCTOBER 2014

REFERENCE GROUP

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

Co-Chair
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Bill & Melinda Gates Foundation

Co-Chair
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John Skibiak
Reproductive Health Supplies Coalition

Dr. Julianto Witjaksono
National Population Family Planning Agency, Indonesia

COUNTRY ENGAGEMENT WORKING GROUP (CE WG)

CE WG works with existing partners to provide additional support to countries as they develop, implement and monitor progress against their transformational family planning plans, building on existing country plans wherever possible, and within the context of countries' wider RMNCH and health sector plans.

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Co-Lead
Jagdish Upadhyay
United Nations Population Fund

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Dr. Rita Columbia
United Nations Population Fund

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Government of the Netherlands

Fatimata Sy
IntraHealth International

MARKET DYNAMICS WORKING GROUP (MD WG)

MD WG improves global and national markets to sustainably ensure choice and equitable access to a broad range of high-quality, affordable contraceptive methods in select countries.

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Reproductive Health Supplies Coalition

Co-Lead
Alan Staple
Clinton Health Access Initiative

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Dr. Renee Van de Weerdt
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Trisha Wood Santos
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PERFORMANCE MONITORING & ACCOUNTABILITY WORKING GROUP (PMA WG)

PMA WG enables the collection, analysis and use of data necessary to measure FP2020's progress and to bolster accountability for implementing the financial, policy and programming commitments made by governments, donors, the UN, civil society and others.

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Marie Stopes International

Dr. Eliya Zulu
African Institute for Development Policy

RIGHTS & EMPOWERMENT WORKING GROUP (RE WG)

RE WG leads in developing a rights-based family planning framework to guide FP2020 and will ensure that their work is deeply embedded in the work of the Country Engagement, Market Dynamics, and Performance Monitoring & Accountability Working Groups.

Co-Lead
Suzanne Ehlers
Population Action International

Co-Lead
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Bridget Anyafulu
International Centre for Women's Empowerment & Child Development

Muhommad Bun Bida
Muslim Family Counseling Services

Jacqueline Bryld
Danish Family Planning Association

Elizabeth Tyler Crone
ATHENA Network

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Population Services International

Dr. Christine Galavotti
CARE

Nomuhle Gola
Restless Development

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Sandra Jordan
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Population Council

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International Center for Research on Women

Elly Leemhuis-de Regt
Ministry of Foreign Affairs, Netherlands

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Jessica Schwartzman
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Emily Smith
Program Associate

Erika Studt
Working Group Associate

Anna Wolf
Business Services and Contracts Officer

Alisa Wong
Working Group Manager

ANNEX 3
COMMITMENT MAKERS AS OF OCTOBER 2014

COMMITMENT-MAKING COUNTRIES

Bangladesh
Benin
Burkina Faso
Burundi
Côte d'Ivoire
DR Congo
Ethiopia
Ghana
Guinea
India
Indonesia
Kenya
Liberia
Malawi
Mauritania
Mozambique
Myanmar
Niger
Nigeria
Pakistan
Philippines
Rwanda
Senegal
Sierra Leone
Solomon Islands
South Africa
Tanzania
Uganda
Zambia
Zimbabwe

PRIVATE SECTOR AND CIVIL SOCIETY

ActionAid
Advance Family Planning
CARE International
DSW (Deutsche Stiftung Weltbevoelkerung)
EngenderHealth
Female Health Company
FHI 360
Guttmacher Institute
International Center for Research on Women (ICRW)
International Planned Parenthood Federation (IPPF)
IntraHealth International
Ipas
Jhpiego
Marie Stopes International (MSI)
Merck for Mothers
Pathfinder International
Planned Parenthood Federation of America and Planned Parenthood Global
Population Action International (PAI)
Population Council
Population Reference Bureau
Reproductive Health Supplies Coalition (RHSC)/ Resource Mobilization & Awareness Working Group (RMAWG)
Rotarian Action Group for Population and Development (RFPD)
Save the Children
Woman Care Global and PSI

DONOR COUNTRIES

Australia
Denmark
European Commission
France
Germany
Japan
Netherlands
Norway
South Korea
Sweden
United Kingdom

FOUNDATIONS

Aman Foundation
Bill & Melinda Gates Foundation
Bloomberg Philanthropies
Brush Foundation
Children's Investment Fund Foundation (CIFF)
David and Lucile Packard Foundation
United Nations Foundation
William and Flora Hewlett Foundation

UN, MULTILATERALS AND PARTNERSHIPS

Norway, Bill & Melinda Gates Foundation and United Kingdom
United Nations Population Fund (UNFPA)
World Bank
World Health Organization (WHO)

ANNEX 4
ACRONYMS

AFP	Advance Family Planning
AUSAID	Australian Agency for International Development
BMGF	Bill & Melinda Gates Foundation
CE WG	Country Engagement Working Group (FP2020)
CH	Child Health
CHAN	Christian Health Association of Nigeria
CHW	Community Health Worker
COIA	Commission on Information and Accountability
CPR	Contraceptive Prevalence Rate
CRS	Creditor Reporting System
CSO	Civil Society Organization
CYP	Couple-Years of Protection
DAC	Development Assistance Committee
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
EWEC	*Every Woman Every Child*
FBO	Faith-Based Organization
FHE	Field Health Educators
FP	Family Planning
FP2020	Family Planning 2020 initiative
FPEI	Family Planning Effort Index
HEW	Health Extension Worker
HMIS	Health Management Information System
ICPD	International Conference on Population and Development
IERG	Independent Expert Review Group
IPPF	International Planned Parenthood Federation
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
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	Monitoring and Evaluation
MH	Maternal Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NFPCI	National Family Planning Composite Index
NGO	Nongovernmental Organization
NHA	National Health Account
NIDI	Netherlands Interdisciplinary Demographic Institute
ODA	Official Development Assistance
OECD DAC	Organisation for Economic Co-operation and Development's Development Assistance Committee
PMA WG	Performance Monitoring & Accountability Working Group (FP2020)
PMA2020	Performance Monitoring & Accountability 2020 (Project)
PMNCH	Partnership for Maternal, Newborn and Child Health
RE WG	Rights & Empowerment Working Group (FP2020)
RG	Reference Group (FP2020)
RH	Reproductive Health
RHS	Reproductive Health Survey
RHSC	Reproductive Health Supplies Coalition
RMNCH+A	Reproductive, Maternal, Newborn and Child Health plus Adolescents
RRM	Rapid Response Mechanism
SBCC	Social and Behavior Change Communication
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
UNPD	United Nations Population Division
USAID	United States Agency for International Development
WHO	World Health Organization

ANNEX 5 FP2020 FOCUS COUNTRIES

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

EASTERN AND SOUTHERN AFRICA
Burundi
Comoros
Djibouti
Eritrea
Ethiopia
Kenya
Lesotho
Madagascar
Malawi
Mozambique
Rwanda
Somalia
Tanzania
Uganda
Zambia
Zimbabwe

CENTRAL AFRICA
Cameroon
Central African Republic
Chad
Congo
DR Congo
Sao Tome and Principe

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

MIDDLE EAST AND NORTHERN AFRICA
Egypt
Iraq
South Sudan
State of Palestine
Sudan
Western Sahara
Yemen

EASTERN AND CENTRAL ASIA
Kyrgyzstan
Mongolia
DPR Korea
Tajikistan
Uzbekistan

SOUTH ASIA
Afghanistan
Bangladesh
Bhutan
India
Nepal
Pakistan
Sri Lanka

SOUTHEAST ASIA AND OCEANIA
Cambodia
Indonesia
Lao PDR
Myanmar
Papua New Guinea
Philippines
Solomon Islands
Timor-Leste
Vietnam

LATIN AMERICA AND CARIBBEAN
Bolivia
Haiti
Honduras
Nicaragua

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FP2020 would like to thank its partners from around the world who are dedicated to ensuring that women and girls have access to voluntary family planning information, services and supplies.

We acknowledge and are humbled by the many individuals and organizations that contributed information, insights and research to inform the development of *FP2020 Partnership in Progress.*

We are deeply grateful for the continued support of our core partners at the Bill & Melinda Gates Foundation, the UK Department for International Development, the United Nations Population Fund and the United States Agency for International Development.

We would like to express our special thanks to the Ministry of Health of Tanzania and EngenderHealth for graciously hosting FP2020 in the Western and Lake Regions of Tanzania. The team is grateful to the staff at the Ujiji Health Care Center, the Bitale Health Care Center, the Kalinzi Dispensary, the Gungu Health Care Center, the Igoma Health Care Center and the Sekou Toure Hospital, whose demonstrated commitment to the health and empowerment of women and girls is catalyzing lasting change within their communities.

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Finally, our deepest appreciation goes to the policymakers, innovators in the field, service providers and health care workers: the champions without whom all efforts to ensure the health and well-being of women and girls would be futile. Their dedication and perseverance inspires our efforts to advance family planning worldwide.

Feedback

If you have questions or comments about the contents of this report, we welcome your feedback via email at

info@familyplanning2020.org

FP2020 Progress Report 2013-2014: Partnership in Progress, Washington D.C.: FP2020, 2014.

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, multilateral 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 sociocultural 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 supports the UN Secretary-General's global effort for women and children's health, *Every Woman Every Child.*

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